Mapping the Path: Navigating Monitoring and Evaluation Challenges and Solutions

in Mental Health and Psychosocial Support across Red Cross National Societies

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März 2024

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Content Table

Abstract

Mental Health and Psychosocial Support (MHPSS) is a critical yet historically neglected area in international development cooperation, particularly within humanitarian contexts. Existing literature often overlooks the psychosocial aspects of problems, with emphasis primarily placed on clinical forms of intervention. The Red Cross and Red Crescent (RCRC) Movement has recognized the importance of MHPSS and developed a framework. One key component of the roadmap is the prioritization of monitoring and evaluating interventions to gauge their effectiveness, essential for improving interventions. Nevertheless, numerous challenges associated with Monitoring and Evaluation (M&E) for MHPSS remain unrecognized. This study aims to address this gap by investigating three research questions: (1) What challenges do National Societies encounter regarding M&E practices in the area of MHPSS? (2) How have successful National Societies managed to overcome their M&E challenges in the field of MHPSS? (3) What are the requirements for National Societies to address these challenges effectively? Semi-structured interviews were conducted with representatives from four National Societies, including two experienced in M&E and two in the early stages. These interviews are supplemented by expert insights. Thematic analysis revealed various obstacles to effective M&E for MHPSS, including resource limitations, structural constraints within National Societies, challenges with MHPSS practices, and a lack of understanding of M&E principles. Successful National Societies have implemented strategies such as capacity building, dedicated M&E personnel for MHPSS, meticulous planning, digitalization of data, and extensive collaboration to overcome these challenges. Key requirements for addressing M&E challenges include enhanced financial resources, support, and capacity building at various levels. Tips from the champions include digitalisation of data collection, advice on how to start, and promotion of collaboration. The discussion intertwines the findings with theoretical frameworks, delineates limitations and opportunities, and provides actionable recommendations. These suggestions map the path toward enhancing M&E practices in MHPSS with the overarching goal to advance mental health and well-being of the affected populations within the Movement.

Abbreviations and Acronyms

ARC:	Australian Red Cross
CRC:	Cameroon Red Cross
HIC:	High Income Country
IASC:	Inter Agency Standing Committee
ICRC:	International Committee of the Red Cross
IFRC:	International Federation of the Red Cross
KRC:	Kenyan Red Cross
LMIC:	Low- Middle Income Country
M&E:	Monitoring and Evaluation
MH	Mental Health
MHPSS:	Mental Health and Psychosocial Support
Movement:	(International) Red Cross and Red Crescent Movement
PMER:	Planning, Monitoring, Evaluation and Reporting
PMER-L:	Planning, Monitoring, Evaluation, Reporting and Learning
PS Centre:	Psychosocial Centre
PSS	Psychosocial Support
PTSD	Post-Traumatic Stress Disorder
RCRC	Red Crescent and Red Crescent
SPS	Structured Psychosocial Support
SRC:	Swiss Red Cross
WG4:	Working Group 4
WHO	World Health Organisation

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Solutions in Mental Health and Psychosocial Support across Red Cross National Societies

Theoretical Framework

In emergency contexts where individuals and communities are highly vulnerable, mental health and psychosocial support (MHPSS) interventions are imperative (ICRC, 2021). This recognition has permeated numerous humanitarian entities in the past decade, including the Red Cross and Red Crescent Movement (hereafter Movement). However, a critical inquiry arises: do these interventions work? Addressing this fundamental question falls within the area of Monitoring and Evaluation (M&E), which aims to gauge the effectiveness, efficiency, and impact of interventions. This is particularly important in terms of accountability to stakeholders, but above all to the populations concerned. However, challenges persist in implementing robust M&E frameworks within the Movement. This study aims to delve into the multifaceted landscape of M&E for MHPSS within National Societies of the Movement. Through a reflective thematic analysis of interviews conducted with both novice and successful National Societies, this research seeks to address three primary objectives: (1) to identify the barriers hindering effective M&E practices in MHPSS, (2) to elucidate the strategies employed by successful National Societies in overcoming these challenges, and (3) to propose recommendations for enhancing M&E capacity and efficacy in MHPSS interventions. By illuminating the complexities surrounding M&E in MHPSS and offering actionable insights, this study seeks to contribute to the ongoing discourse on improving the delivery and impact of MHPSS services in the Movement.

1. Mental Health and MHPSS in international cooperation and humanitarian support

1.1 Mental Health in International Cooperation

In 2001, the World Health Organization (WHO) published the World health report 2001 titled - *Mental health: new understanding, new hope*, emphasizing the importance of mental

health by stating: "mental health – neglected for far too long – is crucial to the overall well-being of individuals, societies and countries and must be universally regarded in a new light" (World Health Organization, 2001). Two decades later, the recommendations from this report still are of utmost importance. Although there has been some progress, mental health disorders still impose a significant health and economic burden on society, ranking among the leading causes of years lived with disability (Collins & Saxena, 2016; Mnookin et al., 2016). They are also linked to increased risk of other health issues due to associated unhealthy behaviours (Mnookin et al., 2016). The economic impact is substantial, estimated at around $1 trillion annually (Chisholm et al., 2016). Consequently, mental health has emerged as a priority in international development cooperation efforts, evidenced by its incorporation into the Sustainable Development Goals. Goal 3.4 of the Sustainable Development Goals aims to "reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being" by 2030 (United Nations, n.d.). In 2020, the COVID-19 pandemic unexpectedly contributed to prioritizing mental health on the international agenda. The global increase in mental disorders during the pandemic forced a response, leading to a push for MHPSS interventions and advocating for prioritizing well-being at the government level (Belkin et al., 2021; World Health Organization, 2022). If mental health disorders are concerning on a global scale, addressing them becomes even more urgent in emergency situations.

1.2 Mental health in emergencies: a growing concern

In conflict zones like Palestine, Ukraine, or the Democratic Republic of the Congo and extreme situations worldwide, the use of sexual violence as a weapon, the impact of natural disasters (e.g., earthquakes in Türkiye-Syria), and widespread migration (the Sahel, Horn of Africa, Asia) contribute to complex interconnected and interdependent crises (ICRC, n.d.-b) with devastating consequences. At every level, emergency crises undermine protective mechanisms, increase the risk of various health problems, and tend to exacerbate pre-existing social injustices and inequalities (IASC, 2007). This results in overlapping and multiplying long-term effects on mental health and psychosocial well-being. These effects can jeopardize peace, human rights, the development of affected populations, as well as social cohesion (IASC, 2007). Assistance for mental well-being and psychosocial support are crucial for affected individuals and communities,

with statistics revealing that one in five persons in conflict-affected areas suffers from mental health issues—three times higher than the general population (ICRC, 2021). These mental disorders include depression, schizophrenia, anxiety, PTSD, and bipolar disorder (Charlson et al., 2019). The prevalence of mental health conditions is likely to more than double in humanitarian crises (ICRC, 2021). Moreover, in the general population, suicide is the second leading cause of death among young people, numbering 800,000 per year (WHO, 2019). The WHO estimates that globally, two-thirds of people faced with mental health burdens do not have access to care (IASC, 2007). For low- and middle-income countries (LMICs), disproportionately affected by humanitarian crises, the situation is particularly critical. Pre-existing factors and structural constraints, as well as those caused by disasters and conflict, place the population at even greater risk (WHO, n.d.-b). Despite their vulnerability, the populations most in need of mental health assistance are also those with the fewest human and financial resources with only 2% of the health budget at their disposal (Saxena et al., 2007; The Lancet Global Health, 2020; WHO, 2021). The WHO's Mental Health Atlas (2021) points out that the global median number of mental health workers is 13 per 100,000 inhabitants. It drops to 1.4 and 3.8 in low- and lower-middle-income countries respectively.

1.3 MHPSS response

Globally, mental health is one of the most neglected areas of international cooperation in health, including in humanitarian settings (World Bank, 2021). For much of the history of humanitarian action, MHPSS has been sidelined in favour of meeting physical needs or addressing mental disorders through a purely biomedical approach (Farre & Rapley, 2017). Yet, it has gained in importance over the last decade, integrating broader aspects. Building on Sphere Health Standards (Sphere, n.d.), in 2007, the Inter-Agency Standing Committee (IASC) developed Guidelines on MHPSS in Emergency Settings. These Guidelines stress the importance of MHPSS interventions in populations affected by emergencies. MHPSS is defined as "any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder" (IASC, 2007). The guidelines are designed to be implemented by specialists, staff, and volunteers alike. On a practical level, the implementation of MHPSS in humanitarian settings can take many forms. Indeed, wellbeing and mental disorder each lie at

one end of the mental health spectrum, and individuals locate and move along this continuum (World Health Organization, 2019). To focus on specific diagnoses at one extreme would be to overlook a large proportion of people suffering from other mental health and psychosocial issues. However, if one looks at the literature, the focus is primarily on specialized services, provided by mental health specialists or health professionals (Tol et al., 2011; Ubels et al., 2022). Person-oriented interventions have taken the lead, as have support outcomes for PTSD and internalized symptoms (Haroz et al., 2020; Tol et al., 2011). In the field, humanitarian organizations rely on biomedical responses with a social aspect and/or concentrate on basic psychosocial support and focused psychosocial support programs. These interventions include family- and community-based programs (Bangpan et al., 2019; Haroz et al., 2020; Tol et al., 2011). The severity of the humanitarian crisis, the context as well as social and cultural characteristics need to be taken into account when implementing MHPSS. While clinical interventions are attributable to the health sector, MHPSS is an intersectional field which, in the literature, is associated with the fields of health and protection, to mention but a few (Haroz et al., 2020). Given the cleavage between research and practice, Tol et al. (2011) have made several recommendations to bridge it, including collaboration between researchers and practitioners, to focus on the most implemented interventions.

Research is therefore not completely representative of the humanitarian MHPSS landscape. However, the structure of the MHPSS interventions in the Movement, which is one of the most important providers of humanitarian aid, can help understand the praxis of those interventions, as well as the translation of research into action.

2. MPHSS in the Movement

2.1 Structure and mission of the Movement

The Movement is a global network dedicated in providing humanitarian assistance and reducing human suffering in times of disaster and crisis (IFRC, n.d.-a). Its mandate is to help those facing disaster, conflict, health, and social problems. The Movement comprises the International Committee of the Red Cross (ICRC), the International Federation of Red Cross and Red Crescent Societies (IFRC), and more than 192 National Societies (IFRC, n.d.-c). It is the world's largest humanitarian network.

The ICRC works in countries affected by armed conflict and other forms of violence. Its mission is to protect the lives and dignity of victims. The ICRC also responds to natural disasters in conflict zones, which are aggravated by war conditions (*e.g. earthquake relief in Taliban-ruled Afghanistan*). The ICRC further strives to prevent suffering by promoting and strengthening humanitarian law and universal humanitarian principles (ICRC, 2014b). The humanitarian law, also called the rules of war defines what "can and cannot be done during armed conflict" (ICRC, n.d.-a). The ICRC's activities for war-affected people include supporting detainees, restoring family links, combating sexual and *gender-based* violence, fostering education, tackling the climatic challenges of war[1], and cooperating with National Societies (ICRC, 2014a).

The IFRC comprises the 191 National Societies. The Federation operates under its own constitution and is independent of governmental, racial, sectarian, and religious entities. Political decisions are taken through its governing body (IFRC, n.d.-a). The Federation intervenes in non-conflict man-made and natural disasters. It "inspires, encourages, facilitates and promotes" the humanitarian activities of National Societies (International Red Cross and Red Crescent Movement, 1986). Support for National Societies is provided by the secretariat. The latter also coordinates humanitarian aid and is responsible for representing and defending the Movement's interests worldwide (IFRC, n.d.-b). The secretariat acts as a supervisory body and can intervene at the request of National Societies. The Federation has several offices throughout the world with different roles, ranging from global to local work. The IFRC headquarters are in Geneva, followed by five regional offices in Panama (Americas), Nairobi (Africa), Beirut (MENA), Budapest (Europe), and Kuala Lumpur (Asia Pacific). These offices are responsible for strengthening and improving cooperation between National Societies at a regional level. They are also responsible for disaster and crisis risk management. Assistance to National Society programs and organizational growth is provided by 50 cluster and country support offices around

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[1]Conflict, exacerbates climate vulnerability, including because it fuels environmental degradation, erodes people's incomes and assets, and takes resources away from adaptation efforts. People in war-affected countries have in addition to deal with the consequences of climate change (Jaramillo et al., 2023).

the world. There are also 3 representative offices in charge of advocacy and influence in major international organizations (IFRC, n.d.-b).

National Societies are the pillars of the Movement and the first line of action for humanitarian aid and continue to help affected communities after reinforcements have left. Made up of a network of volunteer community workers, they act as humanitarian auxiliaries to public authorities.

2.2 MHPSS in the Movement

Health is paramount, and mental health aims to become a priority within the Movement. The Movement recognizes the need to integrate MHPSS into humanitarian aid (ICRC, 2021; The Lancet Global Health, 2020). This extends beyond the staff of the Movement to prioritize the well-being of crisis victims. Efforts focus on providing psychological support, specialized mental health care, and strengthening health systems through professional training (The Lancet Global Health, 2020). By enhancing safety, dignity, and rights protection, the Movement aims to prevent and address mental health and psychosocial needs. This commitment was underlined by the 33rd International Conference of the Red Cross and Red Crescent in December 2019, where the Movement and 196 States Parties to the Geneva Conventions approved a resolution addressing this urgent humanitarian concern. The objective is to enhance the Movement's joint approach to meeting MHPSS requirements and ensuring prompt access to comprehensive MHPSS interventions. This involves taking action to address issues of stigma, exclusion, and discrimination (PS Centre, 2019).

2.2.1 Definitions

The Movement builds on the IASC definition of MHPSS. In their 2019 "Movement policy on addressing MHPSS needs", the Movement also defines the terms "mental health" and "psychosocial support" independently of each other. Based on the WHO definition, Mental Health is characterized as "a state of well-being in which every individual realizes 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" (International Red Cross and Red Crescent Movement, 2019). The term psychosocial refers to the social aspect and the interplay of the

environment, interpersonal relationships, culture, and/or community with the person. Psychosocial support therefore involves interventions that address the social and psychological needs of individuals, families, and communities (International Red Cross and Red Crescent Movement, 2019). It is important to emphasize that mental health cannot be evoked without taking into account psychosocial well-being. The two are closely linked as mental health is not defined by the absence of mental illness *per se* but is rather tied to the well-being of the individual, which includes social components (IFRC-PS Centre, 2017b).

2.2.2 MHPSS institutional and policy framework

The Psychosocial Centre (hereafter PS Centre), a reference facility under the IFRC, supports the Movement in advancing MHPSS initiatives. Hosted and assisted by the Danish Red Cross, the PS Centre has an "expert" role in MHPSS. They work with various donors, academic institutions, and international organisations (PS Centre, 2023b). As a part of the IFRC, the PS Centre has a supportive role for the National Societies and operates within the IFRC Framework (PS Centre, 2023c). This framework was defined by the Council of Delegates of the International Red Cross and Red Crescent Movement in 2019 when resolutions were passed for the whole Movement regarding MHPSS. Some of these commitments include an overview of mental and psychosocial health requirements, the response and the strategy adopted by the Movement with regard to mental and psychosocial health, as well as the presentation of eight general policy statements accompanied by guidelines.

