IASC Inter-Agency Standing Committee

Technical Note

LINKING DISASTER RISK REDUCTION (DRR) AND MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS)

Practical Tools, Approaches and Case Studies

IASC Reference Group on Mental Health and Psychosocial Support

March 2021

Endorsed by IASC Operational Policy and Advocacy Group (OPAG)

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Contents

Acknowledgements

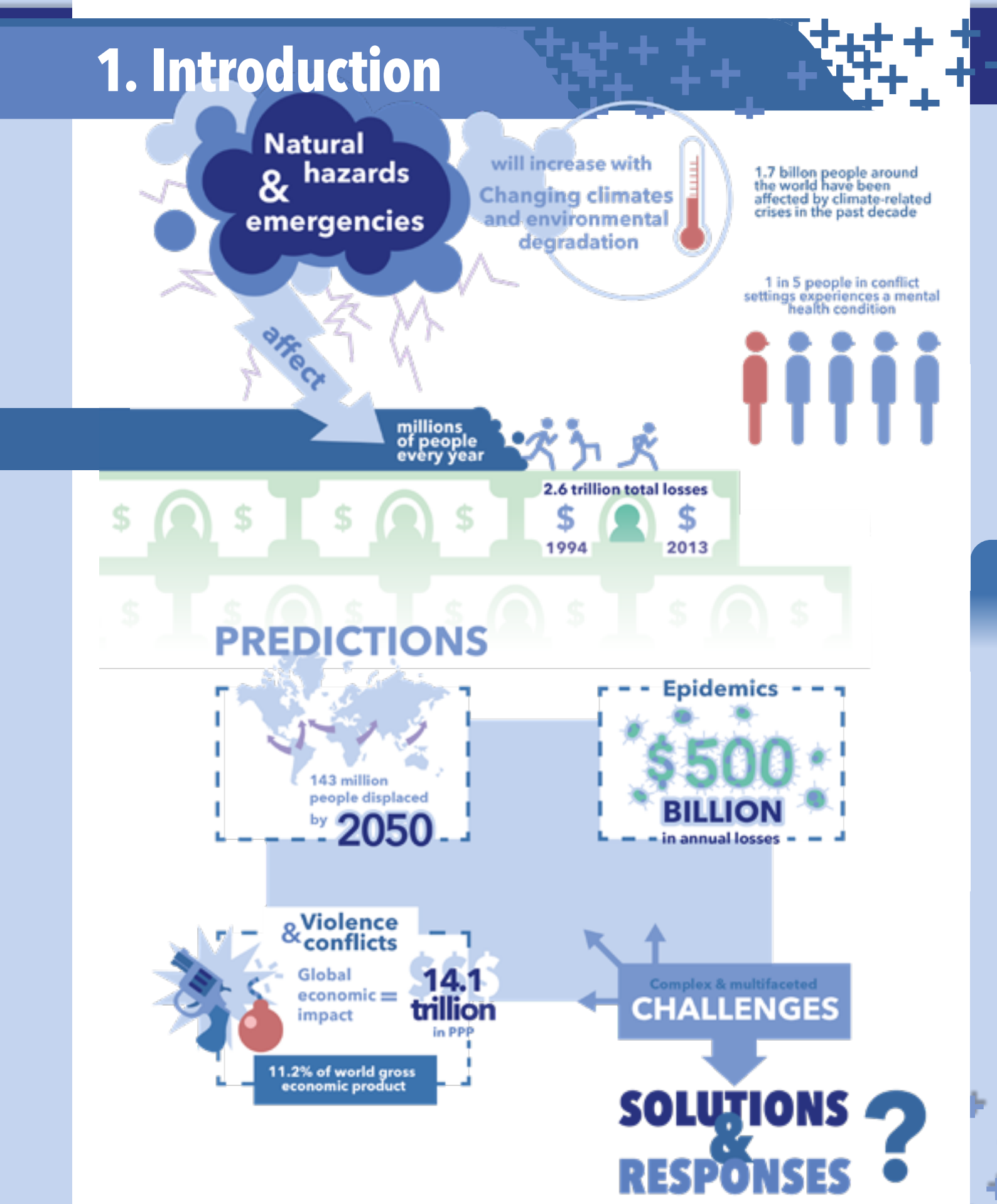
The content of this publication was developed by the IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. The development of the publication was managed by the World Health Organization (WHO) and overseen by a thematic working group of member agencies of the Reference group, including CBM International (CBM), International Medical Corps (IMC), IsraAid, Médecins du Monde (MdM), MHPSS.net, the MHPSS Collaborative, Save the Children and the United Nations Children's Fund (UNICEF).

Through consultation and peer review processes, valuable inputs to this publication and the common framework were also received from IASC Reference Group agencies and from other agencies, including the Caribbean Development Bank (CBD), the National Institute of Mental Health and Neurosciences, India (NIMHANS) and the United Nations Office for Disaster Risk Reduction (UNDRR), as well as many individual practitioners, experts and academic partners.

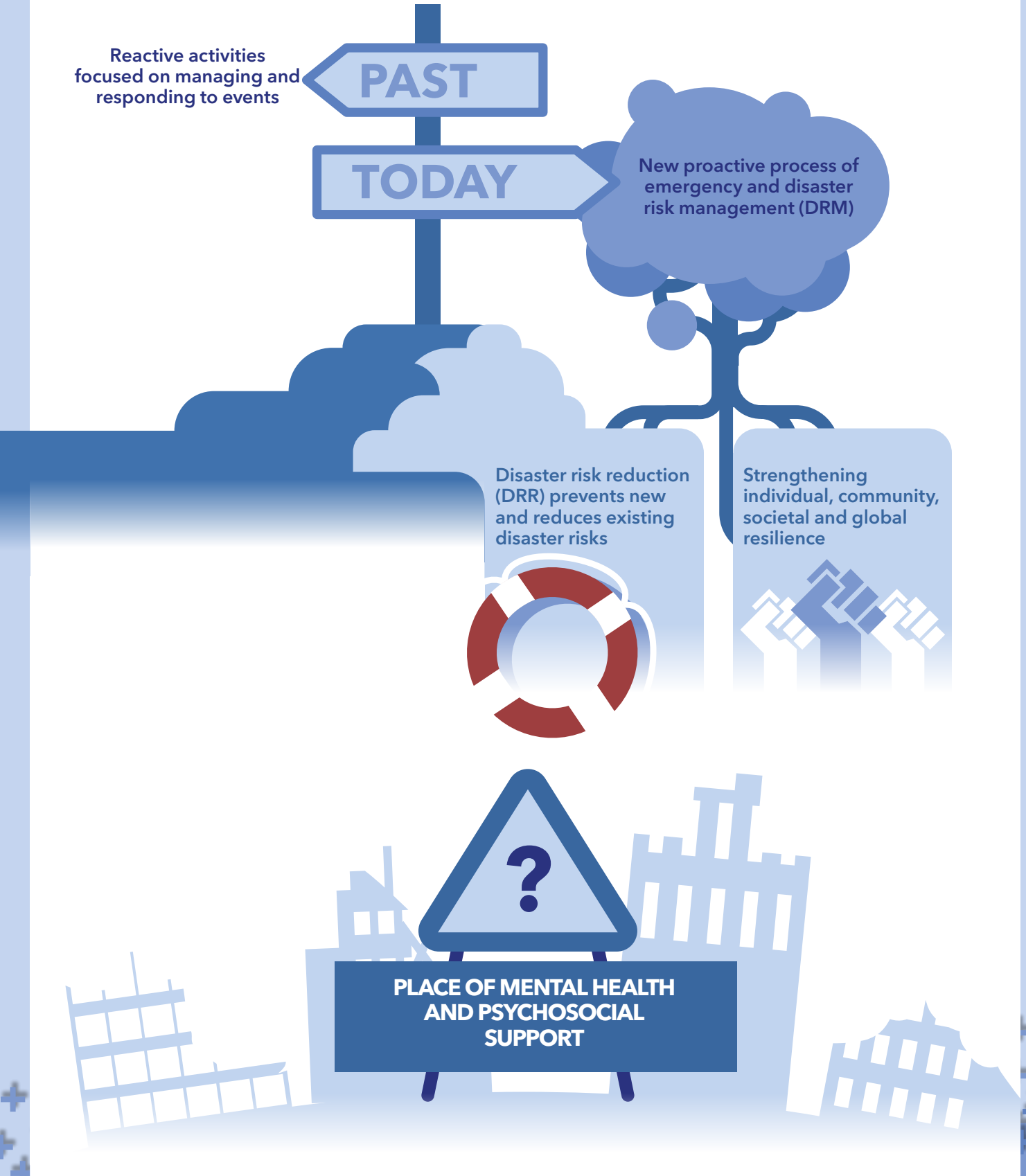
Abbreviations

BBB	Building back better
CBO	Community-based organization
CSO	Civil society organization
DAISY	Digital Accessible Information System
DALYs	Disability-adjusted life years
DiDRR	Disability-inclusive disaster risk reduction
DRM	Disaster risk management
DRR	Disaster risk reduction
ECHO	European Civil Protection and Humanitarian Aid Operations
EWS	Early warning system
Health EDRM	Health Emergency and Disaster Risk Management
IASC	Inter-Agency Standing Committee
IASC RG	IASC Reference Group on MHPSS in Emergency Settings
IDRR	Inclusive disaster risk reduction
M&E	Monitoring and evaluation
mhGAP	Mental Health Gap Action Programme
MHPSS	Mental health and psychosocial support
NDMA	National disaster management agency
PFA	Psychological first aid
ToT	Training of trainers
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNDS	United Nations development system
WiA	Words into Action

1. Introduction



THE APPROACH TO HAZARDOUS EVENTS



IMPORTANT OPERATIONAL DEFINITIONS

Recently, the approach to hazardous events has undergone a considerable shift, away from reactive activities focused on managing and responding to events and towards a more proactive process of emergency and **disaster risk management (DRM)**. The ultimate goal of this shift in focus is to prevent new and reduce existing disaster risks, a process known as **disaster risk reduction (DRR)**, while strengthening individual, community, societal and global resilience.

