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DEUTSCHE ZUSAMMENARBEIT

Published by
giz Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH

Mental Health and Psychosocial Support (MHPSS) in the context of the crises in Syria and Iraq

Guiding framework for development cooperation

In cooperation with:

Working paper, July 2017

What is the purpose of this guiding framework?

This document was drawn up on the basis of expert publications and inputs from partners in the GIZ regional programme Psychosocial Support for Syrian and Iraqi Refugees and Internally Displaced People[1] in order to serve as guidance in the design, implementation and assessment of psychosocial support measures for refugees in the context of the crises in Syria and Iraq. It is aimed at actors from the MHPSS sector working with refugees in the Middle East and at ministries and academic/scientific institutions in the context of the Syria and Iraq crises. Donor organisations can use the quality criteria as a decision-making aid for project proposals. The paper presents the state of the debate among relevant institutions and experts on what constitutes good psychosocial work with refugees and what risks need to be considered. To explain this, it includes a set of quality criteria that are intended to guide projects which aim at psychological and social stabilisation of people who have experienced violence and loss, and which address the consequences of displacement. It explains the advantages of trauma-sensitive development cooperation (DC).

> Adopting a trauma-sensitive approach, or organising activities in a trauma-sensitive manner, means avoiding everything that constitutes a traumatic experience and could lead to retraumatisation: feeling threatened and defenceless, experiencing extreme fear and powerlessness, and losing trust and control. The focus is therefore on establishing frameworks that create the greatest possible degree of safety, predictability and trust in order to enable those affected to take control and exercise self-determination over every step. Everyone who works with traumatised individuals or distressed populations should be aware of basic patterns of the dynamics of trauma (for example that there are factors that can re-evoke severe disorders), and make sure that the project meets the specific context requirements of the survivors.

The guiding framework should be seen as a **living document**, which will be refined and updated as the MHPSS practitioners in the Middle East gather experience and will be produced as a publication in mid-2018.

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[1] This document was produced by the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH in cooperation with German civil society actors and freelance psychologists working on mental health and psychosocial support (MHPSS) with refugees and internally displaced people in the Middle East region and in Germany in the context of the crises in Syria and Iraq.

Any queries or suggestions relating to the content are welcome, and should be sent to Dr Judith Bäßler (judith.baessler@giz.de), head of the regional programme Psychosocial Support for Syrian and Iraqi Refugees and Internally Displaced People.

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1. What are the psychosocial impacts of violence and displacement?

Armed conflicts have devastating impacts not only on a country's infrastructure, security and economic development but also and above all on the mental and social wellbeing of the people affected. A failure to recognise and deal with mental suffering at individual and collective level has a detrimental effect on a society's social cohesion, its economic productivity and its stability (1). The link between violent conflicts and psychological distress is complex and often unpredictable (2).

Forced displacement in the wake of armed conflict and violence not only has material consequences but also leads to serious experiences of loss, including the loss of family members and friends, a sense of belonging, control and autonomy, and access to resources. Refugees suffer greater vulnerability, more exposure to violence within their immediate environment, as well as poverty, a lack of prospects, and uncertainty over what the future holds.

People fleeing from a crisis region have often been exposed to painful and unsettling experiences not only in that region itself but also en route and after the flight: in refugee camps, in host countries, as victims of discrimination and when facing deportation.

Arrival in the host country is often associated with new challenges, such as problems with authorities, uncertainty over residency status, insufficient language proficiency and conflict with the local population. The pressure of expectation from the country of origin can be an additional source of stress. Ordeals of torture and other human rights violations destroy functional world views and self-images, exposure to rejection or xenophobia reinforces a sense of constant threat, and competition in the hunt for work is a strain on social relationships that are still intact (3). Feelings of rootlessness and homelessness make it harder for people to integrate and can cause them to view their life as merely a stopgap. While many people long to return to their countries of origin, in many cases this is impossible; those who do return often experience it as a complicated restart due to the huge changes that their homeland has frequently undergone (4).

In summary, the experiences of refugees can be described as an extreme form of disempowerment, which is often accompanied by shame and feelings of guilt, but also by hate and feelings of revenge. Apart from living under difficult conditions, they often suffer from grief, worry, fear, despair, hopelessness, loneliness, homesickness, alienation, helplessness, powerlessness and aggression, all of which can shape their behaviour (5) (6). The impacts of forced displacement do not stop with the individual, however: they also extend to the immediate and wider network of relationships between the people concerned. For example, avoidance behaviour, social withdrawal and lethargy also affect people's interactions. Couples may find it difficult to maintain trust and intimacy, and parents are often less capable of offering their

children secure attachment. Suffering that remains unexpressed among family members can lead to an atmosphere of silence and secrecy. Similarly, consequences of violence and forced displacement manifest themselves in the wider social context of communities and societies. Individuals' fears, mistrust and social withdrawal disrupt social cohesion and solidarity and can lead to violence and social numbness, which in turn means that neither the community nor society are able to perform their important stabilising roles any more. The consequences at individual and collective level are of course mutually dependent, and as a result quite frequently form a vicious circle that increasingly destabilises individuals and groups yet further. Measures to strengthen mental health and psychosocial wellbeing must therefore be applied at all of these levels simultaneously.

Besides the negative impacts outlined above, however, the fact must not be overlooked that many refugees develop skills and personal resources that enable them to survive under these difficult conditions. Often, then, it is possible to observe the simultaneous occurrence and intertwining of survival skills and strength on the one hand and psychological, psychosomatic and/or somatic abnormalities and illnesses (such as depression, anxiety disorders and or post-traumatic stress disorders (PTSDs)) on the other. The World Health Organization (WHO) estimates that the number of severe cases of mental illness can double in the context of conflict. Even moderate forms of mental disorder among the population increase from 10% to 15–20%. The high prevalence of psychological distress is reflected in all areas of social functioning and performance.

2. What particular ambiguities apply to the psychosocial needs of victims of human-made violence?

Violence and destruction caused by human beings is usually experienced as a huge injustice by those affected. Often the need for this experience to be recognised as an injustice and the longing for empathy and solidarity are very much to the fore. Being diagnosed with illnesses such as depression or PTSD may be felt to be a pathologising label loaded with stigma, which presents an additional obstacle to this need for recognition. Interventions with the sole focus on symptoms of illness are liable to cause a renewed sense of disempowerment. On the other hand, disease models also have the potential to relieve the burden on the individual because they show that it is natural for certain reactions to occur after experiences of violence.[2] In order to counter these ambiguities in a trauma-sensitive manner, it is vital to leave control over and decisions on

[2] Description according to the International Classification of Diseases: typical features include episodes of repeated reliving of the trauma in intrusive memories ('flashbacks'), dreams or nightmares, occurring against the persisting background of a sense of 'numbness' and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma (36). It must not be overlooked that these symptoms only denote an illness after chronification.

intervention processes and interpretation with those affected. Their autonomy and potential to find their own way of dealing with the experiences should be respected. In this connection it should also be borne in mind, however, that alongside their need for autonomy refugees and internally displaced persons (IDPs) often also have a simultaneous need for safety. This need may inhibit their ability to be proactive and take the initiative and when surrounded by unfamiliar sociocultural norms can lead to them having a preference for clear guidelines (7).

Another key ambiguity in the handling of human-made violence is the issue of trust and mistrust, especially in the context of conflicts that are decades old, highly complex and undergo rapid change. In most cases they create a variety of front lines and victim-perpetrator relationships that make it extremely difficult to develop trust in any relationship. Since an individual's experience of violence often mirrors political and historical conflicts, psychosocial work must take regional conflict dynamics and power structures into account.

Precise knowledge of the target groups and of the various national, regional, political, religious affiliation, ethnic and gender-specific conflict lines is essential in order to ensure that asymmetric, conflict-ridden constellations of relationships that generate mistrust are avoided in psychosocial work. People burdened by their experiences as refugees feel that the creation of an atmosphere that is characterised by predictability, credibility and appreciation is helpful as a means of overcoming their feelings of rootlessness and being at the mercy of events, and as a mechanism for developing fresh perspectives.

3. What are the particular psychosocial needs of refugees and displaced persons in the context of the crises in Syria and Iraq?