The MHPSS framework, known as the MHPSS Pyramid, illustrated in Figure 1, symbolizes the essential services designed to address the needs of individuals, families, and communities in need, in any given context. The four complementary levels enable the full scope of mental health to be apprehended, and the varied needs of different groups to be met. While all components of the Movement do not need to intervene at every level of the pyramid, they are expected to take into account the entire spectrum, from basic psychosocial support to specialized mental health support**.**

The levels range from the promotion of mental and psychosocial well-being to the treatment of psychological disorders at the other end of the spectrum, via the prevention of future disorders or mental distress. All of the above are framed by a protective environment. The level

of expertise, formal training, supervision/skills, and competence required increases up the pyramid, while the number of people impacted decreases.

Figure 1:

The Movement's MHPSS Framework
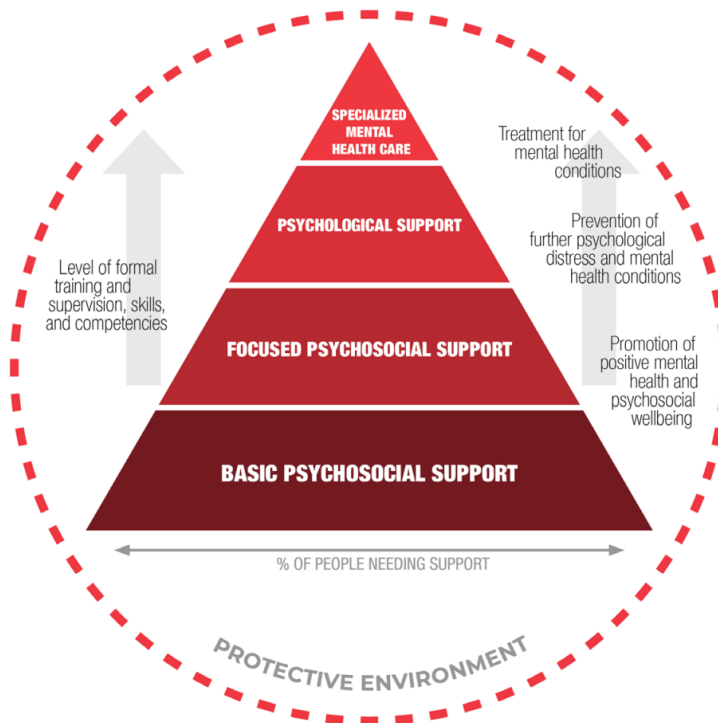
Note. From "Progress Report on Mental Health and Psychosocial Support Activities within the International Red Cross and Red Crescent Movement", PS Centre, 2023 p.4. In the public domain.

The bottom of the pyramid focuses on basic psychosocial support, promoting positive mental and psychosocial health at a community level. Frequently integrated into the health, education, and protection sectors, these interventions should be accessible to all. Generic psychological first aid interventions and recreational activities fall into this category. This type of support, widely implemented, can be provided by volunteers, staff, and community members, all three of whom are trained beforehand. The second level of the pyramid concerns focused psychosocial support, also aimed at positive mental and psychosocial health, and is confined to certain at-risk groups, families, and individuals. Group work and support groups are examples of

this category. Those who apply basic psychosocial support are also eligible for these interventions. The activities that fall in the two first levels of the bottom half of the pyramid are the most commonly implemented (Tol et al., 2011). When individuals or families suffer from greater psychological distress, or if there is a risk of mental disorder, psychological support is offered. This type of support is frequently provided in health or community establishments, where culturally appropriate. Finally, the tip of the pyramid, rigorously evaluated in the literature (Tol et al., 2011), concerns specialized mental health. Implemented by public health and social care systems, as well as detention centres, people suffering from chronic mental disorders or disabling psychological distress get these services. Centres for torture survivors and alternative drug therapies exemplify these interventions (International Red Cross and Red Crescent Movement, 2019).

There are 8 policy guidelines resulting from the 33rd International Conference of the Red Cross and Red Crescent in December 2019: The first is to provide unbiased MHPSS access and to focus on prevention and early response. The second is a guarantee of comprehensive, multi-layered integrated support for individuals in need of mental health and psychosocial services. Recognition of people's resilience, participation, and diversity in MHPSS activities is the third policy. As for policies 4 and 5, they respectively concern the protection of safety, dignity, and rights, along with addressing stigma, exclusion and discrimination that people with mental health and psychosocial needs often face. Dealing with the implementation and development of MHPSS is contained within the sixth policy. The Movement is expected to base its interventions on internationally recognized standards and practices, and on evidence-based data. The final two policies concern MHPSS for staff and volunteers, and MHPSS capacity building (International Red Cross and Red Crescent Movement, 2019).

2.2.3 MHPSS Roadmap

Aligned with the commitment to Addressing Mental Health and Psychosocial Needs, a Roadmap for implementation was designed to "strengthen the Movement's collective response to mental health and psychosocial needs" (PS Centre, 2019). The Roadmap identifies six interconnected priority action areas that collectively create the essential conditions for services

that are pertinent, efficient, and enduring. Each priority area is associated with an expected outcome for the end of 2023 (PS Centre, 2019).

The first priority for action is to guarantee a basic level of psychosocial support and the integration of MHPSS across the different sectors. The aim is to have achieved basic psychosocial support in the three Movement components by 2023, and to have considered the different key humanitarian sectors. The second objective is to develop a holistic approach to MHPSS in certain sectors, in collaboration with the various Movement parties and other actors. An increase in the offer of quality services in selected areas of the Framework is expected. The third action plan concerns staff and volunteers. By protecting and promoting their mental health and psychosocial well-being, a supportive and caring working environment is created for members of the Movement. The impact of MHPSS interventions is at the heart of the 4th priority. Through research, evidence, monitoring, and evaluation, the Movement hopes to demonstrate the impact of its interventions through innovative approaches. The 5th priority highlights the funding of MHPSS in humanitarian responses. Increased financial resources through mobilization strategies will be made available to MHPSS. Finally, advocacy and humanitarian diplomacy aimed at mobilizing political support for MHPSS represents the last priority for action. In 2023, national and international policy and legal frameworks should have been included. Each of these priority actions has a dedicated working group tasked with focusing on these specific areas of MHPSS.

In its Roadmap (2019) the Movement points out various barriers to achieving the objectives of the priority actions. These include a limited global understanding of MHPSS and low priority in humanitarian action. This is reflected in the limited human and financial resources available to MHPSS. In addition, there is a lack of harmonized and coordinated responses to needs. The final obstacle is the pervasive stigma associated with mental health.

2.2.4 MHPSS Survey: achievements and bottlenecks

Following the surveys on mental and psychosocial health in the Movement of 2019 and 2021, a third survey was carried out in 2023 to assess the MHPSS situation (PS Centre, 2023a). The ICRC, IFRC, and National Societies were involved. These surveys allowed observation of the Movement's progress over the years. MHPSS activities were offered by 90% of the

participants in 2023, representing a slight drop since 2021 (96%). In terms of psychosocial support activities, psychological first aid topped the list in 2023, as in previous years, with 83% of respondents claiming to have offered these services. This was followed by activities to care for staff and volunteers (75%), and then by the implementation of activities targeting volunteers in particular (64%). The focus has therefore shifted slightly from restoring family links and local events to concentrating on staff. The target groups in 2023 were volunteers (85%), staff (68%) as well as adolescents (68%) and children (67%). Mental health (MH) activities stood at 82% in 2024, slightly up on 2019's 78%. The most recurrent activity was psychological support (67%), a figure that has tripled since 2019. Second place goes to training community operators in basic psychological support (48%), with a modest increase noted since 2019. These are followed by offering consultations (46%) and training healthcare staff in basic psychological support. It can be emphasized that respondents offer a higher percentage of psychosocial support (PSS) than MH. As in the case of structured psychosocial support (SPS), and as in 2021, the main targets are volunteers (62%) and staff (55%), followed by adolescents, seniors, and children. The survey also showed that MH/PSS was implemented by 93% of respondents in emergency situations, compared with 90% in 2019. The difficulties linked to human and financial resources mentioned above are illustrated by the survey. The main barrier to providing MHPSS services is the financial aspect. Indeed, 78% of respondents say that this obstacle limits their activities. Challenges within the organization itself are second (50%), followed by a lack or limitation of expertise (42%). To highlight these barriers, we look at the findings on financial and human resources.

In order to identify the budget dedicated to MHPSS, the survey provided 4 categories with brackets of 50,000 CHF starting at 1,000 and ending at 200,000CHF. The lowest budget category, up to CHF 50,000, corresponds to the reality of 15% of respondents. This is followed by 10% with a budget of up to CHF 100,000 and 7% with a budget of up to CHF 150,000. Finally, the highest range, with a maximum of 200,000CHF, is allocated by 7% of respondents. Budgets allocated to MHPSS are increasing in comparison with 2019 and 2021. The remainder of the participants either had no budget allocated (25%), which can be explained by the intersectionality of MHPSS, a different range (18%), or answered, "I don't know". Concerning human resources, 82% of participants report having one or more focal points, i.e. an MHPSS

representative with the appropriate skills, in 2023. This number is rising steadily. Concerning the number of staff, 29% have fewer than 5 members involved in activities. If we look at the equivalent of a National Society, that's less than 5 people for an entire country. For 28% of respondents, these are 5-19 members, followed by 15% with 20-49 members, 8% with 50-99 members and finally 18% with over 100 members. Staff are complemented by a larger number of volunteers. Participant responses reveal that 12% have fewer than 5 volunteers, 20% have 5-19, 10% have 20-49, 10% have 50-99, and finally 37% have more than 100 volunteers involved in MH/PSS activities.

Overall, the results look promising, with progress in most areas of interest. Compared with the Roadmap, basic psychological support was more in place, in line with the objectives of priority area 1. Activities have focused on staff and volunteers (priority 3), so these areas have been given greater prominence. Resource mobilization, while improving, remains a recurring problem for the Movement (priority 5). Advocacy, the humanitarian diplomacy of priority 6, is implemented by a large number of respondents (72%). MHPSS services are mentioned in national laws and policies for a third of National Societies, a decline since 2019. However, the objectives have not yet been achieved.

In order to be able to track progression and improve MHPSS one has to evaluate and monitor them. This leads to the crucial role of M&E for MHPSS in the Movement, addressed in the fourth priority action area for which the objectives have not been achieved. This is in line with research by Tol et al. (2011) and Haroz et al. (2020), who advocate for strengthening the evidence base in humanitarian settings, particularly for widely implemented programs such as community-based psychosocial programs.

3. M&E in MHPSS

Evidence-based practice[2] is fundamental in MHPSS and has been notably overlooked in academic settings (Tol et al., 2011). As a consequence, evidence on the impact of Psychosocial Support interventions is limited (Lee et al., 2019). A solution with the potential to narrow down the divide between research and practice within the MHPSS domain involves the crucial

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[2] Evidence-based practice refers to approaches that are based on the best available scientific evidence (WHO, 2022).

functions of M&E (Augustinavicius et al., 2018). Monitoring is the methodical collection of information aimed at assessing the progress of an intervention over time. Specifically in emergencies, it entails a structured process of gathering and analysing information to guide humanitarian decision-making regarding ongoing or potential new activities (IASC, 2021). Evaluation involves analysing the relevance and effectiveness of ongoing or completed activities by assessing specific information or aspects at specific time points. This process aims to determine whether the actions taken have achieved the intended results. M&E are two interconnected yet distinct practices. Both enable the assessment of program effectiveness and the identification of various challenges, needs, risks, and vulnerabilities within the target group. Adjustments to interventions can then be made as necessary, lessons learned gathered, and experience capitalized. The aim is to provide universally applicable and practical evidence-based guidance, establishing the foundation for an all-encompassing plan in the field (Dückers et al., 2022). Moreover, the systematic M&E reinforces accountability for actions taken and ensures adherence to the principle of doing no harm (Ajdukovic, 2008; Augustinavicius et al., 2018; Coral, 2021; IFRC-PS Centre, 2017b).

Implementing M&E in MHPSS interventions presents numerous challenges. M&E and evidence-based practice are not always clearly delineated in the literature. While M&E is crucial for ensuring quality in MHPSS practice, unlike sectors with tangible measures in humanitarian settings like the provision of food, MHPSS relies on qualitative concepts like well-being, making quantification challenging. The IFRC's well-being flower, introduced in 2021, underscores its various components. In MHPSS, the aspects of culture and faith, varying across contexts are of particular relevance (Amigues & Eddebo, 2022). Recognizing the importance of aligning measures of well-being with the local understanding of MHPSS, it becomes imperative to adapt these measures to effectively capture and address the unique nuances present in diverse cultural and faith-based contexts. Compounding the complexity, as MHPSS is not a standalone sector but is implemented within areas like health, protection, water sanitation hygiene, and nutrition, it lacks systematic evaluation (Haroz et al., 2020). Augustinavicius et al., (2018) stress the need for a more standardized approach in key MHPSS areas in LMICs, emphasizing inconsistencies in terminology and measurement between research and practice, which significantly impact the M&E of MHPSS programs. In order to respect the do no harm principle and given the

vulnerability of target populations, it is particularly important to pay attention to conduct ethical research (Ager et al., 2014; Chiumento et al., 2017).

The challenges of research for MHPSS in humanitarian settings are compounded by the broader challenges of research in these contexts. Carden et al., (2021) highlight time constraints, funding limitations, as well as a perceived lack of relevance to humanitarian practice and actors in the Global South as the primary hurdles to research utilization. Overcoming these obstacles is crucial for effectively integrating research findings into humanitarian decision-making processes and interventions. This is what makes the currently unachieved priority action number four of the 2019 MHPSS Roadmap aiming to demonstrate the impact of MHPSS interventions so important.

3.1 M&E in the Movement

3.1.1 Program, Monitoring, Evaluation, and Reporting institutional framework

M&E is a critical component embedded in the Movement program management framework. It acts as a tenet, guiding decision-making from the program's initial planning stages to the eventual reporting and dissemination of results. M&E serves as a compass, ensuring accountability and nurturing a culture of continuous improvement within the program. The Program, Monitoring, Evaluation, and Reporting (PMER) cycle delineates the customary steps and primary activities in a program or project. This cycle unfolds across three overarching phases and encompasses seven essential steps illustrated in Figure 2.

