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FIELD TEST VERSION

OPERATIONAL GUIDELINES

COMMUNITY-BASED MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN HUMANITARIAN SETTINGS:

Three-tiered support for children and families

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LIST OF ACRONYMS

BFS	Baby-friendly spaces
CBCPM	Community Based Child Protection Mechanism
CB MHPSS	Community Based Mental Health and Psychosocial Support
CCC	Core Commitments for Children in Humanitarian Action
CCCM	Camp coordination and camp management
CFS	Child-friendly spaces
CP	Child protection
CPWG	Child Protection Working Group
CSO	Civil Service Organization
DRR	Disaster risk reduction
DWC	Department of Women and Children (Nepal)
ECD	Early childhood development
IASC	Inter-Agency Standing Committee
IOM	International Organization for Migration
IPT	Interpersonal therapy
LGBTI	Lesbian, gay, bisexual, transgender and intersex
MEHE	Ministry of Education and Higher Education (Lebanon)
MNS	Mental, neurologic and substance abuse
mhGAP	Mental Health Gap Action Plan
M&E	Monitoring and evaluation
MHPSS	Mental health and psychosocial support
MoPH	Ministry of Public Health (Lebanon)
MOSA	Ministry of Social Affairs (Lebanon)
MoU	Memorandum of Understanding
NMHP	National Mental Health Programme (Lebanon)
PCA	Project Cooperation Agreement
PFA	Psychological first aid
PM+	Problem Management Plus
SDC	Social Development Centre (Lebanon)
SEL	Social and emotional learning
SGBV	Sexual and gender-based violence
SOP	Standard operating procedure
SSFA	Small Scale Funding Agreement
SSOP	Simplified Standard Operating Procedures
TPO	Transcultural Psychosocial Organization (Nepal)
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, sanitation and hygiene
WHO	World Health Organization

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DEFINITION OF KEY TERMS

CHILD	*Child* is defined as all children and adolescents aged 0-18 years of age (according to the Convention on the Rights of the Child). The term is inclusive of boys, girls and LGBTI children; children with protection risks or exposed to serious events; and children with disabilities or with mental, neurologic and substance abuse (MNS) disorders.
CAREGIVER	*Caregiver* refers to those responsible for the care of children, and may include mothers and fathers, grandparents, siblings and others within the extended family network, as well as other child caregivers outside of the family network.
COMMUNITY	*Community* includes men and women, boys and girls, and other stakeholders in child and family wellbeing, such as teachers, health workers, legal representatives and religious and governmental leaders. Community can be defined as a network of people who share similar interests, values, goals, culture, religion or history – as well as feelings of connection and caring among its members.
COMMUNITY MOBILIZATION	*Community mobilization* is "Efforts made from both inside and outside the community to involve its members (groups of people, families, relatives, peers, neighbours or others who have a common interest) in all the discussions, decisions and actions that affect them and their future." (IASC MHPSS Guidelines, Action Sheet 5.1, p. 61[1])
COMMUNITY PARTICIPATION	*Community participation* is the process by which individuals, families or communities assume responsibility for their own welfare and develop the capacity to contribute to their development. Community participation refers to an active process whereby the beneficiaries influence the direction and execution of projects rather than merely receive a share of the benefits.[2]
CULTURE	*Culture* is a set of shared values, beliefs and norms among a society. Culture is dynamic, changing as societies adapt to new information, challenges and circumstances.
FAMILY AND KINSHIP	*Family* is a socially constructed concept that may include children who live with one or both biological parents or cared for in various other arrangements such as living with grandparents or extended family members, with siblings in child- or youth-headed households, or in foster care or institutional care arrangements. *Kinship* indicates culturally recognized relationships defining roles and obligations between individuals and groups. In many contexts, kinship relationships extend far beyond those included in the conventional idea of a "nuclear family".
RESILIENCE	*Resilience* is the ability to overcome adversity and positively adapt after challenging or difficult experiences. Children's resilience relates not only to their innate strengths and coping capacities, but also to the pattern of risk and protective factors in their social and cultural environments.[3]
WELLBEING	*Wellbeing* describes the positive state of being when a person thrives. In mental health and psychosocial work, wellbeing is commonly understood in terms of three domains[4]: 1. Personal wellbeing – positive thoughts and emotions such as hopefulness, calm, self-esteem and self-confidence 2. Interpersonal wellbeing – nurturing relationships, a sense of belonging, the ability to be close to others 3. Skills and knowledge – capacities to learn, make positive decisions, effectively respond to life challenges and express oneself

1 IASC MHPSS Guidelines, Inter-Agency Standing Committee, Geneva, 2007.

2 Paul, Samuel, "Community Participation in Development Projects: The World Bank Experience," in 'Readings in Community Participation', Washington, D.C.: EDI. Chapter 2. (WHO, COMBI), 1987.

3 Dr. Michael Ungar, in Hague Symposium Report, 2015.

4 UNICEF, Inter-Agency Guide to the Evaluation of Psychosocial Programming in Emergencies, United Nations Children's Fund, New York, 2011.

It has long been known that children's development benefits from positive attachment to caregivers. Nevertheless, new findings show that the social environment of children and families – such as cultural adherence, social cohesion, material resources and identity – are also important.

INTRODUCTION

UNICEF reports that almost one in ten children around the world live in areas affected by conflict and over 400 million children live in extreme poverty.[5] At the end of 2016 the United Nations High Commissioner for Refugees (UNHCR) reported that the number of displaced people was at its highest ever, a total of 65.6 million, and that almost 100,000 children were separated or unaccompanied in 78 countries. [6]

The challenges children face grow more threatening every day, ranging from large-scale conflict and displacement to poverty, violence and exploitation in many forms.

The escalation and protracted nature of conflicts today and the large-scale migration of families in search of safety and economic opportunity have led to a child protection crisis. Terrorism, disease outbreaks, intensifying natural disasters and the impacts of climate change also contribute to the changing dynamic of threats for children, families and communities in such contexts. They may lack adequate security, access to psychosocial support and recreational activities, and school for months, sometimes years. Moreover, in such vulnerable situations children can also be targeted by violent extremist groups and may experience various forms of violence or recruitment into extremist ideologies.

Mental health and psychosocial support (MHPSS) is a critical component of the United Nations Global Strategy for Women's, Children's and Adolescents' Health for 2016-2030. It is also a fundamental part of UNICEF's Core Commitments for Children (CCC) in Humanitarian Action, released in 1998 and revised in 2010. Building upon decades of experience in programming for children and adolescents, the *UNICEF Guidelines for Community based MHPSS in Humanitarian Settings: Three-tiered support for children and families* aim to protect and promote children's wellbeing and full participation within the family and community systems that surround and support them.

WHY WERE THE GUIDELINES DEVELOPED?

The CB MHPSS operational guidelines were developed in response to emerging evidence on the determinants of children's resilience, lessons learned from the evaluation of existing approaches, and the unique challenges that today's crises pose for children's safety, wellbeing and optimal development.

During the symposium 'Growing Up in Conflict: The impact on children's mental health and psychosocial wellbeing', convened by UNICEF together with the Government of the Netherlands and a wide range of humanitarian and academic partners in May 2015 in The Hague, it was noted that interventions "help promote resilience by aiming to strengthen protective factors in children's lives so that they are able to develop attachments and rebuild hope and agency."[7] It has long been known that children's development benefits from positive attachment to caregivers.8 Nevertheless, new findings show that the social environment of children and families – such as cultural adherence, social cohesion, material resources and identity – are also important.7 These findings and lessons learned from decades of MHPSS programming in humanitarian settings inform the UNICEF guidelines and support the focus on community engagement and systems strengthening from national to community levels.

UNICEF has always promoted a holistic, community based approach to child programming. However, there is a need to reaffirm and better operationalize that commitment in evolving humanitarian contexts and crises. Models centred on child-friendly spaces (CFS) have demonstrated certain limitations in engaging families and communities, as well as in transitioning early emergency response to recovery and regular programming. Evaluations of CFS approaches also emphasize the need to improve both the scale and quality of MHPSS

5 UNICEF Child Alert, 'Danger Every Step of the Way: A harrowing journey to Europe for refugee and migrant children', June 2016.

6 UNHCR, *Global Trends: Forced displacement in 2016*.

7 Maria Bray, Sabine Rakotomalala, Leslie Snider, Saji Thomas, *Report on the symposium Growing Up in Conflict: The impact on children's mental health and psychosocial wellbeing', The* Hague, 2015.

8 J. Bowlby, *Attachment and Loss, Vol. 1 Attachment*, New York, Basic Books, 1969.

MOVING BEYOND CHILD-FRIENDLY SPACES TO SYSTEM STRENGTHENING

Child-friendly spaces (CFS) play an important protective and supportive function for children in adverse circumstances, ensuring children have a safe place to gather for play, for self-expression and learning.

In a 2015 collaborative study by UNICEF, World Vision, Columbia University and Save the Children found that while CFS are instrumental in promoting children's well-being, they are weaker in engaging communities; this limits community ownership and resilience and the likelihood of sustaining the longer-term impacts of psychosocial interventions. Additionally, while unstructured play in a safe space can be a protective factor for children facing certain risks, unstructured play does not have the same potential impact for positive growth in terms of healing and recovery for children who have experienced very stressful or traumatic events.

Accordingly, for CFS to ensure children's mental health and psychosocial wellbeing, they need to be established and operated in a way that engages or strengthens support systems within families and communities. When CFS activities are provided by staff or volunteers trained in psychosocial principles – such as children's reactions to stressful events at different ages and appropriate activities for calming, expression and socialization – children's psychosocial wellbeing is protected and may also improve.

interventions to improve children's wellbeing.[9] The guidelines offer practical information and tools to implement a range of MHPSS interventions to rapidly address the protection and psychosocial support needs of children and families, in parallel with tailored mental health interventions for those most in need.

Based on experience, there is broad international consensus for shifting from a single focus on treatment of psychological symptoms to "contextually appropriate, multi-layer systems of support that build on existing resources."[10] This includes, for example, strengthening refugee communities' own capacities for protection and psychosocial wellbeing.

WHAT IS THE AIM OF THE GUIDELINES?

The CB MHPSS operational guidelines are designed and intended to help UNICEF staff and partners support and promote safe, nurturing environments for children's recovery, psychosocial wellbeing and protection. The guidelines present an operational framework that emphasizes engaging actors at all levels (children, caregivers, families and community service providers) to design and implement MHPSS strategies that are locally relevant, comprehensive and sustainable in order to more effectively restore, strengthen, and mobilize family and community supports and systems with the ultimate goal of supporting child and family wellbeing in humanitarian settings.

Restoring, strengthening and mobilizing family and community supports and systems ultimately aims to support child and family wellbeing by:

- Reducing and preventing harm.
- Strengthening people's resilience to recover from adversity.
- Improving the care conditions that enable children and families to survive and thrive.

WHO SHOULD USE THE GUIDELINES?

These guidelines are intended for UNICEF staff, partners and other agencies in humanitarian settings to help effectively embed MHPSS programmes for child and family wellbeing in communities. They are especially relevant for partners working in child protection, health and nutrition, education, camp management and water, sanitation and hygiene (WASH) to better understand the MHPSS needs of people facing or recovering from adversity. A deeper understanding of the guidelines in the field will help to improve coordination across sectors, facilitate referrals to ensure that MHPSS needs are met, and enhance coordinated implementation of effective and culturally sound humanitarian interventions that reduce the potential for further harm.

9 J. Metzler, K. Savage, M. Yamano and A. Ager, 'Evaluation of child friendly spaces: An inter-agency series of impact evaluations in humanitarian emergencies', Columbia University Mailman School of Public Health and World Vision International, New York and Geneva, 2015

10 M. Jordans, H. Pigott and W. Tol, 'Interventions for children affected by armed conflict: A systematic review of mental health and psychosocial support in low and middle income countries, *Curr Psychiatry Rep*, 18: 9, 2016. DOI 10.1007/s11920-015-0648-z.

WHAT PRINCIPLES AND STANDARDS UNDERPIN THE GUIDELINES?

UNDERPINNING PRINCIPLES OF THE CB MHPSS OPERATIONAL GUIDELINES

- Wellbeing depends upon the interplay of physical, social, cognitive, emotional and spiritual elements.
- MHPSS has a critical role in creating and supporting conditions for children's optimal development and wellbeing in emergencies.
- Engagement and participation of families, caregivers and communities and children themselves is central to ensuring enabling environments for children's development and securing their protection, wellbeing and future potential.

The CB MHPSS operational guidelines align with and draw from multiple international, widely adopted guiding principles, frameworks and conventions related to child protection, child rights and MHPSS in emergencies which are critical to safeguarding and promoting enabling environments in which children can reach their full potential. Three core underpinning documents to these guidelines are: *Convention on the Rights of the Child*[11], *Minimum Standards for Child Protection in Humanitarian Action*[12], and the *IASC Guidelines on MHPSS in Emergency Settings*.

Fundamental tenets of child wellbeing as enshrined in the Convention on the Rights of the Child and principles and strategies of the *Minimum Standards for Child Protection in Humanitarian Action* are cornerstone to the guidelines. They are integral with the intention to capitalize and operationalize

11 UN General Assembly, *Convention on the Rights of the Child*, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3

12 Minimum standards for child protection in humanitarian action. Child Protection Working Group (CPWG) (2012).

standards that set forth to protect the rights of every child – including rights to basic health and welfare, family life, education, leisure and cultural activities, and special protection in certain situations such as humanitarian emergencies – and establish common principles and practices among CP actors.

The IASC Guidelines on MHPSS in Emergency Settings (2007) provide the basis for the UNICEF operational framework in emergencies as described in this document. The guidelines enable humanitarian actors and communities to plan, establish and coordinate a set of minimum multisectoral responses to protect and improve people's mental health and psychosocial wellbeing in the midst of an emergency. The IASC guidelines note that MHPSS refers to "any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental disorder" and are based on the following core principles, supporting a community based approach:

TABLE 1: CORE PRINCIPLES OF THE IASC GUIDELINES FOR MHPSS IN EMERGENCIES

HUMAN RIGHTS AND EQUITY	Promote human rights of all affected persons and protect those at heightened risk of human rights violations; ensure equity and non-discrimination in the availability and accessibility of MHPSS supports
PARTICIPATION	Maximize the participation of local children, families and communities in assessment, design, implementation and monitoring and evaluation of humanitarian response
DO NO HARM	Reduce the potential for MHPSS and other humanitarian interventions to cause harm, through for example effective coordination, adequate understanding of the local context and power relationships, cultural sensitivity and competence, and participatory approaches
BUILD ON LOCAL CAPACITIES AND RESOURCES	Support self-help and identify, mobilize and strengthen existing resources, skills and capacities of children, families, the community, government and civil society
INTEGRATED SUPPORT SYSTEMS	Support activities integrated into wider systems (e.g., community supports, formal/non-formal school systems, health and social services) to advance the reach and sustainability of interventions and reduce stigma of stand-alone interventions
MULTI-LAYER SUPPORTS	Develop a multi-layer system of complementary supports to meet the needs of children and families impacted in different ways

HOW ARE THE GUIDELINES STRUCTURED?

The CB MHPSS Operational Guidelines consist of three sections:

- UNDERSTANDING COMMUNITY BASED MHPSS: This section covers what is meant by community based MHPSS and its key elements.
- SOCIAL ECOLOGICAL MODEL OF CHILDREN'S DEVELOPMENT AND THREE-TIERED SUPPORT: This section covers the importance of networks of people and structures that surround children, safeguarding their wellbeing and supporting their optimal development; understanding child wellbeing, resilience and development; and UNICEF's MHPSS theory of change.
- OPERATIONALIZING COMMUNITY BASED MHPSS: This section elaborates on the nine circles of support; intervention strategies implemented within the three tiers of the social ecological model: children, family/caregivers, and community; monitoring and evaluation of MHPSS projects; and community engagement, participation and mobilization including information on working with different stakeholders toward integrating MHPSS across humanitarian sectors.

SEE COMPENDIUM
Various Compendium resources are indicated throughout the guidance in text boxes like this.

In addition, seven annexes provide further details on: community based MHPSS in practice (annex 1); action sheets for other actors from the IASC Guidelines on MHPSS in Emergency Settings (annex 2); key commitments, frameworks and minimum standards (annex 3); UNICEF CB MHPSS log frame (annex 4); scalable interventions (annex 5); changing contexts and responses to strengthen resilience (annex 6) and entry points for MHPSS in the humanitarian program cycle (annex 7).

The CB MHPSS operational guidelines were developed in close alignment with the accompanying *Compendium of resources for community based MHPSS in humanitarian settings*. The Compendium provides key resources for the design, implementation and monitoring and evaluation (M&E) of CB MHPSS programmes. The resources chosen for the Compendium provide programme implementers with the tools to develop interventions according to evidence-based criteria and good practice standards.

The CB MHPSS operational guidelines are designed and intended to help UNICEF staff and partners support and promote safe, nurturing environments for children's recovery, psychosocial wellbeing and protection.

UNDERSTANDING COMMUNITY BASED MHPSS

A number of interventions can be labelled as community based MHPSS provided they are part of a more strategic psychosocial and mental health approach with the aim to build on existing individual and community resources, capacities and resilience. A community based approach:

- Strengthens natural supports and systems.
- Makes use of community knowledge and capacities.
- Requires skills and a thorough analysis of local practices and resources to carry out MHPSS. programmes in line with the principle of 'do no harm'.
- Involves community engagement in all phases of programming.
- Addresses interventions at all layers of the IASC MPHSS pyramid.
- Includes both lay and professional services and psychological and social supports.

STRENGTHEN NATURAL SUPPORTS AND SYSTEMS

A community based approach to MHPSS in emergencies strengthens the care and protection environment for the benefit of all children and families. The approach works with and through a community's natural supports and systems. This contributes to a stronger overall care environment, which promotes inclusion of the most vulnerable children and families in existing supports and reduces the potential for stigma. Mapping and systematically building on local resources such as community networks, practices and processes helps to build scalable and sustainable programmes.

SEE COMPENDIUM
Section 6. Additional Resources for information, communication and education materials for advocacy and awareness-raising.

Strengthening natural supports and systems also helps to link MHPSS responses to recovery and regular, non-humanitarian response programming. Emergency situations focus attention on the mental health needs of the population and provide an opportunity to transform MHPSS care for children and families for the long term – including specialized psychological and social services for those in need, for example children and caregivers with mental, neurologic and substance abuse (MNS) disorders, protection risks or serious distress.

CAPITALIZE ON COMMUNITY KNOWLEDGE AND CAPACITIES

The community based MHPSS approach recognizes that all people have skills, assets and resources for coping. The coping capacity of people varies according to individual and environmental characteristics, and may be undermined or weakened by the emergency. It is, however, clear that families and communities know the risks and resources in their environment, and the factors that support and hinder the wellbeing and protection of children and families.

Strengthening resources and capacities for self-help makes best use of people's knowledge and capacities to recover, and to help their children do the same. Interventions that engage participation by the community are more likely to be meaningful and sustainable – and to help restore people's sense of competence and self-agency to meet new challenges and be hopeful about the future.

DEVELOP COMPETENCIES FOR IMPLEMENTATION IN CHALLENGING HUMANITARIAN SETTINGS

Working in a community based approach in a humanitarian setting is challenging. It requires time and commitment, and a willingness to listen and be open to new ideas and ways of approaching problems. It also requires the ability to effectively and respectfully address harmful practices or historical patterns of exclusion and marginalization of some groups. Because some local practices can cause harm, MHPSS workers must examine and support local practices and resources only if they fit with international standards of human rights.

"...All affected groups have assets or resources that support mental health and psychosocial wellbeing. A key principle – even in the early stages of an emergency – is building local capacities, supporting self-help and strengthening the resources already present... Where possible, it is important to build both government and civil society capacities."

Source: IASC MHPSS Guidelines, pp. 10-11

> **"Facilitating community social support and self-help requires sensitivity and critical thinking. Communities often include diverse and competing subgroups with different agendas and levels of power. It is essential to avoid strengthening particular subgroups while marginalizing others, and to promote the inclusion of people who are usually invisible or left out of group activities."**
>
> *Source: IASC MHPSS Guidelines, p. 100*

In some emergency situations, the political situation or specific dangers may limit community participation. But to the extent possible, community mobilization and participation are worthy investments that offer substantial returns in terms of appropriateness, acceptability and effective targeting of interventions. Furthermore, any intervention aimed at strengthening the protection environment for children – and at promoting inclusion of vulnerable or marginalized children – can only be truly effective through community understanding, will and participation.

ENSURE COMMUNITY ENGAGEMENT

A community based approach entails a process of community engagement and involvement through all phases of the programme cycle – assessment, design and implementation and M&E. Community involvement ranges from partnership to ownership, depending upon the situation and the community's resources to implement and sustain interventions. Given the mandate to 'do no harm', it is essential that interventions do not damage natural community supports. Instead, they must identify, engage and work within existing supports.

For example, community assessments should be participatory, involving diverse community members. This may require speaking to groups separately – such as men and women, adults and children, people of different ethnicities or castes – so that everyone feels comfortable expressing their opinion and ensuring that a diverse array of voices are heard.

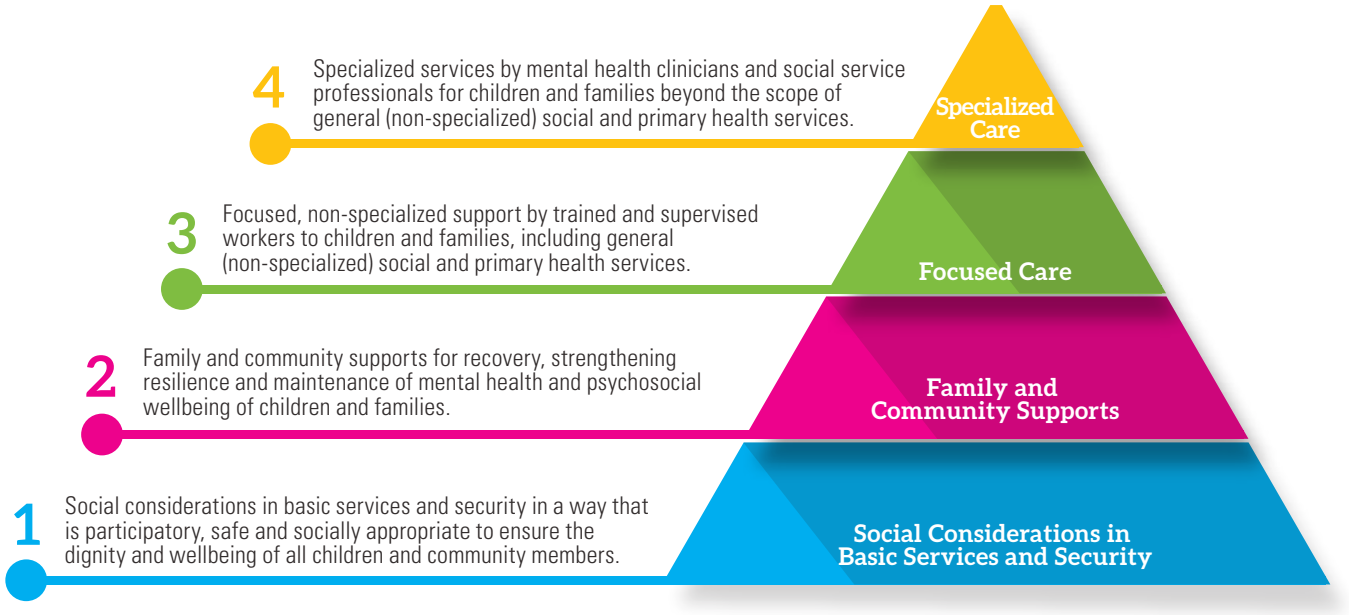
ADDRESS INTERVENTIONS AT ALL LAYERS OF THE IASC MPHSS PYRAMID

The IASC MHPSS intervention pyramid (see figure 1) shows the four layers in the system of supports for people's recovery and wellbeing in humanitarian emergencies.[13] It begins with community foundations and works its way up to specialized care, with fewer people needing the services at each layer.

The **first layer,** social considerations, is the broadest. It represents the foundations of wellbeing for all people affected by crisis events. It ensures that basic services and security are delivered in

13 This is an adaptation of the IASC MHPSS intervention pyramid that continues to benefit from application in the field and further discussion among experts.

FIGURE 1: THE IASC MHPSS PYRAMID



ways that are participatory, safe and culturally appropriate.

In the **second layer**, family and community supports, many people also benefit from strengthening supports and protective functions for family and community resilience.

The **third layer,** focused care, includes person-to-person support for distress, to address protection risks, or to maintain or enhance mental health and psychosocial wellbeing. It is delivered by trained and supervised lay or non-specialized workers.

The **fourth layer**, specialized services, consists of professional care for people who have complex protection needs or for assessment and management of MNS disorders. Delivered by mental health clinicians or social service professionals, specialized services are provided for children and families whose care and protection cannot be managed at lower layers of the pyramid.

Multiple layers of MHPSS support are needed to adequately meet the needs of *all* children and caregivers, including those with MNS disorders or those exposed to serious protection risks or traumatic events. Just as community health and social workers do not operate in isolation from formal health and social service systems, nor do MHPSS actors operate in isolation from specialized mental health, protection, social service and other systems that support child and family wellbeing. Although the percentage of children and adults who require focused or specialized services may be small, they are a significant number in today's increasingly protracted and violent emergencies.

It is important for actors across all sectors to be aware of the continuum of MHPSS needs of children and families in emergencies, and to ensure functional referrals up and down the layers of the pyramid. Interventions can best reach children and families when they are integrated within sectors and structures, such as health and protection structures, rather than as stand-alone programmes (e.g., specialized services without other layers of support).

Other structures also serve as entry points, such as schools, social service systems, community centres and safe spaces, and community organizations such as youth clubs, women's cooperatives and religious organizations. MHPSS programmes also should avoid over-targeting sensitive groups (e.g., survivors of sexual and gender-based violence [SGBV] or children formerly associated with armed forces/groups) in ways that further their discrimination and exclusion in communities. Instead, it is best to work towards broad support and advocacy to promote the inclusion and wellbeing of all community members.

INCLUDE LAY AND PROFESSIONAL SERVICES; PSYCHOLOGICAL AND SOCIAL SUPPORTS

As the term 'mental health and psychosocial support' implies, there is a close relationship between the psychological and social aspects of a child's development and wellbeing. Various personal, social and environmental factors influence the wellbeing of children and families and their ability to recover from adversity. MHPSS approaches therefore cover social and psychological interventions at all layers of the pyramid as well as supports delivered by both professional and lay staff.

Lay people who receive proper training and regular supervision by mental health clinicians can also provide scalable interventions to support adults suffering from depression, anxiety and stress. (*See Annex 5: Scalable Interventions for more information.*)

In a comprehensive MHPSS approach, lay and professional actors work together across the pyramid to meet the community's needs. Both lay and professional support providers require certain competencies to do their tasks. Establishing minimum qualifications and standards of lay and professional MHPSS providers is an important aspect of a community based MHPSS approach.

Specialized services may include:

- Clinical services provided by mental health professionals (e.g., psychological or psychiatric services including pharmacological treatment of mental disorders).
- Management of MNS disorders by nurses, clinical officers and physicians.
- Specialized protection and social services (e.g., case management, outreach to vulnerable families) provided by social service professionals.14

With training and supervision, lay people can provide non-clinical psychosocial support to children and families, such as:

- Peer support.
- Cultural and recreational activities for children.
- Identification of vulnerable families for referral to specialized supports.
- Psychological first aid (PFA), which includes assessing needs and concerns; helping people address basic needs; listening to and comforting people and helping them feel calm; helping connect to information, services and social support; and protecting people from further harm.[15]

These elements are also reflected in three action sheets of the IASC Guidelines on MHPSS in Emergency Settings dedicated to community mobilization and support:

14 UNICEF may work through credible partners in the field in providing specialized services such as clinical mental health care. Partners should be familiar with and comply with international quality standards for specialized services, such as the IASC MHPSS Guidelines and mhGAP in Humanitarian Settings Guidelines.