The devastating and prolonged civil war in Syria and the conflicts in Iraq have resulted in the greatest refugee movements of our times. Since 2011, around 12 million Syrians (8) and 4.3 million Iraqis (9) have been driven from their home regions. Many have witnessed massacres, executions and bomb attacks. Large numbers have had to endure forced displacement, kidnappings, imprisonment, torture and rape. Countless people have lost family members and friends, or are living in a state of uncertainty over their fate. In refugee camps and emergency accommodation the disintegration of social structures, precarious life circumstances and lack of prospects frequently give rise to new acts of violence, above all against women and children. Forced marriages, child marriages and forced prostitution are widespread. In today's refugee situation, differing gender concepts and legal codes among the host communities and refugees clash with each other and again cause conflict. In addition, internally displaced persons in particular suffer from siege situations and attacks on hospitals, and the consequent difficulties in accessing food and medical care. Poverty and unemployment are key psychosocial stress factors.

Those population groups that are especially vulnerable, apart from women and children, include young people, elderly people, persons with physical disabilities and mental illnesses, and other marginalised population groups such as lesbian, gay, bisexual, transgender and intersex people (10).

Before the armed conflict began, Syrian society was characterised by great social, socio-economic, ethnic and religious diversity, which – along with demographic factors such as age and gender – is reflected in the group of refugees. These various characteristics shape the sense of belonging and loyalties within the refugee community, and they have implications for people's psychosocial needs and adaptation mechanisms, as well as the manner in which they seek help. The significance of religious and group affiliation has increased, for example, as the power of the state has diminished (10). The large number of children who attended school in Syria before the outbreak of conflict cannot be fully integrated into the school system by their host communities, to the detriment of the children's and young people's sense of normality. All in all, living conditions for the refugee population are highly dependent on the willingness and capacity of the host countries and communities to encourage integration. In those countries with which cultural and economic links existed prior to the crisis, such willingness is often more apparent (10). The great majority of people seeking protection live in urban areas: roughly 88% in Turkey, 80% in Jordan and 100% in Lebanon – where there are no official refugee camps for Syrian refugees (11). Their needs in terms of psychosocial assistance often differ from those of people in the camps because of the different circumstances in which they live. The number of refugees living in overcrowded accommodation has constantly grown, and contributes to the greater vulnerability of the refugee population (12).

For the most part, the group of refugees and IDPs from Iraq has experienced systematic persecution for decades. Certain population groups, especially Kurds and Shiites, have been subjected to political oppression, and have been terrorised, tortured and murdered. The Iran-Iraq war in the 1980s claimed hundreds of thousands of victims on both sides and caused unprecedented displacement. The Anfal campaign was a military operation conducted by the Iraqi Baath regime under Saddam Hussein against the Kurdish population of Northern Iraq between 1988 and 1989. In the course of the 2003 US-led invasion and the subsequent collapse of state structures, and then when the so-called Islamic State ('IS') grew stronger after the end of the war, other population groups fled to neighbouring countries. As well as political persecution, religious persecution has been and still is rife in Iraq, and has further escalated since 2005 as a result of the actions of various extremist groupings. 'IS', for example, is attempting to wipe out the Yazidi population through murder, rape, enslavement and starvation. More than 3,000 women and girls have been abducted and enslaved since 2014. Around 100,000 Sunni Arab families are seeking refuge from 'IS' in the Germian district (Sulaimaniya Province) in the south-east of the Kurdistan region, and also from attacks carried out by Shiite militias fighting against 'IS' alongside the Iraqi Army and taking revenge on the Sunni Arab population. Iraqi society is

deeply fragmented as a consequence of its long and complex history of violence and is the breeding ground for a spiral of hate and retribution that explains the tensions and mistrust between various groups of displaced persons and between displaced persons and their host communities. Of the Iraqi refugees, too, only a minority live in camps; the majority are scattered across the towns and cities of the region in makeshift accommodation.

Clinical studies and diagnoses of mental disorders are extremely difficult to conduct among refugees and IDPs, both ethically and methodologically, and are often only partly adapted to the relevant culture and context. There are few reliable figures; results of studies vary widely, and accordingly can only give an indication of trends. High levels of distress, in some cases accompanied by symptoms of anxiety and depression, were declared by 42% of a sample of Syrian refugees in Turkey and Lebanon (13). Alpak et al. (2014) found symptoms of PTSD in a third of a group of Syrian refugees in Turkey, with higher figures for women and for people who had suffered multiple traumatic events. (14). According to UNHCR, 8.5% of the refugees at the Za'atari Camp in Jordan undergoing consultation for mental problems show symptoms of PTSD (15). A study by the International Medical Corps (2015) revealed that a third of those surveyed had persistently high anxiety scores (6). Sirin and Rogers-Sirin found particularly high prevalence rates of 45% for PTSD (and 44% for depression) among Syrian refugee children in Turkey (16).

4. What does MHPSS mean in the context of conflict and displacement?

MHPSS is a commonly used abbreviation worldwide, and stands for **Mental Health and Psychosocial Support**. It came about as a result of a broad debate on psychosocial work in which the guidelines of the Inter-Agency Standing Committee (IASC) were formulated. The concept of psychosocial wellbeing, at which the support is aimed, is briefly defined as follows:

The term **psychosocial** is an attempt to capture and comprehend the relationship between psychological (thoughts, feelings, behaviour) and social (attachment figures, life circumstances, culture) aspects of human experience. The linking of mental health and psychosocial wellbeing in the term MHPSS makes it plain that it is never a matter of social circumstances on the one hand and psychological disposition on the other but rather the fact that social conflicts and mental health problems always have to be viewed with reference to each other, and neither one nor the other of these elements must be neglected when it comes to addressing these issues. The term **wellbeing** is closely related to mental health, but is even broader in scope. Psychosocial wellbeing refers to a positive physical and mental state that encourages personal growth. This enables the individual to relate constructively with other people and is a lifelong dynamic process.

Psychosocial support in the context of forced displacement and violence is aimed at creating safe spaces in which people can broaden their coping strategies in order – despite stressful and potentially traumatising circumstances – to deal with events that jeopardise their self-worth such that detrimental consequences in everyday life are largely avoided or reduced. This takes account of the particular needs of people burdened by their life stories.

5. What differentiates psychosocial, psychotherapeutic and psychiatric approaches?

In all three of these approaches the aim is to improve a person's psychosocial wellbeing and to prevent and manage mental disorders. A mental disorder or illness is diagnosed when an individual's impairments prevent him or her from coping with everyday life's demands. These illnesses are listed in international classification systems, as are all somatic illnesses (17) (18).

The generic term **psychosocial support** embraces a variety of approaches that strengthen people's ability to cope, their mental wellbeing, and functioning at the emotional, social, spiritual, cognitive and behavioural level without having recourse to a medical treatment model.

Measures that come into the category of psychosocial support include:

- stability and stress reduction through the fulfilment of basic needs such as protection, security and the provision of water and food
- strengthening and rebuilding constructive interpersonal relationships that pave the way for social acknowledgment and mutual support
- establishing a framework within which the individual and/or the group has the opportunity to experience their own effectiveness and a positive role in their social environment and of perceiving themselves and others in the context of their needs, strengths and weaknesses
- activating the individual's personal and social resources that help them in coping with everyday life and integrating what they have experienced into their self-image and world view
- the restoration of dignity, justice, control and autonomy
- support for the development of new goals and life plans in order to experience life as meaningful and enriching and to lead it in tune with certain values (shared by a socio-cultural group).

For the most part these support measures are designed to be easily accessible, and are often situated at community level. They are aimed at reaching as many people as possible. They are often positioned in the health, education and social work sectors or are integrated into other

sectors to complement their measures, for example income generation, employment promotion or training. In many instances psychosocial measures are implemented by social workers,[3] teachers, pastoral workers or employees of non-governmental organisations. These people should have qualifications and skills that, although different from psychotherapeutic training, nevertheless establish a basis for exerting a positive influence on destructive social interactions and supporting others in the constructive rebuilding of a self-image and world view.

In addition to professional expertise and in-depth knowledge of the political and cultural context, expert personnel in the psychosocial sector require the following core competences:

- capacity for self-reflection and a willingness to question one's own behavioural patterns, power models and ways of thinking
- empathy and an ability to build relationships
- an open, culturally sensitive attitude based on solidarity, with an ability to shift perspective
- communication and conflict transformation skills
- capacity for self-care
- an ability to link in with existing local resources and to strengthen them

Psychotherapeutic measures are used to treat mental illnesses. Depending on which school of thought is applied, the approaches adopted are based on an understanding of the individual that prescribes the methodology and steps involved in the therapy. Psychotherapy for people who have had traumatic experiences also addresses psychosocial aspects; the object of the treatment is the patient's difficulties in regulating dysfunctional thoughts and feelings and/or establishing and maintaining constructive interpersonal relationships. Usually the therapy focuses on the illness (deficiency) and on dealing with it and alleviating the suffering. Psychotherapy should only be carried out by trained experts. **Psychiatric interventions**, i.e. the medical treatment of mental illnesses, include pharmaceutical treatment. In their work with refugees, more and more psychologists and psychiatrists are interested in integrating psychosocial aspects into the therapy they provide, or expanding existing provision.