Hazardous events and emergencies continue to dramatically affect millions of people every year, with natural hazards causing thousands of deaths and US$ 2.6 trillion in total losses between 1994 and 2013 (CRED, 2015). Compounded by the developing global climate and environmental emergency, these damages are likely to increase, with an average of 25 million displaced annually by sudden-onset natural disasters since 2008 (Internal Displacement Monitoring Centre/Norwegian Refugee Council, 2016) and predictions of more than 143 million people being forced to move/migrate by 2050 due to climate-related risks in just three regions – Latin America, South Asia and sub-Saharan Africa (Rigaud et al., 2018). Meanwhile, epidemics were estimated to result in annual losses of approximately US$ 500 billion, 0.6% of annual global income (Fan, Jamison & Summers, 2018), even prior to the COVID-19 pandemic, and these losses may be exacerbated by continued environmental degradation (Settele, Diaz, Brondizio & Daszak, 2020). Violence and conflict have resulted in further devastation, with a global economic impact of $14.1 trillion in purchasing power parity (PPP), equivalent to 11.2% of the world's gross economic product, in 2018 alone (Institute for Economics & Peace, 2019). Taken together, hazardous events and emergencies of all kinds present a complex and multifaceted set of challenges that require unique solutions to address their effects. Recently, the approach to hazardous events has undergone a considerable shift, away from reactive activities focused on managing and responding to events and towards a more proactive process of emergency and **disaster risk management (DRM)**. The ultimate goal of this shift in focus is to prevent new and reduce existing disaster risks, a process known as **disaster risk reduction (DRR)**, while strengthening individual, community, societal and global resilience. The Sendai Framework for Disaster Risk Reduction 2015–2030 has reinforced the move

towards proactive measures, while the World Health Organization (WHO)'s recently published Health Emergency and Disaster Risk Management (Health EDRM) Framework describes the many capacities and functions in health and other sectors at all levels of society and across phases that are required to reduce health risks.

Despite these clear shifts in the risk-informed sustainable development and emergency management fields and the explicit inclusion of psychosocial support in both the Sendai and WHO Health EDRM Frameworks, the degree to which the mental health and psychosocial support (MHPSS) field has been integrated with or has followed this trend towards proactive action is relatively limited (Gray, Hanna & Reifels, 2020). Traditionally, MHPSS services have been focused in the areas of response and recovery. In the past decade, experience from these activities has suggested a need for guidance on MHPSS programming from the perspective of reducing risks in advance of events and linking these approaches with response and recovery actions aligned with DRR principles. Therefore, this technical note was commissioned by the Inter-Agency Standing Committee Reference Group on MHPSS in Emergency Settings (IASC RG, co-chaired by WHO and the International Federation of Red Cross and Red Crescent Societies (IFRC)) in order to design a replicable model and a set of tools for preparing MHPSS services linked with DRR. The intention of this effort was in part to expand the Building Back Better (BBB) approach (WHO, 2013) to include the notion of "building better before", thereby reducing risk from local to global levels, while strengthening the humanitarian and development nexus. This technical note is informed by a prior mapping exercise and literature review that identified current practices in integrating MHPSS and DRR as well as gaps in this integration (Gray, Hanna & Reifels, 2020) and is designed according to an iterative review and consensus-building process. It outlines the rationale, actions, indicators, tools and terminology to foster joint MHPSS-DRR integration and programming.

Purpose of this document and it's target audience

This *Technical Note on Disaster Risk Reduction (DRR) and Mental Health and Psychosocial Support (MHPSS): Practical Tools, Approaches and Case Studies* was developed to assist humanitarian aid, development and disaster risk management organizations, national and local governments and community actors within and across sectors with the delivery of a priority set of actions to reduce suffering and improve mental health and psychosocial well-being through integration with risk management perspectives and approaches that link prevention, preparedness, response and recovery. Additionally, it was designed to assist governmental actors, domestic sources of financing and donors in understanding and supporting activities focused on MHPSS as part of DRR and sectoral programmes. It was developed in concordance with and was inspired by WHO's Health EDRM Framework and the United Nations Office for Disaster Risk Reduction (UNDRR)'s Words into Action (WiA) guidelines for the many aspects of implementing the Sendai Framework for Disaster Risk Reduction 2015–2030. Further guidance on implementing DRR as part of humanitarian action can be found in the UNDRR Recommendations for the Humanitarian Programme Cycle (UNDRR, 2020).

It must be stated that this technical note is not intended to serve as a universal approach and should instead be used as a guide that requires local and contextual adaptation. Furthermore, the elements it contains need to be implemented through collaboration between a number of stakeholders and with local individuals and communities. No single agency or actor can be expected to implement all of the actions discussed in this technical note. Potential stakeholder roles and responsibilities are listed below in Table 1.

Recommended actions and indicators begin on p.16 and practical implementation tools on p.24, while case studies and lessons learned begin on p.28.

TABLE 1: POTENTIAL STAKEHOLDER ROLES AND RESPONSIBILITIES

STAKEHOLDER	POTENTIAL ROLES AND RESPONSIBILITIES
AT-RISK AND AFFECTED PEOPLE	• Taking a leading role in identifying local risks, needs and capacities and working, in collaboration with governmental and non-governmental actors, to inform, develop and engage in risk management efforts. • Promoting acknowledgement and awareness of local mental health and psychosocial well-being issues and raising awareness to help integrate these efforts within DRM approaches and actions.
COMMUNITY-BASED ORGANIZATIONS (CBOS)	• Guiding hazard identification, local capacity assessment, development of localized risk management strategies and ownership, and implementation of prevention, preparedness, response and recovery efforts. • Creating enabling environments for particularly vulnerable groups and empowering them to take a leading role.
ORGANIZATIONS FOR PEOPLE LIVING WITH DISABILITIES	• Tracking people living with disabilities in their localities and sharing information widely with relevant stakeholders to help provide safe environments and increase resilience, including coordinating mapping for inclusive evacuation, early warning and search and rescue efforts. • Establishing strong linkages with governmental and nongovernmental actors and leading advocacy at different levels to make policies and local social protection measures inclusive for persons with psychosocial disabilities.
YOUTH GROUPS AND CIVIL SOCIETY ORGANIZATIONS (CSOS)	• Advocating for community commitment, policy and action at multiple levels. • Engaging actively as leaders in identifying local risks and planning for and implementing MHPSS in sectoral and multisectoral DRM plans.
LOCAL AND NATIONAL GOVERNMENT	• Committing to the development of national and local DRR strategies or platforms aligned with UNDRR's WiA guidelines, including plans to implement climate change mitigation and adaptation actions. • Allocating necessary funding, resources and supports to implement these actions.
NATIONAL AND LOCAL DRR PLATFORMS AND DISASTER MANAGEMENT AGENCIES [1]	• Integrating mental health and psychosocial well-being and DRM into relevant policy, planning and coordination. • Ensuring that MHPSS actors and agencies are actively involved in all aspects of DRM and that DRR experts are included in the development of MHPSS policies and strategies.
MINISTRIES RESPONSIBLE FOR ADDRESSING CLIMATE AND ENVIRONMENTAL CRISES	• Engaging in collaboration with DRM agencies to implement climate change mitigation and environmental protection and to reduce duplication. • Including diverse stakeholders, among them MHPSS actors, in the design and implementation of climate change mitigation and environmental protection measures.

1. National disaster management agencies (NDMAs) and the functions typically handled by them can be found within a variety of government ministries, agencies and offices, depending on the country. NDMAs or related functions are most commonly part of the civil protection agency, national DRR agency, environmental protection agency, ministry of internal affairs, ministry of planning and development or office of the prime minister.