15 Source: 'Psychological First Aid: Guide for Field Workers', World Health Organization (WHO), War Trauma Foundation and World Vision International, 2011.

ACTION SHEET 5.1

FACILITATE CONDITIONS FOR COMMUNITY MOBILIZATION, OWNERSHIP AND CONTROL OF EMERGENCY RESPONSE IN ALL SECTORS. The response to an emergency should be owned and controlled as much as possible by the affected population, utilizing their own support structures. At every step, relief efforts should support participation, build on what local people are already doing to help themselves, and avoid doing what local people can do for themselves.

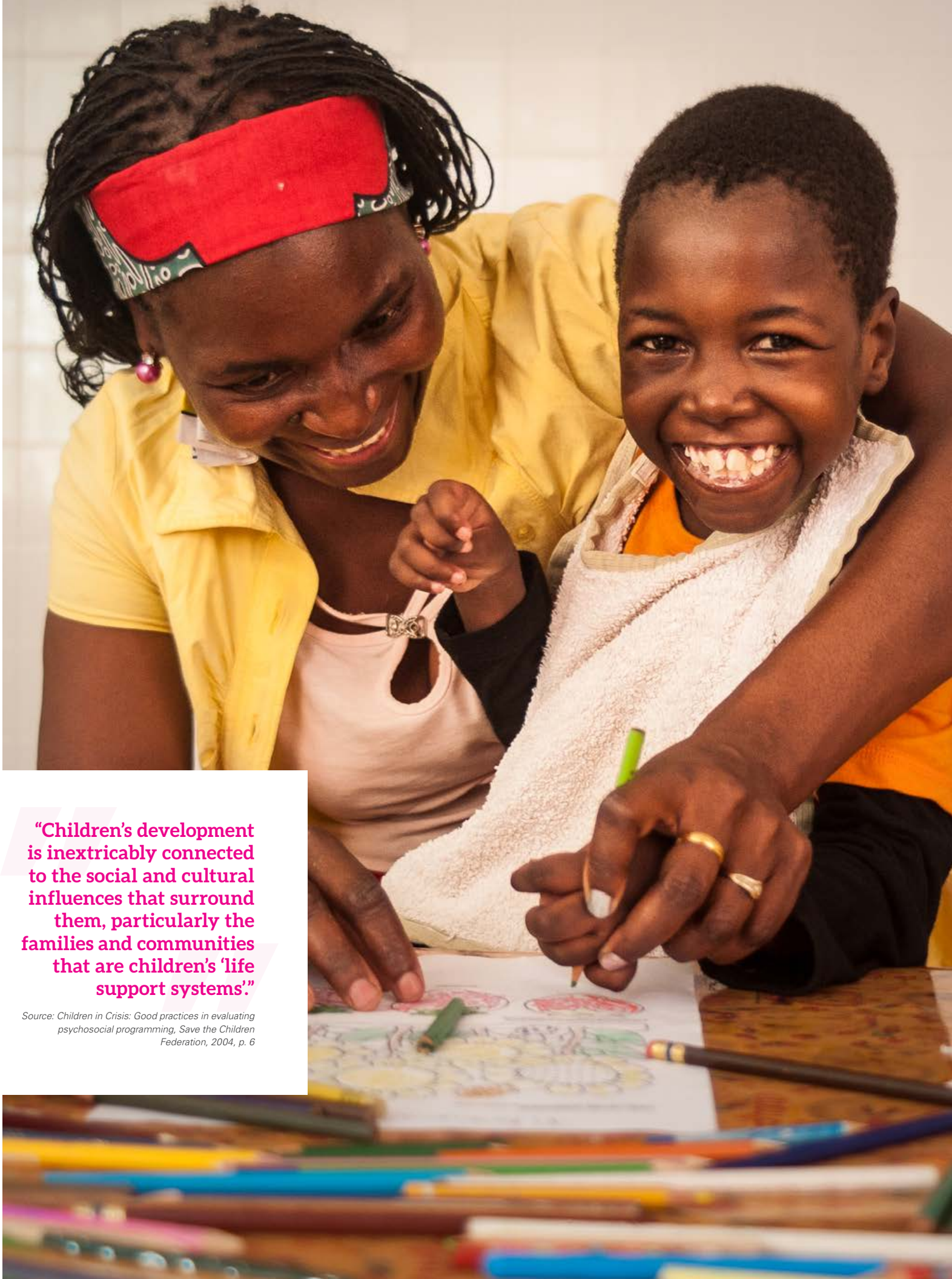
ACTION SHEET 5.2

FACILITATE COMMUNITY SELF-HELP AND SOCIAL SUPPORT. Nearly all groups of people affected by an emergency include helpers to whom people turn for psychosocial support in times of need. In families and communities, steps should be taken at the earliest opportunity to activate and strengthen local supports and to encourage a spirit of community self-help.

ACTION SHEET 5.3

FACILITATE CONDITIONS FOR APPROPRIATE COMMUNAL CULTURAL, SPIRITUAL AND RELIGIOUS HEALING PRACTICES. Understanding and enabling or supporting cultural healing practices can increase psychosocial wellbeing for many survivors. In many contexts, working with religious leaders and resources is an essential part of emergency psychosocial support.

> Interventions can be labelled as community based MHPSS provided they are part of a more strategic psychosocial and mental health approach with the aim to build on existing individual and community resources, capacities and resilience.



"Children's development is inextricably connected to the social and cultural influences that surround them, particularly the families and communities that are children's 'life support systems'."

Source: Children in Crisis: Good practices in evaluating psychosocial programming, Save the Children Federation, 2004, p. 6

THE SOCIAL ECOLOGICAL MODEL: THREE TIERS OF SUPPORT

Children's optimal development and wellbeing are contingent upon a number of contextual factors including family, community, sociocultural and political influences, and the services and structures that surround them. These factors have been articulated through various frameworks – child development theories, social ecological models and studies of children's resilience in the face of adversity – all of which emphasize that children and families are active agents in their own wellbeing and bring their own skills, assets and resources for coping in emergencies. The social ecological model illustrates the importance of networks of people and structures that surround children, safeguarding their wellbeing and supporting their optimal development.

Based on this model, the child is at the centre nested within concentric circles consisting of family, community and culture/society (see figure 2). The family comprises the circle closest to the child. This circle is made up of the people with whom children interact with the most, especially in the earliest years; typically, family members with whom a child lives (e.g., parents/primary caregivers, siblings). It is the primary resource for their care and protection while extended family, close friends and peers, teachers and other community members form additional tiers of support and influence in a child's development. The next circle is made up of community service providers and structures that surround the child and family. These include political, economic and social service structures (e.g., health and education), as well as institutions and structures for culture and leisure and spiritual/religious life. The third and final circle which surrounds the child, family and community is culture and society. This circle includes sociocultural and political contexts that shape values, behavioural expectations and norms, and mediate people's access to services and opportunities. The model further illustrates risk and protective factors outside of the concentric circles to demonstrate their existence and ability to influence a child's wellbeing and development at all levels.

A child's development is shaped by the interplay between the people and elements in this rich social ecological dynamic. The model shows children as active agents in their ecosystems, in dealing with adversity and, in turn, influencing their families and communities. The layers and networks that exist within and between the circles provide for children's social and practical needs, protection, learning, belonging and identity, and their recovery from critical events. It is a way to visually represent and advocate for MHPSS interventions that engage children, families and the larger care community to generate positive change for children and families.

CHILD DEVELOPMENT, WELLBEING, AND RESILIENCE

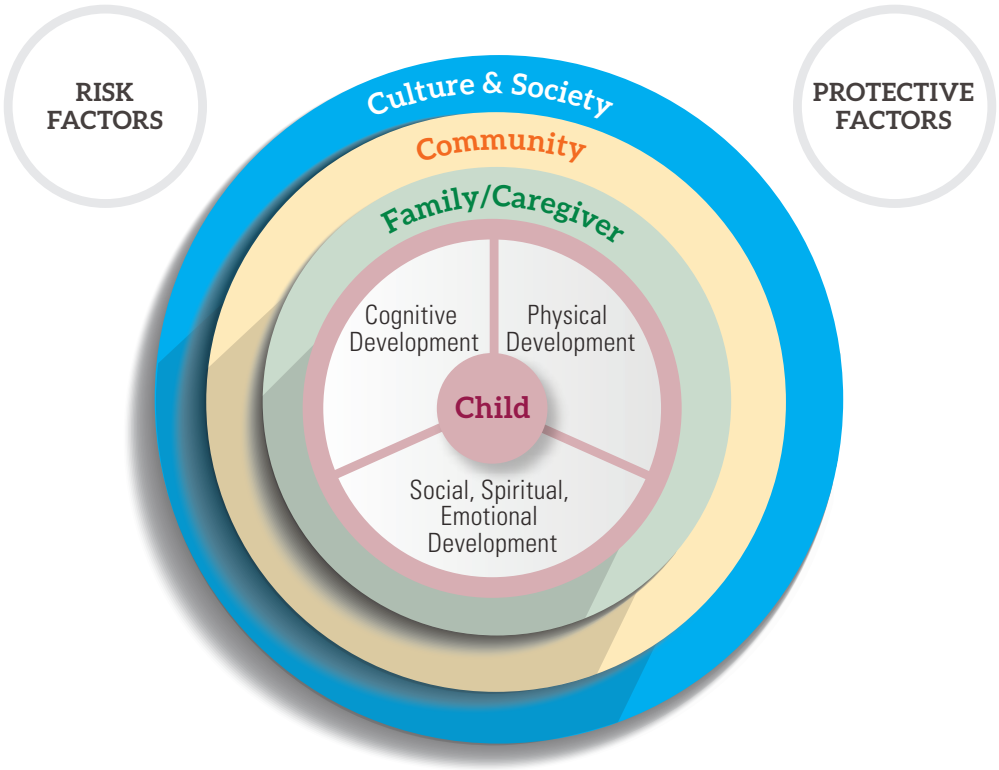
Children's wellbeing and resilience are linked to their stage of development. MHPSS interventions in emergencies must consider how best to reach children at each age and developmental stage and tailor programmes relevant to their needs at that stage.

CHILD DEVELOPMENT

Child development is the process by which children grow and become social and functional members of society. As they mature, children acquire social skills, the ability to love and to develop and maintain relationships. They learn problem-solving skills and acquire capacity and agency, cognitive reasoning and coping strategies.

Children are expected to achieve certain developmental milestones at each stage of development – infancy and early childhood, middle childhood and adolescence. For example, secure attachment to primary caregivers is essential to infants' emotional development. It influences their sense of personal security and their ability to manage emotions later in life. Experiences during **infancy and early childhood** set the foundation for the child's entire life course. Wellbeing and development at this age depend upon a set of interacting factors, such as the family's and community's economic

FIGURE 2: THE SOCIAL ECOLOGICAL MODEL [16]



resources, nutrition and health care, and the type and quality of relationships with caregivers. In middle childhood (primary school age), access to education is essential for social and emotional learning (SEL), knowledge and skill development and developing positive peer relationships is an important developmental milestone for older children and adolescents.

Emergency environments have the potential to disrupt any or all of these factors, and this is why children (particularly young children) are one of the most vulnerable groups in humanitarian settings.

Interventions for **young children** in emergencies are aimed at minimizing harm that can disrupt optimal development. Such interventions capitalize on the crucial window of opportunity in the first five years of life when children are most ready to acquire new skills and adapt. MHPSS interventions may include mother-baby groups, infant stimulation and feeding programmes, and various early childhood development (ECD) activities.

In emergency situations, education serves a critical role in re-establishing safety and structure in the lives of **primary school-aged children**. Organized psychosocial activities further provide opportunities for creativity, play and recovery from stressful events. Intervention strategies must consider how best to include children with physical and developmental disabilities, such as by promoting equal access to learning environments and tailoring structured psychosocial activities (sports, games and creative activities) to ensure their participation.

Older children and adolescents face the challenges of sexual maturation and changing relationships while taking on new responsibilities, particularly in emergencies. They have specific needs for protection (e.g., from gender-based violence [GBV], recruitment and use by armed forces and armed groups, forms of child labour) and commonly with issues related to livelihood and education. Peer support activities can engage older children and adolescents in discussion on relevant issues, giving them an opportunity to voice their concerns and ideas and help them realize their own agency through their contributions to recovery efforts in their communities.

CHILDREN'S WELLBEING AND RESILIENCE

Wellbeing describes the positive state of being when a person thrives. In children, it results from the interplay of physical, psychological, cognitive, emotional, social and spiritual aspects

16 Adapted from: Joan Duncan and Laura Arntson, Children in Crisis: Good practices in evaluating psychosocial programming, International Psychosocial Evaluation Committee and Save the Children Federation, Inc., 2014, p. 16.

that influence a child's ability to grow, learn and develop to their full potential. In MHPSS work, wellbeing is commonly understood in terms of three domains:

- PERSONAL WELLBEING: Positive thoughts and emotions such as hopefulness, calm, self-esteem and self-confidence.
- INTERPERSONAL WELLBEING: Nurturing relationships, a sense of belonging, the ability to be close to others.
- SKILLS AND KNOWLEDGE: The capacity to learn, make positive decisions, effectively respond to life challenges and express oneself.

Resilience is the capacity to overcome adversity and adapt after difficult experiences. The resilience of children in emergencies results from their innate strengths and capacity for coping and the risk and protective factors in their social and cultural environments. These may include personal factors (personality, genetic makeup, presence or absence of physical or developmental disabilities); social factors (positive or negative family environments, supportive teachers, positive friendships); and environmental factors (access to essential services and protection, safety of their environment, inclusion and belonging in society).

SEE COMPENDIUM
Resource in Layer 2. Children's Resilience Program (IFRC and Save the Children)

Children's vulnerabilities increase with exposure to risks, especially if they lack protective factors, such as problem-solving skills, caring caregivers or access to basic services and security. Effective MHPSS intervention strategies therefore work to reduce risks and strengthen protective factors. This includes building the coping capacity of children directly, as well as the social supports and services within their care environments. It also involves providing them with safety, stability and nurturance:

- SAFETY: The extent to which a child is secure and free from fear and harm (both physical and psychological) in their relationships and their physical environment.
- STABILITY: The degree of predictability and consistency in their social, emotional and physical environments.
- NURTURING: The extent to which parents and caregivers are available and able to meet the needs of children and adolescents sensitively and consistently.

In emergency situations, the presence of a stable adult caregiver aids children's feeling of wellbeing, and re-establishing routines boosts their coping ability and recovery. However, caregivers too are affected by emergencies, which may threaten their ability to offer safety, stability and nurturance. MHPSS interventions therefore promote the wellbeing of caregivers so they can provide children with a sense of safety, stability and normalcy, helping to restore or maintain the developmental process.

MHPSS THEORY OF CHANGE

Every humanitarian setting contains multiple drivers for children's vulnerability and resilience. Children, families and communities may define their needs and priorities differently in each circumstance. What works in one context may not work in another, or may need to be adapted or differently focused. Nonetheless, decades of research in children's development, family systems and parent-child interactions, and disaster mental health – combined with the experience and consensus-based guidance in providing MHPSS in emergency settings – give a solid basis for articulating an MHPSS theory of change.

A theory of change explains how activities produce a series of results that contribute to achieving the intended impact or outcome. The MPHSS theory of change explains how mental health and psychosocial support interventions directed at the child, the family/caregiver and the community can help to reduce suffering and improve people's mental health and psychosocial wellbeing. The theory can be adapted and tailored to the particularities of different contexts.

MHPSS programmes ultimately aim to (1) reduce and prevent harm, (2) strengthen resilience to recover from adversity, and (3) improve the care conditions that enable children and families to survive and thrive. These programmes work to activate or restore family and community supports and promote inclusion and participation in community mobilization processes.

MPHSS interventions operate at three layers or tiers: child, family/caregiver and community (see figure 3). The interventions are further elaborated into nine circles of support for children's optimal development and child and family wellbeing (see figure 4). The theory of change includes strategic actions and considers causes of the problems affecting child safety and wellbeing. It also addresses barriers in emergency contexts that may influence programme design, implementation and outcomes.

> ... decades of research in children's development, family systems and parent-child interactions, and disaster mental health – combined with the experience and consensus-based guidance in providing MHPSS in emergency settings – give a solid basis for articulating an MHPSS theory of change.

FIGURE 3: THE MPHSS THEORY OF CHANGE

PROBLEM

Emergencies erode family and community structures and supports for children's mental health and psychosocial wellbeing and safety

CAUSES

Changing emergency contexts have worsened the threat environment for children's wellbeing and development. They involve prolonged conflict, mass displacement, violence, exploitation, terrorism, poverty, disease outbreaks, intensifying natural disasters and climate change. Emergencies weaken or destroy community support structures and services for children's safety and wellbeing, halt access to education and hamper parents' capacity to provide safe environments and nurturing care. Ultimately, children's resilience and development suffer.

GOAL

REDUCED SUFFERING AND IMPROVED MENTAL HEALTH AND PSYCHOSOCIAL WELLBEING OF CHILDREN AND FAMILIES.

OUTCOME

FAMILY AND COMMUNITY SUPPORTS AND SYSTEMS ARE RESTORED, STRENGTHENED AND MOBILIZED TO PROMOTE CHILD AND FAMILY WELLBEING BY:

1. **Reducing and preventing harm**
2. **Strengthening resilience to recover from adversity**
3. **Improving the care conditions that enable children and families to survive and thrive.**

OUTPUTS AND UNICEF INTERVENTIONS (9 CIRCLES OF SUPPORT)

Child	Family/Caregiver	Community
1 **SAFE, NURTURING ENVIRONMENTS** Safe spaces, safe and supportive school environments, support to vulnerable families and violence reduction	**4** **SUPPORTING CAREGIVER WELLBEING** Focused care for distressed caregivers, specialized MHPSS care for parents with MNS disorders, support in coping for parents and teachers	**7** **WELLBEING AND PROTECTION AWARENESS-RAISING** Stigma reduction campaigns for people with MNS disorders, CP messaging
2 **POSITIVE RELATIONSHIPS** Peer-to-peer groups for adolescents, cultural and expressive activities for children, mother-baby groups	**5** **POSITIVE PARENTING** Awareness-raising of distress reactions among children of different ages and developmental stages, promotion of positive parenting knowledge and skills, support for parents/caregivers in caring for children with MNS disorders	**8** **ACTIVATED NATURAL COMMUNITY SUPPORTS** Engagement, mobilization and support to community organizations (communication for development activities), support to community leaders in promoting child and family wellbeing
3 **STIMULATION, LEARNING, SKILLS DEVELOPMENT** ECD activities, building teacher capacities in SEL, vocational training for adolescents	**6** **FAMILY AND COMMUNITY SUPPORT NETWORKS** Caregiver/women's/men's support groups, facilitation for inclusion and participation of vulnerable families in communal activities	**9** **STRENGTHENED CARE SYSTEMS** Training of professional and lay staff in coordinated MHPSS care for children and families and development of functional referral systems for at-risk children and families

BARRIERS

Lack of coordinated MHPSS systems, stigma/discrimination of children/caregivers with MNS disorders/disabilities, lack of financial/human resources, lack of technical expertise, lack of shared community

STRATEGIC ACTIONS ARE FACILITATED BY:

1. **Community mobilization:** Identifying, activating and strengthening local capacity; meaningful and inclusive engagement of child and family wellbeing stakeholders.
2. **MHPSS system strengthening:** Strengthening supports within existing structures, including functional referral systems and capacity among professional and lay providers in quality MHPSS care.
3. **Integrating MHPSS across sectors:** Mainstreaming IASC MHPSS guidelines across protection, health and nutrition, education, WASH and shelter systems.

OPERATIONALIZING COMMUNITY BASED MHPSS: A FRAMEWORK

MHPSS interventions help to activate and restore natural supports within community and family care systems; something essential in times of emergency as well as when communities transition from emergency to recovery. Based on the social ecological model, the CB MHPSS operational framework employs a three-tiered approach involving the family/caregiver, the community and society. The approach elaborates practical ways for practitioners to implement MHPSS interventions from each of the tiers, as appropriate, across the four layers of the IASC MHPSS pyramid. Interventions for each tier are to be further embedded within the unique cultural and societal context of diverse emergency situations.

Interventions may broadly incorporate approaches for child and family wellbeing across tiers and pyramid layers. Alternatively, they may emphasize a particular area, such as opportunities for focused care by and for teachers, or for strengthening family/caregiver support networks. However broad or focused the MHPSS programme, it is important to keep in mind that the layers and tiers of the operational framework are dynamic and interconnected.

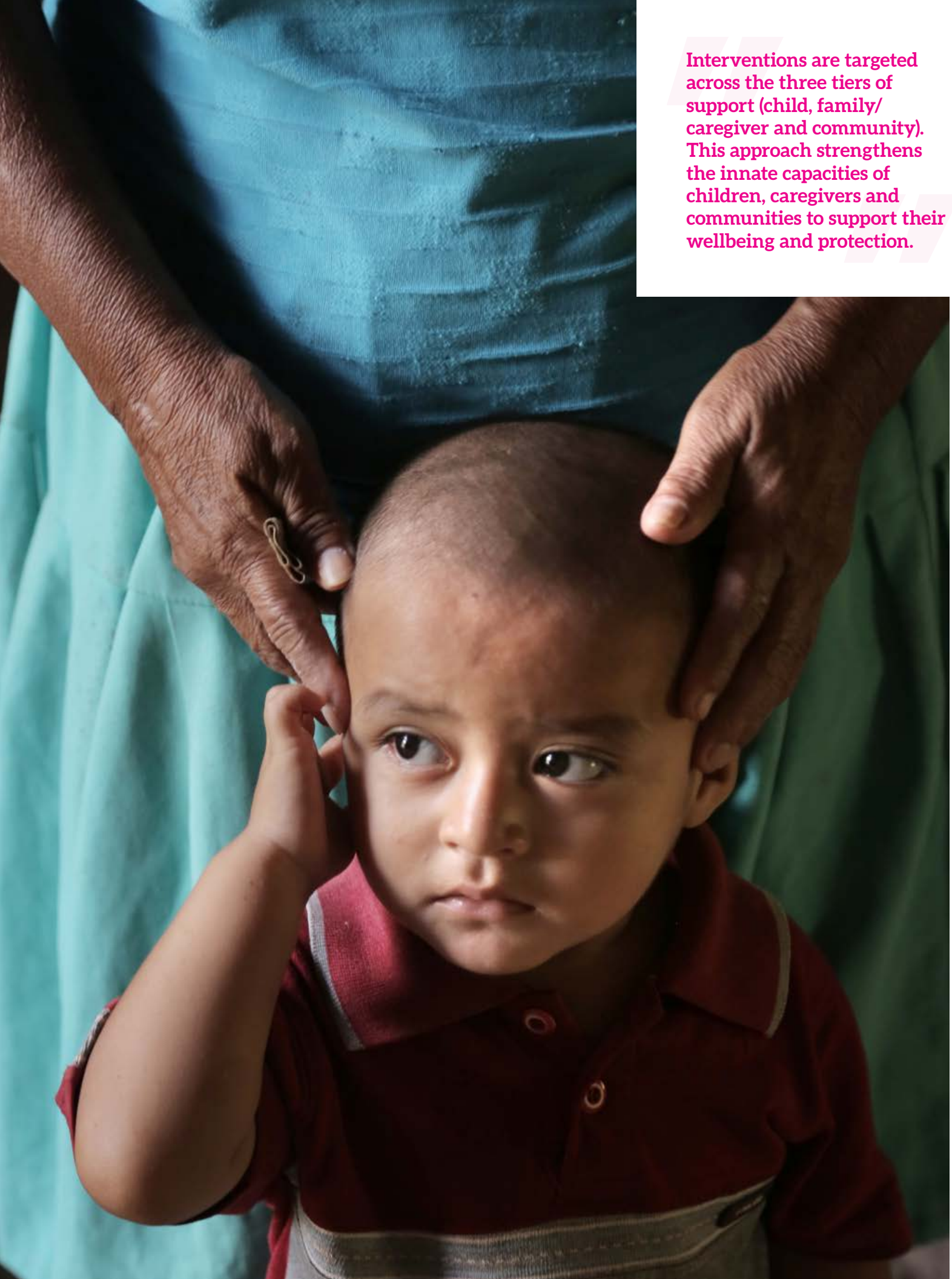
Effectively addressing the range of needs requires attention to all tiers and pyramid layers, and integrating them. For example, an intervention designed to work primarily at pyramid layer 2 should also consider how to identify and refer vulnerable children and families for focused care (layer 3) or specialized care (layer 4). Similarly, an intervention offering focused support to distressed children in schools can enhance its impact by strengthening capacities of teachers and parents to provide supportive care environments at school and at home.

See **Annex 1: Community Based MHPSS in Practice – Three Case Studies f**or examples of best practice implementation of community based MHPSS in South Sudan, Nepal, and Lebanon.

NINE CIRCLES OF SUPPORT

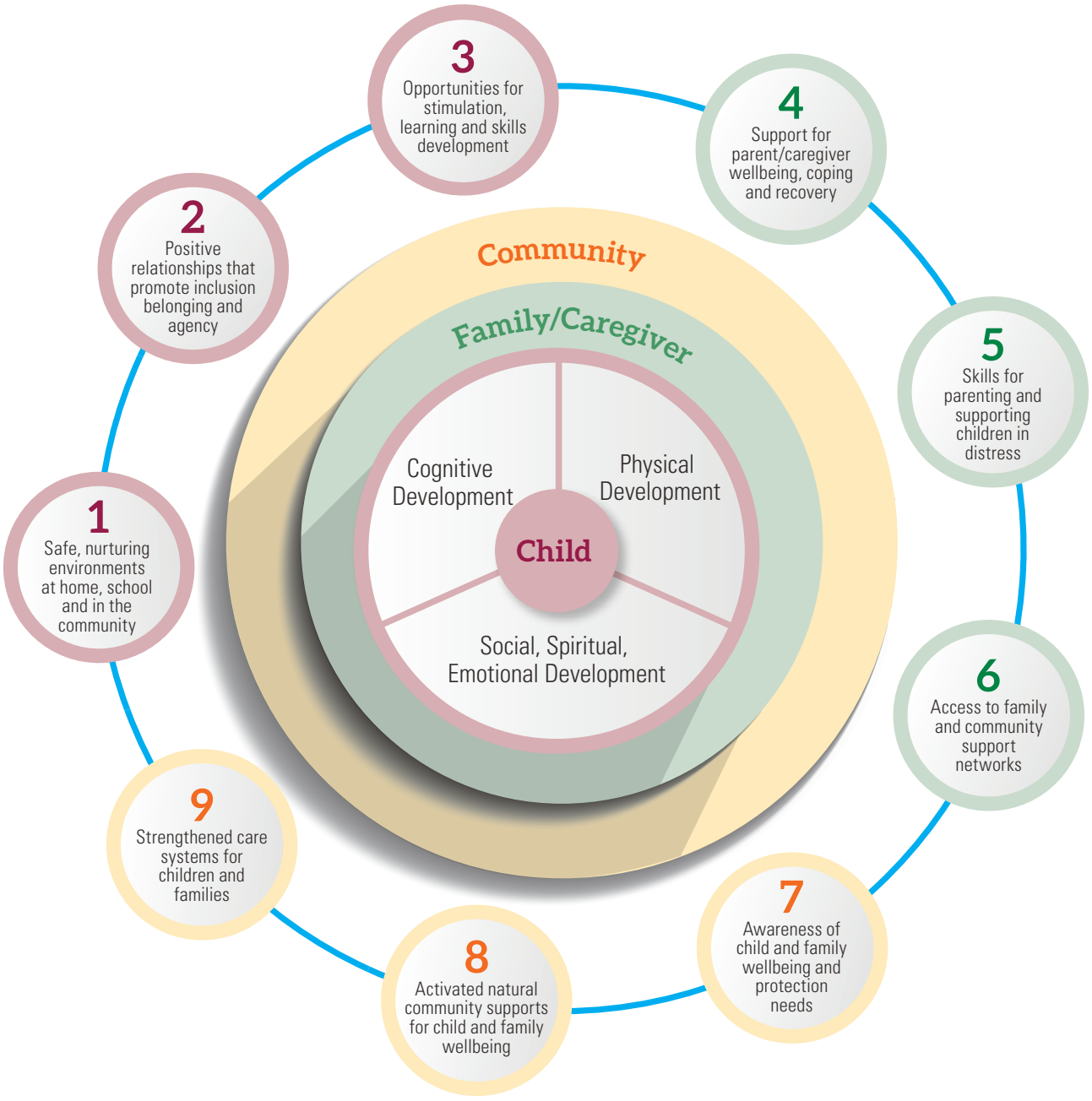
Interventions are targeted across the three tiers of support (child, family/caregiver and community). This approach strengthens the innate capacities of children, caregivers and communities to support their wellbeing and protection. The tiers are further operationalized through the nine circles of support to create the conditions for child and family wellbeing, as shown in figure 4.