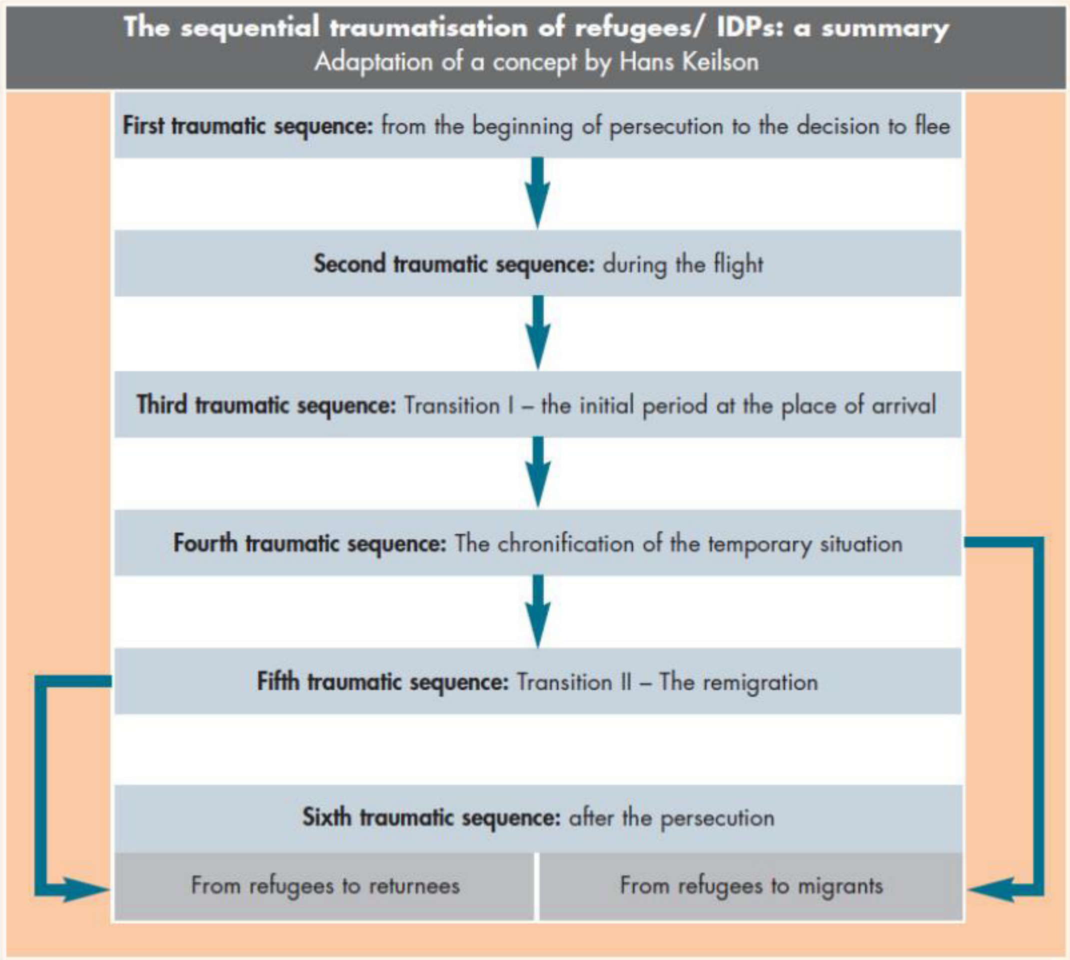
[3] Social workers do not receive uniform training as an occupational group in the countries of the Middle East (different skills are taught in each country), so it cannot be assumed that a standardised PSS approach will be adopted in the region.

6. What understanding of trauma should be used as the basis for development cooperation?

The persistently threatening context and the loss of integration into a protective social group mean that refugees have to adapt and reorient their lives to an extreme degree. In many cases proven coping strategies are no longer enough to face up to the ongoing challenges. Many refugees first and foremost hope for relief from their difficult circumstances. They are focused on immediate survival, and the experiences of persecution and destruction that lie behind them sometimes appear to play only a secondary role, although they can come to the fore at any time. The concept of post-traumatic stress disorder frequently does not adequately cover the suffering that people have endured. Instead the focus has to be on the processes of integrating what they have experienced: their survival attempts, losses and new endeavours – these processes take many years and are different for each individual. Whether or not experiences of violence and loss manifest themselves as an illness is largely dependent on the social context. Beneficial conditions for mental health are to be found in a social environment that acts and responds in a supportive, understanding and acknowledging manner and thus enables new trust to be established. Detrimental conditions are additional strains such as uncertainty, stigmatisation, the experience of rejection, a renewed fight for survival and further cases of abuse, betrayal and loss of control. Psychosocial measures must recognise the severity and depth of the violations, while at the same time the ability of those affected to continue to act as independent subjects must be taken into account and encouraged. Psychosocial measures must therefore be oriented towards available resources, and incorporate and strengthen existing family-based and social support structures.

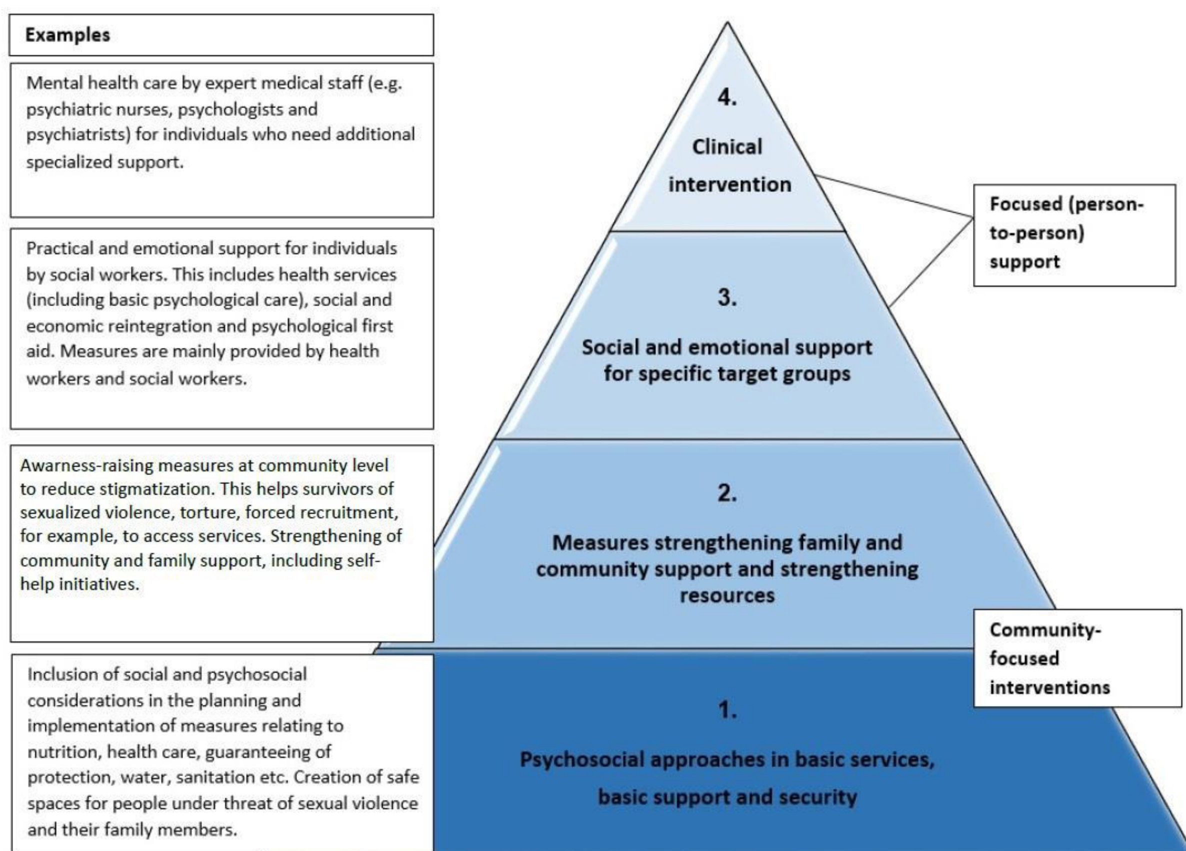
The advantage of seeing trauma as a process within a social context in contrast with a more static, symptom-oriented understanding, such as that of PTSD, lies in the view of complex interactions between individuals and their social group that define trauma. Hans Keilson's sequential traumatisation model (19) has proved to be pioneering in this connection (see below). Understanding trauma as an interaction between different sequences rather than focusing on a singular original violent event offers a more comprehensive picture of the course of various traumatising experiences over time and their impacts on psychosocial wellbeing (20). In his research with Jewish war orphans from the Second World War in the Netherlands, Keilson established that the period after the persecution, in other words when processing begins but for various reasons the individuals are not yet able to come to terms with what has happened to them, accounts for a significant part of the traumatic experience and was 'described by many as the most intrusive and most painful experience of their lives' (20). Keilson (see below) showed that it was not necessarily the severity of the first two traumatic phases that was pivotal to the long-term mental health of the war orphans (21). 'What determines the development of mental health problems is therefore not only how horrific the trauma was in itself but what happened