The initial assessment, as the primary stage, involves evaluating the needs and strengths and developing a theory of change [3], aiding in determining the imperative for a program and subsequently guiding its strategic planning (EvalCommunity, n.d.). The planning phase unfolds in three key steps: the log frame, M&E planning, and the baseline study. The log frame encompasses the operational structure of the program, defining objectives, indicators, means of verification, and estimations. Subsequently, M&E planning focuses on monitoring and

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[3] "The Theory of Change is a structured approach to understanding the underlying assumptions and objectives of a program or project. It helps organizations to identify, analyse, and assess the different components that can affect change within their projects. In addition, it can be used as an evaluation tool to measure the accomplishment of various goals. By taking into consideration the purpose, processes, desired outcomes, and resources associated with a program or project, Theory of Change enables organizations to better understand how change will take place in their initiatives" (EvalCommunity, n.d.)

evaluating the objectives and indicators outlined in the log frame. Concluding the planning process is the baseline study, measuring indicators prior to program implementation. The subsequent stages in the PMER cycle include implementation, monitoring, and evaluation. After program implementation, a mid-project evaluation occurs, assessing and documenting ongoing program implementation. Upon project completion, a final evaluation determines the attainment of objectives and evaluates the intervention's impact on the population. The results then become the focus of a comprehensive report, fostering reflection and learning. This iterative process remains integral to the cycle, positioned at the core of the diagram. Results are disseminated, and lessons learned are instrumental in shaping current and future interventions (IFRC, 2021).

Figure 2:

Key M&E activities in the project/programme cycle:
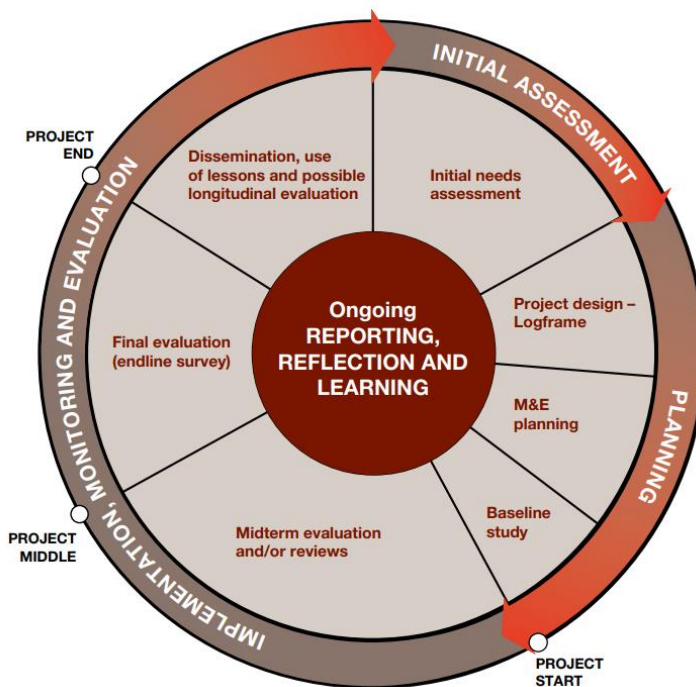
Note. From "Project/programme monitoring and evaluation guide.", IFRC, 2021, p.10. In the public domain.

The log frame is a structured planning and evaluation tool used for project design, management, and monitoring. It emphasizes specific, measurable, achievable, relevant, and time-bound (SMART) objectives, indicators, and activities to achieve short and medium-term results

(IFRC-PS Centre, 2017b). The objectives denote the intended outcomes and are articulated at three levels: goal, outcome, and output. A goal, often referred to as impact, represents the overarching, long-term result sought by an intervention, surpassing its immediate scope. This result is, in part, achieved through the fulfilment of outcome objectives. An outcome is the immediate and observable change in the lives and situations of the target population, directly resulting from project activities and output delivery. Outputs signify the tangible work implemented, and their effectiveness is assessed based on their contribution to the probable achievement of the outcome and, finally, the goal. Each objective has corresponding indicators, means of verification, and assumptions. Indicators, whether quantitative or qualitative, serve as criteria to measure changes and progress toward these objectives. Means of verification outline how information on these indicators will be collected, specifying who will collect it and how frequently. Assumptions encompass external factors beyond the intervention's control yet are crucial for goals, outcomes, and outputs to contribute to higher-level results (IFRC-PS Centre, 2017b).

3.1.2 M&E for MHPSS structure

Through research, evidence, and M&E, Priority Action 4 of the 2019 Roadmap aims to highlight the impact of MHPSS interventions (PS Centre, 2019). The Movement is committed to strengthening its M&E and learning capacities about its MHPSS interventions. To this end, particular attention is paid to data collection, analysis, and reporting. The latter enables evidence-based practice and a better quality of activities. The ultimate aim is to offer quality MHPSS to more people, by improving the effectiveness and efficiency of interventions, as well as to improve the Movement's MHPSS literacy, capitalize on experience, and enhance added value. Activities include support for the implementation of M&E frameworks, several studies on the impact of MHPSS interventions in different contexts, and the development, testing, and documentation of more innovative approaches. As a result, the Roadmap states that by 2023, comprehensive and complementary interventions will have been developed throughout the MHPSS framework, and adapted to various contexts. Movement components have strengthened their capacity to offer quality MHPSS services, aligned with their respective roles and mandates.

Finally, the Movement's broader commitment to MHPSS is documented in specific operational contexts, notably in the response to the COVID-19 pandemic.

The PMER cycle described above is not exclusive to MHPSS, and it is important to recognize that PMER teams are generally comprised of individuals who may not specialize in MHPSS, as their responsibilities span various sectors. Hence, fostering collaboration with MHPSS specialists is essential (Horn, 2023). Although the PMER cycle is specific to the Movement, it may not be incorporated into all M&E tools external to the RCRC but used by some National Societies, such as those of the IASC. Nevertheless, the fundamental principles, such as log frames, indicators, and objectives, remain consistent across various frameworks.

While M&E is conceptually similar across different sectors and detailed steps are outlined in various documents, the actual implementation often diverges from these guidelines.

3.1.3 M&E for MHPSS praxis in the Movement

The Movement has several tools at its disposal for implementing M&E processes. In the 2023 MHPSS survey, respondents were asked to select each of the six different tools that their organization was using for M&E, as illustrated in Table 1.

The IFRC Reference Centre for Psychosocial Support (PS) M&E framework for PSS interventions emerges as the most widely used resource within the Movement, with approximately half of the participants using it. Following closely are the ICRC MHPSS Guidelines (2017) and IFRC M&E Guide (2021), each adopted by around 30% of respondents. External tools, such as those from the IASC are less common among users. Regarding the effectiveness of the PS Centre's tool, Horn (2023), who assessed evidence-building in the Movement, suggests that the tool is beneficial when accompanied by appropriate M&E training. However, users lacking prior training may encounter challenges in adapting the tools to their specific contexts or fully understanding their utility. In scenarios with limited M&E or MHPSS capacity, the implementation of these tools can be perceived as overly complex and/or time-consuming. Given that the evidence-based approach is not regarded as a priority within the Movement, it can be difficult to address these challenges (Horn, 2023).

Table 1:

Resources used to support M&E for MHPSS in 2023

	Tools:	*N: 176*
IFRC Reference Centre for Psychosocial Support 'Monitoring and Evaluation Framework for Psychosocial Support Interventions – Toolbox / Indicator Guide'(IFRC-PS Centre, 2017a, 2017c)		94 (53,4%)
ICRC 'Guidelines on Mental Health and Psychosocial Support' (ICRC, 2017)		53 (30,1%)
IFRC 'Project/Programme Monitoring and Evaluation Guide' (IFRC, 2021)		48 (27,3%)
IASC 'Mental Health and Psychosocial Support Assessment Guide' (IASC, 2013)		40 (22,7%)
IASC 'Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings' (IASC, 2021)		35 (19,9%)
WHO & UNHCR 'Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings' (WHO-UNHCR, 2013)		31 (17,6%)
Other		23 (13,0%)
None of those listed		21 (11,9%)

Note. Of the 177 respondents, 163 were National Societies the remaining thirteen were the IRFC and the ICRC. This Table is based on the raw data of the 2023 MHPSS survey.

In order to ensure quality support, exactly half of the respondents to the 2023 MHPSS survey have set up supervision mechanisms for MHPSS activities. This represents a decrease from 59% in 2021, but the trend remains above 48% in 2019. The systematic M&E of MHPSS by National Societies varies significantly, especially when integrated into programs across different sectors (Horn, 2023). Horn's findings indicate that the majority of National Societies are still in the early stages of M&E. While, 81% say they have a system in place to monitor their organization's mental health and/or psychosocial activities (PS Centre, 2023a), the focus of monitoring efforts tends to be on outputs rather than outcomes (Horn, 2023), which are crucial

for target populations. This can be seen in the 2023 survey (PS Centre, 2023a), which highlights the monitoring measures implemented by National Societies, with 70% focusing on the number of beneficiaries, followed by interviews, focus groups, supervisor reports, and questionnaires, all utilized by half of the respondents. After experiencing an improvement in M&E, evidenced by a decrease in the number of NS without a system in 2021 (13%), this progress has since slowed, with the figure increasing to 17% in 2023. It is important to note that these data are solely based on monitoring and not evaluation.

Table 2:

MHPSS monitoring system in the National Societies in 2019, 2021 and 2023.

Methods	2019 (N=163)	2021 (N=167)	2023 (N=163)
No system / no monitoring	32	22	30
Number of beneficiaries	100	117	112
Timesheets	26	43	46
Supervisor reports	77	94	80
Interviews or focus group discussions	73	81	77
Surveys	43	65	71
Psychometric tools (please specify which tools)	n/a	23	18
Systematic programme review or evaluations	46	53	61
Other	18	13	13

Note. Based on the raw data from the 2019, 2021 and 2023 MHPSS surveys.

Respondents lacking monitoring systems were queried about the reasons behind this absence. Similar to previous years, financial constraints were cited as the main obstacle by almost three-quarters of the respondents, followed by insufficient qualified staff (around 55,6%), as well as deficiencies in planning, lack of practical support for M&E and a lack of suitable tools (36,7%). Staff-related challenges encompassed limited staff for data analysis (60%) and collection (50%), along with a deficit in technical expertise (56,7%). While in 2021, the lack of tools was the second obstacle cited by 70% of participants. By 2023, this concern dropped to

fifth position, with just over a third of respondents identifying it as a barrier. The progress observed may be attributed to the M&E training provided by the PS Centre in 2023, during which one of the foci was on addressing the use of tools.

3.2. Wrapping up: opportunities and limits

The implementation of MHPSS in the Movement faces many obstacles. The 2023 MHPSS Survey helped reveal some of the operational challenges encountered by National Societies. However, some of these factors, such as budget constraints, are beyond the direct control of the latter, as they heavily rely on donor funding. Furthermore, the questions in the survey pertaining to M&E exclusively concentrate on monitoring and do not encompass evaluation, thereby leaving a gap in understanding. These various elements provide insights into the challenges faced by National Societies in M&E, but they do not provide a comprehensive understanding of the specific needs of these organizations for improved implementation. Until August 2023, there was no inclusive overview of the barriers relevant to National Societies. The first step towards addressing this gap was Horn's consultancy report on evidence-based practice within the Movement (2023). Through interviews with key informants within the Movement, Horn (2023) created a visual representation of the M&E challenges specific to MHPSS, illustrated in Figure 3.

Several elements contribute to the lack of expertise and capacity among National Societies, as highlighted by Horn (2023), who identifies four key factors:

- MHPSS programs are often integrated across various sectors, resulting in outcomes that are more closely associated with the particular sector rather than the MHPSS elements of the program. Additionally, MHPSS interventions are often intangible and challenging to observe, making it difficult to measure their impact accurately. Additionally, the brief duration of interventions, especially in emergency situations such as psychological first aid, along with the informal interactions inherent in MHPSS activities, makes measurement challenging. This often leads to the sole indicator being the number of individuals reached.

- MHPSS terminology remains opaque, as also noted by (Augustinavicius et al., 2018) , which poses challenges for PMER staff who often lack a background in MHPSS.

- There is insufficient collaboration between PMER staff and MHPSS focal points, which is crucial for effective M&E implementation. This lack of collaboration may stem from a siloed work environment.
- There is a notable deficiency in MHPSS capacity within National Societies, with many teams having only one MHPSS focal point that my struggle to balance multiple responsibilities, resulting in limited engagement with PMER teams.

In addition to these factors, Horn also highlights the absence of a centralized system for collecting and disseminating existing evidence.

Figure 3:

Specific MHPSS barriers to evidence-building
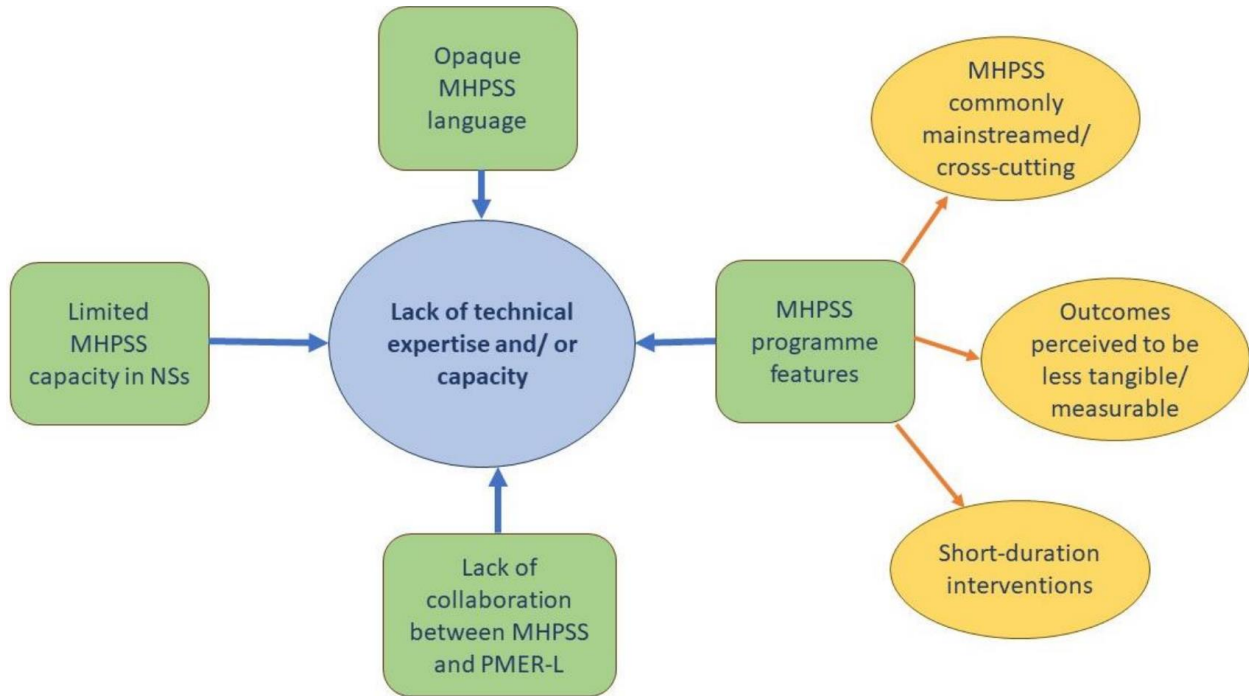
Note. From: "Promoting Mental Health and Psychosocial Support Evidence-Building in the Red Cross Red Crescent Movement", by R. Horn, 2023, p.23. In the public domain.