Integrated support across the layers of the pyramid is represented in the nine circles of support. These address the needs of children and families for wellbeing and safety in their context – from the delivery of basic services in culturally appropriate ways, to strengthening family and community social networks, to focused or specialized care when needed.



Interventions are targeted across the three tiers of support (child, family/ caregiver and community). This approach strengthens the innate capacities of children, caregivers and communities to support their wellbeing and protection.

FIGURE 4: THE NINE CIRCLES OF SUPPORT FOR CHILDREN, FAMILIES/CAREGIVERS AND COMMUNITIES



EXAMPLES OF INTERVENTIONS IN THE NINE CIRCLES OF SUPPORT INCLUDE:

1	**SAFE, NURTURING ENVIRONMENTS** at home, school and in the community ensure that children are protected from harm, abuse, neglect and violence, and that they receive loving care for their recovery and in understanding and coping with events in their lives. Interventions may include:
	Setting up safe spaces, including child- and baby-friendly spaces (BFS).
	Establishing programmes for safe and supportive school environments.
	Promoting family life free from violence and providing support to vulnerable families.

2	**POSITIVE RELATIONSHIPS** with caregivers, friends, teachers and others in the community are essential to children's self-esteem and sense of inclusion, supporting their optimal development. Positive relationships also give children opportunities for self-expression and a sense of agency in their lives. Interventions may include:
	Peer-to-peer groups for adolescents, youth clubs for cultural and leisure activities.
	Group cultural and expressive activities for children.
	Mother-baby groups.
3	**OPPORTUNITIES FOR STIMULATION, LEARNING AND SKILLS DEVELOPMENT** appropriate to the child's age and developmental stage help children develop cognitive and social and emotional skills for life. These include problem-solving skills, emotional regulation and the capacity to form and maintain relationships. Interventions may include:
	ECD activities for very young children.
	Building capacities for teachers in social and emotional learning.
	Programmes to help adolescents develop skills and access vocational training.
4	**SUPPORT FOR PARENT/CAREGIVER WELLBEING, COPING AND RECOVERY** in difficult circumstances includes helping caregivers within and outside the family system (such as extended family, teachers) to best support the children in their care. Interventions may include:
	Focused care for distressed parents/caregivers, including PFA.
	Specialized social service and/or mental health care for parents with MNS disorders.
	Support for the wellbeing and coping ability of teachers.
5	**KNOWLEDGE AND SKILLS FOR PARENTING AND SUPPORTING CHILDREN IN DISTRESS** help improve the quality of caregiver-child interactions at home and school and in the community. This also helps caregivers to know when a child may need referral for more specialized support. Interventions may include:
	Raising awareness of distress reactions of children in emergencies, according to age and developmental stage.
	Promoting positive parenting knowledge and skills among caregivers.
	Training parents and other caregivers in supporting children with MNS disorders.
6	**ACCESS TO FAMILY AND COMMUNITY SUPPORT NETWORKS** helps to develop or re-establish networks of support. This aids in strengthening trust, mutual care and self-help to support children and families, including vulnerable families. Interventions may include:
	Holding support groups for parents and for women and men separately.
	Facilitating inclusion and participation of vulnerable families in communal activities.
7	**AWARENESS OF CHILD AND FAMILY WELLBEING AND PROTECTION NEEDS** helps to mobilize communities to take positive action by providing clear information about the needs of children and how to fulfil them. Interventions may include:
	Stigma reduction campaigns for people with MNS disorders.
	Child protection messaging.
8	**ACTIVATION OF NATURAL COMMUNITY SUPPORTS** for child and family wellbeing acknowledges and strengthens community resources to support children and families. Interventions may include:
	Engagement and support to community organizations through communication for development activities,[17] such as women's groups, to build capacity for outreach to vulnerable families.
	Support to community leaders, such as religious leaders, in promoting child protection and wellbeing.
9	**STRENGTHENING OF CARE SYSTEMS FOR CHILDREN AND FAMILIES** includes capacity-building in the social service, education, protection and health systems, which protect children and families and promote their wellbeing. Interventions may include:
	Training professional and lay staff and volunteers in coordinated MHPSS care for children and families.
	Supporting the development of functional referral systems for children with protection risks or MNS disorders.

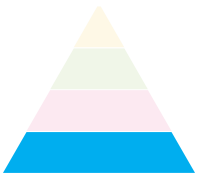
17 Communication for development involves understanding people, their beliefs and values, and the social and cultural norms that shape their lives. It involves engaging communities and listening to adults and children as they identify problems, propose solutions and act upon them. Communication for development is a two-way process for sharing ideas and knowledge using a range of communication tools and approaches that empower individuals and communities to take actions to improve their lives. https://www.unicef.org/cbsc/

IMPLEMENTING ACTIVITIES WITHIN THE FRAMEWORK

The following sections further describe MHPSS approaches and specific activities at each of the IASC pyramid layers. The tables and intervention examples elaborated at each layer offer ideas for MHPSS intervention strategies that can have sustained beneficial impacts. UNICEF and partners can choose from among the approaches to develop implementation strategies for particular programmes. In each programme, different intervention strategies may be prioritized depending on needs, resources and contextual realities. Please also refer to the *Compendium of Resources* for useful resources at each layer of the pyramid, including training manuals, toolkits and guidance documents. Examples of resources from the Compendium are also indicated throughout the text.

SEE COMPENDIUM
The Compendium is organized with resources according to pyramid layers.

IASC MHPSS LAYER 1: SOCIAL CONSIDERATIONS IN BASIC SERVICES AND SECURITY



MHPSS interventions at the first layer of the IASC MHPSS pyramid are meant to ensure that conditions are met for the minimum standards of health, safety and dignity of children and families. Access to basic services and security is fundamental to recovering and maintaining health and wellbeing. Ensuring these conditions are met in ways that promote human rights, dignity and equality can help to mitigate the impacts of emergencies, preventing further harm and promoting wellbeing.

MHPSS interventions at Layer 1 do not typically involve direct provision of basic services or security. Instead, they advocate for such services and work together with protection and other sectors to ensure that:

- Basic needs (shelter, food, WASH) are provided in ways that respect the culture, dignity and agency of children and families and are sensitive to children's developmental needs.
- Vulnerable children and families, who may be less visible in emergency contexts, are assessed and included in provision of basic needs.
- Overall safety for the community is promoted, and protection risks for children and families are identified and addressed.
- Children and families are safeguarded from abuse, neglect and exploitation.
- Family unity is promoted through prevention of family separation, identification and care of separated children, and family tracing and reunification.
- Children and families have access to important information about basic services, loved ones, legal rights and positive coping strategies.

Together with intersectoral interventions, community mobilization and engagement strengthens the networks of support for children and families and helps to rebuild community capacity for longer-term recovery. It supports self-help on individual and communal levels, capitalizing on existing resources. Furthermore, engaging local knowledge provides important information about how best to deliver basic services and security so they are acceptable to beneficiaries and appropriate to local understandings of child development, wellbeing and rearing.

SEE COMPENDIUM
Resource in Layer 1. IASC MHPSS Guidelines on Mental Health and Psychosocial Support Advocacy Package

However, humanitarian intervention can inadvertently cause harm if local sociopolitical structures are not well understood and appropriately engaged. For example, external humanitarian actors may fail to build on existing community networks for future recovery and sustainability. Or conversely, they may inadvertently strengthen local power dynamics that exclude or harm some community members. Developers of psychosocial programmes can help by advocating for involvement of responsible community actors in service delivery. This promotes inclusion and equity, including services for vulnerable children and families.

ROLE OF HUMANITARIAN ACTORS

The IASC MHPSS Guidelines reflect an emerging consensus that a range of humanitarian interventions are needed to promote mental health and psychosocial wellbeing, and that a

'psychosocial' approach is important to enhance the protective qualities and reduce the potential risks of all humanitarian interventions. When MHPSS interventions are integrated into the protection, health/nutrition, education/ECD, camp management and WASH sectors or implemented in close collaboration with them, it ensures that programmes are sustainable, socio-culturally acceptable and contextually relevant.

SEE COMPENDIUM
Resources in Layer 1.

- The IASC MHPSS in Emergency Settings Series of Booklets on "What should 'Humanitarian Health Actors', 'Protection Program Managers', and 'Camp Coordinators & Camp Manager Actors' Know?'"

- REPSSI Mainstreaming Psychosocial Care and Support Series

The IASC MHPSS Guidelines contain relevant action sheets for various sectors. See **Annex 2: 'What Other Actors Can Do –Action Sheets from IASC Guidelines'** for more information and reference to specific sheets by sector.

MHPSS interventions at Layer 1 are aimed at advocating for service delivery that:

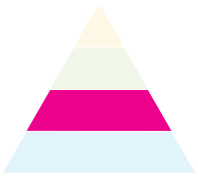
1. Fosters inclusive, participatory processes in community engagement;
2. gives attention to special considerations in the sociocultural context (e.g., cultural beliefs, power structures, gender relationships, help-seeking behaviours, the role of traditional healers); and
3. ensures that appropriate services reach the most vulnerable children and families.

SEE COMPENDIUM
Resource in Layer 1. Six Orientation Seminars to Disseminate and Implement the IASC Guidelines On MHPSS in Emergency Settings (IASC MHPSS Reference Group)

TABLE 2: LAYER 1 INTERVENTION STRATEGIES WITH SUSTAINABLE IMPACT

IASC MHPSS PYRAMID LAYER 1: SOCIAL CONSIDERATIONS IN BASIC SERVICES AND SECURITY; FULFILMENT OF BASIC NEEDS AND SECURITY NIFIED, SAFE AND CULTURALLY APPROPRIATE WAYS		
TIER OF INTERVENTION		
Child	**Family/Caregiver**	**Community**
Work with the community and other sectors to ensure children's access to safe living, playing and learning areas (e.g., communal areas, formal/non-formal school structures)	Raise awareness and promote access for vulnerable families to basic services (e.g., shelter, infant and/or school feeding programmes)	Make sure age, diversity and gender are reflected in the design and delivery of basic services and security for children and families
Promote children's inclusion and participation (as appropriate) in designing and delivering basic services and security	Raise parent/caregiver awareness and engagement in children's safety and wellbeing	Help to activate and mobilize traditional community structures and stakeholders for child and family wellbeing
Assist appropriate identification of vulnerable children (including children with MNS disorders, disabilities and protection risks) for inclusion in basic service delivery and protection	Support parents'/caregivers' ability to provide for the family's basic needs (e.g., facilitate access to livelihood strategies)	Support protection actors in advocating for functioning protection and MHPSS frameworks and referral mechanisms
Work with health and nutrition actors to identify and include vulnerable children in basic health care and to promote a psychosocial perspective in nutrition programmes and feeding practices for infants and children	Work with other sector actors to ensure appropriate shelter accommodation for privacy and comfort of families	Advocate across sectors for: • Safe spaces for children, women and families. • Family and community stakeholder engagement in CP committees. • Safe, accessible and inclusive structures for children's learning that meet minimum standards. • Inclusion of children and parents/caregivers with MNS disorders or disabilities in basic service delivery and security. • Culturally sensitive and age-appropriate health care for children and families (e.g., adolescent reproductive health care).
	Work with community and intersectoral actors to appropriately identify and reach out to vulnerable parents/caregivers (with MNS disorders, disability or serious distress) for care and referral to relevant supports/services	
	Help to ensure access of families/caregivers (especially those who are vulnerable) to information about supports, services, loved ones and rights	

IASC MHPSS LAYER 2: STRENGTHENING FAMILY AND COMMUNITY SUPPORTS



MHPSS interventions at the second layer of the pyramid focus on strengthening family and community supports. These are the foundation of enabling environments for child and family safety and wellbeing, and they support the conditions for maintaining or restoring children's optimal development. Emergencies can disrupt family and community routines, social networks and community structures through displacement, poverty and loss of or separation from key family and community members. In transformed or new environments, children's recovery and wellbeing are enhanced by strengthening the ability of families and communities to re-establish routines and normalcy, supportive social connections, and opportunities for learning, growth and coping with new challenges.

SEE COMPENDIUM
Resource in Layer 2. Training Package on Child Friendly Spaces (CPWG)

It is important that interventions work to mobilize existing community supports (parents, teachers, health and social service workers, religious leaders) or re-establish community structures, while ensuring that they are inclusive and work towards the best interests of all children.

MHPSS activities at this layer aim primarily to foster enabling environments for children that promote positive social relationships and social and emotional learning.

SUPPORTING POSITIVE SOCIAL RELATIONSHIPS

Having positive social relationships with parents and caregivers, peers and the larger community is fundamental to children's wellbeing, protection and optimal development. Connection with nurturing, stable caregivers is protective for all children, and crucial for the coping and recovery of children who experience crises. Loving families provide a foundation for children to develop self-esteem, skills for navigating life challenges and a sense of structure, stability and predictability in their lives. From this starting point, the wellbeing of parents and caregivers strongly influences the wellbeing of children through responsive caregiving. Thus, strengthening family unity has protective effects on children's psychosocial wellbeing and development.

Positive social relationships in the larger community (with peers, family friends and neighbours, and teachers) also give children a sense of inclusion, supporting an enabling environment for their growth and development. In addition to their protective role, supportive community networks provide opportunities for children to engage with and contribute to their society. They also provide respite for overstressed parents and caregivers and encourage them to use positive parenting practices. Community engagement often happens spontaneously in spaces such as parks, community centres, shrines or water points, or in traditional women's gatherings. These natural connections and forums for connecting may be broken during emergencies and thus programmes may focus on supporting their reactivation.

SUPPORTING SOCIAL AND EMOTIONAL LEARNING

As children grow, they gain skills and knowledge. Even in the first months of life, responsive parenting helps children develop the capacity to regulate their emotions and manage adversity. Age-appropriate opportunities for learning and stimulation help children develop problem-solving skills and social and emotional intelligence. Those opportunities come through supportive social interactions with positive role models; safe and supportive learning environments, both formal and non-formal; and participation in play, sports, creative activities and the cultural and spiritual life of their communities.

SOCIAL AND EMOTIONAL LEARNING

Social and emotional learning (SEL) is a process of acquiring social and emotional values, attitudes, competencies, knowledge and skills that are essential for learning, being effective and successful, and having a sense of wellbeing. SEL can play a crucial role in helping children learn skills to manage their emotions, build healthy relationships and more adaptive behavioural responses, and reduce the harmful effects of emergencies on their development, according to a paper by the International Network for Education in Emergencies.

SEL is an important component of MHPSS approaches in emergencies. It helps students learn to make meaning of events in their lives and expand their repertoire of coping and life skills. The qualities that SEL inspires – including empathy, resilience, self-awareness and emotional regulation – support children's recovery and wellbeing while also benefiting the wellbeing of school staff. The result is a more positive, nurturing school environment that may contribute to more peaceful, stable societies.

Source: Inter-Agency Network for Education in Emergencies, Background Paper on Psychosocial Support and Social Emotional Learning for Children and Youth in Emergency Settings, 2016

Schools are at the centre of communities, serving as a valued institutions and community focal points. Restoring access to education is therefore important not only to children, but to the community at large. Schools (or other safe spaces that offer educational or creative activities, such as CFS) provide children a safe place to play, learn, socialize with peers, express themselves, develop knowledge and skills, and return to routine and normalcy. Engaging in educational or creative and expressive activities can also potentially foster healing for children affected by adverse events, particularly when activities are implemented by trained MHPSS workers.

Also, while children are engaged in education or activities in safe spaces, adults have the time to work on rebuilding and livelihood activities essential to the family's survival and

recovery. They can do so knowing that their children are safe and well cared for.

MHPSS activities that engage families and caregivers at this layer can also include parent-teacher committees, involve parents and caregivers in coaching or mentoring children, and engage families and caregivers in school events such as sporting or cultural activities. The community may participate in ensuring that safe structures are developed and maintained for formal and non-formal education, and in identifying and embracing vulnerable children (e.g., children with disabilities).

Other services, such as provision of basic needs, may be incorporated into schools or safe spaces. Support and training for teachers and others involved in child-focused activities can further help to ensure these adult caregivers have a positive impact on children who have experienced stressful events. Capacity-building may focus on helping teachers create or adapt learning environments to better meet the learning, wellbeing and safety needs of children in stressful environments.

ESTABLISHING PEER-TO-PEER SUPPORT STRUCTURES

It is important to capitalize on children's coping strategies. Peer-to-peer support helps to build social connections, teach social skills such as reciprocity and empathy, and give children the opportunity to learn helping skills and contribute to larger recovery efforts.

SUPPORTING PARENTS AND CAREGIVERS

Parents and other caregivers (extended family, foster families, teachers, health workers) may require support during emergencies to cope with the impacts of the emergency on their own daily lives and wellbeing.

BUILDING THE CAPACITIES OF PARENTS AND CAREGIVERS

Parents and caregivers may benefit from information and initiatives that build their skills in responsive caregiving. Information about stress reactions of children at different ages and developmental stages – and strategies to support them – can help parents re-establish a sense of their own effectiveness as parents in challenging situations. Support groups for parents/caregivers of children with MNS disorders, developmental disabilities or serious distress can provide forums for sharing resources, information and strategies.

REBUILDING COMMUNITY STRUCTURES AND RESTORING COMMUNAL EVENTS

UNICEF and its partners may help in activating or restoring community structures that strengthen social networks and protect and support children and families. MHPSS interventions support natural and spontaneous efforts by families and communities to restore protection mechanisms and social routines and promote healing and recovery. Strengthening self-help capacities among families and communities helps to restore a sense of agency and hopefulness for the future. Where structures and supports have been disrupted by the emergency, practical assistance may be needed to rebuild and restore community activities that support children's protection and wellbeing.

MHPSS interventions at Layer 2 may include activities such as the following:

FOR INFANTS AND YOUNG CHILDREN:

- Re-establishing formal and non-formal education.
- Responsive infant caregiving through mother-baby interactions (e.g., in feeding centres, BFSs).
- ECD activities.
- Structured psychosocial activities in child- or youth-friendly spaces.
- Creative, cultural and sports activities for children of different ages that also engage their families and community members.

SEE COMPENDIUM
Resources in Layer 2.
- The IRC Psychosocial Teacher Training Guide

- Safe Healing and Learning Space Toolkit (IRC)

- Helping Hands at School and in the Community: Guidance for school-based psychosocial programs for teachers, parents and children in conflict and post-conflict areas (War Trauma Foundation)

FOR ADOLESCENTS:

- Re-establishing formal and non-formal education.
- Life skills and peer-to-peer groups for adolescents, including groups specific to girls' and boys' needs and interests.
- Creative, cultural and sports activities for children of different ages that also engage their families and community members.

- Opportunities for adolescents to contribute to the community, such as by leading activities for younger children, developing or promoting messages about health and coping, and helping in rebuilding efforts.

SEE COMPENDIUM
Resources in Layer 2.
- Adolescent Kit for Expression and Innovation (UNICEF)

- Life Skills Course: the Deals (War Child)

FOR PARENTS AND CAREGIVERS:

Support

- Support groups for parents (mothers and fathers), women or other child caregivers.
- Information about services.
- Information about stress reactions and positive coping strategies.
- Access to health care, livelihood and educational opportunities.
- Access to support (community support, focused or specialized care) for caregivers with MNS disorders, disabilities, protection risks or serious distress.
- Regular communal activities for parents/caregivers and children that include intergenerational supports for stressed parents.

Building Capacity

- Mother-infant groups that support responsive caregiving (e.g., providing psychosocial care as part of breastfeeding spaces).
- Positive parenting training.
- Community messaging on children's stress reactions and coping strategies.
- Community engagement in identifying vulnerable children and families.
- Information about protection risks for children and how to address them.

SEE COMPENDIUM
Resources in Layer 2.
- Caring for Volunteers (IFRC)

- Self-Help for Men Facing Crisis and Displacement (IOM)

- Parenting Skills Training Materials (IRC)

COMMUNITY – REBUILDING AND RESTORING STRUCTURES AND COMMUNAL EVENTS:

- Support to communities to re-establish rituals or cultural events (e.g., commemoration events to foster communal healing, cultural festivals or religious celebrations) along with traditional healers or leaders as appropriate.
- Support for community sporting or other events to engage children, families and communities.
- Help to establish community child protection committees with broad, inclusive representation.

SEE COMPENDIUM
Resource in layer 2. Different Just Like You: A psychosocial approach promoting the inclusion of persons with disabilities: A training Guide (IFRC)

TABLE 3: LAYER 2 INTERVENTION STRATEGIES WITH SUSTAINABLE IMPACT

IASC MHPSS PYRAMID LAYER 2 STRENGTHENING FAMILY AND COMMUNITY SUPPORTS; ENABLING ENVIRONMENTS FOR CHILDREN'S OPTIMAL DEVELOPMENT, INCLUDING POSITIVE SOCIAL RELATIONSHIPS AND LEARNING		
TIER OF INTERVENTION		
Child	**Family/Caregiver**	**Community**
Support identification, family tracing and reunification, and appropriate care for separated children	Strengthen family care and nurturing family environments through positive parenting training (e.g., how to help children of different ages and developmental stages cope with emergency)	Mobilize natural community supports, stakeholders and structures for child and family care (e.g., existing health and education structures, religious and traditional leaders, women's groups) for child and adolescent wellbeing
Support children's access to and engagement in age-appropriate cultural, recreational and supportive activities (e.g., youth clubs; adolescent peer-to-peer groups; cultural events for healing, normalization and recovery)	Support capacity-building of parents/caregivers in ECD activities such as responsive infant interaction training, 'minding the baby' and nurturing care practices	Facilitate processes for inclusive participation of community members (including those marginalized, with MHPSS problems or disabilities) in assessing, designing and planning child and family MHPSS interventions
Work with the community to establish safe spaces (CFS) for children to be protected and engage in psychosocial structured activities	Build capacity and self-care of teachers to create positive, safe classroom environments.	Support integration of child and family MHPSS services in other sectors (e.g., health care, social services, education and protection)
Support children's access to quality psychosocial structured activities (e.g., creative and expressive activities) within the community (e.g., in CFS and learning spaces)	Help to strengthen networks of support for parents and other child caregivers in the community through, for example, support groups (for parents, mothers/women, men/fathers), safe spaces (for mothers and lactating women, BFS), providing psycho-education on stress reactions, coping and recovery	Work with schools (teachers, administrators) to strengthen safe, positive school environments for children's protection, recovery, wellbeing and social and emotional learning
Support young children's access to and participation in ECD activities, and mothers' and babies' access to supportive feeding programmes in BFS	Promote appropriate identification and outreach support to ensure inclusion and participation of vulnerable families in supportive family and community interventions	Develop community awareness campaigns to promote awareness of appropriate coping and recovery strategies
Support the inclusion and meaningful participation of vulnerable children (e.g., children with disabilities, marginalized children) in community activities and services	Promote links between child caregivers at home and school through, for example, parent-teacher committees for child safety and wellbeing	Support CP messaging to reduce risks to children's safety and promote family/ community wellbeing

IASC MHPSS LAYER 3: FOCUSED CARE TO ADDRESS PSYCHOSOCIAL DISTRESS AND PROTECTION CHALLENGES

MHPSS interventions at the third layer of the MHPSS pyramid provide focused care to children and families who have specific emotional, social, health or protection needs. Although most children and families can cope and recover well if their basic needs are met appropriately (layer 1) and with strengthened family and community supports (layer 2), focused care may be needed for the smaller number of children and families whose coping capacity has been overwhelmed. This may be due to exposure to serious stressors, previously existing vulnerabilities (health or mental health problems, disabilities) or societal status (economic, social or political). It is essential to deliver this care in ways that are appropriate for the individuals' age, gender and culture. Examples of those in need of focused care include:

- Children and families in acute distress due to recent exposure to serious stressors such as violence, abuse or disaster.
- Children (or parents/caregivers) who have been

exposed to protection risks and who may require psychological, health or legal support.

- Children (or parents/caregivers) who are survivors of severe human rights violations (trafficking, SGBV, children associated with armed forces).
- Children and families who are unable to make use of supports and social networks to meet their basic needs (e.g., marginalized families, children or caregivers with specific health or mental health problems or disabilities)
- Children and families who are struggling to cope.
- Children who are not growing and learning according to their age and developmental stage or are unable to function at the same level as their peers.

Focused care aims to strengthen innate coping mechanisms and mobilize and strengthen community social networks and specialized support and referral systems. Providers may be community outreach workers, health or social service staff, counsellors, teachers or others. Regardless of their skill level, providers need close, regular supervision by qualified professions.

SEE COMPENDIUM
Resources in Layer 3.
- Broken Links: Psychosocial Support for People Separated from Family Members (IFRC)

- The Multi-Family Approach to Humanitarian Settings (WTF)

Basic psychosocial competence training can also be useful for caregivers and workers from other sectors who deal routinely with children. Psychosocial competence training topics may include child development, children's reactions to stress, PFA and other skills, and when and how to refer for more specialized care.

BASIC PSYCHOSOCIAL SUPPORT FOR DISTRESSED CHILDREN AND FAMILIES

Basic psychosocial support, given by trained workers, may be offered to individual children or adults or may involve family or group support. Support can take different forms, including empathic listening; counselling or mentoring; conflict resolution; psycho-education about stress and positive coping and how to care for family members with physical or mental health conditions; help with problem-solving; and bereavement support. Support groups facilitated by trained workers can be helpful in addressing specific problems and strengthening support networks among particular groups of people, such as women survivors of SGBV, youth heading their own households, and fathers struggling to cope in new environments.

Basic psychosocial support may also involve assessing needs of children and families for additional support, and linking them with community services or social supports such as extended family, friends or religious leaders. Children and adults in acute distress following a recent stressor may benefit from a form of basic psychosocial support called psychological first aid, described in the box below.