TABLE 1: POTENTIAL STAKEHOLDER ROLES AND RESPONSIBILITIES

STAKEHOLDER	POTENTIAL ROLES AND RESPONSIBILITIES
MINISTRIES OF HEALTH, EDUCATION, WELFARE OR SOCIAL SERVICES, AND FINANCE	• Engaging in advocacy for mental health and psychosocial well-being and DRR perspectives both inside and outside of the health sector and across other sectors. • Designating a focal point (or unit) for MHPSS, as outlined in WHO's Health EDRM Framework (2019), to coordinate with larger risk management efforts and NDMA coordination mechanisms, other agencies and actors, ministries, civil society and the private sector.
HEALTH, EDUCATION, WELFARE AND SOCIAL SERVICES SECTOR AGENCIES AND PRACTITIONERS	• Ensuring the necessary consideration and inclusion of aspects of mental health and psychosocial well-being in all-hazards approaches to health emergency and disaster risk management within and across sectors.
PRIVATE SECTOR	• Engaging in efforts to mobilize and raise awareness with respect to DRR and the integration of MHPSS. • Sharing knowledge, expertise and resources and encouraging innovation for advancing DRM efforts.
INTERNATIONAL AGENCIES AND ORGANIZATIONS	• Providing financial, technical and human resources support to MHPSS-DRR efforts through capacity development, guidance and support for implementation. • Raising awareness and mobilizing support through established and emerging partnerships and collaborations to support whole-society and cross-sector investment and implementation.
UNIVERSITIES AND RESEARCHERS	• Providing guidance and support for obtaining funding, developing programming consistent with evidence, testing its implementation and effectiveness at all levels, and disseminating knowledge to the wider global community.
MEDIA AGENCIES AND JOURNALISTS	• Providing responsible media coverage of traumatic events in line with best practice recommendations.[2] • Disseminating accurate information about disaster risk, including climate change and environmental degradation risks, and raising awareness of the importance of investing in DRR.
AGENCIES INVOLVED IN PHYSICAL (RE)CONSTRUCTION	• Considering the mental health and psychosocial needs of individual and community recipients as well as of agencies and actors involved in reconstruction and rebuilding.
EARLY WARNING SYSTEMS (EWS)	• Engaging a wide and diverse range of stakeholders and partners to develop comprehensive EWS that include both technical (e.g. cell-phone alerts) and traditional or locally tailored methods of warning. • Empowering people living with disabilities and particularly vulnerable groups to lead in the development of these systems.

2. Kawamoto, K. Best Practices in Trauma Reporting: Ideas and insights from award-winning newspaper articles. Dart Center for Journalism & Trauma. 2005 (https://dartcenter.org/sites/default/files/da_best_practices_0_1.pdf).

Mental health and psychosocial impacts of emergencies

Individuals and communities affected by hazardous events, including disasters, react in diverse ways, from relatively transient and minor stress reactions to significant distress and psychosocial impairment. Additionally, social stigma can lead to further stress for those affected (e.g. individuals who test positive during disease outbreaks) as well as those who support affected persons (e.g. frontline health care workers providing care during a disease outbreak). Fortunately, the majority of stress reactions are likely to resolve quickly when individuals are able to access social supports and re-establish community networks. However, these protective factors may be limited during an emergency and some individuals may experience new or worsened mental health conditions, as shown in Table 2.

TABLE 2: WHO PREVALENCE ESTIMATES FOR MENTAL HEALTH CONDITIONS IN CONFLICT-AFFECTED POPULATIONS

	POINT PREVALENCE, ADJUSTED FOR COMORBIDITY (95% UNCERTAINTY INTERVAL)
SEVERE (e.g. psychosis, severe depression, severely disabling form of anxiety condition)	**5.1% (4.0–6.5)**
MODERATE (e.g. mild and moderate forms of depression and anxiety conditions, including mild and moderate post-traumatic stress disorder (PTSD), substance use problems)	**4.0% (2.9–5.5)**
MILD (e.g. mild anxiety, mild PTSD, mild depression)	**13.0% (10.3–16.2)**
TOTAL	**22.1% (18.8–25.7)**

Source: Charlson, van Ommeren, Flaxman, Cornett, Whiteford & Saxena (2019).

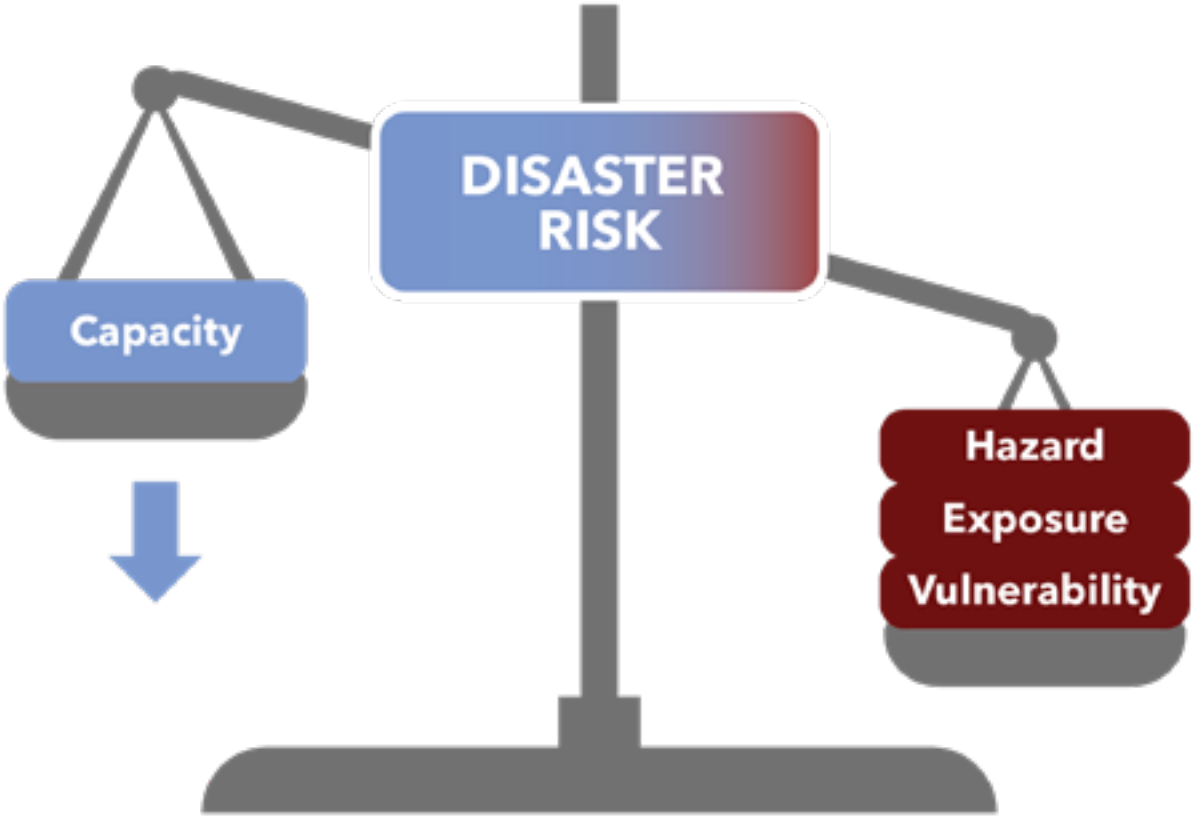
There is a clear and significant need for the integration of MHPSS and DRR practices in order to reduce the risks of these problematic mental health and psychosocial outcomes and to increase prevention and preparedness for and resilience to hazardous events. When mental health and psychosocial well-being are integrated with DRR perspectives, both those who are affected and those who manage the risks are more likely to be resilient, engage actively in prevention, preparedness, response and recovery, and work to re-establish societal functioning. However, to date, MHPSS and the broad spectrum of DRR, especially the focus on prevention and preparedness, have been infrequently linked.

Linking MHPSS and DRR

Many prevailing social and environmental factors – such as poverty, inequality, human rights issues, poor governance, social exclusion, violence and conflict, epidemics, climate crises and environmental degradation – greatly increase the likelihood and the impacts of emergencies. However, scientific evidence and practical knowledge demonstrate that, adequately applied, DRR practices can promote resilience and mitigate adverse events and consequences.

Defining DRR: The overarching intention of DRR is defined in the Sendai Framework as "the substantial reduction of disaster risk and losses in lives, livelihoods and health and in the economic, physical, social, cultural and environmental assets of persons, businesses, communities and countries" (UNDRR, 2015).