Horn's findings offer insights into specific challenges related to evidence-building for MHPSS, which intersect with but are distinct from M&E issues. While this provides an initial understanding of the diverse challenges, supplemented by the quantitative data on monitoring from the 2023 MHPSS survey, it is essential to distinguish between M&E and evidence-building

as distinct domains. Furthermore, qualitative data is essential for understanding the nature of the challenges, as the responses from the survey alone do not provide sufficient depth for analysis. Despite M&E and MHPSS facing various barriers in humanitarian settings, there is a notable gap in research focusing on the specific obstacles related to M&E for MHPSS, as emphasized in this theoretical framework. Therefore, further exploration into the specific barriers and opportunities for M&E within the context of MHPSS is imperative.

`4. Current study: Addressing bottlenecks and shaping solutions in MHPSS M&E

Given the numerous challenges outlined earlier, this research project aims to expand on Horn's findings and the insights from the 2023 Survey by focusing on M&E for MHPSS. The primary objective is to identify the specific challenges faced by National Societies at the intervention level, along with their corresponding needs to address these challenges. Additionally, this work seeks to highlight successful approaches adopted by National Societies, which can offer valuable insights into potential opportunities and solutions for overcoming identified barriers. These objectives serve as the foundation for a broader project within the Movement, aiming to facilitate the development of solutions that enhance M&E capabilities, thereby enhancing the implementation of MHPSS for the benefit of individuals and communities in humanitarian settings. The current study will concentrate on identifying challenges and opportunities in M&E for MHPSS, establishing the groundwork for subsequent solution development in future projects.

Its research will revolve around three key research questions, aligned with the Movement's objectives. These questions have been formulated based on the institutional and political framework outlined earlier, as well as the findings from the different MHPSS surveys (2019-2021-2023).

- What challenges do National Societies encounter regarding M&E practices in the area of MHPSS?
- How have successful National Societies managed to overcome their M&E challenges in the field of MHPSS?
- What are the requirements for National Societies to address these challenges effectively?

To address these inquiries, interviews have been carried out with four National Societies — two acknowledged as champions within the Movement and two relatively new entrants—

operating in diverse contexts, including one in High-Income Countries (HICs) and one in LMICs. This varied approach aims to uncover potential disparities based on context. Adopting a bottom-up methodology, the interviews aim to unveil challenges and potential solutions for M&E in MHPSS. Additionally, interviews with specialists from the PS Centre will provide a top-down perspective to complement the findings. With these research questions, the aim is to derive recommendations on how to improve MHPSS M&E practice in the Movement as a whole.

Method

Following a thorough desk research, it was determined that semi-structured interviews would best address the main questions of this project, with a focus on National Societies. To ensure a diverse range of perspectives and levels of M&E implementation in MHPSS, it was decided to conduct interviews with four National Societies. This included two National Societies that were new to M&E practices and two that were experienced in the field. Additionally, experts from the PS Centre were also included in the interview process to provide valuable insights.

1. Participants

1.1 Participants and Data sources

The main source of information were the semi-structured interviews, with a total of nine interviews. Among these, three interviews were conducted with experts from the PS Centre, and six interviews were held with M&E and/or MHPSS focal points from four different National Societies.

The National Societies were selected in pairs to represent similar contexts, with one pair from HICs and the other from LMICs. These diverse contexts are significant for M&E implementation in MHPSS programs, particularly considering that limited financial resources are often cited as the primary barrier to M&E (PS Centre, 2023a). Additionally, as outlined in the theoretical framework, LMICs bear a disproportionate burden of emergencies and are especially vulnerable to mental health disorders (ICRC, 2021). Consequently, humanitarian needs are heavily influenced by the specific context and available resources in each country. This variability can lead to differing priorities for MHPSS interventions and their M&E processes. Given that MHPSS is not always considered a top priority in emergency action plans, it may be

deprioritized in favour of interventions deemed more urgent. Cultural factors could also influence the implementation of M&E for MHPSS due to varying interpretations and perceptions of mental health and well-being within different cultural contexts (Amigues & Eddebo, 2022). Within each context, one National Society was designated as "champion", and the other as "beginner". The designation of M&E champion was determined through consultations with the PS Centre and regional managers. The choice fell to the Australian Red Cross (ARC) and the Kenyan Red Cross (KRC) for the following reasons: The ARC is acknowledged within the Movement for its evidence-based activities. Indeed, a robust M&E system and external evaluation are typically mandated by the majority of their fund providers (Horn, 2023). Similarly, the KRC is recognised in the African context for its practice of M&E for MHPSS, overseen by a member of the PMER sector supporting the MHPSS Unit (Horn, 2023). Following a similar procedure, the National Societies as beginners were chosen with the help of the heads of Working Group 4 (WG4), responsible for priority action 4 which concerns M&E and the 2023 Survey.

For each National Society, two or three M&E and/or MHPSS focal points were interviewed. As illustrated in Table 3, the National Societies involved in the interviews were the ARC, the Swiss Red Cross (SRC), the KRC, and the Cameroon Red Cross (CRC).

Table 3

Participating National Societies

	M&E Champions	**M&E Beginners**
High-Income Context	Australian Red Cross	Swiss Red Cross
Low/Middle Income Context	Kenyan Red Cross	Cameroon Red Cross

1.2 Recruitment process

The recruitment process with the National Societies proved to be quite challenging. To reach the heads of the National Societies, we followed the hierarchical structure of the Movement. With the help of several managers at the PS Centre, we identified several National Societies that met the required criteria. Once determined, the process of reaching out followed. In addition to considering the context and M&E expertise for MHPSS, we also prescribed that the interviews should be conducted in French, English, or German, to avoid the need for a

translator. Consequently, for the first context of LMIC, our focus turned to national African societies as many of them have French or English as one of their national languages. For the aforementioned National Societies, contact was initially made with the regional Technical Advisor (TA) for the anglophone African NS, facilitated by a member of the PS Centre, to obtain an overview of potential interview partners based on the criteria. The work objectives were outlined during a meeting, following which several National Societies were contacted. Unfortunately, their unavailability led to no success. Subsequently, the regional TA connected us with his colleague, supporting him for Francophone African countries. After meeting with her, an invitation was extended to attend a "MHPSS Community of Practice (CoP) Focal Point Meeting" to present the research objectives and identify potential interested parties. While some participants expressed interest, they needed to consult with their department heads. Despite several e-mail exchanges, the outcome was negative. As a last attempt, it was decided to contact the African National Societies in the WG4 research group, with the WG4 project team making the first contact. Eventually, interviews were arranged with the KRC and the CRC, by extending the interview deadline. However, due to time constraints, securing a second interview partner for these two National Societies was not possible.

For the second, HIC context, the choice fell on Switzerland and Australia since both met the criteria and were easier to approach than other NSs. Contacting the SRC and ARC was therefore more straightforward. For the SRC, direct connections were made with the relevant individuals in charge, and meetings were promptly scheduled with them. In the case of the ARC, assistance was sought from one of the TAs for MHPSS at the PS Centre, introduced by the WG4 managers. As she had previously worked at the ARC before joining the PS Centre, she was interviewed both as an expert and as the head of NS. She then facilitated introductions to two of her former colleagues. However, coordinating meetings proved challenging due to vacation schedules and different time zones. For the second interview, it was ultimately decided that the questions would be sent to the interviewee, who would respond to them in writing. The meetings with the experts were facilitated through the PS Centre initiating contact via invitation emails for the master's thesis, providing details about the aim and significance of the research.

1.3 Participants selection

A total of seven women and a man participated in the interviews (one women was interviewed twice). The three experts are all affiliated with the MHPSS unit at the PS Centre. The first interviewee manages the EU4Health project, focusing on MHPSS for conflict-affected individuals in Ukraine, and is also part of the PS Centre's M&E task force. The second expert serves as the head of the MHPSS technical unit, while the last expert is the technical advisor for the MHPSS unit, responsible for emergencies and M&E activities, including facilitating the "M&E for MHPSS" training program. She also represented the ARC as the former national lead for recovery in psychosocial support and was therefore interviewed twice. As for the other National Societies, the interviewee from the KRC is the Head of the MHPSS unit and is also a clinician. The representative from the CRC is a first aid volunteer with a Ph.D. in nursing and psychology. For the SRC, the interviewees include the International MHPSS focal point who is also the manager of a project developing digital services for refugees, the Head of Foundation and Development overseeing Foundation and Evaluation, and the Focal Point for Mental Health & Psychosocial Support.

Participants were selected based on the criteria outlined in the previous section, including language, context, and level of M&E expertise in MHPSS. The remainder of the selection process involved convenience sampling. Participation, from the moment the criteria of language, context and expertise were given, depended mainly on who was available, who the TA thought could/would be interested, and if the interview could be led in the planned timeframe. The interviews were conducted from December 2023 till February 2024, while the various preparatory meetings with the different groups and TAs took place in November 2023.

2. Design

This qualitative study was designed to address three key research questions. Firstly, it sought to identify the challenges encountered by National Societies during their initial stages of M&E development for MHPSS. Secondly, it aimed to elucidate the strategies employed by successful National Societies in their M&E practice. Lastly, it focused on exploring methods to overcome barriers to effective M&E practices.

2.1 Data collection

We opted for a qualitative approach and – as stated above - chose to conduct semi-structured interviews because they allow for flexibility and depth in exploring participants' responses. This method was considered the most appropriate for addressing the research questions. As a preparation for the construction of the interview guides, we organized focus group discussions involving the participants of the WG4. These focus groups aimed to gather preliminary insights and identify key themes and issues to be addressed in the interviews. Based on this preparatory work, two interview guidelines were developed.

The first was addressed to experts. For the first questions, the focus was on the optimal application of M&E for MHPSS. Subsequently, the specialists were able to outline the barriers identified by National Societies from an external point of view. The role of the PS center in supporting NS was also asked. Then the focus shifted to areas for improvement at the Federation level. The interview concluded with advice to National Societies on the implementation of M&E for MHPSS. The experts were also given the opportunity to address any questions they felt were important to ask the National Societies.

The second interview guide was common to both champion and novice NSs, with several questions being specific to their level of M&E for MHPSS. The structure was slightly different from the experts' guide. Firstly, the protocol included a basic section on the position of the interviewee and the context of their National Society. This was followed by a general understanding of M&E for MHPSS. The core of the protocol covered the implementation of M&E in MHPSS in the National Society concerned, as well as the challenges and barriers they face. For champions, the implementation section included a question on advice for novice NS. These central questions aimed to identify the cleavages and difficulties of M&E by drawing conclusions from their practice, in addition to the barriers raised by the interviewees. More structural aspects of M&E, both facilitating and hindering, were then highlighted. The interview ended with a question on advocacy of monitoring and evaluation, revealing the importance attributed to this subject.

Most questions were open-ended, apart from some concerning Movement tools, in the interest of obtaining as much information as possible. The question protocols were adapted several times. Both the expert and NS interview guides were reviewed with the leaders of WG4

and modified slightly. It was decided that certain questions would only be asked if they had not already been answered by the interviewee. In addition, some questions were used as clarification questions, in case the interviewee required further details. The guide for National Societies was then shown to all the WG4 participants, who were allowed to comment and give their opinions. Their suggestions were taken into account for the interviews.

As data collection progressed, it was found practical to set aside some questions from the protocols, as they had often been addressed in the answer to another question. Through the interviews and prior information, we gained expertise that helped us prioritize specific questions effectively. Adjustments were made during interviews to accommodate varying levels of expertise among National Societies. Some questions were too specific, but the inability to answer them provided valuable insights. In response to missing information, additional interviews were conducted, such as with the SRC due to recording issues. This approach also allowed for a third perspective in these cases.

The interviews lasted between 45 and 70 minutes, the average being 57 minutes. The only exception was S.W., who wore two hats in one interview: that of an expert and that of a National Society. The latter therefore lasted 90 minutes. The second planned interviewee of the ARC requested to receive the questions in writing but eventually did not respond. The interviews were conducted from December 2023 to February 2024 using online platforms such as Microsoft Teams or Zoom. Recordings and transcription functions were utilized during virtual sessions, and for in-person interviews with the SRC, voice recordings were used. All interviews were transcribed, and German interviews were translated into English before being imported into the MAXQDA analysis software.

2.2 Data Analysis

The data was analyzed in MAXDA and examined using a method of thematic analysis developed by Clarke and Braun (2016). This version of thematic analysis presents flexibility and diversity in its theoretical and analytical dimensions. A hybrid approach was used, in which the analysis was both deductive and inductive. The a priori categories illustrate the deductive method. The coding and development of themes were guided by existing concepts and ideas. Preliminary categories were deduced from initial research. Defined in advance, they were mainly

modelled on the interview protocol, itself based on Movement questionnaires and preparatory discussions. It was anticipated, however, that additional categories would emerge during the analysis of the results. In this sense, a more inductive approach was used here - the coding and development of themes was in this case guided by the content of the data. Given the exploratory nature of this work, some of the a priori categories might also prove irrelevant.

Figure 4:

Code hierarchy of the three research questions:
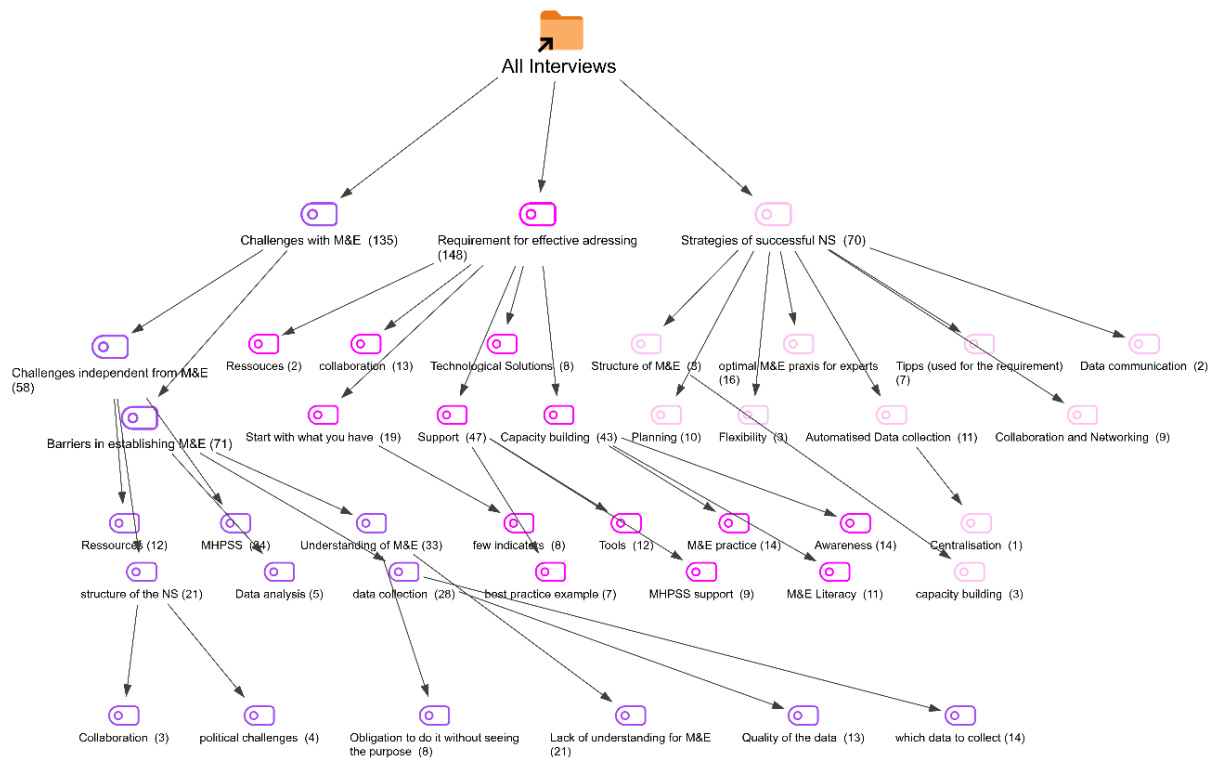
Note: The colours align with the research questions, with frequencies aggregated for parent codes. The height of the codes reflects the level of the sub-codes. There are a maximum of four levels of codes per research question.