PSYCHOLOGICAL FIRST AID

Psychological first aid (PFA) is a form of basic psychosocial support provided to acutely distressed children or adults soon after exposure to a stressful event. It is humane, supportive and practical assistance offered in ways that promote the recipient's safety, dignity and rights. PFA involves:

- Practical care and support that is not intrusive.
- Assessment of needs and concerns.
- Help to address basic needs.
- Sympathetic listening without pressure to talk.
- Comforting people and helping them to feel calm.
- Helping people connect to information, loved ones and services.
- Protecting people from further harm.

Source: Psychological First Aid: Guide for Field Workers. (2011) World Health Organization, War Trauma Foundation and World Vision International. WHO: Geneva.

BASIC PSYCHOSOCIAL COMPETENCE TRAINING

Parents and other child caregivers (teachers, health and social service workers) can benefit from capacity-building in basic psychosocial skills to support children in their care. Topics for psychosocial competence training may include:

- The conditions for optimal child development.
- How children of different ages respond to and understand stressful and traumatic events.
- Skills training in active and empathic listening.
- PFA.
- Knowing one's limits and how and when to refer.

First responders (police, ambulance workers, firefighters)

and humanitarian workers in various sectors (WASH, shelter, nutrition) are often taught PFA as a way to build confidence and skills in helping distressed children and families. Older children and adolescents can learn child-to-child PFA skills to be applied under the guidance of trusted adults.

SEE COMPENDIUM
Resources in Layer 3.
- Lay Counseling: A Trainer's Manual
- Psychological First Aid Training Manual for Child Practitioners
- Psychological First Aid: Guide for Field Workers

OUTREACH AND CASE MANAGEMENT

Children and families with specific health or protection needs may require outreach and case management services to assist with identification of and access to services, follow-up and support. Effective case management requires trained and supervised staff competent in ethical, best practice standards. Also needed are referral resources and coordination mechanisms.

For example, children with protection risks need to be identified quickly, systematically evaluated and referred for appropriate services. MHPSS workers can assist in this process, including by working with specialists to formulate an action plan with the child and family. This will involve ensuring confidential documentation and information management, and monitoring and supporting follow-up appointments.

SEE COMPENDIUM
Resource in Layer 3.
Child Protection Case Management Training Maual for Caseworkers, Supervisors and Managers

Social service systems in some emergency settings may not be well developed, but they should not be ignored, as this workforce may have culturally relevant knowledge and skills. It is important to find out if there is an existing university-trained workforce that could be a source of knowledge if provided with strengthening and support. Collaborating with the social service workforce can help in strengthening systems and helping to build capacity and improving outreach and case management functions for vulnerable children and families.

FOCUSED SUPPORTIVE INDIVIDUAL AND GROUP ACTIVITIES

Focused individual and group support may be helpful to address the MHPSS needs of children and parents/caregivers, alone or in conjunction with specialized care (layer 4). New evidence-based individual and group interventions developed by WHO show promising results in helping parents and caregivers in emergencies. These scalable interventions can be undertaken by non-specialized providers with proper training and regular supervision, or by mental health clinicians. These interventions include:

- PM+ (Problem Management Plus) – a brief, individual intervention for adults (e.g., caregivers) with prolonged, disabling distress.
- GROUP IPT (Group Interpersonal Therapy) – a group activity useful in different age groups to help participants better understand and manage depression.
- THINKING HEALTHY – a support intervention for mothers with perinatal depression.

SEE COMPENDIUM
Resource in Layer 3.
Problem Management Plus (PM+): Individual Psychological Help for Adults Impaired by Distress in Communities Exposed to Adversity

See **Annex 5: Scalable Interventions** *for more information. UNICEF may have a role in supporting capacity-building in scalable interventions for non-specialized staff in communities, including training and supervision linked with specialized supports.*

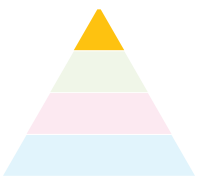
MHPSS Interventions at Layer 3 may include:

- Basic psychosocial support (e.g. empathetic listening, mentoring or counseling, conflict resolution, psycho-education, PFA, etc.).
- Focused individual and group support provided by trained and supervised non-specialized providers.
- Focused individual and group support provided by mental health clinicians.
- Psychosocial competence building for parents, caregivers, siblings, peers, and professionals in other sectors.
- Outreach and case management for complex cases with specific needs addressed by other sectors (e.g., protection, WASH, nutrition, shelter).

TABLE 4: LAYER 3 INTERVENTION STRATEGIES WITH SUSTAINABLE IMPACT

IASC PYRAMID LAYER 3 FOCUSED CARE; PERSON-TO-PERSON SUPPORT TO ADDRESS PSYCHOSOCIAL DISTRESS AND PROTECTION CHALLENGES		
TIER OF INTERVENTION		
Child	**Family/Caregiver**	**Community**
Provide focused psychosocial care (including PFA) for distressed children	Provide focused psychosocial care (including PFA, scalable psychological interventions) for distressed parents/caregivers	Work with specialized and non-specialized care providers to develop and strengthen quality, focused child and family MHPSS care integrated within community care systems (e.g., primary health care, schools, social service systems)
Ensure access of children to age- and gender-appropriate individual and group psychosocial support interventions by trained, non-specialized staff	Support outreach services to vulnerable families for psychosocial support, protection services and referral to specialized care and other sector services as needed	Help to identify and develop functional referral resources and procedures for clinical mental health care and professional social services for children and families in need
Build capacity of children of different ages in self-care and appropriate support to their peers (e.g., child-to-child PFA, adolescent peer-to-peer support)	Promote psychosocial competence of parents and other caregivers (teachers) to support distressed children (e.g., PFA, parenting skills training to support children with developmental disabilities and autism) and in self-care	Strengthen social service systems for coordinated care, case management and referral for children and families with MHPSS and protection needs
Build capacity among community MHPSS workers in identification, referral and case management (e.g., coordination, follow-up support) for children in need of specialized care (layer 4)	Train and supervise lay staff to provide individual and group psychosocial interventions for vulnerable caregivers/families (e.g., support to mothers with post-partum depression, interpersonal group therapy)	Raise awareness and build capacity in school systems to support children with distress, MNS disorders or disabilities, including identification and referral of at-risk children
	Build capacity of families/caregivers in self-help and mutual support for specific psychosocial problems (e.g., scalable problem management self-help interventions)	Promote mental health and community awareness campaigns about available focused care and supports for children, caregivers and families in need
	Build capacity among community MHPSS workers in identification, referral and case management for parents/caregivers in need of specialized care	Work with community leaders and resource people to promote stigma reduction and inclusion/participation of children and families with disabilities or MHPSS problems

IASC MHPSS LAYER 4: SPECIALIZED CARE



In any emergency, a small percentage of children and their caregivers will require specialized care, such as clinical mental health care by mental health and social service professionals. This includes care for children and caregivers with pre-existing MNS disorders and disabilities (including developmental and physical disabilities) that can worsen in crisis situations. It also includes care for those who are prone to developing mental health problems or severe distress that interferes with their daily functioning as a result of the emergency situation. Through MHPSS interventions, children with relevant needs can be identified, provided with general support and focused care activities, advocated for, and referred to specialized services as needed.

SEE COMPENDIUM
Resource in Layer 4.
Resource in Layer 4. mhGAP Intervention Guide for Mental, Neurological and Substance Use Disorders in Non-Specialized Health Settings (cross- cutting Layers 3 & 4)

Whether pre-existing or crisis-induced, children with MNS disorders and disabilities are often excluded, stigmatized, isolated, abused or neglected. MHPSS interventions at this

layer can raise awareness of these children's needs among families and communities through mental health promotion and stigma reduction campaigns. They can also support the inclusion and participation of such children in family and community life. Interventions can build caregiver capacity to provide daily care and support at home and in community institutions, such as schools, and ensure referral to specialized care meeting quality standards.

Specialized services may include mental health interventions (psychological and/or psychiatric treatment) and social services (e.g., case management). Safe traditional and cultural healing practices may also be used as part of specialized care.

Some children impacted by war, natural disasters, poverty, displacement and other traumatic events may require specialized care to facilitate their coping, recovery and resilience. Child survivors of serious protection violations (SGBV, trafficking, recruitment into armed forces or other types of abuse and exploitation) may suffer both physical and emotional consequences of traumatic experiences. Common psychological problems that may result include anxiety, depression, conduct disorder, substance abuse and post-traumatic stress disorder. Likewise, families and caregivers who have experienced serious stressors or traumatic events may require specialized care for their coping and recovery and so they can continue to meet the needs of children in their care.

In some cases, mental health services may increase stigma and isolation of persons who seek care and may actually endanger them. Exceptional care must be taken to ensure that children and families can safely access the help they need without the risk of stigma, isolation or additional harm.

It is also essential for specialized services to be accessible. At-risk children who require specialized care are more likely to be identified and appropriately supported through community based interventions that raise awareness of MHPSS needs and resources, and promote inclusion and participation of vulnerable children and families within community life.

SEE COMPENDIUM
Resource in Layer 4.
Promoting Rights with Psychosocial Disabilities and Community Living for Children

MHPSS interventions at Layer 4 may include:[16]

- Assess the impact of the emergency on mental health, pre-existing MNS disorders and the status of any pre-existing services.

18 Adapted from UNICEF, 'Psychosocial Support of Children in Emergencies', 2009.

- Expand access to specialized mental health care for a range of emergency-induced and pre-existing conditions through general and community based mental health services.
- Support the integration of mental health care into primary health care services.
- Facilitate training and capacity-building of local professionals in specialized interventions.
- Support existing community structures for identifying, referring and supporting children and families in need of specialized services.
- Identify and provide protection and health care for people in mental health institutions.
- Identify and involve traditional healing practitioners in non-harmful healing rituals.
- Advocate for quality specialized services to be accessible to all who need them.
- Coordinate with specialized service providers in programme planning, case management, referral and follow-up activities.
- Ensure that social services are provided in a professional manner.
- Disseminate accurate information to communities about MNS disorders and severe distress, in order to reduce stigma and promote care and protection of affected people

TABLE 5: LAYER 4 INTERVENTION STRATEGIES WITH SUSTAINABLE IMPACT

IASC MHPSS PYRAMID LAYER 4 SPECIALIZED CARE; CLINICAL MENTAL HEALTH CARE AND PROFESSIONAL SOCIAL SERVICES FOR MNS DISORDERS, DEVELOPMENTAL DISABILITY, SERIOUS DISTRESS OR SERIOUS PROTECTION VIOLATIONS		
TIER OF INTERVENTION		
Child	**Family/Caregiver**	**Community**
Ensure referral and access to appropriate clinical MHPSS care and professional social services for children with MNS disorders or exposed to serious protection violations	Ensure referral and access to clinical MHPSS and professional social services for caregivers/ family members with MNS disorders or exposed to serious protection violations	Work with health and mental health professionals to support and strengthen available, accessible, high-quality[19] clinical MHPSS care within health and mental health systems (e.g., hospitals, child and adolescent mental health units, community mental health centres) for children, caregivers and families
Facilitate the management and support of children with MNS disorders or serious protection risks (e.g., assisting their access to medications and follow-up appointments)	Assist referral and access of vulnerable families to therapeutic interventions (e.g., psychotherapy) and specialized social services	Promote quality standards for clinical care of MNS disorders (e.g., mhGAP training for mental health care providers[20])
Provide children support and psycho-education to help them manage and cope with distress, MNS disorders or disabilities	Provide psycho-education and build capacity of parents and other caregivers (e.g., teachers) to respond to the support needs of at-risk children	Raise awareness among specialized care providers of complementary community supports (social services, protection, psychosocial outreach) to strengthen multi-layer, comprehensive services for at-risk children and families
Support children with MNS disorders or disabilities to participate in their communities and lives in meaningful ways	Build capacity and support the work of mental health and social service professionals, (e.g. school psychologists, clinical social workers) with at-risk children and families	Develop mental health promotion and stigma reduction campaigns with persons with MNS disorders or disabilities

19 Quality-focused and specialized MHPSS care includes care and services that are accessible, well-coordinated through functional referral systems and inclusive of all children regardless of age, ethnicity and disability. Quality care for MNS disorders follows the standards laid out in WHO and UNHCR, 'Mental Health GAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical Management of Mental, Neurological and Substance Use Conditions in Humanitarian Emergencies', 2015.

20 The Mental Health Gap Action Programme (mhGAP) was launched by WHO in 2008 to increase the allocation of financial and human resources for care of MNS disorders and increase coverage of key interventions in low- and middle-income countries. Source: www.who.int/mental_health/mhgap/en/.

MONITORING AND EVALUATION

The log frame for the guidelines supports the assessment, design, implementation and M&E of MHPSS strategies implemented by UNICEF and its partners around the world. The guidelines and log frame help programme staff to learn from and improve MHPSS approaches to support children and families in various crisis contexts.

The log frame draws upon the 'Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings' developed in 2016 by the IASC MHPSS Reference Group. It contributes to a shared language about MHPSS approaches and to quality practices in implementation.

SEE COMPENDIUM
Resource in Section 5.
Inter-Agency Resource IASC MHPSS Reference Group: A Common Monitoring and Evaluation Framework for MHPSS in Emergency Settings

However, each MHPSS programme is unique to its context. Each programme requires its own M&E framework depending on the specific activities and envisioned outcomes and goal. This log frame can be used as inspiration for designing an M&E framework relevant to specific programme approaches. It is not expected that programme staff will report against every impact, outcome and output indicator contained in the framework, but rather will choose relevant indicators, adapt them or add their own accordingly.

GOAL, IMPACT, AND KEY OUTCOMES

UNICEF's MHPSS log frame adopts from the IASC MHPSS M&E framework the common strategic goal of 'reduced suffering and improved mental health and psychosocial wellbeing of children and families', six related key impact indicators (GI), and five key outcomes adapted to better target children and families (Table 3). Furthermore, the complete log frame (see **Annex 4: UNICEF's Community Based MHPSS Log Frame**) elaborates specific indicators for each key outcome and their corresponding outputs, also suggesting means of verification (MoVs) and best practices for data collection and reporting.

TABLE 3: IMPACT INDICATORS

GOAL: REDUCED SUFFERING AND IMPROVED MENTAL HEALTH AND PSYCHOSOCIAL WELLBEING OF CHILDREN AND FAMILIES.	
IMPACT INDICATORS	
GI.1	**FUNCTIONING:** For example, the ability to carry out essential activities for daily living, which will differ according to factors such as culture, age and gender
GI.2	**SUBJECTIVE WELLBEING:** Aspects of subjective wellbeing that could be measured include feeling calm, safe, strong, hopeful, capable, rested, interested and happy; not feeling helpless, depressed, anxious or angry
GI.3	**EXTENT OF PROLONGED DISABLING DISTRESS AND/OR PRESENCE OF MENTAL, NEUROLOGICAL AND SUBSTANCE USE DISORDER (OR SYMPTOMS THEREOF)**
GI.4	**ABILITY OF PEOPLE WITH MENTAL HEALTH AND PSYCHOSOCIAL ISSUES TO COPE WITH PROBLEMS:** For example, making use of skills in communication, stress management, problem-solving, conflict management or vocational skills
GI.5	**SOCIAL BEHAVIOUR:** Being able to, for example, help others and avoid aggressive behaviour, use of violence, discriminatory actions
GI.6	**SOCIAL CONNECTEDNESS:** This refers to the quality and number of connections an individual has – or perceives to have – with other people in their social circles (family, friends and acquaintances). Social connections may also go beyond one's immediate social circle and extend, for example, to other communities.

KEY OUTCOMES				
1. Emergency responses do not cause harm to children and families, and are dignified, participatory, community-owned and socially and culturally acceptable	2. Children and families are safe and protected, and human rights violations are addressed	3. Family, community and social structures promote the wellbeing and development of all children and caregivers	4. Communities and families support children who have mental health and psychosocial problems	5. Children and families with mental health and psychosocial problems use appropriate care

THE IASC COMMON MONITORING AND EVALUATION FRAMEWORK FOR MHPSS IN EMERGENCY SETTINGS RECOMMENDS ALL MHPSS PROGRAMMES/PROJECTS USE:

At least one impact indicator from the common goal, plus

At least one outcome and corresponding outcome indicator from the common framework.

SEE COMPENDIUM

Key monitoring and evaluation resources in section 5

- A Common Monitoring and Evaluation Framework for MHPSS in Emergency Settings (IASC MHPSS Reference Group)
- A Compendium of Tools for the Assessment of the Mental Health and Psychosocial Wellbeing of Children in the Context of Humanitarian Emergencies (CPWG and IASC MHPSS Reference Group)
- Evaluation of Psychosocial Programming in Humanitarian Crises (UNICEF Inter-Agency Guide)
- Psychosocial Monitoring and Evaluation (M&E) Framework (IFRC)
- Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings (WHO, UNHCR)
- Evaluation of Child Friendly Spaces: Tools and guidance (World Vision International)
- Psychosocial Needs Assessment in Emergency Displacement, Early Recovery, and Return: IOM Tools

COMMUNITY ENGAGEMENT AND PARTICIPATION

Communities and cultures are dynamic. They provide the structures and systems for safety in people's lives, work and education, and the social and psychological foundations of wellbeing for children and families. They change constantly as they adapt to new realities, environments, resources and challenges, particularly with the upheaval of familiar ways of life caused by emergencies.

Communities are also diverse, with subgroups and power dynamics that determine who participates in decision-making and to what extent. For example, community power relationships may exclude some vulnerable groups (e.g., based on ethnicity, religion, disability).

SEE COMPENDIUM

Resource in Layer 1.

The REPSSI Journey of Life: Community Workshops to Support Children: Workshop series for community mobilization to support children and caregivers in resource-poor settings.

When the structures and fabric of community life are damaged by emergencies, MHPSS interventions use the process of community engagement and participation to help maintain, activate or restore community and family capacity to support children's wellbeing. What existed previously may need to be restored, abandoned or altered in the new context for the wellbeing of all community members following an emergency. People affected by an emergency, (particularly one involving massive displacement) may or may not identify as part of the same community and subgroups within communities may or may not feel included, safe or respected.

Inclusion and participation of all community members is at the core of MHPSS work and requires great efforts of engagement. As such, engagement is not something 'done' to a community; rather, it is a process in partnership with community members as they assess their situation, consider priorities to help children and families and develop solutions based on their needs and resources. It ensures programmes:

- Are relevant to local realities, cultural values and understandings.
- Make the best use of local resources.
- Effectively identify children and families who are vulnerable or have special needs, and actively promote their inclusion in interventions and relief efforts.
- Strengthen the natural supports in families and communities to care for children.
- Strengthen capacities of child care systems for broad impact.
- Promote local ownership of programmes for long-term sustainability.

Community engagement is based on certain principles, including a rights-based approach that incorporates an age, gender and diversity analysis to ensure broad, meaningful participation of community members, including those who may traditionally be marginalized. It is also based on the principle of empowering individuals to understand their situation, make informed decisions and assume ownership of solutions for sustained impacts. It incorporates transparency and accountability of all stakeholders.

ENGAGING COMMUNITIES

In complex situations, careful attention must be paid to the process of approaching communities and ensuring inclusion and participation throughout the programme cycle. Engaging communities begins with recognizing and acknowledging their resilience, capacities, skills and resources for self-care and self-protection. It involves:

- Working with the community and its leaders.
- Understanding the community's dynamics and structures.
- Building on community capacities and strengths to find solutions to identified concerns.
- Working in partnership to plan, implement and monitor interventions at all phases of the programme management cycle.

The process of community engagement raises awareness of the needs of vulnerable or marginalized groups. It can play a powerful role in reducing stigma and discrimination affecting vulnerable children and families.

Communities displaced by an emergency also interact with host communities in a variety of ways – sometimes being absorbed and integrating with them, sometimes living separately. Tensions may arise over resources or sociocultural differences. The relationship between affected people and host communities needs to be examined with host communities involved in the process.

Environment also influences community engagement processes. For example, when refugees or displaced families are scattered in an urban environment, identifying and engaging with them requires different strategies than if they are located together in a refugee camp.

SIX STEPS OF ENGAGEMENT AND PARTICIPATION

1. Learn about the context.
2. Identify and meet community stakeholders.
3. Conduct an inclusive, participatory assessment of needs and resources.
4. Facilitate inclusive, participatory planning of solutions and interventions.
5. Support programme implementation by community actors.
6. Monitor and evaluate interventions together.

LEARN ABOUT THE CONTEXT

Before entering a community, learn about the emergency and the sociocultural context for children and families. A situation analysis provides an overview of the emergency context, including a mapping of risks, resources and priority areas for intervention. It begins with a desk review of existing information about:

- The emergency and environments where affected children and families are living (including host communities).
- How many and who are the most vulnerable (e.g., unaccompanied children).
- The history of the emergency and what the communities have experienced.
- Risks for children and families as well as existing resources (e.g., services, facilities).
- Sociocultural customs; ways of caring for and protecting children and families.
- How children and caregivers with psychosocial distress or MNS disorders are included (or excluded) in support structures.

IDENTIFY AND MEET COMMUNITY STAKEHOLDERS

Stakeholders include individuals and groups who may be affected by MHPSS interventions, can influence programmes, and have an interest in or can be a resource for interventions. Stakeholders are a diverse group including governmental, NGO and civil society personnel; organizations for children's care, such as school boards; religious organizations; youth and women's groups; formal and informal leaders, including women leaders such as female elders and midwives; people with disabilities; women and men (including LGBTI people); child caregivers; and children themselves. Vulnerable children and families may be hidden, so it is important to inquire sensitively about who and where they are, and the appropriate ways to reach them.

SEE COMPENDIUM
Resource in Section 5. Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings (WHO, UNHCR)

A stakeholder analysis is the first step undertaken in partnership with the community and in ensuring inclusive representation in community engagement activities. It is important to make a good first impression. See the tips below for some ideas in meeting and engaging stakeholders:

Tips for meeting and engaging community stakeholders

- Understand community practices and traditions prior to entering communities in order to appropriately engage different groups and members.
- Work with and through community leaders (formal and informal). Inform them of plans for assessment and programme planning and seek their counsel. Community leaders can be instrumental in guiding and supporting entry into communities, and in promoting inclusion and participation of various stakeholders, including women and children.
- Identify an existing committee or community group/organization through which to access the community and share information.
- Explain who you are, why you are there, and what you can and cannot do (manage expectations).
- Focus on listening and use opportunities for informal meetings in various locations.
- Arrange meetings for mutually convenient times and check to be sure meetings accommodate the schedules of children and parents/caregivers.
- Work with leaders on outreach strategies to ensure messages reach everyone, not just a select few.
- Deliver messages in simple, culturally sensitive language that everyone can understand.
- Identify and engage diverse stakeholders, including children of all ages, and children and caregivers with MNS disorders, distress or disabilities.
- Be consistent, respectful and transparent in all dealings. Follow up on any actions in a timely way.

Source: Adapted from 'A community based approach in UNHCR operations', UNHCR, 2008, p. 44.

CONDUCT AN INCLUSIVE, PARTICIPATORY ASSESSMENT OF NEEDS AND RESOURCES

Involving the community in the assessment not only provides valuable information for MHPSS interventions, it also acknowledges and helps engage individual and community agency for recovery and restoring hope. It brings diverse voices to an understanding of the community, how the emergency has affected community coping capacities and how different community members see their own risks and resources.

Talk with all those who influence the structures and systems of support for child wellbeing: mothers, fathers and other primary caregivers; teachers and other child care providers; and various community stakeholders. Find ways to appropriately engage children of different ages, and those who may be marginalized such as children or caregivers with disabilities.

Engaging diverse voices means ensuring that age, disability and gendered perspectives are reflected. This helps include boys and girls, women and men, and vulnerable or marginalized children and families, and it supports meaningful participation. Consider talking with boys and girls separately to get a gendered perspective on children's needs. Appropriately and safely accessing various groups requires careful consideration of the sociocultural context. For example, men may have to get permission to speak privately with women, and caregivers should be consulted to approve children's participation in assessment activities.

Below are some general tips for engaging children in participatory assessment.

Tips for engaging children in participatory assessments

- Meet parents/caregivers to explain the assessment and ask permission for children to participate in it.
- Put children at ease, such as by sitting with them on the ground, singing, playing or drawing, according to their age and developmental stage and culture.
- Use simple language and concepts.
- Be patient and take time to build trust, especially with children who have had distressing experiences.
- Accept and support their emotions – do not judge them for how they feel.
- Help them to reduce any stress and tension.
- Validate what children say – do not challenge, shame or undermine them.
- Do not probe about upsetting details or emotions.
- Convey a sense of hope and safety.
- Understand that they may view and explain their situation through fantasy, inventing explanations, using symbolism or emphasizing seemingly unimportant details – listen respectfully.
- Be sensitive to gender, culture, ethics and power relationships between adults and children.

Source: 'Participatory assessment in operations' (UNHCR, 2006); 'Psychological First Aid: Guide for Field Workers' (WHO, 2011); 'Monitoring and Evaluation Framework for Psychosocial Support Interventions' (International Federation of Red Cross and Red Crescent Societies, Psychosocial Reference Centre, 2015)

Participatory assessments include FGDs, community mapping, key informant interviews and surveys. Key questions to consider in inclusive, participatory assessments include:

- How has the community coped with distress and challenges in the past?
- How has the emergency affected those coping mechanisms?
- How are vulnerable children and families identified, helped and supported?
- How are children or caregivers who have psychological distress or mental health problems viewed and supported (or overlooked)?
- What are the key mental health, psychosocial and protection concerns for children and families?
- What do boys and girls of different ages say are their particular concerns and priorities?
- What do caregivers identify as their concerns and priorities?
- Who is most at risk, and how can they best be reached and assisted?
- What is the perspective of children and families experiencing psychological distress or mental health problems, including developmental disabilities?
  - » What are their concerns and priorities?
  - » What coping strategies do they use and how do they seek help?
  - » What barriers do they encounter in receiving services and support?
- What resources and structures exist?
  - » Who are key resource persons for children and families (e.g., teachers, social workers, women leaders)?
  - » What child care structures and natural supports are currently functioning (e.g., formal and informal education, social service systems) and what are the gaps?
- What is helpful and what is harmful? What support mechanisms can be activated or restored, and what needs to be adapted to respect the rights of children and families?

SEE COMPENDIUM

The Compendium contains resources and toolkits useful for the design of participatory assessment questions and other M&E tools.

Resource in Section 5. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings (WHO, UNHCR, 2012) contains practical tools for designing and conducting an assessment of mental health and psychosocial needs and resources in major humanitarian crises. See Tool 10 "Participatory Assessment: Perceptions by General Community Members" for guidance on interviews with general community members, including free listing and further questions.

FACILITATE INCLUSIVE, PARTICIPATORY PLANNING OF SOLUTIONS AND INTERVENTIONS

The information gathered (situational and stakeholder analyses and the participatory assessment) are then shared and analysed together with stakeholders to plan the way forward. Work with the community to identify women and men, boys and girls – of all ages, as well as from vulnerable or marginalized groups – as representatives in the planning process. Engage children and family and community caregivers in designing programmes they feel are relevant to their needs and suitable to the culture and context. For example, in designing programmes for youth, bring adolescents together to brainstorm approaches and activities they would find interesting and relevant to their lives.

UNICEF and partners may work with a community committee in planning solutions and interventions. The committee's membership should be diverse. The group works together to examine risks and resources for children and families, identify priorities for action, and develop feasible solutions. Ensuring diverse and meaningful participation may require planning. For example, in some cultures, women and children, or people with disabilities, may not have participated previously in such discussions. They may be unaccustomed to speaking up and having their opinions regarded seriously. Sensitize and orient the group on the value of inclusive, participatory processes and together determine what are acceptable ways to achieve this in the culture.