immediately afterwards and later' (22). The supportive potential that becomes apparent from this finding shifts the responsibility for coping with the traumatic experiences from the individual as the bearer of the problem to society and policy-makers, and is thus highly relevant to development cooperation. What comes afterwards gains in importance: what do refugees experience not only in their country of origin but also in their destination country? Keilson's model was adapted for the refugee context as shown below (23) (3):



7. What have we learned so far about MHPSS approaches in the context of war and refugee movements, and what forms of psychosocial support can be used for refugees and internally displaced persons in the context of the crises in Syria and Iraq?

The Inter-Agency Standing Committee (IASC) developed a model that since 2007 has been seen internationally as the reference framework for psychosocial work in the context of crises and conflicts. This model examines four interconnected layers of intervention, which it represents in the form of a pyramid (24).



Layer 1 of the pyramid represents the provision of essential services and the restoration of basic infrastructure in order to safeguard basic physical needs (food, housing, water, basic health care). These services are often provided as part of a continuum between humanitarian assistance and long-term development cooperation. Psychosocial work at this level commonly comprises advising service providers. In the process of meeting basic needs, the aims here include: 1)

ensuring that negative consequences are avoided; 2) ensuring that the service providers' work is needs-based, conflict-sensitive and trauma-sensitive (for example taking care that women and girls are able to access and use latrines in refugee camps without putting themselves at risk and that relief supplies are distributed in a way that promotes the dignity of the recipients and does not give them the feeling that they are grovelling; and 3) ensuring general awareness of psychosocial aspects. The secure provision of essential services to safeguard basic physical needs is vital for people's psychosocial wellbeing. Without guaranteed access to resources that they need in order to survive, people are in a constant state of worry and tension over how their survival can be ensured.

In **layer 2**, as well as providing support for building supportive, stabilising relationships, the emphasis is on creating or strengthening safe spaces for interaction as a community, promoting family reunification and executing income-generating and employment measures, among other things.

Layer 3 is where the more targeted, non-specialised support for individuals, families or groups comes into focus, provided by trained and accompanied social workers, community workers and multipliers.

Layer 4 is the area where specialised treatment options are provided by medical and psychological experts for people who require long-term psychological or psychiatric treatment on account of the severe limitations and difficulties they face in their everyday lives.

The model should be seen as a unified whole in which simultaneous interventions are required on all four layers in order to address the various needs and to do justice to the heterogeneity of the target group. A trauma-sensitive approach is essential on all four layers, and is a key component in the strengthening of constructive interpersonal interactions in everyday life. The model says nothing about whether interventions generally make more sense or are more effective on one particular layer of the pyramid rather than on another. Instead, suitable interventions should be decided upon according to the specific context and should have as broad an impact as possible.

The pyramid represents a holistic approach to mental health and psychosocial support, which means that human rights such as mental health and personal fulfilment as well as the provision of basic food supplies, water, protection, sleep etc. must be satisfied and supported concurrently and with the same degree of relevance. On the basis of this understanding, actors in German development cooperation who are actively involved in MHPSS in the context of the Syria crisis should be guided by the IASC intervention pyramid. Against a background of ongoing violence and forced displacement with such scarce resources in the first-destination countries that, as a rule, there is not even enough psychosocial support available for the indigenous population,

measures should be designed in such a way as to be as inclusive as possible. Generally, this is most likely to be achievable with community-oriented activities. In uncertain and rapidly changing contexts it must also be borne in mind that psychotherapeutic treatments on layer 4 should only be commenced if they will be able to be completed, which is rarely the case for displaced persons, given their unstable situation or the need to keep constantly on the move[4]. In development cooperation in the context of the crises in Syria and Iraq, therefore, psychosocial support measures for refugees are often more appropriate and more sustainable on layers 1 to 3, which reach large numbers of people with small amounts of resources.

This does not at all mean, however, that more specific psychiatric or psychological support at individual level may not be necessary. Many people have symptoms for which it would without doubt be desirable to receive special attention from experts – it is just that because of the poor state of provision it is frequently impossible. It is thus the case that people with no specific psychological or psychiatric knowledge are often the first points of contact even for individuals with severe problems (e.g. in camps or schools). It is all the more important, therefore, to raise awareness of mental illnesses and psychosocial approaches among actors who do not have a specific therapeutic link to their work but operate on layers 1 to 3. This is because the majority of psychosocial problems do not require clinical therapeutic intervention in layer 4; their causes are to be found in stigmatisation, despair, grief, rootlessness, chronic poverty, lack of access to the provision of services and care, and a broken social frame of reference. (25) (10). These difficulties can also be addressed on the three lower layers of the pyramid, where the aim is that the individual's capacity for self-healing should be activated by strengthening the social community. (26).

The purpose of implementing measures concurrently (strengthening existing MHPSS provision on all four layers of the pyramid and where applicable establishing those that are lacking) is to make a range of services available to refugees that meets their specific needs to as great an extent as possible, as well as relieving the strain on the MHPSS workers.

8. What form does German development cooperation take in practice?

There are a variety of MHPSS approaches in refugee work, ranging from exercises in self-regulation and social competence to the expression of the experience of forced displacement

[4] It must be noted, though, that persons with pre-existing MH disorders do require access to treatment because they are on a psychopharmacological care plan

through theatre, poetry, painting, educational games, sport, dance and relaxation techniques, not to mention highly specialised clinical and trauma-centred treatment provision. The various MHPSS approaches also include access to legal assistance, the disclosure of crimes, the pursuit of truth and the prosecution of perpetrators, all of which can support psychological recovery. The establishment of meeting and information centres that offer the opportunity to share thoughts with other people has proved to be a particularly suitable means of boosting refugees' psychosocial wellbeing. Such centres can also be used to provide advice on specific areas of life such as medical care or school attendance for children.
The examples from German development cooperation described in the following can be assigned to different layers of the intervention pyramid.

Layer 1 – Psychosocial approaches in basic services, essential goods and security

The aim here is – in the context of humanitarian assistance – to create awareness, understanding and acceptance of MHPSS measures (advocacy) both among the donor community and in local communities, and, in the course of the restoration of broken systems (infrastructure, education, health, etc.), to ensure and advocate that consideration be given to MHPSS as a cross-cutting issue and that measures are implemented carefully, respectfully and in accordance with the psychosocial needs of the people concerned. Such awareness can be recognised in various ways. For instance:

- the people affected are actively involved in the provision of services and are in control of their own situation at all times
- stigmatisation and victim classification arising from the use of the services are avoided
- measures aimed at providing basic services take account of the fact that people under serious strain are often not reached when it comes to distributing aid supplies because of their need to withdraw or their high level of mistrust, so different access channels have to be opened up
- education measures need to be attuned to the fact that young people who have experienced traumatic events do not have the same capacity to concentrate and process information
- women who have experienced violence stay away from the health system for fear of stigmatisation unless there is a psychosocially informed approach in health care, i.e. community health workers can reach out to people at home.