Braun et al. (2019) delineate a reflective thematic analysis (TA) process involving six stages: data familiarization, code generation, theme development, theme review and definition, and production of the analysis report. Initially, to acquaint with the data, the interviews were transcribed and, where necessary, translated before conducting a thorough review. Subsequently, the process of code generation commenced, initially deductively based on the question guides.

The resulting codes were then organized into main themes representing the three research questions and the M&E situation of the National Societies and the experts. While these themes remained consistent, sub-categories were iteratively developed and adapted based on the interview content. This iterative process aimed to capture both explicit and implicit themes within the interviews comprehensively. Ultimately, our analysis resulted in 826 coded segments, with 167 representing highlighted phrases deemed significant, 281 codes about the M&E status of National Societies and insights from experts, and 25 codes were associated with advocating for M&E. Specifically related to the research questions, 135 codes addressed M&E challenges for MHPSS, 70 codes outlined strategies employed by successful National Societies, and 148 codes proposed solutions for enhancing M&E practices for MHPSS, as illustrated in Figure 4.

2.3 Methodological Integrity

The initial stages of this research were exploratory in nature, given the relative novelty of the subject in the academic realm. Therefore, the research procedure was not predetermined. Initially, discussions were initiated with the leaders of WG4 to familiarize with the topic. Subsequently, various M&E tools and surveys from 2019 to 2021 were analysed to identify potential issues. Several working group meetings were attended, and conversations were held with managers from the PS Centre. Originally, the plan was to categorize the tools to gain a clearer understanding. However, discussions revealed a lack of understanding regarding why M&E was not being implemented. The idea of a classification of tools, deemed unnecessary for the time being, was therefore rejected. As the research progressed, the complexity of the topic and the barriers existing at various levels became evident. This mirrored the gap between the Federation and National Societies, similar to the gap between research and practice mentioned earlier. Recognizing that a top-down approach would not suffice, a bottom-up exploratory method was opted for, aiming to gather perspectives from those directly involved, the National Societies. While initially considering a field-based case study involving two National Societies, logistical constraints prevented its implementation. Consequently, interviews with National Societies became the primary data collection method. Ideally, two National Societies per continent were intended to be interviewed to capture diverse contexts. However, given the scope limitations of a master's thesis, four National Societies were selected for interviews, two of

which were new to M&E and two experienced in the field. Additionally, interviews were conducted with experts from the PS Centre to gather comprehensive insights.

Results

The results highlight the different findings gathered in the interviews. The first part will offer an overview of the different situations in the four National Societies, thus setting the frame. Subsequently, three parts will address the different research questions. The first of these three parts thus focuses on the obstacles faced by National Societies new to M&E in their practice of this activity. This is followed by the strategies employed by successful National Societies. Finally, the last chapter will look at the measures that need to be taken to meet the various challenges of M&E for MHPSS.

1. Situation of the National Societies covered by the study

This first part describes the context of the four National Societies covered by the study in terms of their MHPSS and M&E practices, which provides an overview of their current situation. This descriptive part will allow a better understanding of the findings for the different research questions. The portrayal of the National Societies is solely based on the interviews.

The KRC plays an important role in coordinating mental health support nationwide, particularly in responding to emergencies and providing care for both staff and volunteers. Collaborating across regions and counties, the KRC ensures culturally sensitive practices, building resilience in communities alongside delivering essential mental health services through their MHPSS framework. Their MHPSS unit operates inter alia a tele-counselling centre staffed by counsellors available round-the-clock. The team offers counselling services to individuals and communities affected by disasters, natural calamities, and immigration challenges following the stepped care model of the MHPSS pyramid. The KRC implements M&E to assess the effectiveness and impact of their MHPSS interventions. This includes evaluating the prevention of mental health disorders, particularly by assessing the progression of conditions and the level of resilience among beneficiaries. Indicators such as age, gender, diagnosis, frequency of interventions, stigma, disability, and progress are monitored to gauge the quality of care provided. Capacity building is an integral part of their M&E praxis, with training programs and

tools predominantly based on guidelines from the IFRC. Automated tools aid in streamlining data collection and analysis processes. The KRC has a dedicated M&E department, with a person assigned to MHPSS supporting the planning, implementation, and automation of M&E activities.

The ARC is known for its evidence-based praxis. The interview with the ARC delved into M&E practices within disaster recovery operations in psychosocial support initiated four years ago. These operations involved psychoeducation and stress management in community support sessions. Psychological first aid through door- or phone-based outreach was provided, with a referral when necessary. MHPSS interventions were integrated into broader emergency programs. The unit's head oversaw long-term operations, supporting response teams with assessing needs, developing programs, securing funding, and scaling up operations. Collaboration with government entities, particularly for bushfire relief efforts, was crucial. M&E was conducted nationally to assess the effectiveness of the interventions, employing a theory of change with a log frame and means of verification collected digitally. Volunteers and staff were briefed on M&E and data collection. The indicators on MHPSS were qualitative feedback and training capacity was evaluated. The goal was to enhance the overall M&E system for emergency programs across Australia. In bushfire relief efforts, the ARC established two M&E focal points to develop holistic M&E for the emergency unit and report results. Over the years, the staff capacity for M&E increased.

In the CRC, different interventions implemented at headquarters are replicated at the divisional level across various regions of Cameroon. These interventions encompass a range of first-aid measures adapted to local needs. Additionally, MHPSS is provided during crises such as floods, landslides, or epidemics, extending assistance to affected communities by the mandate. Monitoring as well as assessments and evaluation are integral components to capture the effectiveness of implemented strategies in aiding communities. When diverse needs are recognised across regions, solutions are tailored accordingly. Counselling services are disseminated through various media, including radio and television broadcasts, to reach a wider audience. The identification of different problems and the provision of solutions are central to the approach, aiming to deliver holistic health support. Seminars covering diverse topics within the National Society are conducted, and funding is allocated as needed for community initiatives. Documented assessments and statisticians are employed to evaluate collected data. Adherence to

different mandates guides the decision-making process, ensuring alignment with organizational objectives. The CRC has physician volunteers and health professionals. There is an MHPSS focal point and there is a M&E general head at the headquarters of the CRC.

The war in Ukraine and its wave of refugees to Switzerland catalysed the SRC to actively develop MHPSS interventions. The target groups of these interventions are elders, refugees, young people, and crisis-affected individuals. The problem of stigma surrounding mental health hasn't been nationally addressed yet. The services primarily operate at the lower thresholds of the intervention pyramid with the outpatient clinic established for torture and war victims being an exception. Since 2023, a designated MHPSS focal point has been established to coordinate the Ukraine project and build up knowledge about MHPSS, since there is no common understanding of MHPSS across all levels due to the Federal structure of the SRC and differences in cantonal approaches. Regarding M&E efforts at the national level, they predominantly fall within the intersectional unit of Fundamentals and Development. The primary aim is indeed to assess the effectiveness of interventions and improvements in well-being. However, due to Switzerland's Federal structure, which is reflected in the SRC, each canton independently determines its MHPSS interventions and evaluation methods, resulting in the absence of a centralized national M&E for MHPSS. The unit's role is therefore advisory, intervening only upon request. The cantonal Red Cross associations predominantly use output-oriented and quantitative measurements for their interventions. Reporting occurs internally or nationally, reflecting a decentralized approach, albeit with limited avenues for collaborative learning and standardization.

2. Challenges concerning M&E praxis in the National Societies

Navigating the path of monitoring and evaluating MHPSS programmes is riddled with obstacles. National Societies, particularly those just embarking on monitoring and evaluating MHPSS interventions, find themselves at the forefront of these challenges. This is valid for both the SRC and the CRC. Although the CRC had difficulties in expressing their challenges, a few key obstacles still could be recognized on their side. Following the interviews, the different hurdles can be categorized into those that are independent of the M&E praxis and those directly linked to M&E. The three most significant barriers to implementing M&E for MHPSS,

irrespective of the current M&E practices, include resourcing issues, structural challenges within the National Society, and difficulties related to MHPSS practices. On the other hand, the main challenge related to M&E is the lack of understanding and capacity of M&E. Finally, the challenges related to M&E for MHPSS include outcome measurement and difficulties with the data collection and data analysis.

2.1 Challenges with MHPSS

Limited financial resources:

The three SRC interviewees and the CRC volunteer highlight the significant obstacle of limited resources. Regardless of the type of interventions, financial resources are essential, yet MHPSS often fails to be prioritized in the agendas of the National Societies, particularly those just starting to address this area and lacking M&E frameworks. Even with funding allocated to MHPSS interventions, setting up M&E requires additional finance. As illustrated by one of the SRC representatives: "Whoever gives money commands". Resource challenges were also noted by the champions. The KRC underlined the importance of funding in the improvement of their M&E praxis, while the ARC encountered difficulties with their PMER unit. Furthermore, one expert adds that besides the financial aspect, the time required for the implementation of M&E can also present challenges.

Structural challenges:

The second significant challenge, specific to the SRC, is its federal structure. Akin to National Societies within the Movement, the cantons operate independently. The SRC headquarter, just like the Federation, primarily holds an advisory role within this decentralized structure. The three SRC representatives agree with this challenge. One representative stated, "(…), because there should be one organization per country, but we actually have 25 or so". Another representative emphasized, "The problem really is that we are very decentralized, and the cantonal associations are very insistent on their independence and don't want to be talked into it". Additionally, a third representative remarked, "(…) it's a federal system, we are not centralized and give orders, but the cantonal associations are independent, and we can't tell them what they have to implement". Only national-level interventions reach the Headquarters, which hinders a unified implementation of programmes, including the M&E of MHPSS interventions.

Zooming out from federalism and considering the ARC, which also refers to political difficulties in collaboration, we can conclude that the internal political structures of national organizations can indeed pose a challenge.

Challenges with the development and implementation of MHPSS as a cross-cutting and mainstream topic:

Both the CRC and the SRC concur on the third challenge, which is the difficulty of MHPSS practices. For the SRC, MHPSS is still a relatively new subject, as emphasized by one respondent: "Until now, the SRC has not really positioned itself in the area of mental health. That really came about in connection with the war in Ukraine". Another respondent mentioned, "(…) so it's certainly a new topic (MHPSS) at the SRC and there was no systematic structure, it's still being developed". The interventions offered within the field of MHPSS, primarily low threshold, are often integrated within other sectors and may not be explicitly recognized as MHPSS. As one respondent from the SRC stated: "We really don't have the basics here, and I think that's why we're still a long way from practicing really good M&E. Because we're not even aware that we offer so much MHPSS or at least PSS. That's really, I think, our main task, before we even get to evaluate, we have to realize that we're doing it at all". It is challenging to monitor and evaluate something when you are not aware that you are doing it. In contrast, the CRC takes a less direct approach, with their volunteer advocating for more action in MHPSS: "You put it into action like it should be more action-oriented more of it. Because the truth is a lot of people need it to treat mental health". This suggests that there is room for improvement in this area. The three experts also recognized MHPSS as a potential challenge. They described several reasons for this. Firstly, MHPSS is a cross-sector field. They mentioned that some national organizations are attempting to initiate MHPSS programs but may lack resources for additional endeavours. Additionally, the fact that MHPSS is not always a priority within the Movement further complicates the situation. This is echoed by one of the PS Centre's experts with the following statement "They (NS) are kind of not even started. They're still trying to get MHPSS off the ground or still trying to get people to think that this is important". The National Societies, both having an established MHPSS system made no mention of this challenge.

2.2 Challenges with M&E

Lack of understanding:

The biggest barrier to M&E is the lack of understanding of the subject. This difficulty is mentioned by all the SRC members (except for the M&E specialist), as well as by the champion National Societies and the experts. It begins with a lack of knowledge about M&E in general, as highlighted by one of the experts: "The challenge for National Societies, and I think it's also the case for other local organizations, is that they're not very M&E literate to begin with, irrespective of it being specific for MHPSS. Because it's quite an alienating terminology, some of the M&E, it's got its own language", which is confirmed by the following statement from one of the SRC representatives: "(…) there is already a lack of common understanding: what is monitoring, what is the difference to evaluation?". Additionally, the distinctive context of M&E for MHPSS, characterized by a more qualitative approach than in other sectors, can pose complexities. Therefore, the emphasis for M&E often remains on qualitative aspects. As one expert states, "So we're still very much I think as a Movement, also outside MHPSS, still counting stuff and kind of assuming that tells us something about what it is what we're doing". This lack of knowledge and understanding of M&E is akin to a lack of awareness on the subject, which starts with recognising the importance of M&E. Ultimately, the deficiency in M&E literacy contributes to reluctance in data collection, as many staff and volunteers are hesitant to engage in this process.

2.3 Challenges with M&E of MHPSS

Challenges with measuring the outcome:

Another challenge is associated with data collection, which relies on understanding both MHPSS and M&E. Therefore, if there is difficulty with both aspects, identifying which data to collect can be particularly challenging. As stated by one of the experts: "The third big one would be the overall challenge of M&E for MHPSS. It's the discussion of how to measure well-being, and how to measure the provision of mental health support that is a big challenge for all of us but also on the National Society level". Since MHPSS interventions are less tangible and are based on subjective concepts, they are therefore hard to evaluate. The three representatives of the SRC along with the three experts addressed this challenge. The difficulty that arises at the stage following the definition of the data to be captured concerns the quality of the data collected. This

issue is raised by National Societies who are experienced in M&E for MHPSS, namely the ARC and KRC champions, and by two out of the three experts.

Challenge with data collection:

      Both, of the champions mentioned the difficulty of having volunteers capture the right data and the challenge when having too many data entries.