In planning solutions and MHPSS interventions, help communities identify sociocultural practices for the care and protection of children and families that uphold human rights and do not discriminate or stigmatize certain groups. Work with them on how to sensitively identify vulnerable children and families in ways that do not expose them to further harm. Also help to identify local organizations (community or governmental) and/or people from affected communities to implement interventions for child and family wellbeing and protection.

SUPPORT PROGRAMME IMPLEMENTATION BY COMMUNITY ACTORS

The role of UNICEF and partners is to support programme implementation with technical and financial assistance to community actors. MHPSS interventions seek to maximize community and governmental resources that can continue after emergency funding ends. Whenever possible, support existing community initiatives and structures and build capacity of the community to sustain their own solutions. For example, identify local organizations (community or governmental) and/or people from among affected communities to implement interventions for children and families.

- FINANCIAL ASSISTANCE: Community engagement and participation processes raise awareness of issues and solutions that community members will often begin to address themselves. The level of financial assistance communities receive depends on the emergency situation and phase, the

Tips for inclusive, participatory planning

- When holding a planning meeting, clearly state its goals and objectives and the agenda.
- Respect everyone, being sensitive to culture and providing people ample time to speak.
- Share the results of situation and stakeholder analyses and participatory assessments in ways everyone can understand.
- Do not immediately propose solutions; rather, facilitate a discussion on how best to respond, what resources can be mobilized and how, and what support they can expect from you.
- Facilitate a process to agree on a strategy (objectives, activities, roles and responsibilities), ensuring the strategy is inclusive and rights-based and addresses the needs of vulnerable children and families.
- Clarify links between the planning and budgeting process for implementing programmes.
- Help establish joint problem-solving mechanisms and regular feedback mechanisms.
- Provide a summary of the planning outcomes and ensure community representatives have mechanisms to disseminate the information to community members.

CPMS Standard 16: Community Based Mechanisms

Standard 16 of the CP Minimum Standards for Child Protection in Humanitarian Action focuses on how communities can help to prevent and respond to CP risks. A community based CP mechanism (CBCPM) is a network or group of individuals who work in a coordinated way towards CP goals. Effective CBCPMs include local structures and traditional or informal processes for promoting or supporting the wellbeing of children.

KEY PREPAREDNESS ACTIONS INCLUDE:

- Carry out assessments with female and male community members to identify existing methods of supporting children at risk.
- Determine whether there are any State-mandated community mechanisms for CP.
- Assess the possible effects of an external agency becoming involved with the community.
- Map local (formal and informal) service providers and support mechanisms (e.g., women's groups, health workers, police, teachers, religious leaders) and their strengths and weaknesses to build on existing capacities and mechanisms.
- Choose, recruit and train community volunteers to protect children from abuse, violence, exploitation and neglect and support child survivors. Ensure all role descriptions include clearly defined tasks, responsibilities and skills.
- Work with adults and children to identify risk scenarios facing boys and girls in emergency situations. Develop a community response plan (including early warning) and strengthen capacity to put the plan into practice.
- Encourage fostering for children living outside the care of their biological parents. Ensure that foster parents are supported and children are monitored by CP personnel.

KEY RESPONSE ACTIONS INCLUDE:

- Build on existing processes, resources and capacities in CBCPMs to provide child-friendly support and services.
- Work with the community to include different subgroups, including women, girls, boys and highly vulnerable people such as people with disabilities.
- Strengthen networks and links between the CBCPMs.
- Identify projects that can be carried out by community members, including children and young people, to deal with CP concerns in the community. Provide support for these initiatives where necessary and appropriate.
- When appropriate, encourage existing and newly organized adolescent and youth groups to be involved in CBCPMs and CP issues.
- Mobilize and strengthen peer-to-peer response and monitoring.
- Find areas where CBCPMs' capacity to conduct effective community-level messaging on preventing violence, exploitation and abuse of children can be strengthened.
- Build community capacities for identifying and referring severely affected children for specialized help.
- Support CBCPMs to develop links with formal (governmental) aspects of the national CP system at local, regional and national levels.

urgency of the needs and the capacity of the community to activate their own resources. It is important to manage the use of financial and material incentives carefully. Be careful not to erode natural volunteering and local ownership of the programme by reliance on incentives that may end with changes in funding streams. UNICEF and partners can support natural helping activities not only through financial assistance but also by providing meeting spaces, facilitating sharing, and providing information and training.

- TECHNICAL ASSISTANCE: For plans to be successful, programme implementers need to have the skills, knowledge and systems to implement them, ensure their quality and track their progress over time. Activities in this step of community engagement include:
  - » RECRUIT: Programme staff or volunteers can be recruited locally. Recruitment strategies should avoid weakening existing structures by pulling away skilled staff members. Help programme implementers develop recruitment procedures that ensure fair and equitable opportunities, are appropriate to the culture and gender of children and families they will be helping, and appropriately screen for child protection concerns (e.g., check references).
  - » TRAIN AND SUPERVISE: Build the capacity of local volunteers and staff (within community groups and care structures) through participatory, skills-based training and ongoing supervision. Set minimum qualifications for the various roles and tasks of the job. Train and supervise volunteers and staff to ensure they meet those qualifications and feel equipped for their tasks. Ongoing supervision is essential in MHPSS programmes to build skills and knowledge to respond to emerging challenges and to support staff and volunteers in their work. 'Care for the caregivers' is not a luxury in MHPSS programmes – it is fundamental to quality programming and preventing burnout.
  - » ESTABLISH INFORMATION MANAGEMENT AND SOPS: Systems and procedures are essential to the success of any programme. Help to develop and train programme implementers in useful systems of documentation and information management that meet ethical requirements (e.g., confidentiality). Documentation and information management systems should be feasible and user-friendly to ensure they are implemented and give an accurate picture of needs and progress. SOPs should include systems for assessing and responding to specific problems with guided protocols (e.g., coordination and referrals). SOPs help volunteers and staff do their work effectively and efficiently and make sure that children and families get the care they need.

MONITOR AND EVALUATE INTERVENTIONS TOGETHER

Programme M&E is critical; for transparency and accountability, it should involve diverse members of the community. Do include a wide range of voices in the feedback about programme outcomes and effectiveness in M&E strategies in order to get a clear and comprehensive view of the impact of interventions (including any shortcomings) from different perspectives. Regular feedback mechanisms allow for timely feedback so programmes can be adjusted to ensure their safety and effectiveness. This also ensures that vulnerable children and families are included in participation mechanisms and service provision.

Tips for monitoring and evaluating interventions with the community

- Engage children, their caregivers and other community stakeholders in visualizing programme success in order to design useful indicators.
- Find out what elements of the programme are or are not working well for boys and girls of different ages by triangulating information from parents/caregivers (e.g., teachers) and children.
- Have an established plan to address any risky situations revealed by M&E processes.
- Design monitoring methods that are feasible for staff and community members to implement, and use simple tools for programme evaluation that allow for participation of different community groups.
- Do not be defensive about findings; rather, listen and learn, and agree together on improvements.
- Be sure to provide M&E data to children, caregivers and community stakeholders in forums that help them to improve strategies for longer term care of children and for advocacy purposes.

Engaging diverse voices means ensuring that age, disability and gendered perspectives are reflected. This helps include boys and girls, women and men, and vulnerable or marginalized children and families, and it supports meaningful participation.

ANNEX 1: COMMUNITY BASED MHPSS IN PRACTICE – THREE CASE STUDIES

The following case studies represent best practices in community based MHPSS intervention strategies in current humanitarian emergency contexts in South Sudan, Nepal and Lebanon. The case studies document the processes of community engagement, systems strengthening and integration across sectors in three unique crisis contexts. They reflect different contextual and cultural challenges in working to achieve sustainable, high-quality MHPSS programmes. Resources and constraints, successes, challenges and lessons learned are detailed in these stories from the field to inspire and guide MHPSS programmes in other regions of the world.

SOUTH SUDAN

SNAPSHOT OF THE EMERGENCY

Decades of war following Sudanese independence in 1955 led to serious neglect, lack of infrastructure development, major destruction and massive displacement in the region. Since independence from Sudan in 2011, the Republic of South Sudan has further suffered from internal conflict and a civil war (since 2013). As a result, about 3 million of the country's 12 million people have been displaced.

The conflict is infamous for grave violations of human rights and campaigns of atrocities. Children faced a multitude of protection risks prior to the 2013 conflict, and the further breakdown of security since then has seriously damaged the social fabric and family structures that should provide for their safety and wellbeing. UNICEF and partners report grave violations of human rights for many children in South Sudan.[21] As of 2016, South Sudan has the second highest score on the Fragile States Index. Its health indicators for children are abysmal, and the country has the highest proportion of children out of school in the world.[22]

THE NEED: QUALITY STANDARDS AND TOOLS FOR PROGRAMMING

UNICEF's early responses included establishing 123 CFS from December 2013 through 2014. An evaluation of the programme revealed three major concerns: (1) a gap in attention to the wellbeing needs of adolescents, (2) disconnect from communities, and (3) lack of minimum quality standards for psychosocial activities. Local implementers lacked psychosocial expertise and familiarity with international standards for MHPSS and CP programmes. CFS facilitators tended to improvise activities that were often unstructured, or they supervised children from the sidelines without real interaction. High child-to-staff ratios – as high as 200 children to 1 facilitator – made real engagement with children nearly impossible. Ongoing conflict also frequently disrupted programmes, making it difficult to consolidate quality standards.

SEE COMPENDIUM
Resource in Layer 2. A Toolkit for Community based Psychosocial Support for Children and Adolescents in South Sudan (TPO Uganda for UNICEF South Sudan)

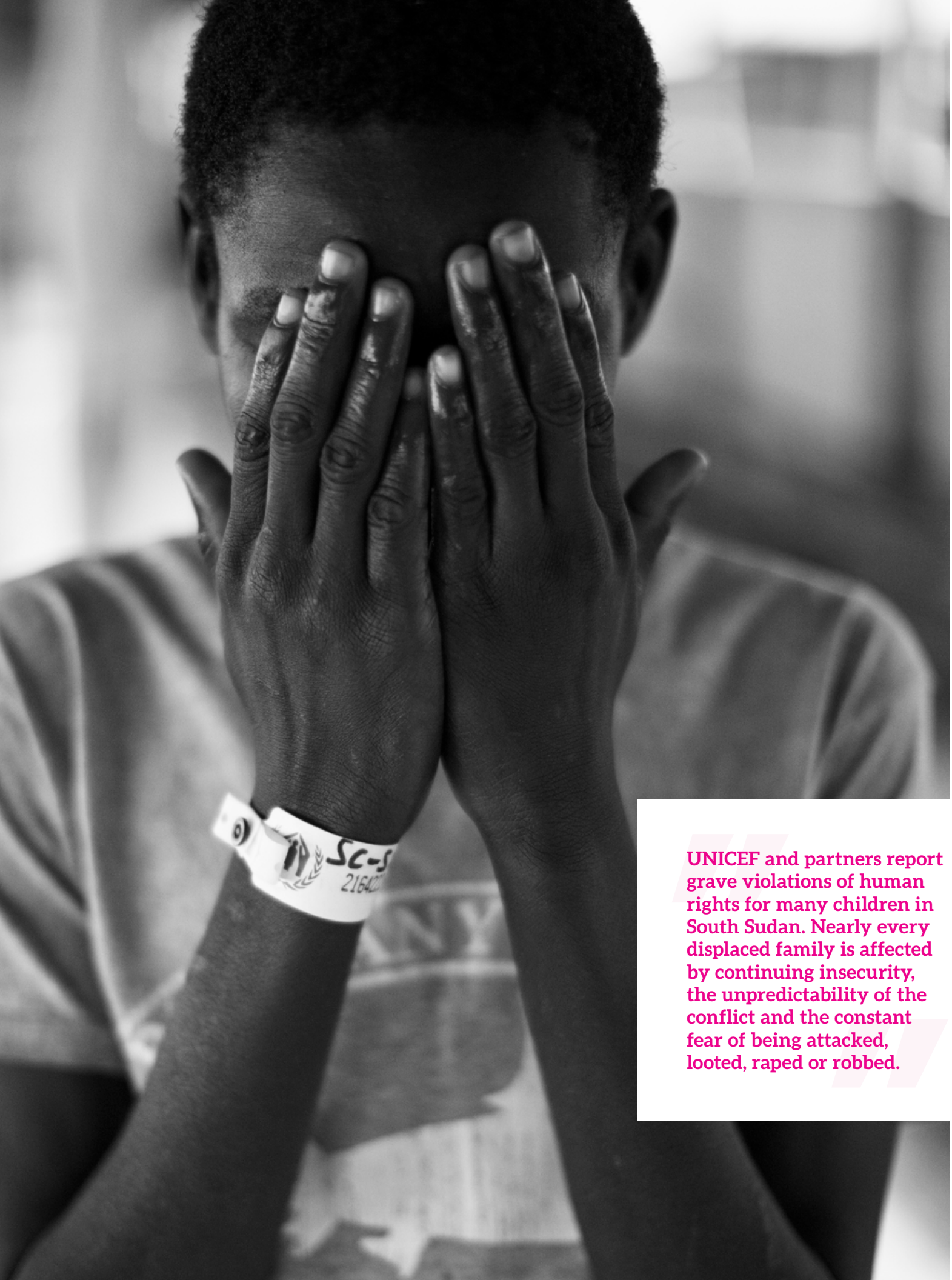
To address these concerns and provide clear benchmarks to guide programmes, UNICEF supported development of a toolkit for community based psychosocial support for children and adolescents. It aimed to improve the capacity of local care providers to meet minimum quality standards, and encourage better targeting of programmes for adolescents and caregivers. The toolkit, which serves as the main reference for MHPSS programmes in South Sudan, consists of four pillars:

Raising community awareness and developing a work plan: Raising awareness about children's wellbeing and protection needs, and preparing work plans for quality programming.

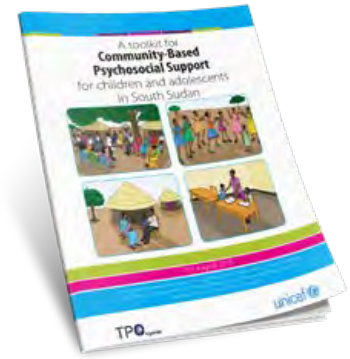
Strengthening child and adolescent resilience: Using tested tools to provide quality age-appropriate activities, focused

21 UNICEF South Sudan, 'Child Protection Update', June 2016.

22 UNICEF South Sudan, 'Back to Learning: one-year report', 2015.



UNICEF and partners report grave violations of human rights for many children in South Sudan. Nearly every displaced family is affected by continuing insecurity, the unpredictability of the conflict and the constant fear of being attacked, looted, raped or robbed.



support and help in building positive coping skills.

Supporting caregivers: Supporting the wellbeing of families/caregivers, enhancing parents' understanding and capacity to protect and support their children.

Working with schools: Strengthening teachers' wellbeing, understanding threats to child safety and wellbeing, building skills to respond supportively, and collaborating with CP officers on the ground (this is the largest component.).

Special attention was paid to contextualizing the guidance for South Sudan by pilot testing the model in four areas and selecting tools that worked best in the context.[23]

Pillar 1: Raising community awareness raising and developing a work plan

NGO partners initially resisted shifting from the familiar CFS model to a community based approach, due to their lack of psychosocial expertise. However, once partners were trained in the toolkit, community based programming was widely embraced. An evaluation of the programme found that adoption of community based MHPSS approaches and programming had increased from 5 per cent to 70 per cent across existing CFS interventions within one year. The remaining CFS in the country are transitioning from stand-alone structures to community based centres. They offer a range of activities with families and community members, and better accountability and transparency, including:

- Caregiver/community stakeholder sessions are held in community spaces (e.g., churches, schools, CFS, 'under the big tree') to raise awareness of MHPSS and protection issues for children and families and to mobilize action. Discussions may include prevention of violations, reporting mechanisms, ways to identify children with protection or MHPSS concerns, and availability of services and support.
- Work plans are displayed so the community is aware of the activities.
- Mechanisms are in place to collect regular feedback from children and adults to improve activities.
- Caregivers actively participate and contribute to CFS activities. Examples include mothers organizing handicrafts activities for girls and grandmothers offering storytelling for children.

A few practical tools helped people make the shift to a community based approach and better incorporate age and gender considerations in activities. One of these tools is the work plan – a simple tool for CFS facilitators. It comes with guidance on how to appropriately organize the space for boys and girls; understand the needs and responses of children of different ages and developmental stages; and design creative activities to support skills development for children. The work plan helped partners to understand 'quality' in programming and to implement changes in CFS, such as ensuring registration of

COMMUNITY BASED PSYCHOSOCIAL ACTIVITIES

"In collaboration with community volunteers and site managers, regular sessions are conducted with selected groups of community members and caregivers. They offer parental skills in providing psychosocial support to children and better care and protection [using Journey of Life for Community workshop]… This has given the community members the ownership and more engagement in the community based psychosocial support activities compared to the centre-based activities, which community members considered to be for the organization."

Source: 2016 UNICEF report on Global Street Samaritans Background Paper on Psychosocial Support and Social Emotional Learning for Children and Youth in Emergency Settings, 2016

23 Various tools were tested and selected for inclusion in the Community Based Psychosocial Support Toolkit, including 'Journey of Life' materials for children and community workshops (REPSSI), 'Better Parenting' (Yekokch Berban/REPSSI), 'Say and Play' (Project Concern) and 'AVSI Manual for School Teachers' (AVSI), among others.

children, respecting child-staff ratios and monitoring children's attendance and wellbeing in both CFS and schools.

Pillar 2: Strengthening child and adolescent resilience

The evaluation also revealed major psychosocial problems among adolescents in the camps crowded with displaced people. With no support programmes and nothing to do, many turned to alcohol abuse and gang involvement, causing serious disturbances within their communities. At the same time, many approached NGOs to ask, "Do you have anything for me?", as they wanted to engage in meaningful activities.

South Sudan was one site selected for pilot testing and roll-out of the UNICEF *Adolescent Kit for Expression and Innovation.* It offered local organizations the capacity and skills to implement activities for adolescents, such as music, dance, drama, sports, games and group discussions as well as daily group meetings at which adolescents can safely share experiences and emotions with their peers for mutual support.

The clear, step-by-step structure of the model helped to build the facilitation skills of local implementers. It also provided guidance in how to discuss topics with adolescents and encourage participation. Although a maximum group of 20-25 participants is recommended, local implementers found that upwards of 50 adolescents would show up. Building strong, flexible facilitation skills was necessary to maintain programme effectiveness.

Six steps of engagement and participation Activities for adolescents

"Adolescents in schools and community have been involved in activities like music, dance and drama, sports games, group discussions and board games. The adolescents have been grouped into two groups, ages 10-13 and 14-18, and supported through the circle approach, which has enabled the facilitator to reach a large group of adolescents."

Source: 2016 UNICEF report on Global Street Samaritans

Adolescent clubs in schools also help young people to form their own groups to implement activities. Some groups organize dances or dramas to raise awareness about sensitive issues (e.g., early marriage, girls' right to education, fear of recruitment into armed forces). Others engage in creative or traditional activities or organize sports competitions for both boys and girls. Some adolescents have also set up radio programmes.

Pillar 3: Supporting caregivers

UNICEF observed that many caregivers were distressed and struggling to respond to the needs of children. Most families are female-headed, with single women raising their biological children and fostering others. They struggle to meet their families' basic needs. Nearly every displaced family is affected by continuing insecurity, the unpredictability of the conflict and the constant fear of being attacked, looted, raped or robbed. Multiple displacements have destroyed or disrupted traditional community supports for families and caregivers. Tensions among subgroups within displaced populations further weaken the community networks and links that could help families care for children.

A community based toolkit draws upon existing resources in developing activities for children and their caregivers.[24] UNICEF supports weekly sessions for groups of caregivers, providing a safe space for them to come together and support each other. Here they get information about effective parenting strategies for children affected by the conflict, how to recognize and support children in distress, manage stress, and support each other. Given how busy caregivers are, the project monitors attendance to try to keep the same members engaged in the group over time. Frequent, brief sessions (about two to three hours at a time) help them to remain engaged.

Pillar 4: Working in schools

The school system in South Sudan has been severely weakened by the conflict, leaving many rural schools non-operational or insufficient for the number of children. Children often lacked funds for school fees and uniforms, and many teachers went without pay for extended periods. In addition to being personally affected by the conflict, many teachers lacked even primary school education. They had to deal with huge classes and children facing serious problems yet lacked

24 Resource material has been incorporated from 'Journey of Life' (REPSSI), 'Better Parenting' (Yekokch Berban), 'Say and Play' (Project Concern International).

the skills and knowledge to identify, support and refer children in need. Although teachers had received some psychosocial training, mostly this was one-off training with no follow-up. Teachers rarely referred children in need to CP services.

To strengthen school engagement with CP issues and actors, UNICEF piloted a model programme with education cluster actors who were already well known to teachers and school personnel. The programme started with regular meetings so everyone could share what they were doing and identify issues for joint intervention. The programme was designed to focus on children's wellbeing and community engagement, using schools as the focal point for outreach to communities on CP issues. For example, joint activities on wellness were organized by parent-teacher associations.

One issue identified was corporal punishment. Education actors supported schools in raising awareness about this and gaining wide endorsement of a code of conduct. Although codes of conduct existed, they were not always implemented, nor had all teachers endorsed them. A checklist helped to systematize the application of codes of conduct in schools. It also helped teachers to build skills to provide emotional support to children. Schools are being promoted as safe and positive learning environments, and MHPSS approaches are strongly embedded in the strategy of abolishing corporal punishment and endorsing alternative disciplinary methods.

Two tools were developed in the model programme to assist teachers:

- The *Psychosocial Support Checklist for Primary Schools* is a practical tool for school managers to self-evaluate progress in creating safe and positive learning environments. It guides development of a joint work plan in which schools, supported by CP and education actors, identify areas for improvement and commit to actions.
- A *referral form* was developed to help teachers recognize signs of distress in children and develop a joint action plan with CP and MHPSS actors to support and monitor them. Previously, teachers would not take initiative to help an individual child in distress because they did not know about referral resources and procedures. In this model, the psychosocial support facilitator can visit the home to speak with caregivers, while the teacher monitors the child's school attendance and flags absences to the CP officer. Overall, documentation for monitoring vulnerable children greatly improved.

ACHIEVEMENTS IN SCHOOLS

- Teachers trained to identify and respond to children's psychosocial problems, address vulnerable children's needs, adopt positive discipline and classroom management methods.
- Monthly CP meetings with teachers, parent-teacher associations and student leaders.
- Psychosocial volunteer in each school, supported by social worker
- Teachers using referral forms for children in need
- Members of child rights clubs trained to advocate for their rights
- Adolescent boys and girls regularly engaged in group discussions
- Children engaged in age-appropriate psychosocial structured activities (for children 0-5 years, 6-10 years and 11-17 years)
- Adolescent kit for expression and innovation being used regularly.

Source: Global Street Samaritans (from a 2016 UNICEF report)

The integration of MHPSS into the CP and education clusters is an important achievement of the community based programme. The CP team met with teachers on a regular basis (weekly or bi-weekly) for short capacity-building sessions. These frequent, short sessions worked well with teachers' busy schedules and fostered their engagement over time. Participants learned skills on personal and child wellbeing, positive disciplinary methods, and responses to specific problems in the school. The link between MHPSS and CP initiatives in temporary learning spaces and schools has further improved the recent emergency responses for children in Juba and the north of the country.

CHALLENGES AND SOLUTIONS

Building and sustaining engagement – the dilemma of incentives

The issue of compensation or incentives is a challenge in working with underpaid or unpaid teachers and caregivers. Programmes may not have the budget to cover expenses such as refreshments at caregiver meetings or salary enhancements for teachers. Programmes must also balance the need for intervention when situations are dire with the risk that continuation of a programme becoming reliant on external support. In the school-based programme, some teachers were reluctant to take on 'additional duties' without extra compensation. The new joint CP-education programme was not part of agreements already signed by UNICEF and its partners, so no budget was in place to support dedicated staff for school psychosocial and CP activities. Several strategies helped:

- Since teachers already had a relationship with education actors, they were more willing to accept a programme presented by education organizations.
- The school initiative was built into the 2016 CP budget proposals, allowing for dedicated human resources and more systematic implementation.
- High-level endorsement for the joint initiative by CP and education clusters led to effective advocacy for engagement of all actors as a broad, cluster-level strategy.

IMPROVING MULTI-LAYER SUPPORTS AND MHPSS COORDINATION

One challenge faced by MHPSS implementers in South Sudan has been a lack of accessible, high-quality mental health services, including services for children with intellectual disabilities. A mental health platform has been established, co-led by the Ministry of Health and an NGO. Currently, psychiatric interventions are only available for adults, and these are provided by international NGOs in just two or three locations. In parallel, a small PSS task force composed mostly of CP actors focuses on psychosocial programmes.

When a child in need of specialized services is identified through psychosocial programmes, referral is challenging. Plans call for merging the mental health platform and PSS task force under a single umbrella to improve coordination of multi-layer supports and encourage an integrated MHPSS strategy. This would bring together actors from different sectors (e.g., nutrition, SGBV, education).

LESSONS LEARNED

- Combine quality standards with simple, user-friendly tools for tangible implementation.
- Hold brief, frequent sessions for busy caregivers (parents and teachers) to encourage their sustained participation and engagement.
- Focus on capacity-building of local implementers (e.g., build facilitation skills, use clear, step-by-step methods) to increase their confidence and skills in new methods.
- Recognize and respond to the desire of adolescents to engage.
- Regularly inform and engage community stakeholders (e.g., by posting work plans) and institute mechanisms for feedback.
- Utilize the skills of community members for children's activities.
- Pilot test and adapt resources to ensure their relevance to the context.
- Capitalize on existing, valued relationships in forming coalitions to implement new initiatives.
- Avoid one-off trainings and ensure continued mentorship of participants.

NEPAL

SNAPSHOT OF THE EMERGENCY

Nepal was afflicted by a civil conflict resulting from a Maoist insurgency between 1996 and 2006. It claimed the lives of more than 16,000 people, and many more experienced torture, intimidation and abductions. The country also suffered two massive earthquakes in 2015, on 25 April and 12 May. They killed over 8,000 people, displaced over 450,000 and directly affected approximately 8.5 million people.

EXISTING MHPSS CAPACITY

Although the Ministry of Women, Children and Social Services lacks a focal point for emergency MHPSS, there is strong MHPSS expertise in Nepal. This is due to many years of experience and research by national organizations and humanitarian aid organizations. The IASC MHPSS Guidelines were translated into Nepali several years ago and are well known among MHPSS actors and in other emergency sectors.

Early response to the Nepal earthquake followed IASC MHPSS Guidelines, focusing on all layers of intervention. For example, temporary CFS set up in various earthquake-affected locations were not stand-alone activities, and were transitioned to ECD centres or community centres or adapted to after-school activities after the acute phase of the emergency.

For six months following the earthquakes, the Department of Women and Children (DWC) in the Ministry of Women, Children and Social Welfare and UNICEF co-led an active psychosocial working group of 80 to 100 organizations providing early response activities. UNICEF also supported key NGOs[25] to implement a range of interventions integrated with the protection, education and health clusters. These included PFA; capacity-building of community based organizations (e.g., civil society organizations working in protection at district level); community awareness-raising of MHPSS issues and responses; focused care for individuals, families and groups; and identification and referral of those in need of specialized services. Children and families with mental health issues had access to specialized care at district hospitals and the central psychiatric hospital in Kathmandu Valley. In some districts, MHPSS support was also provided through health centres.