Example from German development cooperation in the Middle East: In Northern Iraq, Medico International supports local partners in the provision of emergency aid which boosts self-help and the establishment of solidarity-based structures among refugees and takes account of specific psychosocial needs of vulnerable groups such as women and children.

Layer 2 – Support for families and communities

The interventions on this layer include:

- reunification of family members
- campaigns on constructive ways of coming to terms with the past
- livelihood activities
- family planning work
- promoting the establishment of non-violent family dynamics
- women's groups
- youth clubs
- activities pertaining to formal and non-formal schooling
- collective mourning processes
- reintegration of ex-combatants into their villages through traditional cleansing and reconciliation rituals
- restoration of social relationships between polarised groups

Example of football as a psychosocial measure:

A **football match** between young people would be a psychosocial measure in layer 2, for example, if it is conceived, supported and designed in such a way as to leave space for the players to experience the following:

- empathy
- fairness
- cooperation
- control
- empowerment
- sense of belonging and integration into a group
- following rules without feeling hemmed in
- trying out non-violent and creative solutions to problems
- use of constructive communication and goal achievement strategies
- enjoying success and tolerating frustration and failure, etc.

In a match run by a coach who is not trained in psychosocial support (PSS) none of this can be taken for granted, because during the game there is also potential for intensification of the image of the others as the enemy and for threats, mistrust, exclusion and bullying of individual players, a perception of a loss of control over oneself and powerlessness, or for the display of aggression and destructive tendencies towards the opposing team or one's own team members. In this case the football match could not be described as a PSS measure but would be viewed as exacerbating the conflict or disempowering for a team or individual players.

Example from German development cooperation in the Middle East: In Lebanon, Save the Children supports the reception of Syrian refugees as they arrive and provides emergency aid. It provides non-formal education measures for Syrian children and children in the host communities, and creates child-friendly places in order to respond to the direct and immediate repercussions of their experience of violence and displacement. It creates awareness among parents, teachers and children of the consequences of the ongoing violence and offers training in children's rights.

Layer 3 – Emotional and social support for individuals, families or groups

The support measures on the third layer require a greater degree of counselling skills and relationship work than those on layer 2. It is a matter of giving relief to people who are suffering greatly from their experience of violence, war or disaster and for whom the interventions on layer 2 have too little or no effect. The people affected often isolate themselves, too, and for that reason do not take part in activities on layer 2. This layer is mainly, but not exclusively, the place for psychological first aid (PFA), a support concept for people under strain who have recently been exposed to a potentially life-threatening event.

Psychological first aid was developed by international experts and is aimed partly at stabilisation in the wake of emotional breakdowns and partly at preventing further harm through empathetic listening and support for those affected in the immediate fulfilment of their needs (27).

Example from German development cooperation in the Middle East: medica mondiale and Haukari are engaged in Iraq with a multi-level training project on gender-specific violence and psychosocial support: staff at the counselling centres for women affected by violence and at the contact points for primary health care receive further training on the causes and consequences of sexualised violence, the principles of psychosocial counselling and referral systems. Staff at the Ministry of Health receive training to become multipliers.

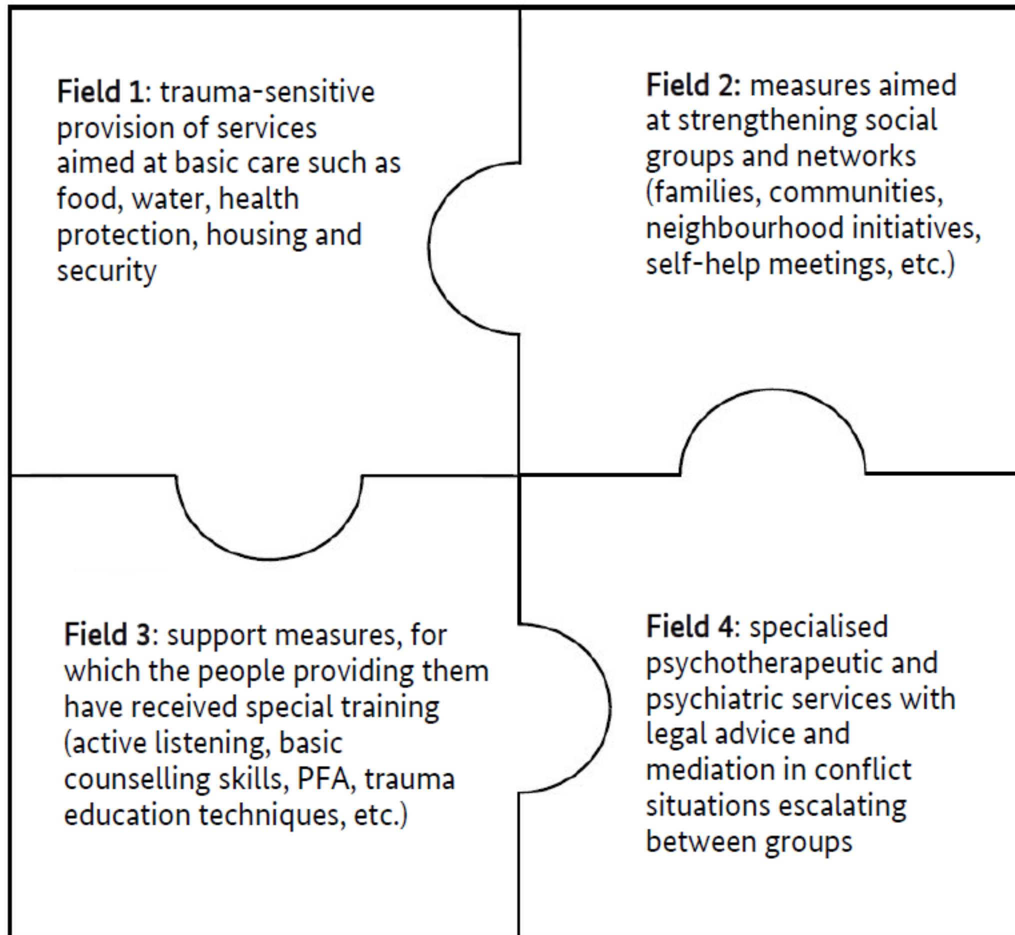
Layer 4 – Specialised and clinical treatment provision

This includes specialised clinical interventions by psychiatrists or psychotherapists to deal with endured violence, loss, grief, human rights violations and trauma. In order to help people suffering from psychosocial disorders or mental illnesses of varying degrees of severity to reorient themselves to the extremely fragile situation in which they live, develop a new identity and regain their emotional equilibrium and their will to live, in some cases there is a need for specialised assistance from various experts who are able to intervene in the given context: individual or family psychotherapy, psychiatric and drug treatment and pharmacological recommendations. The administration of medication and recommendations for psychopharmacological treatment

should be the sole responsibility of specialists – in conjunction with psychotherapeutic support. With regard to the trauma-focused techniques it should be noted that they should not be used without reference to the specific context of the people affected. The effectiveness of a method in principle must not be the sole criterion for deciding on its use; it must fit coherently into the people's everyday reality so that it can unfold its intended stabilising effect. Therapeutic approaches that consider confronting the individual's experience of suffering to be key to coping with such suffering should be examined, and adapted to the specific context. The temptation of always being able to apply a fully standardised method in any circumstance and location blocks off socio-political, intercultural questions and also questions as to the causes of violence. This should be counteracted by designing the intervention to be multidimensional.

Examples from German development cooperation in the Middle East: The Balsam project run by the Charité University Hospital in Berlin and Help e.V. offers basic psychiatric and psychotherapeutic care at three health centres in Jordan through eight Jordanian and Syrian psychiatrists who have undergone training within the project.

The risks of misinterpreting the pyramid are outlined above, but in order to counter these the model can also be imagined in an alternative way, as interrelated services whose components each have different focuses but which are linked by the fact that specialisms of different kinds are required in all fields in order to provide a full range of holistic psychosocial care. In the alternative model, in contrast with the IASC pyramid, other highly specialised services are included in field 4 (= layer 4 in the pyramid) in addition to clinical services.



Example of the holistic approach from psychosocial working practice in Germany: The psychosocial treatment centres for refugees and victims of torture in Germany work as a multidisciplinary team in order to provide low-threshold psychosocial and legal guidance and assistance as quickly as possible and to facilitate networking through the mediation of mentors; they also offer specialised therapy and treatment. At the same time the staff act as multipliers, mediators and trainers in the communities and in the health care, social welfare and education sectors (28).

9. What added value do psychosocial approaches offer to German development cooperation?

Exposure to distressing situations, persistent fear and a wide range of violent experiences of loss shape the lives of people living in conflict regions. This not only has repercussions in the form of possible individual mental disorders arising as a consequence of what the people have experienced, it also impacts all aspects of the social and learning behaviour of those affected.

Chronic experiences of persecution, death and destruction mould the dynamics of interpersonal relationships in families, communities and society as a whole. Psychosocial problems are therefore not purely a health, psychological or social issue: they need to be picked up and reflected upon in almost all areas of society (26). Accordingly, development cooperation should also take account of these dimensions in project areas that at first sight would appear to have little to do with psychological matters. A large number of people affected by such experiences have learned, for example, to mistrust others, keep their own opinions to themselves and to appear to function normally while inwardly they are often permanently fearful, hurt and affected by too many losses. Many are more susceptible to physical illnesses and are less able to cope with strain, suffer from uncertainty and nervousness, and sometimes develop a strong need to withdraw from others. Often the things that they have experienced give rise to avoidance behaviour and hopelessness, and in some cases to greater aggressiveness and a propensity to violence. People burdened by their life stories are more likely to suffer from a diminished ability to concentrate and remember, and many find it difficult to motivate themselves, to see their capabilities in a positive light and to be willing to take risks when it is a matter of taking charge of their own lives again. None of this should be considered to be an expression of an illness but rather a consequence of learned survival mechanisms, which made sense in a war situation but now have an inhibiting and destructive effect on the individuals' behaviour and potential to reshape their lives.

In order to guard against the negative psychosocial consequences of war and violence, thought should be given to promoting MHPSS in the design and progress of projects in all sectors of development cooperation (3). As well as alleviating the degree of suffering for those affected, the added value for society of incorporating MHPSS entails political stabilisation, violence prevention, a higher probability that development cooperation measures will succeed, more sustainable social and material reconstruction, and the consistent application of a human rights-based approach to which German development cooperation is committed. The potential of people who the development cooperation measures would like to reach is boosted by the inclusion of MHPSS considerations and the projects' objectives become more realistic. The table below provides an overview of the risks to which development cooperation projects expose themselves if they disregard MHPSS.

DC sector	Potential negative consequences of disregarding MHPSS
Health	Traumatisation, living in fear for long periods and severe personal losses not only lead to mental problems, they are also expressed in a variety of somatic disorders whose psychosomatic nature is not necessarily immediately apparent. It is often the case that while the individuals concerned suffer the same somatic complaints as people who are not affected by psychosocial stresses, their illnesses frequently have a more protracted course and are more resistant to treatment. When undergoing medical examinations, victims of torture and former prisoners in particular commonly exhibit pronounced fear, which makes examinations such as electroencephalography (EEG) more difficult or even impossible unless they have a very trusting relationship with the medical staff. There are often symptoms of mental illness which – if the connection with past suffering and suppression is not established – are incorrectly diagnosed as schizophrenia or depression. For all of these reasons, psychosocial training for health workers is essential in conflict and post-conflict regions, including particular emphasis on raising awareness of the affected individuals' widespread fear of stigmatisation, which is one of the main reasons why offers of psychosocial care are only reluctantly taken up. The focus on psychosocial health rounds off programmes that are aimed at restoring the quality of life by reducing symptoms of illness.
Education	When hundreds of thousands of people have lived through traumatising events, the wounds that have formed and the serious psychosocial problems that have been created cannot be dealt with primarily by means of psychotherapy at the individual level. This is impossible, if for no other reason than that the required numbers of expert staff are simply not available. The education sector, from early childhood education to schools, vocational training, universities and adult education, and including the great variety of education-oriented community projects, offers central locations where processing of the past can take place. This applies both in relation to coping with mental suffering and to the (re)construction of social coexistence, the overcoming of passivity, subordination, fear etc. and the fostering of curiosity, interest, engagement, self-confidence and positive interpersonal behaviour. The psychosocial aspects of education work help to bring about a lasting improvement in learning behaviour and cooperation skills among young people who have been badly affected by their experiences in conflict and post-conflict regions. For this to succeed, education programmes should take account of the people's past experience of disempowerment.

Employment promotion, Cash for Work, entrepreneurship, capacity development	These projects are aimed at promoting initiative, the ability to reflect, creativity, innovative spirit, the will to prevail, a willingness to cooperate and often a willingness to take a certain amount of risk in investment. However, precisely these capabilities are impaired in (post-)conflict regions, because when war and terror persist for long periods of time passivity, mistrust and authoritarianism or submission become widespread survival strategies. Fear becomes a key regulator of behaviour, even years after the acute threat has passed. A damaged feeling of self-worth, too, resulting from experiences of violence, can lead to (self-)destructive processes that unwittingly undermine the development of successful projects. Neglecting the psychosocial consequences of war and violence costs the global economy enormous sums every year (29). As a result of rising health costs and reduced economic productivity, people suffering from mental illnesses are exposed to a greater risk of slipping into poverty. Mental illness and poverty are closely linked and are mutually reinforcing. Seventy-five percent of people with neuropsychiatric disorders live in low-income and middle-income countries, where the fewest opportunities for treatment are available (30) (31). Including MHPSS in this sector combines employment promotion measures with the promotion of psychosocial health, which has the effect of reducing the risks outlined above.
Peace work, social cohesion, disadvantaged and vulnerable groups: children, women, people with disabilities, people with personal histories whose memories are revived by their recent experiences, LGBT	In war, people learn to avoid or generally mistrust the collective. They learn to believe that 'might is right', and to see destruction as being a solution to problems and consider violence to be normal. Peace work and social cohesion, on the other hand, build on constructive views of humankind that do not correspond to what people have experienced in war and are therefore often felt to be less credible, more disconcerting and more demanding than the 'familiar misery'. In the context of violence one way to aid survival is to keep weakness secret, feign strength and largely avoid social reflection and analysis. Large numbers of actors experience severe internal fractures and separation processes. Vulnerable groups often become even more marginalised than before, or are reduced to their vulnerability. In their attempt to build something new, sufferers have to grapple with destructive events in the past, something that is often painful. Cumulative experiences of violence and loss increase the difficulty of building new trust and approaching other people. The aim of facilitating healthy grieving processes is a vital and highly complex component of peace work and of vulnerable groups' struggle for recognition. The joint planning of projects can encourage the sharing of experiences and ideas, empathy and rapprochement. The timing of peace-building projects must be carefully thought through, because attempting to process the past too soon after the destructive experiences is liable to compromise or impede the success of the project.

Good governance, media, security and the rule of law	Governments in post-conflict regions often find it hard to deal with victims and collective suffering because politicians themselves belong to a particular group that has inflicted or endured suffering. In their capacity as head of state or in other political leadership roles they have to make the public case for a positive future which sometimes may not correspond to their own personal conviction, and accordingly is not considered trustworthy by some segments of the population. Traumatic experiences may be expressed in politicians by the rejection of all forms of criticism and a lack of self-criticism, which makes democratic governance more difficult and hampers respectful dialogue between groups with different interests. MHPSS measures promote empathy and reflection, which are essential components of good governance. The media have a significant role to play in post-conflict contexts, and with the aid of conflict-sensitive journalism they can support and actively advance reconciliation processes and efforts to achieve peace. Unfortunately, however, the media often do not adopt a helpful position; in fact it is not unusual for them to challenge these efforts through one-sided, dramatic and sensational reporting. By posing insensitive questions and presenting selected quotes from affected individuals, the media can play a part in reinforcing mistrust and the consequences of trauma. In many post-conflict regions there is a tendency towards higher levels of violence and delinquency. Security therefore continues to be uncertain, and peace negotiations are commonly accompanied by amnesty arrangements through which former perpetrators remain a threat to their victims or are able to act in such a way. The reinstatement of the rule of law remains a difficult undertaking, which has to address dealing with the past and the introduction of new legitimacy, and often requires reforms of legal bodies. Psychosocial processes play a crucial role in these processes (e.g. victim protection, compensation/redress, collective remembrance ceremonies, the development of narratives, police reforms). The emotional states and concerns of those involved must be included in every development cooperation project in a post-conflict context in order to prevent retraumatisation and to slowly overcome violent behaviour, especially by organs of the state. Furthermore, the quality of social ties within a society has a major influence on the stability and performance of state institutions and on citizens' relations with them.