Challenge with data analysis:

      The last challenge stressed was the data analysis of the qualitative MHPSS data, as emphasized by two of the experts. The reason why it wasn't addressed by the National Societies just starting with M&E for MHPSS can be attributed to the fact that they have yet to reach that stage.

2.4 Connections between the challenges

Figure 5 illustrates the primary challenges and their interconnections reported by interviewees. Initially, the structure of National Societies casts a pervasive influence over various interventions and processes, serving as a constant backdrop. The decentralized framework of the SRC, for instance, impacts all activities of the National Society. Similarly, internal political issues within national entities have ramifications. Financial barriers also hinder both the implementation of MHPSS practices and efforts to monitor and evaluate them. For National Societies with nascent MHPSS, numerous barriers arise, including challenges in raising awareness, gaining recognition, and integrating MHPSS interventions into existing programs. These factors also affect the practice of M&E for MHPSS. Within the realm of M&E practices, deficiencies in understanding - particularly regarding general M&E and M&E for MHPSS literacy - and lack of awareness are compound issues. These, along with inadequate knowledge of MHPSS, impede data collection efforts. The specificity of the subject further complicates the identification of data to be collected. Subsequently, concerns arise regarding the quality of the data collected. And on the next level, their analysis.

Figure 5:

Challenges faced by National Societies in implementing M&E for MHPSS
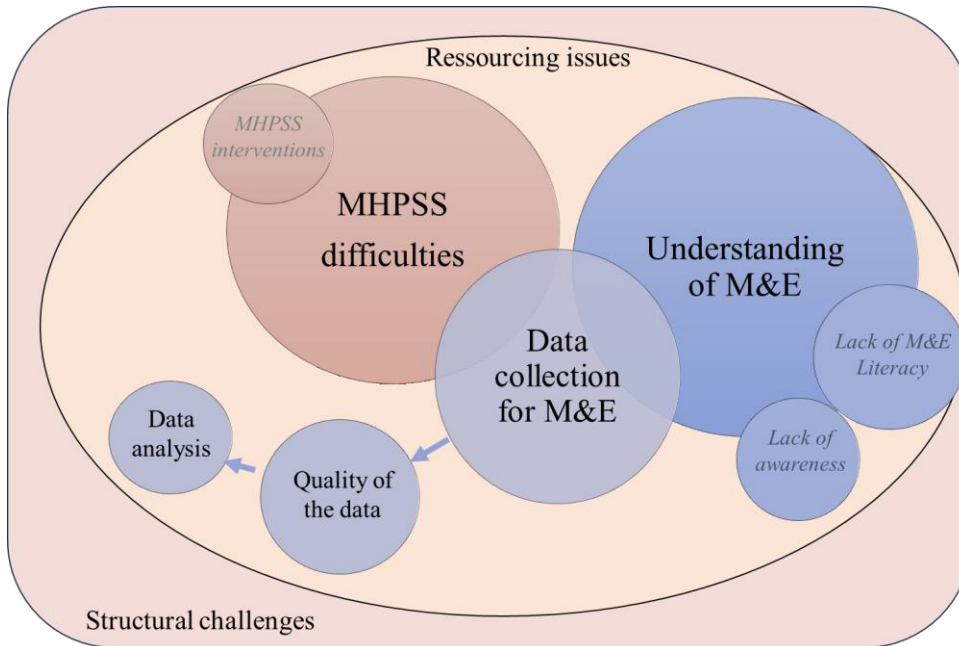
Note. The blue circles represent M&E challenges, and the warm tones represent challenges outside of M&E, including the framework conditions related to the structural challenges and resourcing issues. Furthermore, the circles represent the importance of the challenges.

3. Strategies of successful National Societies

3.1 Optimal M&E practice for experts

Optimal M&E practice for experts is first and foremost M&E that measures what it is supposed to measure. This also means showing when an intervention is not working. The experts agree that M&E holds significant importance in MHPSS, especially within the humanitarian sector, where it is relatively new compared to other fields. Documenting MHPSS activities is crucial to demonstrate their impact and justify the allocation of resources. M&E serves as a means of accountability to both the populations being served and the various stakeholders providing support and funding, including local government authorities and international donors.

One of the particularities of M&E for MHPSS is that interventions are highly contextual due to the different cultural definitions for MHPSS and need to take qualitative aspects into account. The experts state that this is why a particularly important aspect of this process is to

plan the interventions. As one of the experts said: "I think the optimal one (M&E praxis) is where you would have a front load and planned for your M&E. So put it into your project design. You need to have an M&E plan". The experts stressed the importance of a framework and a log frame for the indicators to enable the impact of the intervention to be observed in a wider context. Two experts emphasized the participatory aspect of M&E design. As one of them put it: "An M&E system must be owned at all levels. It's almost in a way a community development programme. You need to get there at the beginning, build a group of people that care about the topic and then build their capacity and then they do the work and you just support, you're like a backbone". Having a common understanding is imperative and can be achieved through capacity-building sessions or focal groups. The manager for the EU4Health project describes that in these sessions project partners can collaboratively select and adapt various components such as the log frame, means of verification, and indicators. This process involves reflecting on culturally relevant issues pertinent to MHPSS, ensuring alignment with the context and needs of the community. One of the members of the PS Centre further stressed the importance of budgeting for the cost of implementing M&E. Drawing from the interviews, it is evident that meticulous planning and organization of M&E implementation are fundamental pillars for establishing a robust M&E practice.

3.2 M&E strategies of the successful National Societies

The M&E practices of champions can be separated into three categories: M&E structure, M&E process, and finally factors not directly related to M&E concerning the centralisation, as shown in Figure 6.

3.2.1 The structure of M&E

In terms of the structure of the champion National Societies, both the ARC and the KRC have dedicated M&E staff to support M&E implementation for MHPSS initiatives. For the ARC, the bushfire project had several people with responsibility for M&E, while the KRC has one of its M&E staff specifically dedicated to MHPSS to support the planning, organisation, and implementation of M&E.

Additionally, both champions are involved in capacity-building efforts. This serves dual purposes. The first is the training of staff and volunteers to ensure a uniform understanding of M&E within the project, leading to improved clarity on various indicators and enhancing the quality of data collection. The second prioritizes capacity building as the ultimate objective. This involves utilizing M&E findings to identify and fund necessary training based on the data collected. This cycle ensures that capacity-building initiatives are informed by M&E data, thus aligning interventions with identified needs. The KRC representative highlights that identified gaps in programs can be utilized to advocate for specific activities aimed at enhancing performance.

Figure 6:

M&E strategies of successful National Societies
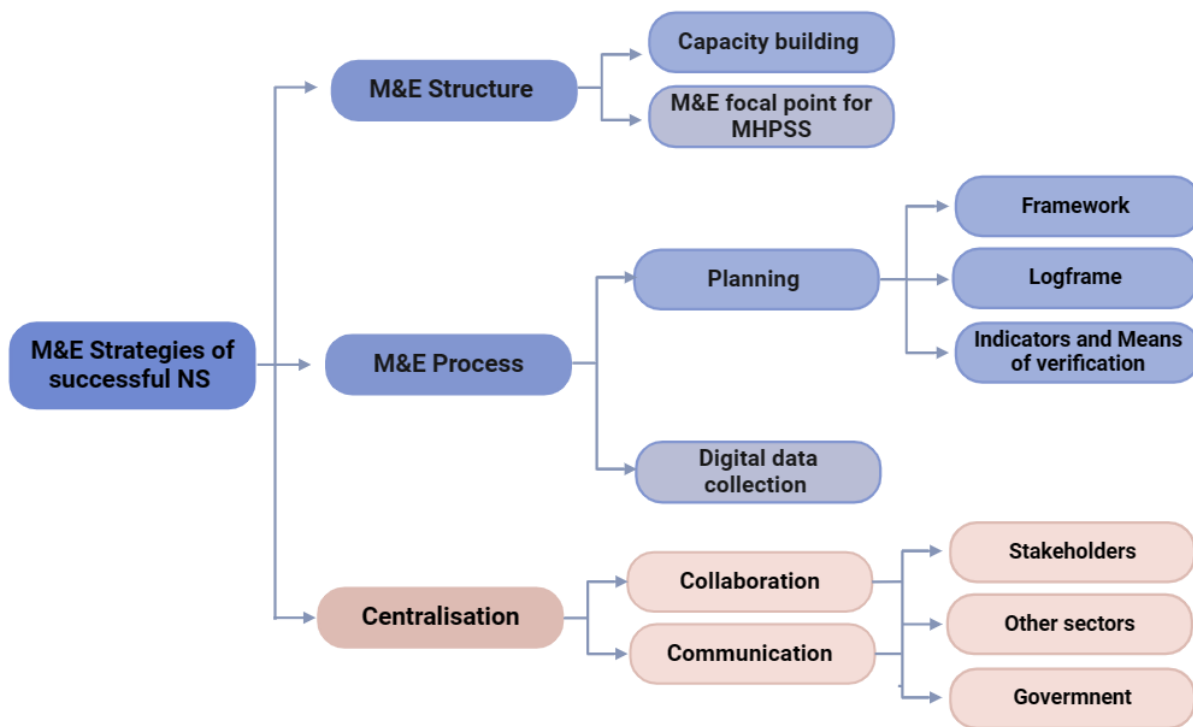
Note: The blue components are related to M&E while the warm tones are not specific to M&E.

3.2.2 The M&E Process

As emphasized by the experts, effective M&E relies heavily on thorough planning. This principle is echoed by the champion National Societies, where planning is a fundamental aspect

of their implementation strategies. This is evidenced by the development of log frames, utilizing tools provided by the Movement or the IASC. Additionally, the ARC has devised a theory of change, while the KRC has established a framework for MHPSS. Regarding assessment tools, the ARC has tailored means of verification in its bushfire project to align with specific requirements, distinct from those provided by the Movement. These tools incorporate outcome reporting. On the other hand, the KRC has adapted indicators from the Movement to suit their context, ensuring applicability nationwide. Both champions stress the importance of standardizing their M&E practices. Furthermore, the KRC assesses the capacity of its volunteers and staff trained in psychological first aid, underscoring their commitment to evaluating the effectiveness of training initiatives.

One of the pivotal aspects of the M&E champions is the automation and digitalization of their data collection processes. This enables the centralization of data, facilitating the evaluation and enhancement of both quantitative and qualitative aspects of operations, including their multi-level model, as highlighted by the KRC representative. Additionally, both champions acknowledge the value of visualization tools, with the ARC noting that: "Once power BI was rolled out across the organisation, it also meant that staff in their field could see their results like their data collection of another way of kind of reinforcing the commitment to using the M&E systems". Although both organizations initially utilized Kobo, they eventually transitioned to Power BI as an automation tool.

3.2.3 Centralisation

One of the key overall strategies employed by successful National Societies involves centralizing their M&E practices. Firstly, automating their data processes provides them with a comprehensive overview not only of the entire country but also of its various regions. This enables easier sharing of results. Both champion organizations highlight the importance of close collaboration and communication with different sectors, government entities, and stakeholders, recognizing that government involvement may also mean acting as a stakeholder. The Kenyan representative underscores the significance of collaborating with the Ministry of Health, sharing results to facilitate mutual assistance, and learning from evidence.

4. Requirements to address the challenges

In the first instance, the needs of concerned National Societies are put forward. These requirements are essential as they mirror the specific needs concerning the challenges encountered by the National Societies in their context. Subsequently, they are complemented by insights from the experiences of the successful National Societies in M&E for MHPSS, along with expert guidance from the PS Centre. Integrating these elements provides a more holistic approach to addressing the challenges posed by M&E and should pave the way for the development of future solutions. Figure 7 offers an overview of the various requirements that will be elaborated on in the following sections.

Figure 7:

Addressing M&E needs:
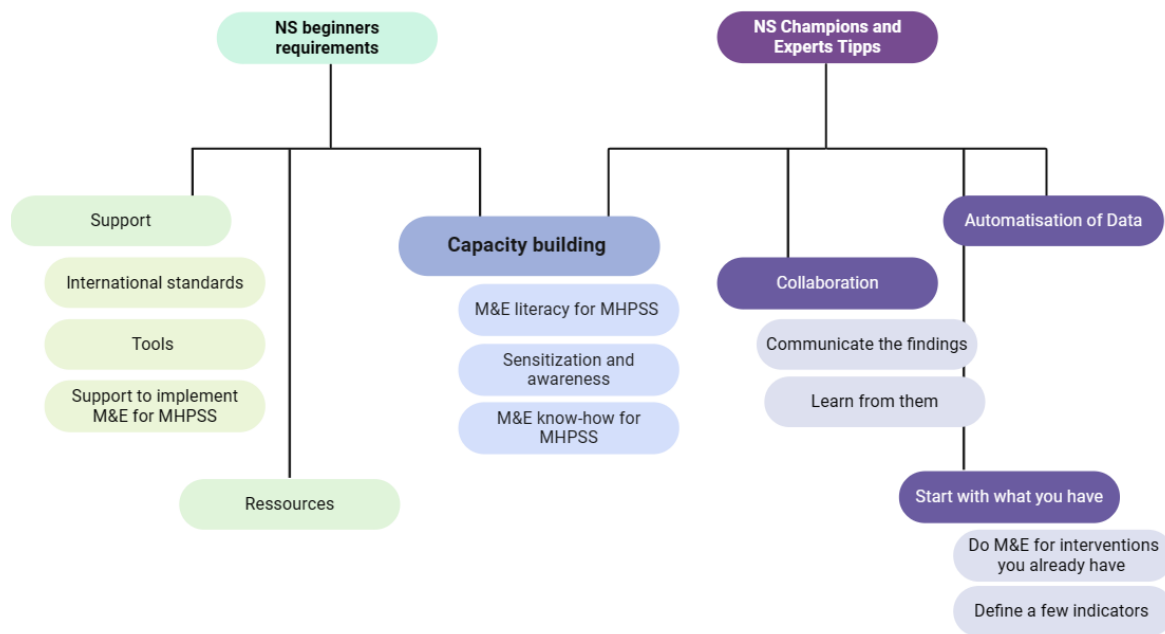
4.1 Requirement from novice National Societies

The needs of National Societies embarking on M&E can be organized into three primary themes, as illustrated in Figure 7. Firstly, there are requirements for various forms of support, such as the dissemination of best practices, the availability of user-friendly tools, and assistance with implementing M&E for MHPSS initiatives. Secondly, there is a need for adequate resources

to facilitate effective M&E activities. Lastly, there is a shared emphasis, alongside champions and experts, on capacity-building efforts to enhance skills and expertise in M&E practices.

4.1.1 Support

The SRC expresses a need for support in their implementation of M&E for MHPSS. The experts and champions corroborate this aspect of support, emphasizing assistance throughout the entire process. The following sections showcase some of the possibilities.

Dissemination of best practice examples:

Two of three SRC members recognise the importance of sharing international best practices to improve their M&E practice. As illustrated by this statement: "I think we would benefit above all from the exchange with other National Societies". They acknowledge that by identifying successful National Societies with similar contexts and structures, they can gain valuable insights from concrete examples to inform their processes. The SRC representatives emphasize that sharing best practices would not only help them acquire practical knowledge applicable to their context but also prevent redundant efforts by leveraging proven solutions. This collaborative approach is seen as important for the development of an effective M&E process. Additionally, it's suggested that the PS Centre could play a role in facilitating the development of best practice demonstrations.