FIGURE 1: DETERMINING DISASTER RISK

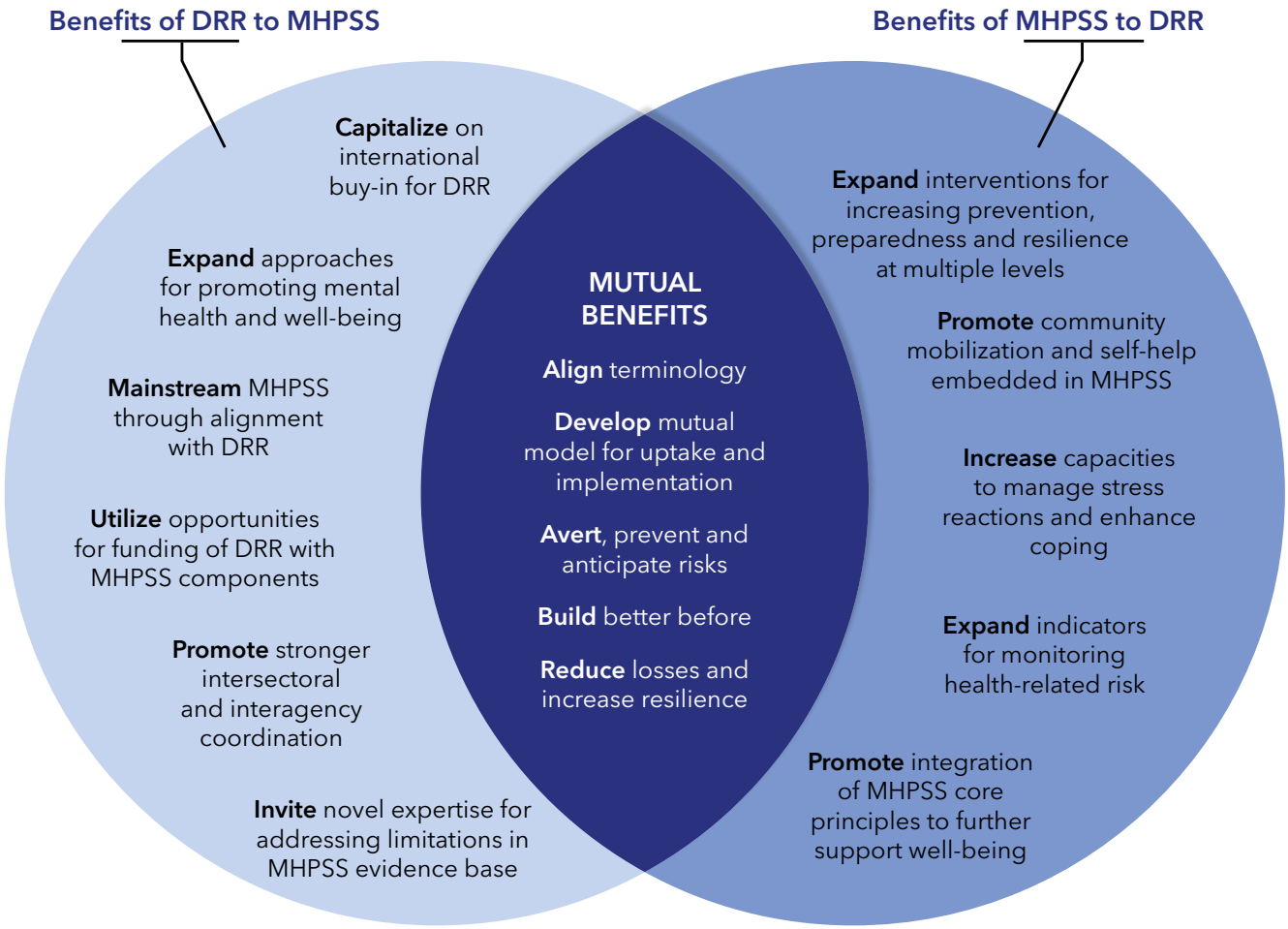


Source: Figure adapted from Peters (2018).

In describing disaster risk, vulnerability includes "the conditions determined by physical, social, economic, and environmental factors or processes which increase the susceptibility of an individual, a community, assets, or systems to the impacts of hazards" (UNGA, 2016). Pre-existing mental health conditions, psychosocial stressors, violence, conflict, outbreaks of disease, environmental degradation, poverty and other social determinants can create vulnerabilities.

Benefits of linking MHPSS and DRR: Strong arguments have been made for linking MHPSS with DRR efforts and for shifting paradigms in the field of MHPSS towards risk reduction generally. However, challenges exist in building consensus on effective strategies for reducing MHPSS risks, including the limitations of evidence for many approaches commonly employed throughout the MHPSS field (e.g. Dieltjens et al., 2014), as well as slower uptake and recognition of evidence-based MHPSS approaches (see Murray et al., 2014; Ventevogel, van Ommeren, Schiperoord & Saxena, 2015; Jordans, Pigott & Tol, 2016). Nonetheless, a number of benefits can be gained in both the MHPSS and DRR fields through such integration. When MHPSS and DRR are integrated, communities are more likely to be resilient and better able to engage in prevention, preparedness, response and recovery activities. This integration is beneficial for both fields. For instance, DRR can benefit from MHPSS being explicitly incorporated within universal health coverage, health security, and social protection mechanisms and safety nets in order to promote well-being and reduce distress while ensuring access to crucial and life-saving social protections and health services. Similarly, MHPSS programmes may benefit from a longer-term sustainability perspective by incorporating DRR actions to prevent and prepare for future emergencies and to build back better in response and recovery. These potential benefits are outlined in Figure 2.

FIGURE 2: BENEFITS OF LINKING DRR AND MHPSS



Special considerations in linking MHPSS and DRR

The following sections briefly discuss a selection of specific considerations relevant to MHPSS and DRR. These topics were identified as essential elements in linking the two sectors during expert consultations in the preparation of this document. Other topics may also be relevant and may require unique consideration beyond what is described here.

Reducing MHPSS risks before, during and after disease outbreaks, including epidemics and pandemics: The global COVID-19 pandemic has again highlighted the world's vulnerability to disease outbreaks and communicable diseases. These biological hazards can result in substantial loss and can present numerous risks if not prepared for effectively. In any outbreak, mental health and psychosocial well-being may suffer distinctive impacts from the unique stress of the situation, from the disruption of social services and economic breakdown and from the necessary protection measures that must be taken to reduce the spread of the disease. However, a number of actions can be taken to ensure access to social services and social protection and to support mental health and well-being during pandemic outbreaks.[3] For instance, the UN Framework for the immediate socio-economic response to COVID-19 provides guidance on five streams of work to save lives, protect people and rebuild better.[4] Furthermore, many approaches discussed in this technical note, such as ensuring a whole-of-society approach, integration of MHPSS into existing health care and response structures, and widespread capacity development, will also increase resilience and reduce the risk of negative mental health outcomes during pandemics (see Appendix C for an overview of the flow from the UN socioeconomic framework streams of work to MHPSS domains of action). In addition to these actions, a number of key considerations can be taken into account to reduce risk and increase resilience across the phases of a disease outbreak. The discussion of each of these actions is beyond the scope of this technical note; however, numerous resources for guiding response to the COVID-19 pandemic have been developed.[5-8]

Climate crisis, environmental degradation, MHPSS and DRR: Climate change and variability and environmental degradation are recognized by the Sendai Framework as being among the many drivers of disaster risk. Likewise, climate change and environmental degradation are recognized as key humanitarian problems by the IASC, and countries everywhere are facing compounded risks from both the ongoing climate and environmental crisis and the COVID-19 pandemic (see "IASC Key Messages" below). Generally, the mental health and psychosocial risks and impacts of a changing climates have been relatively understudied. However, an increasing focus on the relationships between health and mental health impacts of climate-related events, such as that provided by the 2015 Lancet Commission and the later Lancet Countdown (Watts et al., 2018), has highlighted many of the risks posed by a changing climate and the importance of paying increased attention to managing these mental health dimensions. A developing consensus among climate scientists indicates that while the long-term risks and impacts on mental health and well-being are unknown, changing climates, environmental degradation and other related hazards are almost certain to exacerbate risk factors for mental health problems and psychosocial distress, the impacts of which can further increase the vulnerability of an individual or a community. Therefore, preventing, preparing for and responding to these effects must also be considered within the linkage of DRR and MHPSS.

IASC key messages on climate change, humanitarian action and COVID-19

CHALLENGES	HOW TO MOVE FORWARD
• We cannot afford to divert attention from the growing climate crisis. • We face compounded risks from the ongoing climate crisis and the COVID-19 pandemic. • Climate change is already having massive impacts. • We are only as strong as our weakest links, and we will get nowhere without solidarity.	• Empower and invest in local action. • Invest in climate and disaster risk management. • Build a greener, more resilient future to promote recovery from the pandemic. • Prevent infectious diseases through environmental protection and climate change mitigation and adaptation.

3. IASC Reference Group on MHPSS in Emergency Settings. Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19. 2020 (https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/interim-briefing).
4. United Nations Sustainable Development Group. A UN framework for the immediate socio-economic response to COVID-19. 2020. (https://unsdg.un.org/resources/un-framework-immediate-socio-economic-response-covid-19).
5. IASC. COVID-19 Outbreak Readiness and Response. (https://interagencystandingcommittee.org/covid-19-outbreak-readiness-and-response)
6. Mental Health Innovations Network. Resources for mental health and psychosocial support during the COVID-19 pandemic. (https://www.mhinnovation.net/collaborations/resources-mental-health-and-psychosocial-support-during-covid-19-pandemic).
7. MHPSS.net. MHPSS.net Tool Kit for COVID-19 Response Version 2. (https://app.mhpss.net/toolkit4covid19).
8. WHO. Mental Health & COVID-19. (https://www.who.int/teams/mental-health-and-substance-use/covid-19).