The psychosocial working group developed SOPs for use by all members, based on the IASC MHPSS guidelines and providing clear direction on:

- Types of activities constituting psychosocial support (e.g., interventions in the first three layers of the pyramid with referrals to specialized services)
- Minimum standards for each intervention category, including training and qualifications of staff; clinical supervision; clinical guidance on individual counselling sessions; coordination with DWC offices and other relevant government entities; referral procedures; monitoring and reporting; quality assurance; and mobilizing existing community support mechanisms
- Classification for human resources (including specialized and non-specialized MHPSS staff) and appropriate remuneration
- Interventions at each IASC MHPSS pyramid layer adapted for training, supervision and implementation practices in Nepal.

UNICEF also developed a 5W's (who, what, why, where, when) database reporting template to track services implemented by partners working in MHPSS. Within one year after the earthquake, more than 380,000 people had received MHPSS care and support.[26]

KEY COMMUNITY BASED INITIATIVES

Three key MHPSS initiatives were implemented in Nepal: community psychosocial centres within women's cooperatives; school-based programmes; and community MHPSS messaging.

Initiative 1: Community psychosocial centres within women's cooperatives

DWC works with women's committee volunteers and SGBV watch groups in communities, as well as with social mobilizers. Social mobilizers, often members of women's cooperatives, receive a monthly incentive for their work in their communities. During the peak of the emergency, UNICEF and partners trained social mobilizers in basic psychosocial skills, allowing them to identify and support children and caregivers in distress and initiate referrals. In February 2016, after lobbying from UNICEF, DWC proposed a plan to establish community psychosocial support centres in the 14 districts most affected by the earthquakes and

25 Key NGOs included the Transcultural Psychosocial Organization Nepal, Centre for Victims of Torture and Centre for Mental Health and Counselling Nepal.

26 https://www.humanitarianresponse.info/en/operations/nepal/document/5w-update-6-sep-0.

one additional district. These centres would improve access by rural communities to psychosocial care and support and referral to mental health services.

DWC hoped to eventually formalize and institutionalize the centres and included funding for psychosocial services for the first time in the budget of the Ministry of Women, Children and Social Welfare (MoWCSW). A budget of $1,650 per year (NPR 165,000) was budgeted for each centre for running costs. Additional funds are provided to pay a monthly incentive for one psychosocial counsellor in each centre.

UNICEF and partners were asked to support the initiative. They helped in drafting guidance for the centres, reviewed proposals from women's cooperatives to start centres in their communities, and provided technical training and supervision[27] for front-line providers. This included the community psychosocial counsellors and community psychosocial workers.

Social mobilizers and community psychosocial workers received seven days of training in basic psychosocial support skills, learning how to:

- Recognize and address distress in children and adults
- Provide first-line psychosocial care, including empathic listening and PFA
- Identify and refer those needing additional services or specialized care
- Raise awareness of psychosocial issues in the community
- Enhance the community social fabric through dialogue and interaction around psychosocial issues.

The community mobilizers and psychosocial workers were given access to monthly technical supervision meetings to share experiences, discuss difficult cases and offer each other peer support.

Some social mobilizers were selected for more in-depth training as 'counsellors'.[28] They were recommended based on their experience, educational background and work performance by district-level DWC offices. The 780-hour certified course curriculum consisted of 40 per cent theory and skills and 60 per cent field practice over six months. The training was completed in four phases, and participants had field placements in community centres.

Counsellors saw clients in at least in three to five sessions undertaken jointly with professional counsellors from the supporting NGOs, which supervised them. NGO professional clinicians also supported counsellors in treatment planning, jointly conducting community activities such as mobile psychosocial outreach and community psycho-education, and responding to referrals from CP and education actors. Ongoing technical support and supervision were provided over 18 months to ensure adequate transfer of skills and knowledge, and this was viewed as critical to the success and quality of services provided.

Although the initiative was widely welcomed and endorsed, funding remained a challenge, as many organizations left the country after the early recovery phase of the emergency. DWC budgeted for monthly incentives for the counsellors and social

Resources and tools

Tools have been developed to assist non-clinicians, such as social mobilizers and others in the health, social service and protection sectors, in identifying people who may need more specialized support. A one-page tool developed by TPO Nepal helps identify people who may have serious distress or a MNS disorder (e.g., depression, alcohol use disorder, psychosis, epilepsy and behavioural problems in children) and how to consider the need for referral.

The tool uses a narrative description and pictorials to encourage observation of signs and symptoms of severe distress or MNS disorder. Questions at the bottom of the page help the provider reflect on the person's functioning and desire/willingness for support and referral.

27 Technical training and supervision are provided by TPO-Nepal and Centre for Victims of Torture.

28 Patricia Landinez of UNICEF Nepal notes that 'counselling' is a term already established and locally known in Nepal as basic community PSS, mediation and peer-to-peer support.

mobilizers, consistent with their role. UNICEF continued to advocate for future funding to encourage sustainability. Another challenge is sustaining permanent supervision and support for newly trained counsellors, following the initial 18 months of technical supervision.

Three factors were especially important to the success of the community psychosocial centre's within women's cooperatives initiative:

1. ESTABLISHED MHPSS EXPERTISE AND SOCIOCULTURAL KNOWLEDGE: Established MHPSS expertise aligned with international guidelines prior to the earthquakes enabled rapid MHPSS response and scaling up. NGOs had a long presence in the communities and nuanced knowledge of local sociocultural issues, such as the complex caste system. They were able to identify social mobilizers inclusive of all castes and representing the diverse array of languages and ethnic groups in communities. This ensured inclusive, equitable access to psychosocial care for all children and families.
2. READILY AVAILABLE MATERIALS AND RESOURCES: Organizations had an array of materials and resources ready for use and/or adaptation to the emergency. These included leaflets, posters, brochures and cartoon booklets (the Meena cartoon series described below) about psychosocial distress and stress management. They also had the training curriculum for community psychosocial workers and psychosocial counsellors.
3. WELL-ESTABLISHED WOMEN'S COOPERATIVES: Women's cooperatives have been a valued community structure for 5 to 10 years. They serve as a support system for women, such as by providing small business loans and structures for savings and credit. Dedicated funding makes them stable. Members of cooperatives (one has 400 members!) are very motivated to learn new skills and are active in initiating community projects. Many requested psychosocial skills training, and their new knowledge and skills are a source of pride and esteem in their communities. The women's cooperatives provide an ideal base for integrating within the Ministry of Women and Children structures, and ensuring institutionalization and sustainability of the initiative.

Initiative 2: School-based programmes

Education is valued in Nepal and seen as an important contributor to wellbeing. Mass education since the 1960s has allowed many children to transcend class and caste limitations, and it has contributed to an active civil society, exemplified by the women's cooperatives. However, education challenges remain, including exclusion of children from certain castes, bullying of marginalized children, and corporal and psychological discipline by teachers, which has been linked to depression and suicide among students.[29]

Nepal's mental health policy emphasizes the importance of promoting mental health awareness through community structures such as schools, and building appropriate MHPSS in the education sector to reach children. Psychosocial programmes have been implemented in formal and informal education, including through recreational activities and implementation of the Classroom-based Intervention. This 15-session intervention combines elements of creative-expressive therapy, cooperative play and cognitive behavioural

29 IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 'Nepal Earthquakes 2015: Desk Review of Existing Information with Relevance to Mental Health and Psychosocial Support'.

techniques. These initiatives are part of a multi-tiered psychosocial and mental health care package for children affected by armed conflict.[30] Psychosocial support is also included in a teachers' curriculum supported by the Ministry of Education. It focuses on the post-disaster period in supporting children with PFA, drama and other activities.

In addition, disaster risk reduction (DRR) has been included in the education sector in a three-year project to reduce the vulnerability of children, families and their communities. Eight schools participated in the project, which disseminated knowledge about DRR to children, teachers and communities. The programme encouraged the transfer of information from children to parents, as well as encouraging a 'we can do' attitude.

Initiative 3: Community MHPSS messaging

Community messaging about MHPSS has been an important aspect of outreach. Messages are often disseminated during community orientation and training sessions. Communities value such training, and a majority of community members will attend orientation sessions given by MHPSS actors to learn about psychological responses to the earthquake, coping and recovery. These sessions help to reach a large number of people who might not consider consulting a psychosocial counsellor or mental health professional for help (most MHPSS assistance is provided by traditional healers). A particularly effective vehicle for advocacy and awareness messaging is community radio, described below.

Another effective use of messaging is cartoons based on Meena, the beloved fictional character in South Asia. UNICEF developed a booklet and several videos using the Meena character that were found to be very effective in helping children with constructive coping strategies.

Community messaging and mobilization are very effective in Nepal because the informal sector is a major source of support for children and families. Throughout the country are active CP committees and child clubs, which are supported by the government and NGOs. They help to provide access to MHPSS care and referral for vulnerable children and families.

BHANDAI SUNDAI RADIO PROGRAMME

The Bhandai Sandai radio programme, aired daily by the national radio station in the initial phase after the earthquake, provided MHPSS care to children and parents/caregivers. Sponsored by UNICEF, the programme invited mental health professionals (psychiatrists, psychologists and psychosocial counsellors) to respond to queries called in by listeners. The questions covered issues such as insomnia and social withdrawal. The professionals answered questions about how best to address these problems and cope with the aftermath of the emergency.

One comment from a listener underscores the importance of this programme in building resilience and wellbeing among community members:

"This programme was very well designed and appropriate in time… [Since the earthquake], I could not go inside of the home and always felt scared, I could not even take care of my child! But when I listened to this programme, it became like a gift from God for me. Now I am very well mentally, and I can take care of my son and we all sleep inside the home."

Source: Personal communication, UNICEF Nepal

30 D. Gautam, 'Good Practices and Lessons Learned: Disaster risk reduction through schools', 2010.

CHALLENGES AND SOLUTIONS

Integrating NGO work with DWC psychosocial centres

NGOs with deep experience and expertise in Nepal typically implemented their own MHPSS programmes using their own funding. They each had their own tools, training initiatives, psychosocial staff and counsellors, and clients.

The DWC initiative for community psychosocial centres, strongly supported by UNICEF, therefore required a shift in the mindset of implementing partners. The shift to a more integrated way of working required NGOs to share resources within the structure of a government system. They also had to negotiate to harmonize the roles of the NGO staff and DWC counsellors vis-à-vis the communities they serve.

For example, NGO counsellors assist newly trained DWC counsellors in providing direct services. Newly trained counsellors do not 'belong' to one of the NGOs, but rather to the community through the structure of the DWC psychosocial centre. Through this harmonized approach and shared resources, community centres should become institutionalized and sustainable. Operating guidelines were developed and implemented under the leadership of DWC to orient centre staff and women's cooperative members, ensuring consistent quality.

This collaboration was an important factor in harmonizing the NGO activities with the DWC initiative. The MHPSS support provided by various organizations during the earthquake was institutionalized through the establishment of the community counselling centres. This ensured that services would be in place to respond to people's MHPSS needs at all times (not only during emergencies) and would belong to the government services system. The suffering caused by the earthquake – and the resulting high rates of preventable mental health problems, including suicide – motivated all MHPSS actors, both NGO and government.

LACK OF POLICY INTEGRATION, CHILD MENTAL HEALTH CARE AND COMMUNITY SERVICES

Nepal's civil conflict seriously disrupted the health system, but both the health system and living standards have improved significantly in recent years. Health services have been decentralized to the largely rural population since 1991. A policy to integrate mental health care into the decentralized health system was adopted in 1997, though it is not yet implemented, and the budget allocated for mental health is minimal. Thus, mental health services are essentially limited to a few hospitals in larger cities, and these lack specialized services and inpatient beds for children.

As the government lacks a focal point for MHPSS, humanitarian aid agencies have been the primary actors in setting up MHPSS programmes in emergencies, including for children formerly associated with armed forces and groups, families of disappeared people, earthquake and flood survivors as well as refugees. NGOs have also filled the service gap by training primary health care staff in basic mental health care and psychosocial skills. Still, efforts have been hindered by a lack of essential psychotropic medicines, training manuals, screening tools and guidelines for management of common and severe mental disorders. Although the National Health Training Centre has endorsed training manuals for basic psychosocial care, they are not always implemented.

To address these gaps, a mental health working group (led by WHO and the Nepal Ministry of Health) are working on mhGAP training. In addition, UNICEF works to ensure coordination among the actors working in CP and MHPSS. For example, family preservation and anti-trafficking programmes are linked with MHPSS services, and MHPSS is incorporated into other sector programmes.

Other UNICEF-supported initiatives help to fill the gaps in care for vulnerable children and families. These include:

- Case management for unaccompanied, separated and vulnerable children
- Prevention of trafficking and services for child survivors of trafficking, such as temporary shelter, education, focused care, family tracing and reunification, and life skills training
- A family preservation programme to strengthen vulnerable families' socioeconomic status and wellbeing
- Integration of psychosocial care into protection services implemented by DWC offices
- SGBV prevention and response activities in coordination with police.

LACK OF DATA ON SUICIDE

Suicide is a silent but significant problem in Nepal, particularly for adolescents. Nearly everyone knows someone who has committed suicide, and community members say it is the biggest issue they face. It is an ever-growing problem,

particularly among young women. According to a 2015 IASC MHPSS desk review, suicide is the leading cause of death for women of reproductive age in Nepal.[31, 32]

Hospital psychiatrists in Kathmandu report dealing with one case of suicide per day. However, the taboo surrounding suicide leads to under-reporting in police reports and on death certificates, making it difficult to gauge the scope of the problem. An ongoing research study found that families tend to identify fairly simple explanations for a child's suicide – such as young couples kept apart due to caste differences, or interpersonal fights – as well as feelings of failure in life or being overwhelmed by poverty.

Better data are needed for prevention, identification, support and referral. In the meantime, TPO Nepal has developed a tool that community counselling staff can use to help them identify cases, provide PFA and refer immediately to specialized services.

LESSONS LEARNED

- Working through natural support systems and structures capitalizes on community motivation to sustain programmes.
- Working with local actors who have sociocultural knowledge of the community is essential to ensuring inclusive, equitable programmes.
- It is important to plan financial support in ways to avoid creating dependency on external supports and ensure governmental/community ownership of initiatives so they will be sustained over time.
- Existing knowledge, resources and capacities (including tools and resources in the local language) should be used to the maximum extent possible, or should be developed as part of DRR and preparedness initiatives.
- Preparedness is important in responding to a crisis. It allows for interventions to be aligned with international standards and benefit from past experience, supporting fast, high-quality responses.
- Advocacy is needed for focused and specialized care services for vulnerable children and families where these do not exist.
- Integrating NGO services into governmental community structures requires time, skill, patience, dialogue and negotiation – but is well worth the effort.
- Building on relationships between governmental and NGO actors in MHPSS and protection increases buy-in and facilitates new ways of working together.
- Community awareness-raising (e.g., radio programming) is efficient and effective for reducing stress and enhancing coping among affected communities in low-resource settings.
- Links with livelihood initiatives can aid prevention of psychosocial problems and increase resilience of families.
- Special efforts are required to coordinate numerous MHPSS service providers in the immediate aftermath of a crisis and to ensure that quality services reach remote areas. UNICEF can play a role in ensuring knowledge exchange among local MHPSS actors.
- Cross-sectoral coordination (including with government entities) is essential for holistic services.
- UNICEF can play a leadership role to ensure dialogue between government and civil society.

31 IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings, 'Nepal Earthquakes 2015: Desk Review of Existing Information with Relevance to Mental Health and Psychosocial Support'.

32 http://reliefweb.int/report/nepal/nepal-maternal-mortality-and-morbidity-study-200809-summary-preliminary-findings.

LEBANON

SNAPSHOT OF THE EMERGENCY

The 2011 Syrian crisis was a catastrophic event, triggering a focus on the MHPSS needs of both refugees and Lebanese citizens. Lebanon faced a massive influx of Syrian refugees at a time when Lebanon was still in recovery from its civil war (1975-1990) and from conflicts with Israel in 1996 and 2006. In 2006 the country had also coped with the influx of Iraqi refugees, during which time UNICEF and other humanitarian aid agencies had begun to scale up response operations. This included strengthening CP, SGBV and MHPSS support services.

The Syrian crisis occurred while damaged infrastructure and public services were still being restored. MHPSS services were transitioning from emergency to recovery and longer-term development operations for refugee and local populations suffering the effects of protracted displacement, poverty and insecurity. Although early response to the crisis benefited from previous coordination and capacity-building efforts, the sheer scale of the refugee influx soon overwhelmed structures. Critical gaps were revealed in MHPSS and CP services, which needed to be adapted and considerably scaled-up.

THE NEED: COORDINATED SYSTEM STRENGTHENING

According to a 2016 UNICEF situation analysis, more than half of all people residing in Lebanon live in adverse conditions and poverty. Socioeconomic stressors from the Syrian crisis, urbanization and insecurity threaten the resilience of institutions, communities, families and children. The report warned that these stressors could reverse development gains. Populations at risk in Lebanon include Syrian and Palestinian refugees, who comprise one quarter of the population, as well as vulnerable Lebanese children and families.

Refugees tend to reside in the poorest areas where local populations were already struggling. Services were inadequate and few support systems were in place. Regarding the wellbeing and safety of children, two other serious issues exist as well: children out of school and children's regular exposure to violence, including SGBV. Children out of school are more vulnerable to exploitive child labour. Moreover, persistent inequality and multidimensional poverty continue to threaten realization of a broad spectrum of child rights.

The Syrian refugee crisis overwhelmed existing services and revealed a critical need to further strengthen MHPSS and CP delivery systems in Lebanon. Key challenges included:

- A widely dispersed population living in poor rural and urban areas, and in need of access to integrated and coordinated services
- Privatized and poorly regulated mental health and social services disconnected from children and families in need
- Lack of standardized curricula and protocols to coordinate and ensure quality services by multiple actors.

A variety of government, UN and NGO actors have worked to create plans and strategies for integrated, coordinated systems with functional referral systems. The timeline of MHPSS and CP systems strengthening actions since 2011 is shown below.

YEAR	INITIATIVES TO STRENGTHEN CHILD PROTECTION SYSTEMS
2011	Syria crisis erupts, UNICEF declares Level 3 emergency and Ministry of Social Affairs (MOSA) releases National Social Development Strategy (2011-2015)
2012	UNICEF, MOSA/Higher Council of Childhood and University of Saint Joseph carry out national study on CP systems strengthening and resilience.[33] It reconfirms gaps in availability of accessible and high-quality CP systems, focusing on management and lack of specialized support services and referral systems. It also highlights limited capacities of MOSA and Ministry of Justice as regulatory bodies for CP services and enforcement of legal frameworks.
2013	UNHCR assessment sheds light on importance of strengthening MHPSS services and coordination at all layers[34]
2014	Phase I MOSA National Plan to Safeguard Children and Women (2014-2016) is launched. It aims to ensure prevention and response services (including psychosocial support) to vulnerable children and their caregivers and to women impacted by SGBV, and to build institutional capacities of MOSA and its partners to regulate a decentralized CP system National Mental Health Programme is created in Ministry of Public Health (MoPH) to gain consensus for mental health and psychosocial concerns as a national public health issue
2015	National Strategy for Mental Health and Substance Use Prevention, Promotion and Treatment (2015-2020) is launched Government endorses national SOPs for CP case management and CP information management system, developed by MOSA and UNICEF Lebanon
2016	MOSA National Plan to Safeguard Children and Women is extended to June 2017, with a planned review of Phase I in 2017 and start of Phase II (July 2017- July 2020).

These approaches by various actors capitalize on the momentum of the emergency to strengthen provision of public services in CP, SGBV and MHPSS. In order to 'build back better', these efforts foster sustainable development and build resilience by investing in services and institutions that benefit Lebanon as a whole, both refugees and host communities.[35]

33 MOSA, UNICEF and University of Saint Joseph, 'Child Protection System Mapping and Assessment Study', 2012.

34 R. El Chammay, W. Kheir and H. Alaouie, 'Assessment of Mental Health and Psychosocial Services for Syrian Refugees in Lebanon', UNHCR, 2013.

UNICEF supports these efforts to strengthen public service provision as part of its core mandate for CP response in Lebanon (see box), to ensure the most vulnerable children have access to services and are better protected.

UNICEF LEBANON CHILD PROTECTION PRIORITIES	
PREVENTION	Prevention through sensitization and psychosocial support for girls and boys, women and caregivers; and mobilization of gatekeepers/influential community members playing a role in sensitization, detection and referral of vulnerable children
RESPONSE	Response to CP and GBV violations through focused psychosocial support and specialized services
CAPACITY-BUILDING	Capacity-building of communities, CP actors and local institutions to strengthen services, increase their availability and accessibility, and mainstream CP and GBV services across sectors
SYSTEMS STRENGTHENING	Strengthening national CP and GBV systems through alignment with regulatory frameworks and international standards

MULTI-LAYER, COMMUNITY BASED SYSTEMS STRENGTHENING KEY INITIATIVES

This case study highlights three important responses in strengthening community based MHPSS and CP systems in Lebanon. These responses have helped to provide services that are multi-layer and integrated across sectors and ministries, and to ensure accessibility and quality standards. They are:

- MOSA National Plan to Safeguard Women and Children and social development centres
- Development of standardized procedures, tools and curricula for community based MHPSS
- National mental health strategy.

Initiative 1: MOSA National Plan to Safeguard Women and Children and social development centres

Historically, social services in Lebanon were provided largely through private entities and NGOs with the centralized government playing a limited regulatory role. Efforts to extend services to peripheral areas were hampered by weak organizational and accountability systems and a lack of management capacity and qualified staff.[36]

35 UNICEF, 'Situation Analysis of Children and Youth in Lebanon', 2016.

To address these problems, UNICEF and partners provided support to MOSA in developing its national plan. The MOSA National Plan to Safeguard Women and Children (2014) involved the development of social development centres (SDCs). These community based government institutions form the hub for a range of social services for children and families. The aim is to institutionalize SDCs as a decentralized CP system, complementing the social services system.

Through technical, financial and human resource assistance, UNICEF supports 81 SDCs in the 251 localities representing the majority of refugees and vulnerable Lebanese communities. The SDCs offer multi-layer services and referrals in collaboration with 16 UNICEF partners. In 2016-2017, SDCs were supported to facilitate and lead the establishment of Family Support Networks to help regulate services provided by civil society actors at the local level and to ensure access for vulnerable children and women.

Initiative 2: Standardized procedures, tools and curricula

Before 2016, structured psychosocial support activities were delivered by various NGOs through centre-based and mobile approaches. Delivery was often cyclical and the length and number of sessions were limited. In 2016 it was recognized that stronger community based approaches and more focused care (layer 3 of the MHPSS pyramid) were needed to address the needs of high-risk children.

Through improved coordination, UNICEF and partners have supported standardization and quality in community based MHPSS and CP approaches in Lebanon. Three coordination forums have been instrumental in this success: the MHPSS task force under the health umbrella, co-chaired by the National Mental Health Programme (NMHP), UNICEF and WHO; the Psychosocial Support Committee under the Child Protection Working Group (CPWG), co-chaired by UNICEF and War Child Holland; and case

COMMUNITY GATEWAYS AND GATEKEEPERS

Social development centres are one of the 'community gateways' through which MHPSS and CP services are provided. Others include primary health care centres, community centres, schools, refugee registration centres, informal settlements and collective shelters. Through these gateways, MHPSS services have provided an entry point for integrated services. This helps to ensure that children and families, especially those who are vulnerable, have access to information (e.g., on back-to-school campaigns, birth registration, CP key messages). It also gives them access to intersectoral services and psychosocial support, and referrals to focused or specialized care.

With Lebanon's widely dispersed population, it is useful to have numerous gateways for accessing services.

Community gateways also provide a vehicle for UNICEF and partners to quickly respond and scale up MHPSS and CP services at the onset of the emergency.

UNICEF also links with and works through gatekeepers in displaced and host communities. They include community leaders and resource persons who can assist in identifying vulnerable children and families, supporting inclusion of marginalized groups, and disseminating information about services and key CP and MHPSS messages. UNICEF and partners have been working to increase engagement of community based structures such as adolescent/youth clubs, women's groups and CP groups,[37] and networks to lead psychosocial support and CP activities. NGOs have supported community mobilization both around and within SDCs, providing a range of activities, including youth peer support initiatives.

36 Beyond Reform & Development (BRD/I Group S.A.L), 'Strategy for the Reform and Development of Public Administration in Lebanon', 2011; https://reformlebanon.files.wordpress.com/2013/02/public-services_eng.pdf.

37 CP groups are made up of community members and community based organizations who ensure that CP needs are prioritized in community works.

management task force under CPWG. These forums are useful for sharing information related to service gaps, needs, successes and lessons learned. They also provide an opportunity to develop common approaches and tools.

Other coordination efforts include the development of minimum standards, SOPs, common tools and curricula, for example PSS checklists for all agencies to utilize, also the use of the Strengths and Difficulties Questionnaire across agencies as a common tool to measure change in wellbeing on the individual child participating in PSS activities. Standardization has helped to ensure that MHPSS and CP activities are inclusive and implemented with respect to age, gender and diversity considerations, in accordance with the Minimum Standards for Child Protection in Humanitarian Action. Furthermore, strengthening referral systems helps to ensure a continuum of care that links community based work to national systems strengthening. Training and capacity-building initiatives to encourage correct use of these procedures and tools support systems strengthening and sustainability. One aspect of this is their integration into the curricula of Lebanese universities.

Initiative 3: National community based psychosocial support curriculum

A unified curriculum, the 'National Community Based PSS Curriculum' was developed through the PSS Committee[38] in 2016. The curriculum is based on toolkits used by NGOs and civil society organizations in Lebanon and other references and comes with a detailed facilitator's guide. The curriculum promotes a common approach to delivering PSS activities for all vulnerable children. Roll-out will be supported by UNICEF in 2017 through one of its NGO partners.

FOCUSED PSS TOOLBOX

In 2016, recognizing the growing complexity of CP risks, UNICEF expanded its package of services to include focused psychosocial support for children who are at medium to high risk or who have already experienced a CP violation. UNICEF supported the development of a focused PSS toolbox that aims to fill a gap in resources for the implementation of layer 3 interventions for boys and girls who have experienced a CP violation, exposure to violence and conflict, or who are highly distressed.

The toolbox is organized around sessions covering common topics, with a focus on nine risks, including child labour, unaccompanied and separated children, child marriage, bullying and harassment, and violent discipline. It includes specific activities/sessions to address the emotional support needs of these high-risk groups. The toolbox is integrated following an in-country assessment of children's emotional issues (e.g., grief, anger, sadness) in facing certain risks. It includes a how-to guide to help facilitators select which sessions to use for the group they're working with.

Focused psychosocial support is part of a package of multi-layer response services that can also include case management and specialized services such as mental health care. As of 2017, the focused PSS toolbox is being rolled out through training of master trainers, who will then cascade the training at the community level.

In 2016, UNICEF and the PSS Committee also developed a guidance note on community based, focused psychosocial care interventions that provides guidance on:

- The establishment of activity spaces, including the appropriate numbers of children and child-to-facilitator ratios
- Content and expected length of activities
- Skill level of facilitators and training requirements.

Terms of reference were also developed to ensure similar and minimum standards in the profiles for focused psychosocial care facilitators. This goes hand in hand with terms of reference for community volunteers, developed in 2015 by the PSS Committee.

HEALTHY FAMILIES CAREGIVER CURRICULUM

UNICEF has also invested in the International Rescue Committee's *Families Make the Difference* curriculum and supported capacity-building of staff from NGOs, MoPH and MoSA in responding to and preventing CP risks. In 2017, UNICEF and partners made a commitment to ensure that caregivers of high-risk children participating in focused psychosocial support activities are also targeted and that specific sessions are developed to address their needs. This has helped to fill the gap for organizations lacking caregiver-specific curricula. Alongside the *Families Make the Difference* sessions, community-driven caregiver support groups are also facilitated.

38 The PSS Committee, co-led by UNICEF and War Child Holland, is a coordination body for PSS actors under the umbrella of the CPWG in Lebanon.

NATIONAL SOP FOR CP CASE MANAGEMENT

The National SOP for CP Case Management is a resource designed to develop the capacities of government and NGO actors with CP mandates to better identify and manage child victims of violence, abuse and exploitation. Developed by MOSA, University of Saint Joseph and UNICEF in 2013-2014, it enhances the safe identification and referral of children by front-line community based workers and integrates the 'Emergency Guidance on CP Case Management'[39] used previously. It was widely endorsed in 2015 and launched in 2016. The contextualization process of Minimum Standards for CP in Humanitarian Action revised by the PSS Committee and the National Mental Health Programme (NMHP) occurred in 2016, including Standard 10 on Psychosocial Distress and Mental Disorders.

University of St. Joseph and UNICEF have been training governmental and NGO social workers (255 in 2016) on the SOP and information management system to reinforce systematic CP capacity at institutional levels.

Tools for standardizing approaches to monitoring and evaluation

These tools are useful in facilitating the use of standardized approaches to M&E among CP and MHPSS actors:

- Focus Group Discussion Guide for children, caregivers and facilitators, with questions specific to each group.
- Strengths and Difficulties Questionnaire, chosen in 2015 to evaluate changes in the wellbeing of children receiving structured psychosocial interventions. UNICEF and partners provided extensive training to local programme implementers in its use, and over 1,500 children were assessed in 2015.

NATIONAL MENTAL HEALTH PROGRAMME

The Syrian crisis spurred the development of the NMHP in 2014, which supported the transition from privatized and unregulated mental health service delivery to comprehensive, high-quality and

coordinated services. This achievement was spearheaded by MoPH in partnership with WHO, International Medical Corps and UNICEF. In 2015, the programme launched a six-year National Strategy of Mental Health and Substance Abuse Prevention, Promotion and Treatment,[40] following a highly participatory process involving all key stakeholders.

The strategy contributes to the NMHP's goal of ensuring that all people in Lebanon can enjoy the best possible mental health and wellbeing. The programme emphasizes community involvement, a continuum of care, human rights, and cultural relevance in mental health curative and preventive services. Services are multi-layer and integrated into ministries as appropriate. For example, life skills development to prevent drug use in adolescents is coordinated with the Ministry of Education and Higher Education (MEHE), while MHPSS services offered in SDCs are coordinated with MOSA.

The NMHP has succeeded in integrating mental health into primary health care. Through the mhGAP materials, primary health care staff have received training and supervision to build their capacity in developing a coordinated and comprehensive MHPSS system. Since 2014, over 110 general practitioners, social workers and nurses working in 50 primary health care centres around the country have been trained on mhGAP. MoPH provides the trainees with regular support and supervision. This is part of the MoPH Emergency Public Health Restoration Project. Working with WHO, MoPH aims to build the capacity of primary health care staff in assessing and referring people with mental disorders for care and providing psycho-education. For the past two years, NMHP has also delivered a university course in mhGAP for graduate psychology students, supporting a multidisciplinary approach in MHPSS interventions.

CHALLENGES AND SOLUTIONS

The influx of refugees from Syria to Lebanon largely stopped in 2015 due to border closures. However, the needs of children and families – including the vulnerable Lebanese population – are growing as the refugee situation continues and access to

39 Prepared by the Technical Working Group on Case Management, Lebanon 2014.

40 MoPH, National Mental Health Programme, 'Mental Health and Substance Use Prevention, Promotion and Treatment Strategy for Lebanon 2015-2020', 2015.

resources shrinks. Families are resorting to negative coping strategies such as child marriage and child labour, underpinned by strong social norms and values. Now more than ever it is crucial to support communities to take the lead in defining and advocating for their priorities. This needs to be done through culturally relevant community based approaches while providing focused and specialized care.

The main challenge for UNICEF and partners in Lebanon is ensuring that all pieces of the system are properly linked to ensure comprehensive, integrated and equitable MHPSS services. At the NGO level, bringing together CP and health agencies who both deliver MHPSS interventions can be a challenge due to the different backgrounds of staff and approaches. Furthermore, there is a need to involve actors from other ministries. This should include (1) MEHE, to ensure that schools are linked to the system, (2) MOSA, to ensure that SDCs are included in the referral system, and (3) Ministry of Justice, to ensure judicial protection for CP and GBV cases.

To meet this challenge, the NMHP has been working to update the '4Ws' in Lebanon, clarifying who is doing what, where and when.[41] It is also finalizing a WHO AIMS[42] survey that will help in developing the referral system. The referral system will also eventually link to the national SOPs and the CP information management system, which is under development.

Much work has been done in the last couple of years to provide innovative care approaches in Lebanon, linked and institutionalized through work with decentralized government institutions. UNICEF, MoPH and MoSA are now addressing sustainability and mechanisms for taking programmes to scale should there be another influx of refugees or if the emergency worsens. Working with the government to strengthen service provision for all children and families will guarantee public ownership and the capacity to expand and contract services as required. Furthermore, long-term engagement with the government ensures that all children have better access than before the crisis to protection and MHPSS at home, at school and in the community.

41 MoPH, National Mental Health Programme, 'The 4Ws in Lebanon: Who is Doing What, Where and When: Interventions Mapping Exercise', May 2015.

42 MoPH, National Mental Health Programme, 'WHO-AIMS Report on the Mental Health System in Lebanon', 2015.

LESSONS LEARNED

- Major crises can provide the impetus for coordinated, sustained action to decentralize essential MHPSS and CP services to communities.
- Multi-layer supports need to be underpinned by training and capacity-building, including training of trainers and providing SOPs and user-friendly tools to achieve quality services and functional referral systems.
- Engaging various governmental ministries, NGOs and the UN in planning strategies and developing goals builds success and sustainability in comprehensive systems strengthening.
- The needs of all children and families residing in Lebanon – both refugees and host communities – must be incorporated into the design of MHPSS and CP initiatives.
- Coordination forums are important for information sharing, as well as for developing common approaches to programming, including guidance notes, shared tools and curriculums.
- Psychosocial support is a key entry point that can be offered through diverse gateways such as primary health care centres, social development centres, community centres, schools, informal settlements and collective shelters.

ANNEX 2: WHAT OTHER ACTORS CAN DO – ACTION SHEETS FROM IASC GUIDELINES FOR MHPSS IN EMERGENCY SETTINGS

SEE COMPENDIUM
Resource in Layer 2.-Baby Friendly Space: Holistic approach for pregnant, lactating women and their very young children in emergency (ACF)

-Manual for the Integration of Child Care Practices and Mental Health within Nutrition Programs (ACF)

The IASC MHPSS Guidelines contain relevant action sheets for various sectors – these are indicated below for each sector.

WHAT PROTECTION ACTORS CAN DO (ACTION SHEETS 3.1, 3.2, 3.3)

Protection actors in UNICEF and its partner organizations are often the primary implementers of MHPSS programmes. There is a natural link between children's protection and wellbeing, and interventions for each are closely related. For example, MHPSS approaches may focus on:

- Building the capacity of caregivers of children (including teachers) to better recognize and respond to protection needs
- Developing functional referral networks between schools and social services
- Identifying and referring children who have suffered serious protection risks or traumatic events for specialized care and support, as necessary, to help them recover
- Identifying and addressing harmful behaviours
- Preventing separation and prioritizing reunification with caregivers
- Facilitating alternative care arrangements when necessary.

WHAT HEALTH AND NUTRITION ACTORS CAN DO (ACTION SHEETS 6.1 TO 6.5, AND 9.1)

Mental health is an integral part of general health as enshrined in the slogan 'no health without mental health!' However, many emergencies occur in areas of the world that lack adequate clinical mental health services, and existing services are often damaged or weakened by the emergency. Thus, strengthening the capacity of health and nutrition actors in communities is an important aspect of MHPSS intervention strategies. Health and nutrition actors can play an important role in recognizing and providing appropriate treatment and support to children and caregivers with MNS disorders or other specialized MHPSS needs. For example,

- Primary care staff can provide care and treatment based upon the *Mental Health GAP (mhGAP) in Humanitarian Settings* standards.
- Community health workers can receive training and supervision to appropriately identify, support and refer vulnerable children and families to clinical mental health care or social services.
- Nutrition actors can help to identify, support and refer mothers with post-partum depression or infants and young children at risk due to protection concerns, poor growth or developmental disabilities.

Care practices of child caregivers (mothers, fathers, other caregivers, siblings) include providing food, health care, stimulation and emotional support necessary for children to survive and thrive. The ways in which those practices are performed – such as the affection and responsiveness to the child – are critical to positive outcomes for children's growth and development. Nutrition actors therefore pay particular attention to mental wellbeing of caregivers themselves, and their capacity to stimulate social, emotional and cognitive development of their children. One model of intervention is baby friendly spaces, which provide a safe space for feeding and attending to the experiences and wellbeing of mothers, babies and children. Nutrition actors can also support cultural care practices

43 P. Engle, 'The role of caring practices and resources for care in child survival, growth and development: South and Southeast Asia', Asian Development Review, vol. 17, nos. 1,2, 1999, pp. 132-167.

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that support mothers and babies, such as infant massage in India or post-partum rest for mothers in many Muslim countries.[43]

WHAT EDUCATION/ECD ACTORS CAN DO (ACTION SHEET 7.1)

Education (both formal and non-formal) and ECD activities are essential to children's safety, wellbeing and development. ECD activities promote positive care practices during the critical early years of children's development. Examples of ECD activities include:

- Community dialogue and psycho-education, parent support and training to:
  - » Provide infant and young child stimulation and facilitate active play
  - » Facilitate basic nutrition and promote the continuation of breastfeeding
  - » Promote bonding between infants and caregivers
- Programmes to support the care of young children by their families and provide social support to caregivers.

Education is generally highly valued by families and communities, and restarting learning activities for children following emergencies helps to restore routine and normalcy to daily life. Social and emotional learning through formal and informal learning spaces is an important aspect of children's development. It refers to "a process of acquiring social and emotional values, attitudes, competencies, knowledge and skills that are essential for learning, effectiveness, wellbeing and success in life." These are closely aligned with the qualities of psychosocial wellbeing and resilience that children acquire through their optimal development: self-awareness, emotional literacy, persistence, motivation, empathy, relational skills, effective communication, self-esteem, self-confidence, respect and self-regulation.[44]

Sometimes, children and teachers find learning difficult when they are in the midst of conflict or disaster. Schools can be provided with supports to provide developmental learning methods, based on reinforcing systems for the entire school community that can promote growth and learning. Schools and other safe spaces can also serve as important access points for children and families to receive other services, such as nutrition through school feeding programmes. Sports, cultural and other activities can engage children, their families and the larger community, restoring a sense of belonging and promoting healing and recovery.

WHAT CAMP COORDINATION AND CAMP MANAGEMENT (CCCM) ACTORS CAN DO (ACTION SHEET 10.1)

CCCM lead agencies coordinate the operations of various actors that provide essential services in camps for refugees and internally displaced people. They are essential in ensuring human rights standards are upheld, protection and assistance programmes are coordinated in a holistic way, and that psychosocial wellbeing considerations are included to protect the dignity of survivors and enhance the overall humanitarian response.

- The role of CCCM actors begins with assessment, ensuring MHPSS needs and resources of children and families are adequately and appropriately assessed.
- They also ensure all humanitarian staff working in the camps are briefed in basic MHPSS knowledge and skills to support distressed children and families and provide necessary referrals.
- CCCM actors may co-chair an MHPSS coordination group in the camp to help mainstream MHPSS activities across sectors, and engage the affected community in service planning and delivery.
- CCCM actors can also help to assess and address MHPSS needs and resources in host communities, and to liaise with civil society and government representatives to complement the temporary services provided in the camp setting and strengthen the MHPSS care structures in the area.

WHAT WASH ACTORS CAN DO (ACTION SHEET 11.1)

WASH actors play an important role in ensuring boys and girls, men and women have safe and appropriate access to WASH facilities in ways that contribute to their protection and wellbeing. A gendered perspective in the design and implementation of WASH facilities in campsites, schools and other locations is essential because of the unique risks faced by girls and women around these areas. Engaging girls and

44 International Network for Education in Emergencies (INEE), 'INEE Background Paper on Psychosocial Support and Social Emotional Learning for Children and Youth in Emergency Settings', 2016.

women (in addition to boys and men) in assessing needs and priorities around WASH facilities is the first step to ensure safe, appropriate facilities. This includes, for example:

- Separate and private bathing and latrine facilities for men and women, locks on latrine doors and well-lighted latrine areas help to minimize protection risks.
- Water access points should be nearby and easily accessible to women and families who use them frequently for activities of daily living.
- Deciding together with women and child caregivers the best placement and design of water access points can help to promote areas where women can meet each other, have dialogue and form connections.

Keeping a developmental perspective also in mind, WASH actors can help to meet the particular hygiene needs of adolescent girls who are menstruating. They require access to clean water and safe, private facilities for washing in schools and other learning spaces. Being sensitive to these needs and ensuring their access to adequate hygiene in learning environments reduces their risk of dropping out.

Programme M&E is critical.; for transparency and accountability, it should involve diverse members of the community. Do include a wide range of voices in the feedback about programme outcomes and effectiveness in M&E strategies in order to get a clear and comprehensive view of the impact of interventions (including any shortcomings) from different perspectives.

ANNEX 3: UNICEF KEY COMMITMENTS, FRAMEWORKS AND MINIMUM STANDARDS

UNICEF MINIMUM STANDARDS AND GUIDELINES FOR HUMANITARIAN ACTION

OVERALL POLICY	
Core Commitments for Children in Humanitarian Action UNICEF, 2010	UNICEF's central policy for upholding the rights of children affected by humanitarian crisis. The CCCs promote predictable, effective and timely humanitarian action through partnership between governments, humanitarian organizations and others.
CHILD PROTECTION	
Minimum Standards for Child Protection in Humanitarian Action Child Protection Working Group, 2012	Provides minimum standards for child protection work in humanitarian settings. http://www.unicef.org/iran/Minimum_standards_for_child_protection_in_humanitarian_action.pdf
MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT	
Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings Inter-Agency Standing Committee, 2007	Guidelines to enable humanitarian actors to plan, establish and coordinate a set of minimum multisectoral responses to protect and improve people's mental health and psychosocial wellbeing in emergencies. http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf
EDUCATION	
INEE Minimum Standards for Education: Preparedness, Response, Recovery Handbook Inter-Agency Network for Education in Emergencies, 2010	19 standards that aim to enhance the quality of educational preparedness, response and recovery in humanitarian settings, and to meet the educational rights and needs of people affected by disaster. http://www.ineesite.org/en/minimum-standards
HIV/AIDS	
Guidelines for Addressing HIV in Humanitarian Settings Inter-Agency Standing Committee, 2010	Guidelines for providing a minimum set of HIV prevention, treatment, care and support services to people affected by humanitarian crises. file:///Users/useruser/Downloads/IASC_HIV_Guidelines_2010_En%20(1).pdf
CHILDREN WITH DISABILITIES	
Children with Disabilities: Ending discrimination and promoting participation, development and inclusion UNICEF, 2007	Provides recommendations for upholding the rights of children with disabilities in programmes in humanitarian settings.
GENDER-BASED VIOLENCE	
Guidelines for Gender-Based Violence Interventions in Humanitarian Settings: Focusing on prevention of and response to sexual violence IASC Taskforce on Gender in Humanitarian Assistance, 2005	Guidelines for establishing and coordinating a set of minimum multisectoral interventions to prevent and respond to sexual violence in emergencies. http://www.humanitarianinfo.org/iasc/pageloader.aspx?page=content-subsidi-tf_gender-gbv
Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service International Rescue Committee, 2012	Guidance for health and psychosocial staff in providing care and treatment to child survivors of sexual abuse in humanitarian settings. http://www.unicef.org/pacificislands/IRC_CCSGuide_FullGuide_lowres.pdf
Conflict Sensitive Education Pack Inter-Agency Network on Education in Emergencies, 2013	Guidance and tools for integrating conflict sensitivity into education programmes in fragile and conflict-affected settings. http://toolkit.ineesite.org/toolkit/Toolkit.php?PostID=1148

Source: UNICEF Adolescent Toolkit

ANNEX 4: UNICEF COMMUNITY BASED MHPSS LOG FRAME

GOAL: REDUCED SUFFERING AND IMPROVED MENTAL HEALTH AND PSYCHOSOCIAL WELLBEING OF CHILDREN AND FAMILIES.	
IMPACT INDICATORS	
GI.1	**FUNCTIONING:** For example, the ability to carry out essential activities for daily living, which will differ according to factors such as culture, age and gender
GI.2	**SUBJECTIVE WELLBEING:** Aspects of subjective wellbeing that could be measured include feeling calm, safe, strong, hopeful, capable, rested, interested and happy; not feeling helpless, depressed, anxious or angry
GI.3	**EXTENT OF PROLONGED DISABLING DISTRESS AND/OR PRESENCE OF MENTAL, NEUROLOGICAL AND SUBSTANCE USE DISORDER (OR SYMPTOMS THEREOF)**
GI.4	**ABILITY OF PEOPLE WITH MENTAL HEALTH AND PSYCHOSOCIAL ISSUES TO COPE WITH PROBLEMS:** For example, making use of skills in communication, stress management, problem-solving, conflict management or vocational skills
GI.5	**SOCIAL BEHAVIOUR:** Being able to, for example, help others and avoid aggressive behaviour, use of violence, discriminatory actions
GI.6	**SOCIAL CONNECTEDNESS:** This refers to the quality and number of connections an individual has – or perceives to have – with other people in their social circles (family, friends and acquaintances). Social connections may also go beyond one's immediate social circle and extend, for example, to other communities.

KEY OUTCOMES				
1. Emergency responses do not cause harm to children and families, and are dignified, participatory, community-owned and socially and culturally acceptable	2. Children and families are safe and protected, and human rights violations are addressed	3. Family, community and social structures promote the wellbeing and development of all children and caregivers	4. Communities and families support children who have mental health and psychosocial problems	5. Children and families with mental health and psychosocial problems use appropriate care

The following tables describe indicators for each outcome and their corresponding outputs. Indicators should be disaggregated by age and sex, as well as for diversity (including children with disabilities, including intellectual disabilities). Means of verification (MoV) are suggested for measuring outcome and output indicators. [45]

45 Not all outcome indicators from the IASC Common M&E Framework are used in this log frame; only a selection of outcome indicators relevant to UNICEF's CB MHPSS programmes have been retained.

OUTCOME 1

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

OUTCOME 1 INDICATORS	MOV
• Percentage of affected children and families who report that emergency responses fit with local values, are appropriate and are provided respectfully. • Percentage of staff trained on and following guidance (e.g., IASC MHPSS Guidelines, CP frameworks) on how to avoid harm. • Perceptions of needs addressed (that is, needs perceived as serious problems by affected children and families themselves, such as problems with shelter, livelihood).	• Focus group discussion (FGD) reports • Training and supervision reports Quality standards checklist • FGD and key informant interviews (KIIs) and informal interview reports

Outputs	Output Indicators	MoV
1.1 Community members are engaged in assessment, design and planning of child and family MHPSS and protection programmes.	• Per cent of affected children and families who report being actively involved in different phases of emergency response (e.g., in needs assessment, programme design, implementation and M&E). • Per cent of target communities where local people (representatives of children and families, inclusive of age, gender, diversity) have been enabled to design, organize and implement emergency responses themselves. • Per cent of children and family representatives engaged in committees for emergency service delivery.	• Programme cycle monitoring tools (attendance sheets, meeting reports) • Child and family/caregiver questionnaires (disaggregated for age, gender and diversity)
1.2 Basic needs service delivery ensures equitable access by vulnerable children and families.	• Number of vulnerable children and families identified and referred for basic services. • Number of standard operating procedures (SOPs), referral pathways and service directories developed.	• Referral resource lists, forms and procedures, and referral information management system (IMS) (follow-up report) • Service and agency mapping reports
1.3 Intersectoral staff and volunteers have the capacity to provide culturally appropriate, respectful services that minimize harm to children and families.	• Number of intersectoral staff trained in basic psychosocial support principles (e.g., PFA) and 'do no harm' strategies (e.g., IASC MHPSS Guidelines). • Number of girls, boys, women and men reporting satisfaction with the appropriateness and safety of sectoral services (e.g., WASH, shelter, health and nutrition).	• Training reports • Child and caregiver/ family satisfaction survey (disaggregated for age, gender and diversity)

OUTCOME 2

CHILDREN AND FAMILIES ARE SAFE AND PROTECTED, AND HUMAN RIGHTS VIOLATIONS ARE ADDRESSED.

OUTCOME 2 INDICATORS

- Percentage of target communities (i.e., villages, neighbourhoods or institutions such as mental hospitals and orphanages) with formal or informal mechanisms that engage in protection, monitoring and reporting of safety risks or at-risk groups (e.g., children, women, people with severe MNS disorders).
- Percentage of target communities where representatives of children and families are included in decision-making processes on their safety
- Percentage of target group members (such as at-risk children and families) who feel safe.
- Among children and families who have reported human rights violations, percentage of people who believe that responsible institutions are addressing or have addressed their case.

MOV

- Quality standards checklists for CP/MHPSS interventions
- Programme cycle monitoring tools
- CP/MHPSS IMS
- Child and family satisfaction surveys, FGDs and KII reports

Outputs	Output Indicators	MoV
2.1 Safe spaces (including learning spaces) are utilized by and meet the needs of boys and girls, caregivers and women.	• Number of at-risk boys and girls (all ages), caregivers (mothers and fathers) and women who use safe spaces. • Number of schools with a safety policy. • Per cent of at-risk children and caregivers reporting satisfaction with protection and supportive functions of safe spaces.	• Activity reports and registration logs • School safety policies developed • Child and caregiver satisfaction surveys
2.2 Outreach services are provided to vulnerable families.	• Per cent of vulnerable children and families identified and referred for basic services. • Per cent of at-risk children and families (e.g., survivors of SGBV) requiring such services who are referred for appropriate protection and MHPSS services.	• Referral forms, referral IMS data (follow-up report) • Service and agency mapping reports
2.3 Child protection messages are developed and disseminated.	• Number of community members oriented on how to address protection and MHPSS needs of at-risk children and families.	• Programme monitoring tools (attendance sheets, orientation reports)
2.4 Children and families with protection risks are appropriately identified and referred to formal or informal protection mechanisms.	• Per cent of trained target group members who use new skills and knowledge for referral and prevention of risks. • Number of children and families in need who receive help from formal or informal protection mechanisms (such as social services or CP networks). • Per cent of separated children identified and referred for family tracing and reunification services, and successfully reunified with families or provided appropriate alternative care arrangements.	• Pre/post knowledge, attitudes and practices (KAP) measure • On the job supervision, coaching reports • CP/MHPSS IMS data • Activity reports • Referral forms, follow-up reports
2.5 Target communities are engaged in monitoring and reporting safety risks or protecting at-risk groups through formal or informal mechanisms.	• Per cent of target communities with inclusive, representative CP committees. • Per cent of target communities trained on formal and informal mechanisms of protection, monitoring and reporting of at-risk groups. • Number of girls, boys, caregivers and families who report enhanced capacities in recognizing and responding to at-risk children and families.	• Programme cycle monitoring forms (activity and meeting reports) • Training reports. • Pre/post KAP measures • On-the-job competence measures

OUTCOME 3

FAMILY, COMMUNITY AND SOCIAL STRUCTURES PROMOTE THE WELLBEING AND DEVELOPMENT OF ALL CHILDREN.

OUTCOME 3 INDICATORS	MOV
• Extent of supportive parenting skills and knowledge of child development among caregivers. • Quality of caregiver-child interactions (e.g., nurturing and stimulating interactions supporting children's optimal development). • Extent of social cohesion within families and communities. • Percentage of target communities (such as villages or neighbourhoods) where steps have been taken to identify, activate or strengthen local resources that support psychosocial wellbeing and development of children. • Percentage of target communities where children participate in communal rituals and celebrations. • Percentage of formal and informal social structures that include specific mental health and psychosocial provisions or supports for children and families. • Number of affected children and family members who use different formal and informal social structures (such as schools or informal education for children of all ages, health care, social services, ECD programmes, women's groups and youth clubs). • Number of children with defined opportunities to develop their socioemotional skills.	• KAP surveys • FGD, KII and informal interview reports • Programme staff observations of child/caregiver interactions • Programme monitoring reports (activity reports) • IMS data on CP/MHPSS structures developed and used • Child surveys, disaggregated for age, gender and diversity

Outputs	Output Indicators	MoV
3.1 School environments are supportive of children's recovery, development and learning.	• Number of teachers and school administrators trained in assessing and responding to children's needs for psychosocial recovery, development and social-emotional learning. • Number of schools implementing strategies to strengthen supportive environments (e.g., teacher training in basic psychosocial concepts, anti-bullying campaigns). • Training on MHPSS and CP concepts is incorporated into national curricula for teachers and DRR plans.	• Training and supervision reports • School activity reports and materials developed (e.g., anti-bullying) • National curricula incorporating MHPSS/CP quality training
3.2 Adolescent peer and group support is available and accessible.	• Per cent of adolescent girls and boys reporting awareness of appropriate, effective peer and group support activities and how to access them. • Number of adolescent girls and boys engaged in design of youth clubs, peer-to-peer support strategies, etc. • Number of adolescent girls and boys participating in peer and group support.	• Adolescent surveys, disaggregated for age, gender and diversity • Activity reports
3.3 Age- and gender-appropriate creative and expressive psychosocial activities for children are implemented.	• Number of psychosocial structured activities implemented in safe spaces or learning environments for children, appropriate to their age and gender. • Number of children and adolescents participating in creative and expressive psychosocial activities.	• Activity reports, disaggregated for age, gender and diversity • Programme cycle monitoring reports (attendance sheets)

Outputs	Output Indicators	MoV
3.4 Age- and gender-appropriate community cultural and recreational activities are implemented, inclusive of children with disabilities.	• Number of community cultural and recreational activities organized for children and families. • Number of community activities designed to be inclusive of boys and girls of different ages and developmental stages, and of children with disabilities. • Number of girls and boys participating, appropriate to their age and developmental stage, in community activities (religious, cultural, recreational) and/or committees (e.g., CP committees).	• Activity reports • MHPSS programme quality standards checklists • Attendance sheets • Programme cycle monitoring reports, disaggregated for age, gender and diversity
3.5 Coping and recovery of child caregivers is supported.	• Number of at-risk youth, caregivers and families accessing livelihood opportunities. • Per cent of parents and other child caregivers participating in support groups and family network activities.	• Youth, caregiver and family surveys • Activity reports, attendance sheets
3.6 Links between child caregivers at home and school are strengthened.	• Number of parent-teacher committees functioning. • Number of parents involved in supporting school functions (e.g., coaching sports, volunteering in classrooms).	• FGDs, informal and formal interview reports • School activity records • Programme activity records
3.7 Family care and nurturing family environments are strengthened.	• Number of children reunified with family members or in other permanent care arrangements. • Number of parents/caregivers provided with support in positive and responsive caregiving. • Number of parents/caregivers whose support systems are restored or for whom new supports are created. • Number of parent-baby responsive caregiving and stimulation sessions provided (e.g., in feeding centres).	• IMS data from family tracing and reunification activities • Parent/caregiver surveys • Programme cycle monitoring reports • Activity records from feeding centres, etc.
3.8 Psycho-educational messages are developed and disseminated to child caregivers and community stakeholders.	• Number of sessions held to offer psycho-education (e.g., on child development and wellbeing, stress responses and coping for children and caregivers) to child caregivers and community stakeholders. • Number of caregivers and community stakeholders attending psycho-education sessions.	• Activity records • Attendance sheets • Programme cycle monitoring reports
3.9 Traditional community structures and stakeholders for child and family wellbeing are activated.	• Number of sessions held with community leaders and representative stakeholders to identify and assess community needs and resources for child wellbeing. • Number of child and family wellbeing and protection initiatives developed and implemented by and through existing community supports and structures.	• Community mapping of needs and resources • Activity records • Attendance sheets • Programme cycle monitoring reports

OUTCOME 4

COMMUNITIES AND FAMILIES SUPPORT CHILDREN AND CAREGIVERS WITH MENTAL HEALTH AND PSYCHOSOCIAL PROBLEMS.

OUTCOME 4 INDICATORS	MOV
• Capacity of family members to provide support for children and caregivers with mental health and psychosocial problems. • Number of children with mental health and psychosocial problems who report receiving adequate support from parents, caregivers and family members. • Ability of caregivers to cope with common problems of children (e.g., through skills related to stress management, conflict resolution, problem-solving or positive parenting; or knowledge of where to seek help or information). • Extent of supportive social networks of children and families with mental health and psychosocial problems. • Number of children and caregivers with mental health and psychosocial problems who participate in livelihood and social activities in the community. • Perceptions, knowledge, attitudes and behaviours of community members towards children and families with mental health and psychosocial problems.	• Family/caregiver FGDs, informal and formal KIIs • Child and caregiver surveys, disaggregated for age, gender, diversity • Community social network mapping • Programme activity records • Child, caregiver and community KAP surveys

Outputs	Output Indicators	MoV
4.1 Parents/caregivers are supported to recognize and respond to the psychosocial support needs of children and themselves.	• Number of training, supervision, psycho-educational and supportive group sessions conducted for parents and caregivers in self-care and care for children in need. • Number of community care providers trained and supervised in appropriate, focused psychosocial support to caregivers and families with mental health and psychosocial problems.	• Training and supervision reports • Project activity logs (meeting reports, psycho-educational materials developed)
4.2 School staff and systems are supported to recognize and respond to focused psychosocial support and protection needs of children.	• Number of teachers and school administrators (including CFS animators and staff of ECD centres) trained in identifying and responding to focused psychosocial support and protection needs of children. • Per cent of schools with increased links to CP and other mental health and social service referrals.	• Training reports • Referral resource lists, forms and procedures (SOPs), and referral IMS
4.3 Children and caregivers with psychosocial support and protection needs are supported by family and community networks and services.	• Number of children and caregivers reporting access to community support for distress and protection problems. • Number of family and community psychosocial support networks and services identified and activated for the support of children and caregivers in need.	• Child and caregiver surveys • Project reports of documented, active community groups
4.4 Community awareness campaigns for MHPSS and protection issues are implemented.	• Priority areas for community awareness campaigns are identified to support child wellbeing and safety. • Number of community actions for stigma reduction implemented (media dissemination, community meetings, community drama, etc.).	• Reports of FGDs, informal and formal KIIs • Project cycle monitoring reports

OUTCOME 5

CHILDREN AND FAMILIES WITH MENTAL HEALTH AND PSYCHOSOCIAL PROBLEMS USE APPROPRIATE FOCUSED CARE.

OUTCOME 5 INDICATORS	MOV
• Number of people who receive clinical management of MNS disorders through medical services (primary, secondary or tertiary health care). • Number of children per at-risk group (e.g., unaccompanied or separated children, children associated with armed groups, survivors of SGBV) receiving focused care, including PFA, linking people with psychosocial problems to resources and services, case management, psychological counselling, psychotherapy or clinical management of mental disorders. • Percentage of available programmes focusing on MHPSS for children and caregivers that offer evidence-based care. • Satisfaction of children and families with mental health and psychosocial problems regarding the care they received.	• IMS medical services data • Programme cycle monitoring reports • Referral reports • MHPSS quality standards checklists • Child and family satisfaction surveys, disaggregated for age, gender and diversity

Outputs	Output Indicators	MoV
5.1 At-risk children and parents/ caregivers are identified, managed and/or referred to focused and/or specialized MHPSS services.	• Number of children and parents/caregivers with mental health and psychosocial problems identified and provided with appropriate focused or specialized MHPSS services. • Per cent of children and parents/caregivers with identified protection risks or MNS disorders receiving community outreach case management services, as appropriate.	• Referral forms and referral IMS data (follow-up reports) • Programme activity records (outreach visit reports)
5.3 Accessible, coordinated and inclusive focused and specialized MHPSS care are promoted within health, mental health and social service systems and other community systems for children and families.	• Per cent of medical facilities, social services facilities and community programmes that have at least one staff member who is trained to help children and families with mental health and psychosocial problems. • Per cent of medical facilities, social services facilities and community programmes that have at least one staff member who receives supervision to help children with mental health and psychosocial problems. • Per cent of medical facilities, social services facilities and community programmes that have and apply procedures for referral of children with mental health and psychosocial problems. • Number of community child and family care providers trained and supervised in appropriate, focused psychosocial support to children and families with mental health and psychosocial problems. • Number of health staff trained in basic psychosocial support (including PFA) and referral procedures. • Number of medical, social service and community programme staff trained in the identification, management and referral of children and families with mental health problems.	• Quality standards checklists for MHPSS programmes (e.g., mhGAP and IASC MHPSS Guidelines standards) • Supervision reports • Referral resource lists, forms and procedures, and referral IMS • Training and supervision reports
5.4 MHPSS interventions utilize evidence-based strategies aligned with international quality standards.	• Number of SOPs, service directories and referral pathways developed within mental health, CP, social service and other community support systems. • Number of MHPSS programmes demonstrating minimum quality standards per international guidelines. • Number of trainings and supervision sessions provided for MHPSS providers following guidance for evidence-based interventions (e.g., PM+, IPT, Healthy Families).	• Referral resource lists, forms and procedures, and referral IMS • MHPSS quality standards checklists • Programme monitoring reports • Training and supervision reports

ANNEX 5: SCALABLE INTERVENTIONS

Scalable interventions are described at layer 3 of the IASC MHPSS intervention pyramid. They are evidence-based individual and group interventions developed by a range of agencies (including WHO) that show promising results in helping parents and caregivers in emergencies. Scalable interventions can be delivered by non-specialized providers with proper training and regular supervision by mental health clinicians; helpful given the lack of trained mental health providers in many contexts. Scalable interventions include:

- PM+, a brief, individual intervention (also available in group format) that can help adults, including parents/caregivers in emergencies, suffering from prolonged, disabling distress involving depression, anxiety and stress.[46] The term problem management (PM) refers to a type of counselling that helps people address and manage problems and recognizes that many of people's problems cannot be 'solved'.

The plus (+) in PM+ refers to behavioural strategies that are added to problem management, such as behavioural activation ('Getting going, keep doing'), managing stress and strengthening social support. Parents and caregivers in emergencies face many problems, like poverty and ongoing violence that are out of their control. PM+ can help with a range of disabling mood and anxiety problems; it does not attempt to solve all of people's problems or provide a diagnosis of mental disorder.

- GROUP IPT, group interpersonal therapy, is an adaptation of well-documented, evidence-based treatment that has been used for depression and other mental health problems in different age groups and diverse community and health services settings.[47] The WHO model of group IPT is a simplified format of eight-session groups for people with depression to help them understand interpersonal problems (e.g., conflict, changing roles, and bereavement) that contribute to their depression and ways to manage them effectively.

46 WHO, 'Problem Management Plus (PM+): Individual psychological help for adults impaired by distress in communities exposed to adversity' (generic field trial version 1.0), 2016.

47 WHO and Columbia University, 'Group Interpersonal Therapy (IPT) for Depression' (WHO generic field trial version 1.0), 2016.

Both PM+ and Group IPT can be implemented in health and social services structures by dedicated staff (lay psychosocial workers, professional social workers and psychologists) in community centres run by NGOs or government, or by supervised general staff (e.g., nurses, community workers) in non-specialized and specialized service capacities and settings.

- THINKING HEALTHY is an approach developed by WHO and partners for the psychosocial management of perinatal depression[48] This is a priority condition, as around 15 per cent of mothers in low- and middle-income countries suffer from a mental disorder after childbirth. The model involves training community health workers in how to support mothers with perinatal depression through evidence-based cognitive behavioural therapy techniques. Key aspects of the model include:
  - » Integration into routine home visits by trusted community health workers and complementing key maternal and child health messages
  - » Focusing on mother-infant wellbeing rather than maternal depression in order to reduce the risk of stigmatizing the mother
  - » Creating a common agenda of infant optimal development to encourage family participation in infant wellbeing
  - » Empowering and activating mothers to seek and practice health-promoting activities through structured, pictorial guidance, which is also accessible to non-literate mothers.

48 WHO, 'Thinking Healthy: A manual for psychosocial management of perinatal depression' (WHO generic field trial version 1.0), 2015.

"Investing in children and young people, particularly the most vulnerable, must be priority in order to tackle the cycle of poverty and conflict that is driving so many to flee their homes."

Source: 'Danger Every Step of the Way', UNICEF Child Alert, June 2016

ANNEX 6: THE EVOLVING HUMANITARIAN CONTEXT: RESILIENCE STRENGTHENING RESPONSES

According to the 2016 edition of UNICEF's State of the World's Children, emerging threats and challenges are changing the context for children's wellbeing and development. Growing numbers of children and families are experiencing prolonged and complex emergencies, including conflicts, disease outbreaks and the effects of climate change and severe natural disasters. Research also shows that children are exposed to extremely high rates of violence within and outside of their families, often compounded by other adverse childhood experiences. These experiences affect children's brain structure and function, hormonal and immune systems, and even how their DNA is read and transcribed.

Intense and prolonged emergencies hamper the stability of family and community environments for children's care – often devastating access to education, livelihoods, health care, protection, and recognition and inclusion in society. These conditions heighten children's risks of exposure to violence and adverse childhood experiences, with potentially long-term consequences for child development and the recovery of families and communities. In response, myriad community based initiatives have worked to address these challenges in different emergencies. Below are some examples of how MHPSS has helped to mitigate harm and strengthen the resilience of children, families and communities.

CONFLICT AND MASS MIGRATION

Modern conflicts are increasingly associated with large-scale, persistent displacement, and MHPSS interventions must adapt to these new realities for children and families. Almost one in ten children around the world live in conflict-affected areas, and more than 400 million live in extreme poverty. These are critical drivers of mass migration as families search for better lives.[49] UNHCR estimates that by the end of 2016, 65.6 million people had been forcibly displaced worldwide as a result of persecution, conflict, generalized violence, or human rights violations[50] because of conflict and violence. The UN Office for the Coordination of Humanitarian Affairs estimates that half of these are children.[51]

Children, when unaccompanied, face particular wellbeing and protection risks during migration as well as upon arrival in countries where they seek asylum. Many children fall between the cracks in overstretched asylum systems. They face uncertain futures and lack security, access to psychosocial support and recreational activities, and access to school for months or even years. As the targets of violent extremist groups, they experience various forms of violence and recruitment into extremist ideologies.

In response to the refugee crisis in Europe, UNHCR, IOM and MHPSS.net recommend the following strategies in a multi-agency guidance note[52]:

- HELP KEEP FAMILIES TOGETHER in situations of mass migration. According to IASC MHPSS guidance, "family and social supports are the best protection in response to distress, and attachment to a caring adult is a key protective factor for children". The guidance also advises facilitating dignified burials for family members lost during the journey, and engaging people from the same religious background to attend burials and support families.
- IDENTIFY AND PROTECT VULNERABLE CHILDREN AND CAREGIVERS, even during short stays. This includes unaccompanied children, victims of trafficking or survivors of SGBV and people with diverse sexual orientation and gender identity.

49 UNICEF Child Alert, 'Danger Every Step of the Way: A harrowing journey to Europe for refugee and migrant children' June 2016.

50 UNHCR, 'UNHCR Global Trends: Forced Displacement in 2016, p. 2.

51 United Nations Office for the Coordination of Humanitarian Affairs, Global Humanitarian Overview 2016, United Nations OCHA, New York, December 2015, p. 3.

52 UNHCR, IOM and MHPSS.net and partners, 'Mental Health and Psychosocial Support for Refugees, Asylum Seekers and Migrants on the Move in Europe: A multi-agency guidance note', December 2015.

- ENSURE ADEQUATE PROFESSIONAL INTERPRETATION SERVICES. Ideally such services should be provided by people from the migrant's country of origin, and they should be trained and supervised to act as cultural mediators. It is important to avoid using community or family members as interpreters for various reasons, including confidentiality and other ethical considerations.

DISEASE OUTBREAKS

Disease outbreaks have huge impacts for the wellbeing and protection of children and families. The 2014 Ebola outbreak in West Africa devastated families and communities with the loss of caregivers, extended family members, friends, teachers and health care providers. It also weakened school, health and social service systems. UNICEF reports that 23,000 children lost one or both parents/primary caregivers to Ebola, and children accounted for one in four Ebola deaths.[53] The destruction of family links due to loss, stigma and discrimination seriously diminished the quality and quantity of child care.

The Zika virus outbreak, designated a 'public health emergency of international concern', has affected at least 26 countries in Latin America and the Caribbean, and is spreading to Asia, Africa and the Pacific. The disease is suspected to contribute to an abnormal increase in birth defects, and the resulting developmental disability will affect not just the children infected but also their families and community care systems. More than 4,800 suspected cases of microcephaly were reported in Brazil in just a four-month period.[54]

Suggested responses include:

- REDUCE FEAR AND STIGMA by providing communities with accurate information and support. This was essential to preventing further harm to children orphaned by Ebola and survivors of it. MHPSS approaches worked through various community supports, such as burial teams, community health workers and religious leaders. They spread accurate information to prevent transmission of the virus, create safe and sensitive burial rituals, and provide support and comfort to vulnerable children and families. Through natural support networks, most children orphaned and abandoned due to Ebola were absorbed into family and community care arrangements.[55]

53 http://www.unicef.org/media/media_89810.html.

54 http://www.unicef.org/appeals/zika_response.html.

55 https://www.unicef.org/media/media_89810.html

- PROVIDE INFORMATION AND TRAINING FOR PARENTS to help children with developmental disabilities and autism. Resources provided by a WHO/UNICEF collaboration were adapted and rolled out in areas affected by the Zika virus to assist in the care and support for affected children and families.

CLIMATE CHANGE

Climate change is intensifying the impacts of floods and drought, particularly for the most disadvantaged children and families. Over half a billion children live in zones of extremely high flood occurrence, and nearly 160 million in areas of severe drought.[56] Impacts include disrupted education due to displacement and destroyed educational and health infrastructure; subsequent increased risks of trafficking, abuse, neglect and child labour; and increased child deaths from childhood diseases, vector-borne diseases and malnutrition. Slow onset climate change can also undermine development gains and livelihood options for families by exacerbating rural poverty and food insecurity and increasing the risk of family displacement. Children will suffer the most, and they will feel the effects of climate change for a long time to come.

AN INCREASINGLY CONNECTED WORLD

Over the next decades, the world will continue to become more urban and interconnected. Social media and information technology are important influences shaping the social and cultural lives of children, families and communities. These technologies have changed how children access information, form opinions and share their views, and how they interact with peers and an expanded social world. Social media allows the diaspora of displaced families and communities to remain connected across countries and continents; gives them access to global, real-time information about socio-political events that impact their lives; and provides a tool for advocacy and for documenting and sharing their experiences. Unfortunately, social media can also be used to recruit children and adolescents into extremist ideologies and armed groups.

Social media used responsibly can be a powerful tool for advocacy, awareness-raising on MHPSS issues and family tracing and reunification. To encourage and grow positive capabilities gained through this interconnectedness:

56 UNICEF, 'Unless We Act Now: The impact of climate change on children', November 2015, pp. 25, 32.

- HARNESS THE POWER OF INFORMATION TECHNOLOGY AND SOCIAL MEDIA. UNICEF and partners use these tools to track refugee flows, migration, natural disasters and deteriorating conditions that can intensify humanitarian emergencies. Programme staff increasingly use information technology in programme management – from electronic assessment surveys that facilitate rapid data entry, analysis and management; to M&E activities; to innovative training and supervision models.

ANNEX 7: ENTRY POINTS FOR MHPSS IN THE HUMANITARIAN PROGRAMME CYCLE AT UNICEF

For every humanitarian context, UNICEF grounds its programme design in situation analyses and engages extensively with communities and humanitarian actors to design programmes. The humanitarian programme cycle (HPC)[57] provides a framework to jointly-plan, coordinate, and respond to humanitarian needs in a more coherent, effective, and accountable manner to collectively achieve results. The Core Commitments for Children (CCCs) in Humanitarian Action provides a global framework for humanitarian action for children undertaken by UNICEF and its partners. CCC programme commitments include child protection sector commitments to provide psychosocial support to children and their caregivers (Child Protection CCC # 6). In addition, UNICEF Country Offices in humanitarian situations, especially in Layer 3 and Layer 2 Emergencies, have specific, simplified, standard operating procedures (SSOPs) to clarify UNICEF procedures related to emergencies.

The following recommended actions are key considerations for humanitarian actors as they engage in different stages of the humanitarian programme cycle: situation analysis and needs assessment, strategic planning and resource mobilization, implementation, monitoring and reporting, and evaluation. (See corresponding MHPSS entry point adapted HPC diagram, figure 5.)

SITUATION ANALYSIS AND NEEDS ASSESSMENT

General principles and approaches for UNICEF child protection situation analys[58] can be applied in emergencies; however there are additional tools designed for assessing the situation of child protection in a humanitarian context.

Depending on the nature and phase of emergency, coordinated assessments should build upon existing information in the country. In a rapid onset emergency, the analysis is done in phases:

- Preliminary Scenario Definition/ Secondary Data Review (PSD/SDR) is normally conducted within 72hours (Phase 1). Existing data can be used to gather information on mental health and psychosocial distress levels, and can be used to inform a Flash Appeal.
- Multi-Cluster/Sector Initial Rapid Assessment (MIRA) is normally conducted within 14 days (Phase 2), and MHPSS needs should be identified through community engagement in the process. Provision of community based MHPSS should be included in the inter-agency Humanitarian Response Plan, cluster/sector planning, and UNICEF Response Plan.
- Child Protection Rapid Assessment (CPRA) is conducted within 3-5 weeks after an emergency, and should provide a solid basis for a detailed MHPSS assessment. The analysis should inform a community based MHPSS strategy development for the response.

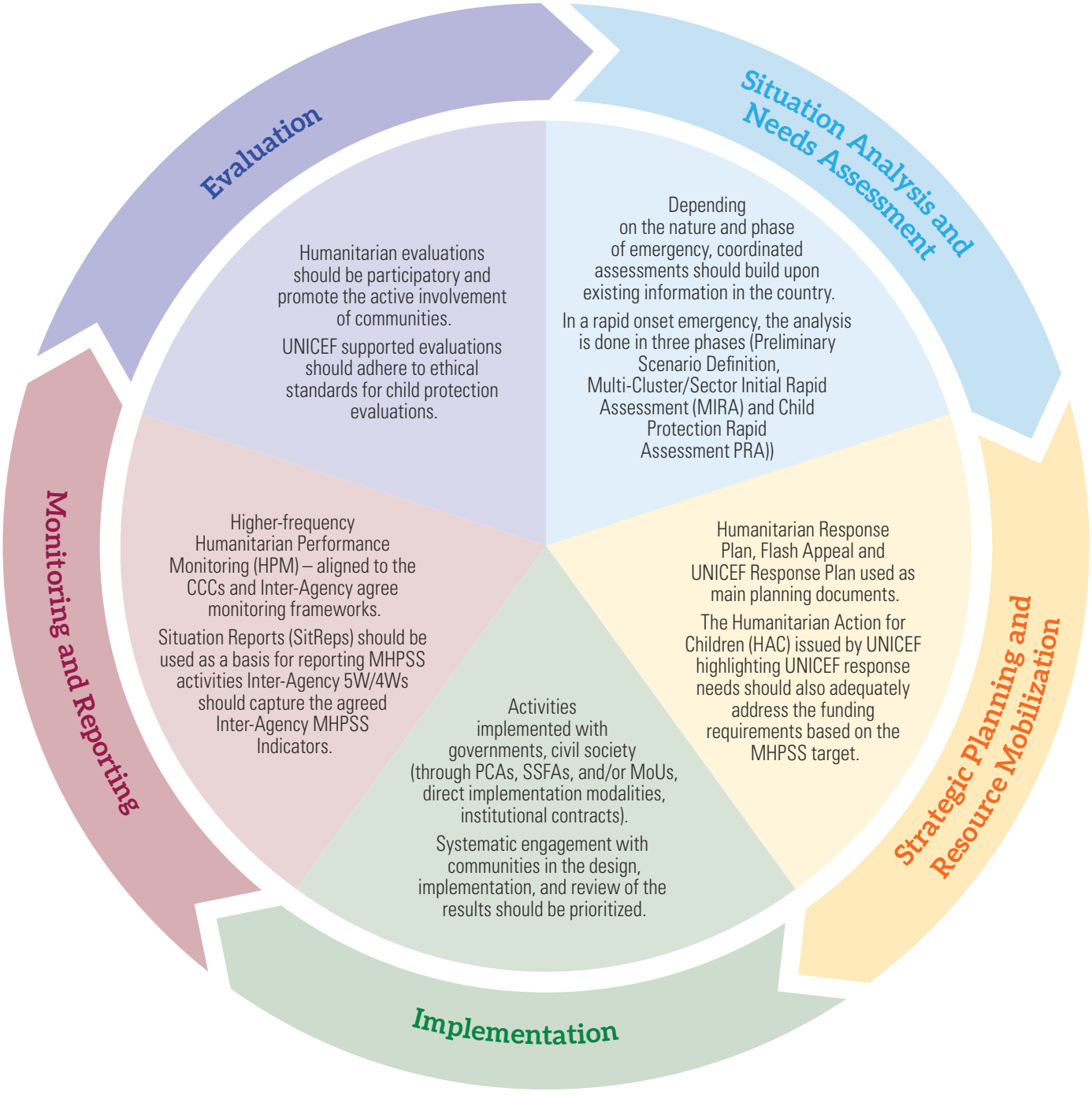
STRATEGIC PLANNING AND RESOURCE MOBILIZATION

- Consolidate and jointly review information gathered on MHPSS situation and response (including gaps and capacity).
- Agree on the scope of MHPSS activities within the child protection sectoral objectives, advocate for community based MHPSS mainstreaming across other sectors.
- The key priority MHPSS activities and funding requirements in the Humanitarian Response Plan and UNICEF Response Plan should respond to the assessed needs.
- UNICEF targets should be based on needs, priorities, and government, partner, and UNICEF capacities to meet these needs.

57 The humanitarian programme cycle (HPC). Available at https://www.humanitarianresponse.info/en/programme-cycle/space.

58 A UNICEF-supported child protection situation analysis follows a basic sequence: Step 1: Agree on analytical framework. Step 2: Gather evidence. Step 3: Assess data quality. Step 4: Analyse manifestations. Step 5: Analyse causes. Step 6: Validate and use. Available at: https://www.unicef.org/protection/files/CPR-WEB.pdf.

FIGURE 5: ENTRY POINTS FOR MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT IN THE HUMANITARIAN PROGRAMME CYCLE



- Inter-Agency Flash Appeal serves as the main fundraising/appeal document, and MHPSS funding requirements should be included in the Flash Appeal.
- The Humanitarian Action for Children (HAC) issued by UNICEF highlighting UNICEF response needs should also adequately address the funding requirements based on the MHPSS target.

IMPLEMENTATION

- Community based MHPSS activities can be implemented with governments, civil society (through PCAs, SSFAs, and/or MoUs) and through UNICEF direct implementation modalities (using institutional contracts, including with CSOs, service delivery by staff).

- Systematic engagement with communities in the design, implementation, and review of the results should be prioritized. The MHPSS log frame serves as a useful tool.

MONITORING AND REPORTING

- Design monitoring tools, based on the UNICFEF MHPSS log frame, higher-frequency Humanitarian Performance Monitoring (HPM)-aligned to the CCCs and Inter-Agency agreed monitoring frameworks.
- HPM Activity tracker and real-time monitoring should have MHPSS indicators and reports should be produced against agreed indicators.
- Situation Reports (SitReps) should be used as a basis for reporting MHPSS activities (frequency to be determined at Country Office level).
- Inter-agency 5W/4Ws should capture the agreed inter-agency MHPSS indicators
- Systematic child protection field monitoring tools and other sectors should include MHPSS indicators and include feedback mechanisms.

EVALUATION

- Humanitarian evaluations should be participatory and promote the active involvement of communities.
- Do no harm: Evaluation activities must avoid exacerbating existing mental health and psychosocial distress among affected populations or putting respondents or their communities at risk.
- UNICEF-supported evaluations should adhere to ethical standards for child protection evaluations.

The CB MHPSS operational guidelines are designed and intended to help UNICEF staff and partners support and promote safe, nurturing environments for children's recovery, psychosocial wellbeing and protection. The guidelines present an operational framework that emphasizes engaging actors at all levels (children, caregivers, families and community service providers) to design and implement MHPSS strategies that are locally relevant, comprehensive and sustainable in order to more effectively restore, strengthen, and mobilize family and community supports and systems with the ultimate goal of supporting child and family wellbeing in humanitarian settings.

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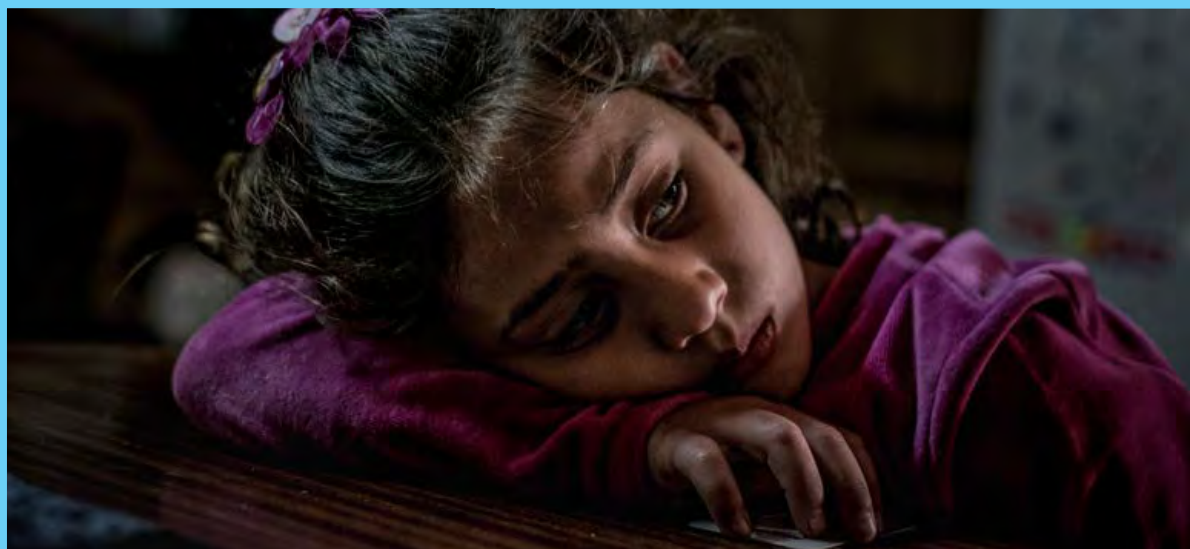
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