Development of appropriate tools:

The two SRC members emphasized the valuable support in developing tools analogous to minimum standards for monitoring and evaluating MHPSS interventions. Echoing this sentiment, the SRC's MHPSS focal point emphasized: *"It has to be a mixture of good and simple tools that define the process and a critical examination of your own situation to see what can be realised pragmatically"*.

Assistance for M&E in MHPSS:

The final aspect of support concerns assistance in implementing interventions. The CRC advocates for the application of MHPSS initiatives, emphasizing the need for action-oriented approaches stating: "Because the truth is a lot of people need to treat mental health and the Red Cross can really help in making sure that all our ideas are more action oriented". This request is

independent of M&E practices. The focus is on increasing action in the MHPSS domain to address population needs, with the belief that the Red Cross Movement can play a pivotal role in this effort. On the other hand, for the SRC, as outlined by two interviewees, the emphasis lies more on supporting the implementation of M&E specifically for MHPSS. According to the MHPSS focal point: "(…), it would need a body that can really accompany the process from the outset and develop appropriate M&E tools". This support is viewed as essential for providing an external and comprehensive perspective on the activities. It could be facilitated by an external entity like the PS Centre or an internal specialist within the organization.

4.1.2: Resources

The second category of requests is directly linked to the challenges of financial resources. Both the CRC and the SRC interviewees pointed this out as one the key issues. One SRC member stated: "M&E needs finances. That's something you really need in project development (...) so in fundraising, you have to take into account that financial resources for M&E simply cost money and you have to budget for that somehow. It needs resources". The direct and implied solution to address the scarcity of resources involves acquiring additional funding.

4.2 Tipps from champions and experts

Both champions and experts formulated a number of tips and advice for novice or emerging National Societies in M&E in MHPSS, see also Figure 7 above.

Digitalisation and automatization:

The first advice provided by the champions, including both the KRC and the ARC, related to the digitization and automatization of data. When asked about tips for National Societies starting in M&E for MHPSS, the ARC representative emphasized the importance of digital data collection systems, stating: "The other thing for me would be if it's possible for them, the data collection system being digital. I think that was the single best decision we made at the beginning". Both National Societies have digitized their M&E systems and assert that this could facilitate the process for beginners in numerous ways. It's noteworthy that a standardized system across the National Societies simplifies data comparison and centralization.

Start with what you have:

The two champion National Societies and two experts from the PS Centre advise newly established National Societies to initiate M&E by integrating it with existing MHPSS activities. One of the experts suggests: "I'd say start small. Start with the activity you're currently doing and see if you can measure it in some way. See if you can measure them in one way". The KRC further underscores the significance of conducting baseline surveys to identify key MHPSS issues and indicators, setting the stage for comprehensive evaluation efforts. Both the National Societies and the experts advocate for a focused approach, emphasizing the use of a limited number of relevant indicators to ensure clarity and effectiveness in evaluation processes. As noted by the ARC: "I think it's important to ask yourself why you're asking certain questions". This ensures that assessments yield meaningful insights. Two of the experts further stress the significance of simplicity in M&E processes and emphasize the importance of giving priority to qualitative data.

Collaboration:

The last piece of advice from champions and experts underscores the significance of collaborating with a diverse array of stakeholders. The KRC highlights: "Being a humanitarian organization at times is a bit unique and it would help to work with other like-minded partners to be able to achieve more even in terms of raising finances and raising the support that is necessary". This aspect is further emphasized in the context of M&E as noted by one of the experts: "(…) M&E is also very much dependent on the good coordination with different departments, different sectors. It is so crosscutting in so many different ways that it cannot just go along". Indeed, both M&E and MHPSS are interdisciplinary fields requiring robust collaboration among stakeholders, including the PMER team, the MHPSS team, and external partners. This collaborative effort is characterized by ongoing communication throughout the process, particularly concerning the dissemination and utilization of results to enhance programs and foster continuous learning.

4.3 Cross-cutting requirements

As shown in Figure 7, the need for capacity building is highlighted by both the beginner and the experienced National Societies and experts.

M&E Literacy:

Capacity building is essential to improve competence and knowledge in M&E and is the first step to address the challenges. Whether it is M&E in general or M&E specifically tailored for MHPSS programmes, it is necessary to improve team members' knowledge of the subject. As one of the experts illustrates, the focus needs to be on: "What M&E is for the first training and then a second layer would be M&E for MHPSS and so there is definitely a need, to begin with". The primary goal of these training initiatives is to empower participants with a comprehensive understanding of M&E practices for MHPSS. This common understanding enables them to contribute effectively to the M&E praxis in MHPSS but also to simply grasp what M&E entails.

M&E awareness and sensitization:

Another important aspect that can be promoted through capacity building is raising awareness and sensitization to the subject of M&E. Once a certain level of M&E literacy is attained, it becomes possible to emphasize the significance of M&E for MHPSS. It also serves as a way to address the reluctance towards M&E practices and data collection. This sensitization entails highlighting how M&E validates the effectiveness of interventions and its role in strengthening accountability to donors and securing funding. While one of the constraints to the practice of M&E is a nascent MHPSS practice, there is often a lack of awareness about the interconnectedness of M&E and MHPSS. This poses a challenge, particularly among newcomers to the field. As underscored by an expert it is important that the M&E aspect of MHPSS is brought to the fore: "So that National Societies that are coming on board with MHPS programming see that one can't be without the other". This underscores the positive influence they can have on each other. Another expert suggested the following: "Try to change the narrative around M&E, not phrasing it as a donor requirement or something imposed but as something that we all can learn from and do for the sustainability of the project. This involves presenting concrete examples of how M&E has enhanced program success and impact, facilitating participants' understanding of the benefits of robust M&E practices. The KRC's MHPSS focal point recognizes the importance of using practical examples to advocate for M&E within the organization.

M&E know-how:

The final stage involves technical know-how training aimed at providing participants with the necessary skills and knowledge to identify indicators and effectively use M&E tools and technologies. This includes training on data collection method and helping participants to understand where to initiate M&E processes and how to execute them. As highlighted by a member of the SRC: "I think it's important to discuss exactly what can be evaluated and what information can be obtained to improve our work and make it more sustainable. Where to start and how to implement it". This capacity-building should foster a certain degree of independence among participants, enabling them to autonomously identify and collect the required data, as emphasised by another SRC representative.

A noteworthy aspect of capacity-building efforts is the existing training provided by the PS Centre. This training mentioned in the interviews with the experts, would actually address a majority of the requests for capacity-building. It begins with a session dedicated to general M&E literacy, followed by M&E literacy for MHPSS. Subsequently, the objective is to empower participants to independently engage in M&E practice using the tools. Participants become then familiar with the tools and receive guidance on their use. Additionally, the training includes instruction on the usage of Kobo forms.

Discussion

The analysis of the results obtained in this study provides insights into addressing the three objectives established within this research framework. Furthermore, the implications arising from these findings will be thoroughly discussed. Additionally, this discussion will encompass the identification and exploration of both opportunities and limitations encountered during the research process. Moreover, recommendations will be provided for future research, and actionable proposals for implementing the insights gained from this study will be presented.

1. Research questions

1.1 Challenges faced by National Societies

The first research question, entitled "What are the challenges faced by National Societies in relation to M&E practice in MHPSS?" revealed several barriers. As mentioned in the

theoretical framework, these challenges concern both MHPSS and M&E, as well as their specific intersection. In line with the MHPSS survey results, the main challenges are a lack of resources and technical knowledge. Looking more closely at these challenges, the first aspect is structural and impacts the whole M&E process for MHPSS, as well as the wider context. This challenge can also be described as political. As far as MHPSS is concerned, the difficulties stem from the lack of recognition of the subject, its abstract and subjective nature, and its cross-sectoral nature, which makes it difficult to identify solutions. Since neither MHPSS nor M&E are priorities in many National Societies, viewing this field as an afterthought, resourcing becomes a particular issue. There are also difficulties with M&E. The lack of understanding of the role and interdependence of both processes M&E and MHPSS, is a major concern. The excessive focus on evaluation, particularly on tangible, quantitative results, often neglects the monitoring aspect. Moreover, once M&E has been mastered, new obstacles arise with M&E for MHPSS, combining the specificities of both fields. This leads to additional challenges in data collection, particularly in the choice of indicators to measure concepts such as well-being, which may discourage some beginners.

The interviews also revealed that most of the challenges mentioned by novices National Societies are at the beginning of the M&E process and, neglect to take into account the subsequent stages. This is why later challenges are mainly addressed by experts and champions. Once the indicators have been defined, data collection can be hampered by the reluctance of volunteers and by the quality and quantity of the data collected. Analysis of the data can also be complicated by its qualitative nature, which may be unusual for those responsible for results. In addition, difficulties are often encountered when reporting or using M&E information.

As emphasized in the theoretical framework, mental health remains a neglected aspect of humanitarian services (World Bank, 2021). The role of MHPSS remains unclear in Cameroon, this sector has long been overlooked within the SRC. Overall, the challenges mirror Horn's evidence-building barriers in MHPSS. The opaque language of MHPSS, limited capacity within MHPSS programs, and the lack of collaboration between MHPSS and PMER are all somehow reflected in these challenges, illustrating the interconnectedness of M&E and evidence-building. However, the most significant challenge, beyond the lack of technical expertise, lies in understanding the broader significance of M&E, particularly in the context of MHPSS, and its

pivotal role in enhancing MHPSS services. Furthermore, the challenges were outlined concerning the M&E process for MHPSS as underlined in the interviews without directly referencing the issues identified in the survey data or in Horn's report.

1.2 Strategies of successful National Societies

The second research question focused on how successful National Societies have managed to overcome their M&E challenges in the field of MHPSS. Successful National Societies have effectively addressed M&E challenges in the MHPSS field through dedicated staff, capacity building, and thorough planning. Both the ARC and the KRC have specialized M&E staff for MHPSS initiatives, ensuring focused expertise. Capacity-building efforts prioritize uniform understanding and use of M&E data to implement an optimal M&E practice and inform training needs. Thorough planning, log frames, and standardized tools guide M&E processes, with tailored means of verification. Automation and digitalization, particularly through Power BI, centralize data and enhance visualization. The centralization of M&E practices enables comprehensive oversight and collaboration with stakeholders, including government entities and the Ministry of Health. Furthermore, after capacity-building and a clarification of the data collection process M&E is owned at all levels of the National Societies, from the project manager to the volunteers. Overall, these strategies ensure effective M&E, enhancing the impact of MHPSS programs and corroborating with the optimal M&E practices described by the experts.

It's noteworthy that in successful National Societies, MHPSS receives higher priority and increased funding. Additionally, Kenya has organized its system around the MHPSS pyramid and makes use of tools provided by the IFRC for their M&E. The strategies for M&E adopted by both successful National Societies closely align with the PMER process. For instance, both mentioned conducting initial assessments and employing log frame monitoring of indicators, which corresponds to the planning stage of M&E. The cyclical nature of the PMER cycle is further evidenced by the ARC's implementation of various improvements based on its findings and the KRC's utilization of its M&E outcomes to advocate for capacity-building initiatives aimed at enhancing service quality. This underscores the importance, as emphasized by one expert of conducting monitoring to facilitate effective evaluation. Moreover, these National

Societies exhibit a comprehensive integration of M&E across all levels, indicative of an effective system. The KRC, in particular, leverages this system for advocacy purposes, echoing Horn's model concerning the organizational traits of National Societies engaged in evidence-based practice. Horn (2023) emphasizes that showcasing evidence through publications and presentations not only influences the funding acquired but also enhances program effectiveness and advocacy efforts. Moreover, it catalyses changes in both policy and practice.

1.3 Requirements to address the challenges

These requirements were categorized into demands articulated by the National Societies themselves on one side, recommendations provided by champions and experts on the other side, and finally common requirements identified by both parties.

The novice National Societies identified three key areas for improving their M&E practice for MHPSS: increased funding, support, and capacity building. While the need for additional funding is self-explanatory it also involves priority setting and redistribution of financial resource within a National Society. The aspect of support encompasses several facets, the capacity building is a common concern shared by both novice and champion National Societies and will be elaborated upon later. In terms of support, there was a call for external assistance to disseminate best M&E practices from countries with similar contexts to their own, serving as a source of inspiration. Furthermore, there is a recognized need for the provision and development of user-friendly tools and ongoing support throughout the M&E implementation process. These measures are perceived as essential for facilitating effective M&E practices within the novice NS.

These recommendations were further reinforced by insights from experts and champions, who offered additional tips not mentioned by novice National Societies. This underscores a common observation made by an expert, highlighting the tendency of newcomers to be unaware of certain aspects of M&E. One member of the SRC echoed this sentiment, noting the challenge of devising solutions without delving deeply into the foundational aspects of the subject. Firstly, champions and experts emphasized the importance of digitizing and automating data collection systems to streamline processes and facilitate beginners' navigation of M&E practices. Standardized systems across National Societies aid in data comparison and centralization,

ultimately enhancing efficiency. Secondly, they advised starting with existing MHPSS activities and gradually integrating monitoring and evaluation. This targeted approach involves conducting baseline surveys to identify key questions and indicators, ensuring clarity and effectiveness in evaluation processes. They also emphasized the priority of qualitative data and advocated for simplicity in M&E processes. Finally, collaboration emerged as a cornerstone, with champions and experts stressing the importance of engaging a diverse array of stakeholders. Given the interdisciplinary nature of MHPSS and its cross-contextual relevance, collaboration across sectors is essential.

Capacity building is crucial for improving competence and knowledge in M&E especially tailored for MHPSS interventions. It begins with foundational M&E concepts before focusing on M&E for MHPSS, empowering participants to contribute effectively and understand the fundamentals. Raising awareness about M&E is critical to address reluctance and highlight its importance in validating interventions and securing funding. Experts stress the interconnectedness of M&E and MHPSS, advocating for a narrative shift to view M&E as a learning opportunity for sustainability. Technical know-how training equips participants with skills to identify indicators and use M&E tools effectively. This fosters independence, enabling them to collect required data autonomously.

1.4 Concluding Insights

After addressing the three research questions, it becomes evident that the primary challenge underlying the others is the lack of awareness regarding the importance of M&E in MHPSS interventions for National Societies that are starting, particularly in determining the effectiveness of interventions. Once effectiveness is established, appropriate actions can be taken. This core principle enables successful interventions to be scaled up, refined when needed, and harmful interventions to be halted. Beyond financial considerations, M&E serves as a means of upholding the "do no harm" principle and being accountable to affected populations, which is a fundament of the Movement. This is even more crucial considering that the Movement operates within highly vulnerable populations, whose vulnerabilities are further exacerbated if they experience issues related to mental health. Therefore, it is paramount to exercise utmost care and attention in addressing MHPSS concerns within these communities. M&E for MHPSS may

be a highly complex domain, but it has to be showcased and fought for. As a way to implement this, successful National Societies have systematically integrated M&E into MHPSS interventions, but also throughout the organisation largely through close collaboration. For the novice National Societies, the first step towards enhancing M&E application for MHPSS involves essential literacy and awareness-building through.