Inclusive DRR: In addition to these considerations, prevention and preparedness are important for all. However, people in particularly vulnerable situations, such as those living in poverty or as members of at-risk groups (e.g. people with pre-existing mental health conditions, women or children, migrants or displaced people), are more likely to experience detrimental outcomes and to have different support needs. People or communities who are excluded for more than one reason are particularly at risk – for example, if they are excluded because of gender, caste/ethnicity, sexuality, age or disability or underlying health condition. Moreover, as stress increases in times of emergency, so do rates of interpersonal violence, particularly towards these vulnerable persons. It is therefore important to consider the needs of these groups by ensuring that they can prepare appropriately and are properly considered in planning and response through inclusive DRR (IDRR) approaches that leverage MHPSS in order to protect those at risk. DRR as a field is supported by decades of evidence and experience in inclusive and participatory approaches to engaging communities in risk assessment, planning, and decision making. Throughout this technical note, it is crucial to consider inclusive approaches to building resilience in relation to the mental health and psychosocial needs and resources of particular groups, such as people with pre-existing disabilities, women or children, while also considering IDRR practices for people with more profound mental health problems and psychosocial disabilities. Further information and step-by-step practical guidance on IDRR can be accessed through CBM Global's Inclusive DRR Hands-On Tool, an app designed using progressive web app technology, which is available through standard website and smartphone apps.[9]

Article 11 of the UN Convention on the Rights of Persons with Disabilities (UNCRPD), which focuses on situations of risk and humanitarian emergencies, calls for States Parties to undertake "all necessary measures to ensure the protection and safety of persons with disabilities in situations of risk, including situations of armed conflict, humanitarian emergencies and the occurrence of natural disasters". As with all other parts of the UNCRPD, the goal is to ensure equal access to rights for all. This has been recognized in the major conventions related to DRR, including the Sendai Framework (United Nations University et al., 2015). Likewise, the following key principles should be considered in any action resulting from this technical note:[10]

1. Ensure that DRR policies and programmes always include disability and related mental well-being as a priority and that inclusion is mainstreamed in all parts of frameworks and guidelines.

2. Add targets and indicators of inclusion, for example by disaggregating data to include disability (including access to mental health and psychosocial well-being) in DRR.

3. Include people living with disabilities, including psychosocial disabilities, in decision-making and design, planning and implementation. In particular, organizations for people with disabilities, family members and caregivers are a key resource.

4. Ensure that the participation of people with disabilities, and activities promoting inclusion, in all parts of the DRR process – prevention, preparedness including planning, response and recovery (including review and evaluation) – are mainstreamed across sectors.

9. The CBM Inclusive DRR Hands-On Tool can be accessed at: (https://idrr.cbm.org/en/)
10. Taken from: Assisting People with Disabilities in Case of Disaster. European Network for Psychosocial Crisis Management, 2017. (http://www.cop.es/uploads/PDF/ASSISTING-PEOPLE.pdf.)
For further guidance, please see: WHO. Guidance note on disability and emergency risk management for health. 2013 (https://www.who.int/publications/i/item/guidance-note-on-disability-and-emergency-risk-management-for-health).

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2. Recomended actions (matrix)

The following matrices are provided as a common set of priority actions to foster integrated MHPSS and DRR programming in alignment with the four priorities set out in the Sendai Framework (see Table 3) as well as with the overall goal, outcomes and indicators of the Framework for Mental Health and Psychosocial Support Programmes in Emergency Settings.[11] There is no expectation that every initiative will include each and every action or monitor every indicator listed. Instead, these may be considered within the broader context of frameworks previously mentioned and specifically tailored to each setting. Finally, it must be noted that while the Sendai Framework places responsibility on national government, local individuals and communities must be supported as primary leaders and stakeholders. Similarly, MHPSS-DRR actions will require cross-sectoral approaches.

TABLE 3: SENDAI FRAMEWORK PRIORITIES

Sendai Framework priority	Domain of action
Priority 1: Understanding disaster risk	Information gathering and management
	Risk detection and communication
Priority 2: Strengthening disaster risk governance	Policies, strategies, legislation
	Human resources
	Monitoring and evaluation (M&E)
Priority 3: Investing in DRR for resilience	Financial resources
	Building better before
Priority 4: Enhancing disaster preparedness for effective response and to "Build Back Better" in recovery, rehabilitation and reconstruction	Preparedness
	Coordination
	Response and recovery
	Building back better

11. Available from: https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-common

ACTIONS LINKING MHPSS AND DRR

OVERALL GOAL: Reduce suffering, improve mental health and psychosocial well-being and increase resilience

SENDAI PRIORITY 1: UNDERSTANDING DISASTER RISK

Outcome	Activities
Increased access to information and understanding of potential hazards and risk management capacity	Conduct multi-hazard risk assessments to identify and analyse emergency risks for hazardous events at local, subnational and national levels in line with UNDRR's WiA guidelines for national disaster risk assessment and WHO's Health EDRM Framework.
	Design and implement disability-, gender- and age-sensitive MHPSS assessments before, during and after emergencies, using for example WHO and UNHCR's toolkit for assessing mental health and psychosocial needs and resources (WHO & UNHCR, 2012) and considering necessary adaptations (for examples, see Appendix B).
	Assess capacities for managing health- and MHPSS-related risks associated with emergencies and hazards, map existing services across sectors and review and update existing assessments on a regular basis. Existing tools may be used to identify strengths and areas for development in managing assessed risks (adapted from WHO Health EDRM Framework).[12]
	Monitor and evaluate risks, capacities and progress towards meeting emergency and disaster risk management objectives through standardized indicators integrated within existing multisectoral monitoring systems (adapted from WHO Health EDRM Framework).
	Maintain a repository of existing assessments and disseminate information collected for use by policy-makers and stakeholders.
	Promote academic research and initiatives seeking mutual understanding of mental health risks and prevention (adapted from UNDRR, 2015).
	Develop and test early detection and inclusive warning systems (UNDRR, 2015).

12. For example, see IHR (2005). State Party Self-Assessment Annual Reporting tool (SPAR) and voluntary Joint External Evaluation (JEE); WHO Survey of Country Capacities for Health EDRM and regional assessment and reporting tools; Sendai Framework Monitor; Capacity for Disaster Reduction Initiative (CADRI Partnership); and the Inter-Agency Standing Committee (IASC) Preparedness for Response assessment.

SENDAI PRIORITY 2: STRENGTHENING DISASTER RISK GOVERNANCE TO MANAGE DISASTER RISK	
Outcome	**Activities**
Disaster risk management strategies, including response plans, reduce risks, do not cause harm and are dignified, participatory, community-owned and socially and culturally acceptable	Encourage the adoption of policies and programmes addressing disaster- and emergency-induced human mobility in accordance with UNDRR's WiA guidelines on disaster displacement (adapted from UNDRR, 2015).
	Respect and promote the central role of local governments, communities and professionals, and design efforts in accordance with the context and in line with UNDRR's WiA guidelines for national and local DRR (adapted from UNDRR, 2015), the WHO Health Emergency and Disaster Risk Management Framework (2019) and other policy recommendations for DRR and MHPSS integration (Valle & CBM International, 2016).
	Develop and test the MHPSS coordination body and responder roster with prior training and clear task descriptions and link the MHPSS coordination body with larger multisectoral and sectoral DRM bodies as well as with specific focal points (e.g. gender, disability, law enforcement).
	Conduct a review of DRM plans for human care facilities (e.g. health facilities, medication dispensaries, schools, child care centres) to ensure that they include MHPSS aspects and align with risk reduction principles.
	Create a voluntary emergency registry that members of the public, including particularly vulnerable groups, such as older adults or people with psychosocial disabilities, can register with before an emergency for use during emergencies and in collaboration with community organizations, such as disabled persons' organizations or faith-based organizations.
	Mainstream and integrate DRR and MHPSS within and across all sectors and review and promote the coherence and further development of all-hazard national and local frameworks, regulations, plans and policies (adapted from UNDRR, 2015; WHO, 2019).