Environment, biodiversity, energy, climate, water	Wherever resources are a factor, old conflicts are liable to break out again or new ones can arise. It is vital to pay attention to conflicts within communities when implementing water projects because otherwise resistance to the project could jeopardise its success and technically expedient solutions could be ruined. However, the projects also present the opportunity to address problems at community level in a constructive manner and to encourage optimistic prospects of a return to normality. The standard of hygiene in an accommodation or settlement for refugees affects not only their state of health but also their psychosocial wellbeing. At the same time, it is often difficult for traumatised people to devote adequate attention to their own hygiene and that of their surroundings; neglectful and self-destructive tendencies are frequently observed. Although women bear principal responsibility for their families' water supply in most parts of the world, they continue to be involved too little in the planning and implementation of infrastructure projects. In conflict situations, their participation is often also hampered by their being overworked on account of changes to the distribution of roles (for example if the father of the family has been wounded or killed in the war or is unable to remain with the family because of military duty).
Food security, rural development	Many projects which make good economic sense fail because they do not take adequate account of the psychosocial state of the people involved. People who have lived for a long time in a state of dependency often tend to repeat dependent relationships, in other words they do precisely the opposite of what would help them to overcome their problems and regain control. The productivity of a family farm in a poor rural area depends not only on the quality of the seed they sow but often to a greater degree on the relationships within the family. Gender relations also need to be taken into consideration in this regard. In many cases, it has often only been possible to ensure survival in conditions of extreme poverty and violence with the assistance of extended family networks. Therefore, successful development for individual family members or smaller family units can generate envy and a fear of losing survival networks, and consequently prevent success in agriculture or even devastate it again. Natural disasters such as hurricanes, landslides or earthquakes can reduce the motivation to aim for long-term development because people fear that the next natural disaster is just around the corner. So even when it comes to promoting agriculture, fear and relationships are often also important, not just technical concerns.
Infrastructure, construction measures	When infrastructure and construction measures are implemented, considerable difficulties may well arise if the psychosocial sensitivities of the subsequent users are not taken into account. A lack of ownership can lead to entirely sensible measures being ruined by the users. The key here is therefore the way in which measures are implemented, because this

	has an impact on the wellbeing and dignity of the people. These aspects are strengthened if care is taken, for example, that camps are not overcrowded, that sufficient lighting is provided or that sanitation facilities are arranged such that they do not present a risk of physical or sexualised violence. Cultural characteristics and customs also have a part to play – one that should not be underestimated. Certain places sometimes have a specific significance (for instance because someone has been killed or buried there), which needs to be taken into account when measures are implemented in order to prevent discord and destruction. Every infrastructure project in conflict regions should be thought through and revised in conjunction with the community in light of psychosocial considerations.
Camp management	The principle of 'might is right' is liable to multiply in an aid context, old survival networks may continue to exist in a refugee camp and often there is little or no trust in structures or the claim that they ensure equitable distribution. If these dangers are not explicitly counteracted by the establishment of trust, the experience and fear of having to cope alone and without support at all times often continues. Trauma-sensitive management, on the other hand, can help to restore trust in organisational structures and to reinstate fairness as an important principle of interpersonal coexistence.
Cross-cutting issues: human rights, gender	Human rights violations, such as gender-specific violence, torture, detention, forced recruitment, and child abuse attack the identity of the victim. The greatest destructive potential comes from sexualised violence. Making speaking about sexualised violence a taboo, leads to the emotional isolation and social exclusion of the victims and thus intensifies the violation they have suffered. Support for the survivors and the prevention of this form of violence must therefore complement each other. The role of gender-specific violence in war must be laid bare, and the perpetrators must be held to account. By linking rehabilitation with research and advocacy, the work to counter gender-specific violence can become a form of self-help for the survivors (3). If psychosocial wellbeing is perceived as being an inalienable right, this can have a positive impact on people's world view, self-confidence and feeling of self-worth.

10. How can MHPSS staff ensure psychosocial wellbeing?

The foundation for good psychosocial support is the MHPSS personnel's own mental health and professionalism, whether they are seconded staff or personnel from local partner organisations. MHPSS staff confront suffering, injustice and human rights violations on a daily basis. If

employees are to be able to maintain an empathetic attitude in a spirit of solidarity over the long term, it is a professional necessity for every MHPSS organisation to protect its staff's psychosocial wellbeing. Only expert staff who are able to recognise and relieve the stress they themselves are facing will be able to help others to reduce stress and deal with traumatic experiences. Without the capacity to self-reflect and self-regulate, there is a risk that support workers will additionally transfer their own stress onto the people they are trying to help. One of the ways of contributing to the staff's psychosocial wellbeing is to provide respite and relief services that are a permanent part of the organisational structure and offer space for mutual support of the employees and reflection on personal stresses. These services should be well integrated into work procedures and be tied in with existing self-care strategies that are in place for staff. Establishing spaces for reflection and protection in order to incorporate peer support structures into project management is an example of good practice. Opportunities promoting physical exercise and creativity have also proved valuable, as has regular supervision.

However, stress-relief activities alone are not sufficient to protect staff. Organisations are well advised to arrange for their structures and practices to be explicitly examined for risks to the psychosocial wellbeing of their employees. Work must be organised in a professional, supportive manner, with stable and predictable support conditions. Good examples of these are having a reliable link between field staff in the outposts and the central structure, preventing staff in remote areas from becoming isolated by having them work in fixed teams, clearly defining each position's area of responsibility and limits to that responsibility, deploying staff with careful consideration of their qualifications in conjunction with offering continuous professional development, providing refuges for personnel at all workplaces, providing transparency about workplace safety and if possible promoting it, and ensuring reliable security management. The role of the leadership style at the workplace is a factor in the psychosocial wellbeing of employees that should not be ignored. The means by which the organisation can be appropriately geared to providing psychosocial protection for its employees depend on the specific project context and on the project's financial framework. Funds for the suitable remuneration of the staff should therefore be a fixed component of the budget of every MHPSS initiative, together with regular stress-relief activities. Making the project term as long as possible increases job security and frees up space for team building. It has also proven worthwhile to provide support in administrative processes, especially for applications to acquire extra funding and for further training for employees. In addition, identifying and networking with existing MHPSS initiatives involving actors operating in the local and regional environment can contribute to the professional exchange of best practices and thus to a further increase in the degree of professionalisation of the work.

11. What quality criteria and principles should be applied to development measures aimed at promoting mental health and psychosocial support?

The table below presents the widespread consensus among international practitioners in relation to criteria that characterise successful interventions and provides pointers to pitfalls that should be avoided (32) (33) (34). It should be noted that the criteria will be further refined as practitioners in the field gain experience and continue the debate; sometimes the criteria reach their limits in project work.

No.	Principle	☺	☹
1	People focus/ attitude	The self-efficacy expectations and **dignity** of the individual are reinforced and are enabled at every stage of the intervention. Targeted individuals have scope to act and have **agency and control** over their decisions, which helps them cope with and overcome experiences of violence and loss. Prospects for the future are opened up.	Refugees and IDPs are not seen as autonomous individuals with skills and resources, but instead are pathologised collectively as part of a disenfranchised group that is in need of help. There is a risk that experiences of powerlessness and loss of control will be repeated and dependencies will be established or reinforced.
2	Human rights	Within the measure, human rights are considered inalienable, applying without restriction and regardless of nationality and residency status (35). Accordingly, the measure is compatible with the '**right** of everyone **to** the enjoyment of the highest attainable standard of (...) **mental health**'.	The avoidable disadvantaging of certain social groups such as asylum seekers or people without legal residency status is perceived as unjust, but is merely supposed to be corrected by individual actions. There is no identifiable human rights approach.
3	Alignment/ comparison with what already exists	The measure is **needs-based** (on the basis of international assessments in the sector) and operates **in harmony with and complements** national and international actors' plans. It is integrated into existing **community-based** initiatives and structures and does not run the risk of establishing parallel structures.	The measure is a stand-alone intervention that has not been preceded by an analysis of actors/interventions and thus runs the risk of duplicating and competing with existing interventions.
4	Sensitivity to culture and context	The measure is in line with useful **culturally appropriate and context-sensitive practices** that local and international actors consider to be effective and valuable.	The measure is based on universal intervention approaches and competes with local coping strategies and structures. Western approaches are used without integrating any approaches or adaptations relevant to the culture or context.
5	Participation, ownership	The development of the measure is preceded by a context and conflict analysis in which **women and men from the target group have participated**. The measure is developed **in conjunction with**	The design of the measure is based entirely on studies or experience from other contexts. No account is taken of the special circumstances of the specific

No.	Principle	☺	☹
		representatives of the refugees / IDP or the destination community, which encourages acceptance, ownership and sustainability of the intended project.[5] The measure is offered jointly with or by representatives of the target group.	context. The measure is not planned or implemented in conjunction with representatives of the refugees / IDP.
6	Diversity & inclusion	The measure is **inclusive** and explicitly takes account of the **needs of vulnerable groups** (women, children, the elderly, people with disabilities, and other marginalised population groups such as lesbian, gay, bisexual, transgender and intersex people). The measure considers the **heterogeneity of the target group** and takes account of this in a differentiated intervention design.	Individuals or groups are labelled without being differentiated (e.g. 'the refugees are all traumatised'), which on the one hand can have a stigmatising effect and on the other runs counter to the desired effect of strengthening resources. The specific needs of vulnerable groups are not addressed.
7	Gender sensitivity	During planning and implementation of the measure, care is taken to ensure that the specific requirements of **men and women** are taken into account, for example with regard to the handling of past gender-specific or sexualised violence etc.	The measure makes the implicit assumption that men and women will benefit from it equally. It does not take account of the particular needs of men and women who have experienced violence.
8	Trauma sensitivity	The particular **needs and characteristics of people who have experienced traumatic events** have been taken into consideration in the planning, implementation and evaluation of the measures. Retraumatisation or intensification of people's stress is avoided.	The measure does not take account of the particular needs and characteristics of people who have experienced traumatic events. Retraumatisation is liable to occur.
9	Do no harm/ conflict sensitivity	The do-no-harm principle is applied. Duplications and gaps in care provision are avoided. Potential **unintended negative effects** are considered, and it is made plain where these are thought likely to occur. Precautions are taken that **prevent/reduce the occurrence of undesired results** (e.g. strengthening of existing power structures, preference given to one group over others or failure to give equal treatment to unequal groups, various forms of discrimination).	The do-no-harm principle is not applied. No analysis of potential negative effects was carried out.
10	Monitoring & evaluation and flexible steering	Plans have been made for in-process **participatory monitoring** (e.g. regular feedback from the target groups, ongoing supervision of MHPSS staff, evaluation of results), which plays a part in steering the course of the project while taking account of lessons learned. Monitoring should be disaggregated according to gender, with the focus on particularly	No attention is paid to findings pertaining to negative consequences in crises or post-crisis situations that could affect the project (e.g. the fact that intimate partner violence in camps often increases).

[5] If up-to-date participatory MHPSS studies are already available in the envisaged intervention context, they should be used rather than being replicated, in order to protect the refugees from being over-researched.

No.	Principle	☺	☹
		vulnerable population groups. There is flexible scope for action to take account of individual **needs within the project context**.	There are no plans for reflections on the course of the project or on deviations from the intervention plan from input/feedback given by the target groups.
11	**Multi-dimensional approach**	A multi-level approach is used, in line with the IASC principles. The provision of services is **holistic** and encompasses the various needs of a heterogeneous population. Trauma-sensitive and conflict-sensitive basic services are provided, as well as accessible community services. Targeted counselling is offered for certain target groups, and specialised clinical treatment can be provided.	The measures are one-sided, consisting solely of specialised therapeutic services, for example, or only low-threshold, community-based services.
12	**Referral mechanisms**	**Detection/reference structures** are in place for severe clinical cases. Referrals can be made to clinical experts and other service providers. Consideration has also been given to social and community-based needs in clinical facilities.	The project does not include appropriate referral mechanisms should the need arise during project work.
13	**Support structures/ employee welfare**	**Support structures** are in place **for MHPSS staff**. Professionalism is improved through continuous reflection on the work. Burnout processes and secondary traumatisation are prevented by **organisational mental health measures**. Ideally, a package of measures is in place to maintain the staff's psychosocial health over the long term. Supervision and peer coaching are integrated into the project, as are organisational variables such as security of funding, occupational safety, recovery structures and security management.	There are no support structures. It is not clear whether provision has been made to maintain the mental health and professionalism of the MHPSS staff implementing the project. The project budget does not include funds to relieve the strain on staff.
14	**Professionalism**	The MHPSS staff implementing the project, preferably local, are verifiably **experienced, trained, supervised and culturally competent**.	An international, contextually alien team (often experts from a different culture or region) have been earmarked for implementation. Local personnel are insufficiently trained and supervised in MHPSS intervention.
15	**Exit strategy & sustainability**	The **sustainability** of the project is assured thanks to successive **handover** to local structures and actors from the target population. An **exit plan** for the project has been drawn up or is envisaged which counteracts long-term dependence on external financing.	This project has no exit strategy, and sustainable results cannot be guaranteed.

12. Further recommendations

As donors, it is advisable to take care that instructions to achieve rapid and visible results for large groups of refugees do not have a counter-productive effect on MHPSS quality. In the case of more specialised and target-group oriented services on layers 3 and 4 of the IASC pyramid it makes sense to exert as little time pressure as possible and to set the objectives in the medium to long term. A minimum period of three years should be allowed for MHPSS projects. Time and patience are essential in order to enable local ownership to take hold and thus ensure sustainability. This is also confirmed by the World Bank's 2016 study that looked into the effectiveness of psychosocial measures, among other things (1).

To make best use of the synergistic effect obtained from relieving difficult circumstances and rebuilding future prospects, projects that combine psychosocial interventions with income-generating measures are especially important. This applies in both directions: income-generating measures on their own are less effective than they are in combination with psychosocial measures (1).

One approach that is often chosen is to train local multipliers in as short a time as possible. This approach should be re-examined, however, to ensure that the multipliers are able to apply and test their still fragile knowledge and newly acquired skills to an adequate extent themselves before they are expected to operate as trainers. Longer-term mentoring, supervision and backup are crucially important in this connection.

It is advisable to integrate the psychosocial support services offered by development cooperation into existing local systems (schools, health, social services), and beyond that to avoid one-sided or exclusive support for any specific group of affected individuals. Measures should be designed such that the local population also benefits from them, not only the refugees. This creates broader acceptance, contributes to integration and reduces the potential for conflict between groups that consider themselves to be victims of injustice and violence but experience different degrees of recognition and international attention.

The intervention design of multi-ethnic and/or multi-confessional dialogue projects must not force survivors of violence to engage with perpetrators or opponents before the people affected feel ready for this and express a desire to do so.

Development cooperation must exercise care and regional balance in its operations so as not to exacerbate local and regional conflicts as a result of the particular focus of its support. One-sided assistance and advisory services run the risk of having a negative impact on the balance of internal political power and on tensions between various victim groups.

Development cooperation must not inadvertently enter into competition with local advisory and care services, nor must it neglect the longer-term building and strengthening of local, sustainable structures as a consequence of short-lived promotion of new, short-term projects that take the form of emergency assistance and are often inadequately aligned with local structures.

In interventions offering psychosocial support it should be borne in mind that many survivors of repeated extreme and multi-faceted violence have mobilised huge resources in order to survive, have formed networks based on solidarity and have developed collective coping strategies. Strengthening these collective approaches and linking them to local coping strategies appears to be a promising and potentially effective methodology. Offers of individual therapeutic measures must explicitly examine the risk that detaching victims from their collective protective networks and placing a culturally alien focus on 'healing' can produce negative results and weakens the sense of belonging to their social reference group.

Results-based monitoring for MHPSS measures is hugely relevant. Exclusively linear models (such as logframes) are of limited use for determining an improvement in mental health and psychosocial wellbeing. It is recommended that process-oriented, qualitative methods should be used to track positive changes and to identify negative, unintended results in good time and to counteract them.[6] In a process extending over several years, the IASC and the International Federation of Red Cross and Red Crescent Societies have developed reference frameworks for monitoring MHPSS measures that provide helpful guidance.

Finally, it is worth pointing out that as a consequence of the heightened media attention to psychological challenges and the willingness of national and international donors to provide MHPSS, crises and conflicts also present an opportunity to improve inadequate mental health and psychosocial care systems (29).

If you have any questions or suggestions relating to the guiding framework, please contact the head of the regional programme, Dr Judith Baessler (email: judith.baessler@giz.de; tel.: +962 (0) 777 171 115).

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[6] The monitoring of MHPSS measures will be discussed in more detail in a separate paper planned for a later date.

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