1.4.1 Comparison between the contexts

The selection of the different National Societies aimed to facilitate contextual comparison, recognizing the significant role of socio-political contexts, especially in LMICs which are often more susceptible to emergencies and mental health challenges. Additionally, the field of MHPSS is intricately linked to culture, as emphasized in both literature and interviews. Cultural nuances, particularly evident in African countries where MHPSS is often stigmatized, cannot be overlooked. While expectations of varying challenges and solutions across contexts were present, limitations hindered a comprehensive comparison. In Cameroon, the interviewee lacked expertise in M&E for MHPSS, impeding meaningful analysis. Moreover, with only one interview per National Society, data for detailed analysis was lacking. However, "psychological first aid" emerged as a recurring theme in African countries, distinguishing them from others. Given Cameroon and Kenya's geographical proximity to conflict-affected regions, notably Nigeria, the Central African Republic, Sudan, and Somalia, influences on M&E for MHPSS are inevitable (ICRC, n.d.-b). Both Cameroon and Kenya are therefore impacted by armed conflicts, refugee influxes, and other complexities, shaping the priorities and challenges faced by their respective National Societies.

1.4.2 News on MHPSS and M&E

In January 2024, the PS Centre unveiled a new web page, offering a user-friendly showcase of its resources divided into six categories (PS Centre, 2024a). Concurrently, the IFRC, in collaboration with the Danish Red Cross, launched an online e-learning course on psychological first aid, later in the month (PS Centre, 2024b). February marked a significant milestone with the ICRC, the IFRC, and the Danish Red Cross signing an agreement to transform the PS Centre into the International MHPSS Hub, signalling a major leap in

prioritizing MHPSS within the Movement (PS Centre, 2024c). These recent developments highlight the increasing emphasis on MHPSS and, consequently, on M&E for MHPSS, illustrating a growing commitment to elevate MHPSS on the organisational agenda. Beyond the Movement, among other normative and policy products, the WHO has recently introduced a new manual designed to facilitate the implementation of psychological interventions by integrating evidence-based practices into current services. Notably, the manual allocates a dedicated section, the sixth part, to the M&E of psychological interventions (WHO, 2024). These interventions correspond to the third level of the MHPSS pyramid and therefore focus on the upper part of the pyramid. This handbook illustrates the measures taken within the humanitarian context, as well as on a global scale concerning MHPSS, indicating an increasing acknowledgement of the importance of the subject.

3. Limitations and opportunities

This research work has several limitations that need to be considered when interpreting the findings. Firstly, the representativeness of the interviews was compromised due to the challenges in contacting and scheduling interviews with desired participants, as described in the methods. This resulted in a limited number of representatives from certain National Societies, with Australia, Kenya, and Cameroon having only one instead of two. The level of informativeness also varied across the interviews, reflecting their different level of competence. For instance, the lack of specialization in M&E for MHPSS from the CRC volunteer may have limited the depth of insights obtained. A second interview would have allowed a more comprehensive understanding. Another element to be taken into consideration, is that the data obtained from the interview with the ARC may not fully reflect the current situation, as the interviewee was no longer directly involved in the organization at the time of the study. Moreover, the inability to compare contexts prevented the assessment of potential variations or higher barriers in non-Eurocentric settings. Discrepancies between interview responses and previous survey data were also noted, possibly influenced by the hierarchical structure of the Movement, leading to socially desirable responses from one of the participants. Lastly, the study focused on only four National Societies out of 191 within the Movement, limiting the generalizability of the findings. Future research with broader representation and more extensive

resources will be necessary to draw conclusions applicable to the entire Movement. Additionally, the conscious exclusion of the ICRC from the study's focus further restricts its scope and applicability to the broader humanitarian landscape.

Notwithstanding these limitations, it is important to view this work as a first step toward future research and actions. As delineated in the research questions, this work seeks to initiate progress in enhancing M&E practices for MHPSS with the ultimate goal of enhancing the well-being of affected individuals going forward. The primary objective to identify barriers was accomplished by shedding light on challenges encountered by National Societies in their M&E for MHPSS efforts, aligning with the insights from Horn's survey findings (2023). It could also be highlighted, that for some National Societies, it could be tempting not to invest in M&E for MHPSS because it is considered to be too complex. Furthermore, champion National Societies offer exemplars of effective M&E systems for MHPSS, providing valuable benchmarks. These best practices can serve as a model within the Movement. Lastly, the recommendations and guidance provided for improved MHPSS implementation contribute to formulating actionable suggestions for advancement. This work has thus addressed questions that had previously remained unanswered. These findings can serve as a point of reference for in-depth research as well as for action in the field. Furthermore, this work provides an opportunity to advocate for the importance of M&E in MHPSS within the Movement, as well as in the broader research community, which predominantly focuses on clinical interventions.

4. Further research

Further research should delve into the M&E challenges specific to MHPSS in various contexts, taking into account factors such as language barriers and the socio-political situations of National Societies, particularly in conflict-affected regions where the ICRC is actively engaged.

A crucial aspect to explore is the impact of language barriers on the adoption and utilization of M&E tools, considering that many resources are predominantly available in English, with limited translations into other languages such as French, Spanish, and Arabic. This raises questions about accessibility for National Societies that may face difficulties in utilizing tools due to language constraints. Additionally, research should examine the socio-political

situations of National Societies, especially in conflict-affected regions. Understanding how political instability, security concerns, and humanitarian crises intersect with M&E practices can provide valuable insights into the unique challenges faced by National Societies operating in such environments. Highlighting best practices and successful National Societies in M&E for MHPSS within these contexts can help to find the most appropriate and efficient solutions. By addressing these aspects in further research, we can gain a deeper understanding of the complexities surrounding M&E in MHPSS and develop more tailored strategies to overcome barriers and improve the effectiveness of M&E practices in diverse contexts.

A second important aspect of future research concerns the assessment of the effectiveness of the PS Centre's training on the practice of M&E in National Societies. An evaluation of the impact of the training will help to identify areas for improvement and develop strategies for scaling up successful training models.

5. Actions areas

Due to the hierarchical nature of the Movement, leadership plays a critical role in advancing MHPSS policy and evidence-based action, requiring efforts to raise awareness and promote collaboration within the Red Cross community. By prioritizing MHPSS and its M&E, leaders and ambassadors can advocate for its importance and encourage active participation.

Funders should be encouraged to shift their focus towards evidence-informed and outcome-based results rather than purely quantitative metrics. Recognizing the nuanced nature of MHPSS outcomes, funders need to understand the significance of having a robust M&E plan in place to effectively measure impact and ensure accountability. This is all the more important in a context of increasingly fragmented space and scarcity of resources for international cooperation in health.

Within the Red Cross Movement, several actions can be taken to enhance collaboration and knowledge sharing. Establishing a platform where National Societies can share experiences and learn from each other, segmented by regions and contexts, could be valuable. This could be achieved through an interactive web platform showcasing successful interventions and lessons learned as it is also important to see what didn't work. Additionally, fostering a community of practice involving National Societies with expertise in M&E for MHPSS, such as the KRC and

external experts and institutions working on the same issues can provide guidance and support in implementing effective M&E practices. Moreover, establishing regional PS Centres within one National Society per continent, selected for their expertise and leadership in MHPSS, could further broaden operations and provide localized support and resources tailored to regional needs. Advocacy efforts are also essential to garner recognition and support for M&E and MHPSS, both within the IFRC and among National Societies. Highlighting the interconnectedness of M&E and MHPSS is crucial for their legitimacy and effectiveness. Furthermore, developing online training resources accessible to all, and offered in multiple languages, can enhance capacity building in M&E for MHPSS globally.

Fostering collaboration with universities, beginning with foundational crash courses, can promote research on MHPSS interventions and facilitate knowledge exchange between academia and practitioners. This collaboration could further reduce the gap between practice and research.

Finally, peer exposure to other institutions involved in MHPSS could be facilitated, and active participation and contribution of NS representatives to normative and policy work carried out by WHO and other stakeholders outside of the Movement should be encouraged.

In emergency contexts where individuals and communities are highly vulnerable MHPSS interventions are imperative (ICRC, 2021). The armed conflicts in Gaza (Taha et al., 2024), the Democratic Republic of the Congo (WHO-Regional Office for Africa, 2023), Sudan (The MHPSS Collaborative, 2023), and Ukraine (WHO, n.d.-a), as well as non-conflict related crises like the Türkiye-Syria earthquake (British Red Cross, n.d.) have catastrophic ramifications on mental health. In an era marked by escalating violence in conflicts and emergencies situations exacerbated by the effects of climate change (Baxter et al., 2022), humanitarian crises are on the rise. In such contexts, MHPSS interventions are indispensable. Yet, their impact hinges on the systematic implementation of M&E. Only through rigorous M&E can the effectiveness of MHPSS interventions be guaranteed. Therefore, advocating for M&E on a global scale is a necessary step in addressing the urgent mental health needs of those affected by crises worldwide.

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Appendix

1. Questions for experts:

- You are the M&E Focal Point at the PS Centre? What exactly do you do in this function? How concretely do you support NS in this role?
- What is your understanding of M&E of MHPSS? What definition do you use? Is M&E for MHPSS different to other sectors, if yes why or no why?
- Why is M&E important for MHPSS?
- What resources do you work with or recommend to NS? Why? What makes these resources good? Where do you see challenges with existing resources?
- What does an optimal M&E practice look like for you? What is integral to the success of MHPSS M&E for NS and what is needed to achieve this?
- What are the missed opportunities if NS are not evaluating their MHPSS services?
- Where are the biggest common gaps in knowledge on M&E in MHPSS in the NS you are in touch with?
- What are the main reasons for the NS not to invest more in Monitoring or Evaluating their MHPSS activities or the reasons for not having a system in place to monitor or evaluation your MHPSS activities?
- What are some of the things NS usually find easy to do when developing an MHPSS M&E programme, why were these things easy?
- What are the main common challenges or barriers that NS you work with face when establishing or implementing monitoring and evaluation programs or measures for MHPSS?
- How do/can you support them to overcome those barriers/challenges?
- What is most supportive for NS?
- What could be done more/better to empower NS to do more M&E? (eg. more trainings, information about opportunities) Is there - from your experience - anything missing that you think would be helpful?
- How can NS best build their M&E process in MHPSS? What can they use?
- Do you know any best practice examples? What made the difference?

- Do they know and apply the existing resources/guidance to monitor and evaluation MHPSS activities? (IFRC PS Centre M&E Framework, ICRC Guidelines etc)? Are they helpful to them? What is helpful? What not?
- What do they need to apply those resources in their NS? (Finances, technical support?) What kind of support do they need or like to improve their M&E practice? (eg Trainings, Guidance, help with cultural adaptation) From whom?
- What would be the three most important things you would recommend to NS when developing MHPSS M&E?

Extra question from WG 4

How can NS best collect data on the effectiveness of PFA? Do you know any best practice examples?

2. Questions for NS

Information about Person and Context

- What is your function at the NS? What is your specific role in regard to M&E of MHPSS?
- Problem faced by population/ people in relation to MHPSS? What MHPSS interventions are you involved with?

Understanding of M&E

- What is your understanding of M&E with MHPSS? What definition do you use?
  - What is different from M&E for MHPSS and M&E for other sectors?
- What is a successful MHPSS intervention in your perception?
  - How will you know if it is successful?
  - How do you define indicators that are able to tell you if your intervention was successful - give an example.
  - What indicators do you use (qualitative vs. quantitative and output (number of users, number of trainings) vs outcome (improvement of wellbeing))
  - How do you see the importance of M&E for MHPSS interventions?

M&E Practice

- How concretely do you monitor/evaluate the MHPSS activities your NS is involved with?
  - eg. external evaluations, inhouse evaluations via interviews or focus group discussions, number of beneficiaries, supervisor reports, surveys, systematic programme review or evaluations, timesheets, psychometric tools or other.
  - Why did you choose this form of monitoring or evaluation?
  - Could you share any documents (eg. used frameworks, etc.)
  - How do you monitor/evaluate your Psychological First Aid (PFA) activities?
- What did you use to build your M&E MHPSS process? How did you go about it?
- What are some of the things you found easy to do when developing an MHPSS M&E programme, why were these things easy?
- Did you use any key guidelines when developing your MHPSS M&E programme?
- What existing resources/guidance/tools or trainings do you currentliy use to monitor and evaluation MHPSS activities?
  - eg. IFRC PS Centers M&E Framework, ICRC Guidelines etc)
  - Are the existing resources helpful and applicable in the field? What is helpful? What not?
  - What would you need to better apply them in your NS?
- How is M&E in your NS organized: Are you in charge also or do you have…
  - a focal point for M&E or
  - PMER-L people, who support you or
  - external help (eg academia)?
  - When do they get involved (from the planning?) Are they specialized in MHPSS?
- What is the main purpose of your M&E activities?
  - eg. for funding partners, to improve the services, for publicity
  - Who uses the results?
  - Do you publish the results? Finance, health, report, control of interventions, quality checks, online, ethics
- Is there anything you would like to do differently concerning your actual M&E practice at your NS ? Why?

- What are some key lessons you have learnt in developing your MHPSS M&E? And what would you do differently?

- What would you need to make your M&E of MHPSS activities even better? Is there anything missing that you think would be helpful?

- What type of support would you need to… (specify)? From whom?

- Champions: What advice would you give to NS that want to start establishing an M&E system for MHPSS activities?

    o How should they go about it?

    o What lessons learned do you want to pass on to other NS doing M&E.

    o what would be three most important things you would recommend to another NS when developing MHPSS M&E

Challenges with M&E

- What are the main challenges or barriers that you faced when establishing or implementing monitoring and evaluation systems/programs in your NS?

    o eg. funds, lack of technical knowhow?

- What did you try/do to address or overcome these challenges?

    o What worked or helped, what did not work/help? And why? Why not?

    o Can you give me one or two concrete examples?

- What are the biggest gaps in knowledge on M&E in MHPSS in your NS?

- What are current barriers? What would help to overcome this?

Structural/Organizational Factors

- Champions: What are the main reasons for your NS to invest in Monitoring or Evaluating your MHPSS activities?

- Beginners: What are the main reasons for your NS not to have invested more into Monitoring or Evaluating of MHPSS activities in the past?

- What organizational or structural factors facilitate M&E of MHPSS activities in your NS?

- What organizational or structural factors complicate M&E of MHPSS in your NS?

Advocacy for M&E

- Why is it important in your personal perception to invest (more) into do M&E? What makes ist beneficial?
- How can we develop or advocate for more evidence-building activities within NS?

Erklärung zur Masterarbeit

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Ort / Datum: Bern, den 28. März 2024

Unterschrift: