IASC

Inter-Agency Standing Committee
IASC Reference Group for Mental Health and
Psychosocial Support in Emergency Settings

COMMUNITY-BASED APPROACHES TO MHPSS PROGRAMMES: A GUIDANCE NOTE

INTRODUCTION

Community-based approaches to Mental Health and Psychosocial Support (CB MHPSS) in emergencies are based on the understanding that communities can be drivers for their own care and change and should be meaningfully involved in all stages of MHPSS responses. Emergency-affected people are first and foremost to be viewed as *active participants* in improving individual and collective well-being, rather than as passive recipients of services that are designed *for them* by others. Thus, using community-based MHPSS approaches facilitates families, groups and communities to support and care for others in ways that encourage recovery and resilience. These approaches also contribute to restoring and/or strengthening those collective structures and systems essential to daily life and well-being. An understanding of systems should inform community-based approaches to MHPSS programmes for both individuals and communities.

- **Individuals** are engaged in **interpersonal relationships** with family members, colleagues, friends and neighbours.

- Individuals are also part of **communities**. They can be members of political parties, congregations, women's and youth associations and interest groups. Such groups are embedded in **cultures** and social norms and subcultures with shared world views, beliefs, traditions, histories and customs and are subject to changes. Networks of relationships and community membership are fundamental in defining an individual's identity and contributing to well-being. They support people in acquiring knowledge, attitudes and skills, including on how to cope with impacts of crises, and provide protection and a sense of belonging. The communities around an individual support the many steps in a person's life that lead to responses to unexpected events; they can also sometimes be obstacles due to negative social norms (e.g. a GBV survivor might be rejected by her/his community, a child associated with an armed group might be rejected by her/his family, etc.). Communities also contain organizations and institutions such as schools, health centres, religious organizations and civil society organizations, which serve similar supportive functions for individuals, offering a sense of belonging, safety and protection.

- The community context is embedded within the larger **societal level** which involves higher level social, economic and political structures.

- All these networks of relationships have effects on individual well-being. Often these effects are positive and constitute important sources of protection and support. But these social networks can have negative effects, limiting freedom of choice, stigmatizing differences, discriminating against the outgroup, etc. These negative effects can be magnified by any types of crisis. **Analysing and understanding the effects of social groups and connections on individual well-being and striving to strengthen the positive effects and mitigate the negative effects are at the centre of community-based approaches to MHPSS**.

The strong link between the ways that humanitarian aid is delivered and the well-being of those who receive the aid is usually referred to the promotion of meaningful participation, the respect of religious and cultural practices and the empowerment of the ability of affected people to holistically promote their well-being. This is crucial for community-based approaches to MHPSS: in order to improve psychosocial well-being, **what** services are delivered is as important as **how** people are involved in the **process** of working towards improved well-being. This involvement can have different gradations, and consist of informing, consulting, involving, collaborating and empowering.

This guidance note comprises information already available in the Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings, and other sources, with an aim to frame and validate what most practitioners already know from their daily practice in a short reminder.

ETHICAL DILEMMAS AND PRACTICAL DIFFICULTIES

The process of implementing CB-MHPSS may lead to ethical dilemmas and practical difficulties that are inherent to activities that engage communities to a larger extent. Potential dilemmas and difficulties for humanitarian responses regard:

Balancing the need for comprehensive assessment and the need for rapid action: Establishing a CB MHPSS responses requires caution and awareness that community members themselves are always the first line of response in an emergency. Invariably, individuals, families and communities will respond in an emergency before any external support arrives. A CB MHPSS process aims to foster collaboration between knowledgeable community representatives and

experienced humanitarian professionals. Getting these types of programmes started can be time-consuming and there is often a concurrent need for rapid and at times immediate support to the affected population. It is therefore important to find the right balance between responding rapidly and engaging and consulting affected communities.

Being careful to avoid exacerbating marginalization/discrimination/ stigmatization. There are many possible ways in which exclusion can take place within a community. At times, paying close attention to one group of concern, can lead to the needs of another group of concern being overlooked or neglected, sometimes making people feel discriminated against. Marginalization can also be caused by drawing attention to survivors in certain circumstances, especially when their experiences are likely to attract social stigma. It is therefore important to be aware of community dynamics and power structures and to aim for an approach that is inclusive while also being responsive to the needs of different subgroups. A gender analysis can also be a powerful tool to identify power dynamics in a community. Programme methodologies may have to change to reach different subgroups, even if the outcome is the same. Examples include conducting awareness-raising sessions at household level and at a community centre to ensure that women, persons with disabilities or others with movement limitations outside of the home also have access to information. One should also be mindful of inadvertently reinforcing power imbalances or subverting existing power balances in a way that creates tensions and further oppression. Therefore, when providing humanitarian relief and facilitating community participation, it is critical to understand the local power structures and patterns of community conflict, to work with different subgroups and to avoid privileging particular groups.

Do Not Harm: When terrible things happen in a community, particularly following mass violence or during armed conflict, the existence and espousal of different narratives can intensify feelings of rage and hatred. Participatory needs assessments and tools can invite the above-mentioned feelings. In turn, these narratives can marginalize those with conflicting views or those who have family members on the "other side"; and may be used to organize retaliatory violence. It is important to be mindful of group composition (e.g. differences in gender, political affiliation) and the types of questions asked. The content of discussions needs consideration as does the most suitable time to carry out a focus group

discussion, separate discussions among specific groups (e.g. women only) or one on one (key informant) interviews.[1]

Respecting traditions and promoting change: Cultural traditions and identities are in a constant evolution. Some traditions entrench unequal power relations, or are a source of rights violations or incite social violence. As important as it is to support existing traditional support systems, community based MHPSS should also include actions that can shed light on harmful and exclusionary practices, thereby allowing positive traditional aspects to develop and negative ones to be left aside (Bragin, 2014). In the case of specific vulnerabilities, a MHPSS worker should exercise extra caution in identifying the most fruitful community-based mechanisms to activate; i.e. to provide care for GBV survivors; women's groups truly supporting gender equality are preferred to male-dominated civil society associations.

COMMUNITY-BASED APPROACHES TO MHPSS AS A PROCESS

Using community-based approaches to MHPSS is a process with different phases. In each of those phases minimum actions need to be taken to ensure that the programme is meaningfully community-based:

ASSESSMENT PHASE

1. **Use a participatory, gender and age appropriate contextual approach:** it is essential that the mental health and psychosocial support needs of affected populations are assessed in ways that involve community members. This is clearly defined in the Inter-Agency Standing Committee Guidelines on Mental

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1   About the 'Do no harm' approach and conflict see the following:
   • H. Haider (2014), *Conflict Sensitivity: Topic Guide.* Birmingham, UK: GSDRC, University of Birmingham.
   • M.G. Wessells, "Do no harm: Toward contextually appropriate psychosocial support in international emergencies" (2009). *The American Psychologist,* 64(8):842–854. Available in www.apa.org/about/awards/humanitarian-wessells.pdf.

Health Psychosocial Support in Emergency Settings.[2] Wherever possible, community members of all ages and sexes should be part of the assessment team. At the very least, assessment objectives, methods and priorities should be discussed with key community members. Custom-designed participatory assessment methods that consider the language and literacy barriers of some community members are to be preferred.[3] Particular care must be taken to ensure that local authorities, governments as well as community subgroups across age, gender and diversity spectra, are represented throughout the process, to the greatest extent possible.

2. **Identify risks as well as resources and strengths:** A CB-MHPSS assessment should identify mental health and psychosocial *problems* as well as safe and quality *resources and strengths*; including individual – family – community – traditional – religious – cultural coping mechanisms, social support mechanisms, community action and government and NGO capacities. It should include an inventory of resources, both present at the moment of the assessment as well as those that were present before the crises and could be reactivated. Negative coping mechanisms should also be identified to address them and not reinforce them.

3. **Share assessment results:** Review findings in conjunction with all involved in the assessment process including: NGOs, government, community and subcommunity representatives and clarify needs and available resources as well as obstacles, misperceptions or any issues of credibility related to the assessment. Share findings (e.g. as report, summary and/or presentation) in the local language and in culturally appropriate ways, when possible.

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2   See:
   - The Action Sheet 2.1, Conduct assessments of mental health and psychosocial issues in : IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC, 2007, pp. 38–45.
   - IASC Reference Group Mental Health and Psychosocial Support Assessment Guide, IASC, Geneva, 2013, p. 3.
3   See for example World Health Organization and United Nations High Commissioner for Refugees. *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings.* Geneva: WHO, 2012, tool 10, pp. 63–69.

PLANNING PHASE

It is necessary for all involved in providing CB-MHPSS to affected communities, to recognize that communities affected by emergencies have many inherent resources and capacities to help themselves. Affected communities' resilience, and the capacity of their institutions, should be respected and enhanced. Outside interventions should leverage and support existing resources and where necessary strengthen or activate them for effective self-help and institutional development.

1. **Prioritize problems and needs:** Following the gathering of information, problems and needs must be prioritized together with the target individuals and communities to determine a programme strategy. A discussion with the community on what may be feasible and a prioritization of issues to address can be necessary at this stage, and building a partnership with people of concern is as important as the resulting list of priorities.

2. **Jointly identify indicators:** Indicators help to measure success and must be identified at the start of the programme. Donor requirements and time constraints may result in tempting to hastily define indicators and select commonly used or general universal indicators of what psychosocial well-being entails. Using these, however, can risk missing important aspects of what matters the most for this population. Ideally, indicators should be designed together with the community.[4] The Inter-Agency Standing Committee's Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support Programmes in Emergency Settings includes suggested impact indicators for CB MHPSS programmes.[5] Designed for universal use, they require contextualization and definition of what they mean in a community. Since a sustainable impact also requires systemic and structural change at community and societal level. Indicators should be included that look not only at indvidual improvements but also at systemic effectiveness.

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4   M. Bragin (2014). "To be well at heart: Women's perceptions of psychosocial well-being in 3 conflict-affected countries – Burundi, Nepal, and Uganda", *International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict*, 12. 171–186; IFRC (2016), *Monitoring and Evaluation Framework for Psychosocial Programmes: Toolbox*, "Exploring Local Concepts of Well-being", Chapter 2.

5   Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings, *A Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings*, IASC, Geneva, 2017. https://interagencystandingcommittee.org/system/files/iasc_common_monitoring_and_evaluation_framework_for_mhpss_programmes_in_emergency_settings_2017.pdf.

3. **Avoid fragmentation:** Activities and programming should be designed in line with the MHPSS IASC Guidelines. The proliferation of stand-alone services, such as those dealing only with rape survivors or only with people with a specific diagnosis, such as PTSD, can create a highly fragmented care system and above all can lead to stigmatization and harm. Activities that are integrated into wider systems (e.g. existing community support mechanisms, formal/non-formal school systems, general health services, general mental health services, social services, etc.) tend to reach more people, are often more sustainable, and tend to carry less stigma and mitigate protection risks.

START-UP AND IMPLEMENTATION

1. **Resource mobilization:** The results of the assessment will indicate the areas that need to be addressed and the resources available to meet those needs. Humanitarian actors then need to analyse and decide with communities on which areas they can support, and work out to mobilize resources a) individual skills and expertise, since communities may include relevant specialists or professionals, or highly motivated individuals who have relevant capacities and abilities to be trained; b) social resources including families, community leaders, teachers and universities, women's groups, youth clubs, civil society organizations, and c) significant religious/spiritual resources including religious leaders, local healers, practices of worship and rituals.[6]

2. **Community mobilization and strengthening:** Efforts should be made inside and outside the community to involve its members in all discussions, decisions and actions that affect them and their future. As people become more involved, they are likely to become more hopeful, better able to cope, and to be active in rebuilding their own lives and communities (IASC 2007, action sheet 5.1). This involves establishing contact with community members and leaders, building an understanding of the social, gender and power dynamics, and bringing people together to agree on ways to address challenges. A general model which can be adapted to context includes, at the minimum, the following steps:[7]

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6   IASC MHPSS Guidelines 2007: Action sheet 5.2.
7   REPSSI – *"Mainstreaming Psychosocial Care and Support Facilitating Community Support Structures"*, p. 14–16 http://mhpss.net/?get=83/1305805326-mainstream_guides_emergency-community.pdf.

Step 1: From the assessment findings and priorities, select community and/or target population for your MHPSS programme.

Step 2: Whenever possible, identify multiple Community Support Structure (CSS), such as a youth group, or a volunteer group, a professional association, or a service user organization. If no CSS exist, consider supporting their creation (i.e. Child Protection Committees).

Step 3: Assess the perceived needs and capacities of the CSS.

Step 4: Development of an activity and/or capacity-building plan for a CSS.

Step 5: Facilitate Interactive Learning and Activity Sessions as well as ongoing support (e.g. technical, resources) with a CSS.

Step 6: End engagement with the CSS by planning for an exit strategy from the beginning (step1).

3. **Provide information:** Throughout implementation, tap into existing communication feedback and complaints mechanism to develop an easily accessible information and communication mechanism to ensure that everyone, including potentially marginalized groups, have access to information on assistance and other issues in line with the principles of AAP (Accountability to Affected Populations). For instance, use storyboards/images, verbal and audio mechanisms like radio or case stories, if literacy rates are low.

4. **Monitor, collect feedback and adjust activities:** Regular participatory monitoring is important because planning and implementation processes are rarely perfect and situations change constantly. This can be done in very simple ways, like feedback mailboxes, or more elaborated ones such as satisfaction surveys or feedback sessions. Safe mechanisms for enabling people of concern to present complaints to programme staff are important monitoring tools, including for those with low literacy levels, foreigners, children, or with disabilities.

5. **Facilitate meaningful participation of marginalized people:** Communities often include diverse subgroups with different agendas and levels of power. It is essential to avoid strengthening subgroups at the expense of others, and to promote the inclusion of people who are usually marginalized.

EVALUATION

1. **Share and discuss evaluation findings with the community:** Monitoring and evaluation refer back to the participatory assessments and first baseline for determining what is or is not working. As with assessments and mid-term reviews it is important to share and discuss findings, both to celebrate success and to determine whether activities have the intended effect. Existing methodologies could be used, such as 'Most Significant Change', which does not use pre-defined indicators and utilises the 'story' approach.

2. **Re-adjust goals and activities:** Use participatory methods such as discussions with community members to identify reasons why activities may not have had intended effects; or if they have, whether some groups have been missed and how they could be reached. Try to speak with community members who have NOT been involved or attended activities to explore and better understand the barriers to their participation. Use this as a basis for adapting plans, goals and activities.

ETHICAL MINIMUM GUIDELINES FOR COMMUNITY-BASED MHPSS IN EMERGENCY SETTINGS

Applying ethical principles to Community-Based MHPSS in Emergency Settings is necessary to avoid potentially risky or bad practices and keep communities safe. Generally, ethical guidelines in mental health and psychosocial support work are governed by two areas of consideration – that of non-maleficence or "do no harm", such as the principle that harm should not be disproportionate to the benefit of the intervention, and those relating to the quality and the effectiveness of intervention (Wessels, 2009; Shah, 2011). Ethical standards for humanitarian programmes are defined and enshrined in a series of guidelines, including the IFRC Code of Conduct[8] and the Core Humanitarian Standard.[9] More specific to psychosocial support programmes in emergencies are the 6 core principles of the IASC Guidelines on MHPSS.[10] In particular, when promoting a CB approach to MHPSS it is paramount that:

● The needs, best interests and resources of the emergency affected population must be of primary consideration when planning and implementing interventions, not only the agenda of the provider or donor.

● Care must be taken that all those engaged in any aspect of CB MHPSS are aware of the ethical prohibition against sexual exploitation and abuse, sexual activity with programme participants or any other potentially exploitative "dual" relationships.[11]

● Confidentiality must be maintained. This includes providing services in such a way that vulnerable groups can receive services without being specifically identified by their vulnerabilities.

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8   International Federation of Red Cross (IFRC), *Code of Conduct in Principles of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Response Programmes*, 2007.
9   Core Humanitarian Standard on Quality and Accountability in *The Sphere Handbook*, CHS, 2018.
10 IASC Guidelines on MHPSS in Emergency Settings, Core Principles, IASC (2007), Geneva, 2007, p. 9.
11 See the UN website on Preventing Sexual Exploitation and Abuse (PSEA): www.un.org/preventing-sexual-exploitation-and-abuse/content/tools.

- All forms of racial, sexual, linguistic or religious discrimination should be avoided when providing MHPSS to communities, and suport should be granted to all in a community without leaving anyone behind, including indigenous people, migrants, minorities, people with disabilities, regardless of the person's gender orientation or identity.

- Practitioners should have the capacity to respect local cultures and values and to adapt their skills to suit local conditions.

- Potentially negative effects of programming should be discussed with the community early on and monitored throughout to address them.

CONCLUSIONS

The understanding of how community components influences people's psychosocial response to crises is fundamental in devising effective and meaningful MHPSS programmes in those circumstances. A Community-Based MHPSS approaches put individuals, communities and social systems at the centre of the intervention, in all phases of the response. It starts with community engagement and involvement in the identification and prioritization of their own needs, continues with mapping local resources and mobilizing them in all phases of the response and implementation, and ensuring ongoing collection of communities' feedback and evaluation for participatory programme revision, modification and improvement.

A CB MHPSS programme is built on the awareness that communities are comprised of individuals of different ages and gender identities, of subcommunities, and subcultures and have considerable diversity and power dynamics. Putting communities at the centre of humanitarian MHPSS response enables self-efficacy, reducing the impact of what is "delivered" and enhancing the significance of what is "built" together, in line with the main principles of the IASC Guidelines on MHPSS in Emergency Settings.

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