SENDAI PRIORITY 3: INVESTING IN DISASTER RISK REDUCTION FOR RESILIENCE	
Outcome	**Activities**
People are safe, protected and prepared for emergencies, and human rights violations are addressed	Develop community, school-based, family- and individual-level preparedness activities that are inclusive of vulnerable groups and people living with disabilities and that reduce rights violations and increase protection for vulnerable groups.
	Promote cooperation between health and mental health authorities and other relevant stakeholders, such as organizations for people living with disabilities and mental health service users, to strengthen the country's capacity for the building of resilient systems and communities (adapted from UNDRR, 2015; WHO, 2019).
	Integrate the assessment and management of common mental health conditions, particularly those that may develop in specific emergencies, into general health care through capacity-building (e.g. for Mental Health Gap Action Programme (mhGAP) tools, programming and follow-up supervision in line with the Toolkit for the Integration of Mental Health into General Healthcare (International Medical Corps, 2018)).
	Promote regular all-phase exercises and planning, including evacuation drills, training and the establishment of area-based support systems, including access to safe and accessible shelter, essential food and non-food relief supplies (including assistive devices and mobility aids) and health and MHPSS services appropriate to local needs (adapted from UNDRR, 2015).
	Develop capacity to implement basic psychosocial support (IASC, 2020) for all affected adults, children and response staff and for implementing low-intensity psychological interventions for persons impaired by distress.
	Promote and support the development of social safety nets as DRM measures linked to and integrated with livelihood enhancement programmes in order to ensure resilience to shocks at the household and community levels (UNDRR, 2015).
	Develop and implement organizational strategies that promote prevention, preparedness and resilience for local actors, first responders and emergency response personnel.
Public and private resources and finances are allocated to reduce risk at multiple levels and build better before	Raise and allocate necessary public and private sector funding for policies targeting the reduction of risk drivers and social determinants of MHPSS problems, the bolstering of protective factors and improvements in health, nutrition, housing, education and economic security.
	Allocate the necessary resources, including finance and logistics, as appropriate, at all levels of administration for the development and implementation of DRM and MHPSS strategies, policies, plans and/or laws and regulations in all relevant sectors (adapted from UNDRR, 2015).

SENDAI PRIORITY 4: ENHANCING DISASTER PREPAREDNESS FOR EFFECTIVE RESPONSE AND TO "BUILD BACK BETTER" IN RECOVERY, REHABILITATION AND RECONSTRUCTION

Outcome	Activities
People with mental health and psychosocial problems use appropriate focused care	Develop layered and integrative MHPSS services aligned with the IASC (2007) service pyramid, coordinated with broader response efforts prior to emergencies, inclusive of women, men and children living with disabilities across all age ranges, and link to response/recovery planning.
	Implement minimum MHPSS responses (e.g. IASC, 2007) when hazardous events, emergencies and crises occur, and develop protocols for adapting services to specific hazards.
	Provide MHPSS activities, including basic psychosocial support (e.g., PFA) and low-intensity psychological interventions (e.g., Problem Management Plus (PM+)), for potentially vulnerable groups when hazardous events occur, such as: 1) response staff; 2) children, older adults, persons with disabilities or persons with serious mental health conditions, 3) people living in poverty and 4) other potentially marginalized groups (e.g., refugees, migrants or displaced persons).
Family, community and social structures promote the well-being and development of all their members and reduce risks	Allocate resources for and develop formal and informal social structures that are sustainable, inclusive (e.g., structures that support durable solutions for displaced persons), and combat stigma.
Building back better through the development of systems and services that enhance recovery schemes to provide psychosocial support and mental health services for all people, reduce risks and increase community and individual preparedness for future events	Review and revise national policies and plans and risk management efforts based on lessons learned (adapted from UNDRR, 2015) and foster ongoing peer review processes among national and international agencies involved in MHPSS/DRR programming.[13]
	Use emergency and hazardous events as opportunities to reform the mental health system and ensure equality of rights through a process of de-institutionalization and community integration.
	Avoid duplication of rebuilding and reform efforts through continued coordination via the MHPSS coordination body, linked with larger multisectoral and sectoral emergency response/DRM coordination.

13. See, for example, the European Civil Protection and Humanitarian Aid Operations (ECHO) peer review process described at: https://ec.europa.eu/echo/what-we-do/civil-protection/peer-review_en

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3. Indicators (matrix)

Realization of the goals described in this technical note requires strong monitoring and evaluation (M&E) in order to ensure that actions produce the desired outcomes. Additionally, the alignment of the DRR and MHPSS fields further requires indicators against which to measure progress. Therefore, it is recommended that agencies involved in implementing the elements of this technical note engage at the minimum in continued M&E and internal reporting of progress. The matrix below outlines indicators for this purpose. Additional technical guidance on operationalizing relevant indicators such as the Sendai Framework, WHO's Health EDRM Framework, the UNDRR Technical Guidance for Monitoring and Reporting on Progress in Achieving the Global Targets of the Sendai Framework for Disaster Risk Reduction, or the IASC Common Monitoring and Evaluation Framework – should be used in conjunction with this document when implementing these actions and measuring outcomes. All of these documents have been consulted in order to design the outcome indicators set out below.

LINKING MHPSS AND DRR OUTCOME INDICATORS

OVERALL GOAL: Reduce suffering, improve mental health and psychosocial well-being and increase resilience

PRIORITY 1	**Understanding disaster risk**
Outcome	**Increased access to information and understanding of potential hazards and risk management capacity.**

Key indicators

1.1 Development and maintenance of a central public (e.g. online) repository of mental health-related disaster risk information (including information on effective psychological preparedness and coping, relevant MHPSS policies/guidelines, response information and mapping and hazard assessments).

1.2 Percentage of affected people reporting awareness of and access to emergency-related warning system information, including vulnerable and at-risk groups and people living with disabilities (adapted from UNDRR, 2018).

PRIORITY 2	**Strengthening disaster risk governance to manage disaster risk**
Outcome	**Disaster risk management and response strategies and plans reduce risks, do not cause harm and are dignified, participatory, community-owned and socially and culturally acceptable.**

Key indicators

2.1 Percentage of affected people who report that MHPSS-DRR activities 1) fit with local values, 2) are appropriate and 3) are provided respectfully (adapted from IASC, 2017).

2.2 Level of implementation of national and local community-led all-hazard strategies with MHPSS-DRR considerations (adapted from UNDRR, 2018).

PRIORITY 3	**Investing in disaster risk reduction for resilience**
Outcome	**People are safe, protected and prepared for emergencies, and human rights violations are addressed.**

Key indicators

3.1 Percentage of families with prevention and preparedness plans incorporating MHPSS-DRR considerations.

3.2 Percentage of social structures with accessible and inclusive prevention and preparedness plans incorporating MHPSS-DRR.

Outcome	**Public and private resources and finances are allocated to reducing risk at multiple levels.**

Key indicators

3.3 Total official support for national DRM and MHPSS strategies and plans (adapted from UNDRR, 2018).

3.4 Total official support for community-based MHPSS-DRR capacity development efforts.

PRIORITY 4	**Enhancing disaster preparedness for response and to "Build Back Better" in recovery, rehabilitation and reconstruction**
Outcome	**People with mental health and psychosocial problems use appropriate focused care following emergencies.**

Key indicators

4.1 Percentages of health and social services, community facilities and emergency response and management agencies with staff trained to identify and support MHPSS problems, provide focused care to at-risk groups and refer to more specialized care when necessary (adapted from IASC, 2017).

4.2 Percentage of health and social services, community facilities and emergency response and management agencies with contingency plans and protocols in place to adapt services in response (adapted from IASC, 2017).

Outcome	**Family, community and social structures promote the well-being and development of all their members and reduce risks.**

Key indicators

4.3 Percentage of formal and informal inclusive social structures with specific activities that promote well-being and prevent or reduce mental health and psychosocial problems (e.g. promotion of mental health, reduction of stigma, evacuation and simulation drills) (adapted from IASC, 2017).

4.4 Level of social capital in target community, both cognitive (level of trust and reciprocity within communities) and structural (membership and participation in social networks, civil or community groups) (adapted from IASC, 2017).

Outcome	**Building back better through development of systems and services that enhance recovery schemes to provide psychosocial support and mental health services for all people and that reduce risks and increase community and individual preparedness for future events.**

Key indicators

4.5 Post-event conferences to revise national policies and plans, reshape mental health systems and retrain health workers based on lessons learned.

4.6 Percentage of target communities (such as villages or neighbourhoods) where steps have been taken to identify, activate or strengthen local resources that support psychosocial well-being and development (IASC, 2017).

4. Implementation tools

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Quick Links to Operational Tools and Resources

In order to support local operationalization of integrated MHPSS and DRR programming recommended in this document, several tools and resources have been developed. It is essential that these tools be adapted to local contexts and community needs. These include:

Basic MHPSS-DRR actions across sectors

- Include MHPSS considerations in water, sanitation and hygiene (WASH) risk assessments.
- Pre-plan WASH activities in a participatory manner that reduces risks.
- Ensure equal access to activities in a manner that promotes safety and dignity.

- Identify infrastructure and housing risks using an inclusive and multi-hazard approach.
- Use participatory approaches to develop pre-emergency site and shelter planning.
- Maximize privacy, ease of movement and community cohesiveness in site design.

- Assess local psychosocial risks related to food security, nutrition and food aid.
- Plan to distribute food in a culturally adapted manner that promotes dignity and integrity.

- Assess and identify health- and mental health-related risks.
- Invest in mental health care systems by building local capacity and ensuring systems for regular clinical supervision.
- Integrate MHPSS into existing systems, such as primary health care settings.

- Build school capacity for implementing DRR plans and include MHPSS considerations.
- Design inclusive DRR school committees tasked with planning and raising awareness.
- Coordinate and conduct simulation and evacuation exercises to promote resilience.

- Assess and identify risks for human rights abuses and particularly for vulnerable groups (e.g., refugees, migrants or displaced persons).
- Build capacity for community-guided protection activities.
- Apply a human rights framework to DRR activities across sectors.
- Mainstream MHPSS considerations in the protection of migrants and displaced persons.
- Ensure the availability of culturally-sensitive and appropriate MHPSS for all migrants (regardless of their status).[14]

14. For further guidance on community-based approaches, please see: IOM. Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement. Geneva, Switzerland: IOM, 2019.

TABLE 4: PREPAREDNESS CHECKLIST[15]

QUESTIONS	DECISION (YES/NO/IN PROGRESS (IP))
• Existence of an MHPSS coordination body, with governmental support, linked with DRR and other bodies, with clear task descriptions in case of emergency?	☐ Yes ☐ No ☐ IP
• Availability of an assessment for existing MHPSS risks, services and capacity for MHPSS and repository of existing assessments?	☐ Yes ☐ No ☐ IP
• Implementation of action to strengthen capacities for prevention, preparedness, response and recovery of MHPSS services?	☐ Yes ☐ No ☐ IP
• Implementation of learning programmes with curricula focused on DRM and basic MHPSS services?	☐ Yes ☐ No ☐ IP
• Mutually agreed upon indicators for monitoring MHPSS and DRM activities across different sectors and capacity for continued M&E?	☐ Yes ☐ No ☐ IP
• Responders trained in providing basic psychosocial support (e.g., PFA)?	☐ Yes ☐ No ☐ IP
• Professionals trained and supervised in providing 1) basic management of mental health conditions in health services (e.g., WHO's mhGAP-HIG) and 2) scalable psychological interventions?	☐ Yes ☐ No ☐ IP
• Developed and coordinated plans for preparedness, response and contingencies integrating MHPSS and DRM, particularly for educational and health care facilities?	☐ Yes ☐ No ☐ IP
• Approved essential psychotropic medication lists and information on availability of these medications in stock and at different facilities?	☐ Yes ☐ No ☐ IP
• Emergency simulation exercises and drills aligned with local context and coordinated with relevant stakeholders conducted, and early and inclusive warning systems developed and tested?	☐ Yes ☐ No ☐ IP
• Communications strategies for promoting mental health and psychosocial well-being (such as messages about positive and negative coping) and targeting reductions in stigma are developed and disseminated, in partnership with people with mental health conditions?	☐ Yes ☐ No ☐ IP
• Review and revision, if necessary, of policies and plans to ensure alignment of MHPSS with DRM and to increase emphasis on preparedness and prevention?	☐ Yes ☐ No ☐ IP

15. Also consider the UNDRR (2020) Checklist for Scaling Up DRR in Humanitarian Action. Available at: https://www.undrr.org/media/47913/download

TABLE 5: STEPS FOR DESIGNING AND IMPLEMENTING AN MHPSS-DRR ACTION PLAN

PHASE	ACTIONS	PRACTICAL TIPS
PLAN	1. Allocate funding and resources	• Allocate funding for at least one full-time MHPSS-DRR focal point and for coordination activities
	2. Designate an MHPSS-DRR focal point and coordinating body	• Ensure capacity and autonomy for action
	3. Identify target area and scope of project	• Coordinate with local efforts and governmental actors
	4. Develop a working group	• Identify potential partners and relevant stakeholders
PREPARE	5. Assess risks and prepare communications	• Use existing and context-specific assessments if possible
	6. Define objectives and shared vision	• Emphasize collaboration and coordination
	7. Develop a work plan	• Prioritize practicality and feasibility
	8. Review all response and risk management strategies	• Consider both in-agency and local or governmental plans
	9. Consolidate information and draft strategy	• Identify actions, indicators, roles and responsibilities
PROVIDE	10. Secure and activate funding of implementation	• Engage further with funders and advocate for risk reduction plan
	11. Mobilize community actors for implementation	• Ensure community ownership and leadership
	12. Monitor, evaluate and report on relevant indicators	• Gather lessons learned and link with future planning

5. Case studies and lessons learned

This section outlines case examples of initiatives that have integrate MHPSS and DRR, representing diverse political, social, cultural and emergency contexts. These efforts establish proof of concept for the possibility of integrating considerations of mental health and psychosocial well-being with risk management, including prevention, preparedness, response and recovery, by applying the principle of "build back better". Combined lessons learned are discussed following these case studies, along with a list of "Do's and Don'ts", to highlight valuable insights from actors in the field. Further resources documenting case studies are listed in Appendix E.

CASE STUDIES

Bangladesh

Following massive population movements from Myanmar in August 2017, large numbers of Rohingya refugees and members of other ethnic minorities crossed the border into Bangladesh, with over one million people taking shelter in the camps and villages in Cox's Bazar. Even without this influx, Bangladesh was already one of the most vulnerable countries to climatic hazards. In May 2017, heavy rains and landslides caused by Cyclone Mora affected more than nine million people. In order to prepare actions to reduce these vulnerabilities and the related risks, a national MHPSS Technical Working Group (TWG), a coordination mechanism comprised of various humanitarian actors active in MHPSS, took the lead in developing a national emergency preparedness and response plan (EPRP). The plan aimed to address four main risks posed by potential hazards to mental health: 1) increased incidence of MHPSS problems; 2) loss of social supports and networks during relocation from high-risk areas (e.g. in the case of flooding, landslides); 3) interruption of MHPSS services during emergencies; and 4) lack of knowledge of self-care or of measures applied by responders during humanitarian situations. The base plan was thus developed and integrated with larger health sector response planning. Next, actors involved tested the plan through intersectoral simulation exercises in various locations to identify gaps and issues that might occur during a response. Through these exercises, actors learned that referral pathways were fragmented and agencies providing MHPSS services were often unaware of each other. In response, the plan integrated referral focal points who would ensure wider knowledge of available supports in each area and would serve as the mechanisms for referral across agencies and sectors. Additionally, actors learned that having a dedicated team for MHPSS was often leading to overcrowding and confusion during simulation exercises, and instead trained health workers responsible for a number of tasks to also conduct basic psychosocial support if an emergency occurred. Through this process, responders across the country were better prepared to address the MHPSS impacts of emergencies.

Meanwhile, in the city of Dhaka an international NGO, Action contre la Faim (ACF), also partnered with the national government to develop training

and outreach efforts, given the high-risk nature and large population in the specific area. These outreach programmes were integrated with pre-existing government initiatives focusing on a number of risk reduction topics, including the dissemination of appropriate health practices and considerations, in order to ensure local acceptance and uptake. As a result, ACF increased access to MHPSS by conducting psychological first aid (PFA) trainings and mental health awareness workshops in hazard-prone areas. It trained over 3,000 religious leaders, teachers, health and humanitarian workers, first responders and community members in psychosocial support in an effort to develop local capacity to handle both current and future emergencies.

The Caribbean

In September 2017, many Caribbean countries were severely affected by Category 5 hurricanes Irma and Maria. During the emergency response and recovery phase, MHPSS needs often went unmet and many areas struggled to recover. The majority of affected countries had developed comprehensive MHPSS plans, but implementation was limited due to workforce, financial and practical limitations. In order to address this gap during future hazardous events, the Caribbean Development Bank (CDB) partnered with the Pan American Health Organization (PAHO) to implement an 18-month project in Caribbean countries that had limited to no MHPSS planning implementation. The project began with four objectives: 1) capacity-building; 2) communication and awareness; 3) monitoring and evaluation; and 4) country-specific development of realistic planning. A four-day training of trainers (ToT) workshop for mental health professionals was held in 2018 to build capacity for providing PFA and the mhGAP-HIG and to develop a roster of MHPSS professionals who would respond to emergencies and disseminate trainings. Thereafter, refresher trainings with a more specific focus, such as needs assessment, M&E and community violence, and an online virtual platform were established. In the aftermath of 2017, PAHO also recognized the continued influence of stigma and traditional gender roles among Caribbean communities in determining help-seeking behaviour. Based on the "one love, one family" principle of many Caribbean cultures, PAHO and CDB simultaneously developed an awareness campaign and a slogan, "Stronger Together", to disseminate information on better coping and to raise awareness to reduce stigma around help-seeking. This campaign consisted of public service announcements, audio and video testimonials, social media and illustrated comic strips depicting PFA in action. Together, these approaches were tested and contributed significantly to increased capacity for effective MHPSS responses in the aftermath of Hurricane Dorian in late 2019.

Dominica, Guatemala, Mexico, Puerto Rico and the Philippines

Globally, emergencies frequently disrupt the functioning and safety of learning environments and can lead to significant psychosocial issues among affected children. Preparing schools and children to reduce this psychosocial impact can mitigate the difficulties that may arise later. With the goal of creating safe learning environments and mitigating psychosocial risk, Israeli humanitarian NGO IsraAID began working with national and local governments to prepare school systems for local emergencies and to develop emergency plans that considered the MHPSS needs of children, families, schools and communities. IsraAID staff quickly identified the importance of the involvement of MHPSS actors at all levels of DRM programme development and of collaboration with local government and stakeholders in order to ensure adequate consideration and sustainability. As a result, successful integration efforts tailored to local emergency contexts have been made in Dominica, Guatemala, Mexico, Puerto Rico and the Philippines. IsraAID's approach focuses on increasing a sense of control and self-efficacy while building community commitment and maintaining structure and continuity for school members. This model is implemented in stages and includes trainings for mental health professionals, social workers, teachers and youth leaders on coping and personal resilience, risk assessment, DRR in schools, preparation and planning, and PFA. Trainings are then tested against practical emergency drills and revised according to lessons learned. In total, over 148 schools across these countries have benefited from these integrated MHPSS and DRR initiatives.

The Philippines

In November 2013, the Philippines was impacted by Typhoon Haiyan, one of the deadliest tropical cyclones in recent history. The country is vulnerable to hydrometeorological hazards and, prior to the typhoon, investment and resources for preparedness had been limited. After the event, the UK Department for International Development (DFID) played a leading role in supporting the response, with relief efforts reaching over 800,000 survivors in the first three weeks. In an effort to further develop coordinated, effective and efficient response and recovery for the longer term, the Philippines Department of Health, International Medical Corps, Médecins Sans Frontières (MSF), Save the Children and WHO formed an international collaboration to promote MHPSS and to build a better mental health system, thereby promoting recovery while increasing preparedness to address future risks. To do this, the partners implemented a widespread capacity development programme in Eastern Visayas, an area badly affected by the typhoon. More than 90% of non-specialist health personnel in the region's 159 health units and 32 district and provincial hospitals were trained to provide mental health care and guaranteed access to psychotropic medicines. Furthermore, 1,038 community health workers were trained in psychosocial support and care. As of January 2020, over four million people in the region had access to quality mental health services. The programme continues to represent a replicable model for developing systems and services that enhance recovery schemes to provide MHPSS services for all, as well as reducing risks and increasing preparedness (adapted from Ryan et al., 2020).

India

India is frequently affected by multiple hazards and demonstrates a diverse risk profile. "Developing Resilient Cities through Risk Reduction to Disaster and Climate Change", started in 2017, is a collaborative DRR project supported by USAID, facilitated by UNDP and implemented by the National Institute of Mental Health and Neurosciences (NIMHANS) in India. NIMHANS' part of this pilot preparedness project focuses on MHPSS preparedness in larger DRM efforts across six municipalities, and represents the first large-scale MHPSS preparedness initiative in the country. Following a psychosocial mapping and needs assessment exercise, NIMHANS engaged in extensive advocacy and awareness-raising activities across the departments of government involved in emergency response and risk management. Through these efforts, it developed partnerships that aided in integrating mental health and psychosocial components into existing DRR initiatives. Thereafter, NIMHANS actors implemented a three-day training on basic psychosocial support and PFA at the community level as an additional element of pre-existing DRM-related trainings. A ToT was held, involving 20 trainers from each of the six municipalities. Following the ToT, master trainers returned to their cities and began implementing preparedness efforts at the local level. Due in part to the political capital and name recognition of the institute, these trainings continue to be accepted and implemented across the country, and have been tested by recent emergencies. As part of the wider COVID-19 response in India, relief camps were established by the Ministry of Home Affairs to provide food and shelter to many citizens and migrant workers. Within these camps, community health workers trained previously have been engaged in raising awareness of effective coping strategies, providing basic psychosocial support and conducting outreach and referral for individuals in need of greater care (For more information on this case study, please see Gray et al., 2021).

Japan

In Japan, natural hazards such as earthquakes, tsunamis, flooding and heavy rainfall are common. In order to provide timely and accessible referral pathways to services, the Japanese government has developed and implemented a community-based approach using public health nurses (PHNs). In Japan, PHNs are multitask community-oriented health professionals who provide maternal and child care, nutrition guidance, vaccinations, hygiene procedures, basic psychosocial support and PFA, and referral to necessary services. Additionally, they help to conduct outreach and awareness-raising and provide workshops on various health- and mental health-related topics. This community-based multitasked approach enables PHNs to act as a first line of contact and to develop strong relationships with community members, which may aid in discussion of more sensitive topics, such as mental health concerns. The functionality of the PHN community-based model has been demonstrated in recent emergencies, such as in 2011 following the Great East Japan Earthquake and subsequent tsunami. Hundreds of PHNs were deployed to assist through outreach in affected communities, shelters and health centres in order to reach those affected. Deployed PHNs were given the task of initiating first contact with affected persons, assessing their physical and psychosocial status and providing necessary referrals and follow-up. PHNs were able to engage with affected persons, provide basic support, facilitate access to necessary services and reduce the risk of further distress.

Urakawa, Japan

People living wiht disabilities, including psychosocial disabilities are particularly vulnerable during hazardous events due to issues such as mobility or communication. In Urakawa, Japan, Bethel House, a group home for more than 100 persons with psychosocial disabilities, implemented training in disaster risk assessment and effective evacuation. This training was conducted using a Digital Accessible Information System (DAISY), allowing audible access to written materials, and personalized evacuation manuals. Recognizing the importance of this work, the local government requested that representatives from Bethel House serve on DRR planning committees in the city and included disability-inclusive DRR (DiDRR) programming in its planning. As a direct result of Bethel House's efforts, all residents of the group home were evacuated within the space of four minutes during the 2011 Great East Japan Earthquake and tsunami.

Jordan

Hazards such as flash floods, earthquakes and sandstorms are common in Jordan and can greatly disrupt the functioning of society, including that of schools and children. International Medical Corps (IMC), in cooperation with the Jordanian Civil Defense Directorate and the Ministries of Education and Interior, and supported by the UNICEF and the Swiss Agency for Development and Cooperation (SDC), developed the "Creating Resilient Schools and a Healthy Environment of Social Cohesion" project to build DRM capacity in Jordanian schools. To reduce risk and increase preparedness, IMC collaboratively developed a four-day curriculum with the Jordanian government, which included both DRR components and sessions focusing on mental health and psychosocial preparedness and PFA skills development. Following the collaborative development of the curriculum and adaptation to targeted schools, the first two phases of the DRR project focused on setting up DRM preparedness plans at the school level, complemented by capacity development of teachers, students, community members and Ministry of Education staff. In addition, school-level DRM committees including teachers, students and government officials were established and tasked with raising local awareness of DRM, conducting simulation and evacuation drills, and increasing social cohesion across the school and the local community. In the project's third phase, IMC extended activities to ensure sustainable gains in disaster preparedness, and extended coverage of at-risk schools to include additional schools in southern, central and northern Jordan.

New Zealand

Individuals and communities in New Zealand have been significantly affected by both natural and human-induced hazardous events in the past decade. Recently, the "All Right?" campaign was developed as a population-based multimedia social marketing campaign to support psychosocial well-being. "All Right?" is a partnership between Canterbury District Health Board and the Mental Health Foundation of New Zealand, funded by the Ministry of Health. Campaign partners have included the Ministry of Social Development, NZ Red Cross, Christchurch Earthquake Appeal Trust and Waimakariri District Council. The campaign supports people to care for their well-being, and that of those around them, by offering a range of simple activities based around the five ways to well-being – communicate, learn, be active, take notice and give (Aked et al., 2010). Campaign messages are shaped in response to qualitative research which indicates how people are feeling and the language they use to describe their feelings. This approach has enabled the campaign to capture an authentic local voice and to normalize local experience e.g. "It's all right to feel a little blue now and then"; "It's all right to keep ticking along"; "When did you last share kai with the whānau?" (meaning "When did you last share a meal with the family?"). This language is shared on street posters, billboards and the backs of buses, along with postcards and posters available at libraries, cafes, workplaces and schools. Campaigns have included various tools that support psychosocial well-being. The campaign has been continuously evaluated through a series of studies over several years. In June 2019, 88% of Cantabrians (population 400,000) were aware of the "All Right?" campaign, and of those who were aware of it, 47% could recall acting as a result of seeing the campaign'. Evaluation further suggests that the campaign has a cumulative effect on well-being and is effective for both women and men.

Sierra Leone

In 2010, the mental health system in Sierra Leone consisted of a single psychiatric hospital in Freetown (Mental Health Atlas, 2011), located near the coast and hundreds of kilometres away from many communities. During the 2014–2015 West African Ebola outbreak, many communities in Sierra Leone were significantly affected. In addition to the stress, fear and suffering that occurred as a result, social stigma also increased mental and psychosocial problems. Prior to the outbreak, the NGO CBM, the Ministry of Health and Sanitation and other partners established a strong coalition through the "Enabling Access to Mental Health in Sierra Leone" initiative. This coalition was crucial to successfully promoting investment in a sustainable mental health system, training 21 psychiatric nurses, providing mental health skills to over 400 other clinicians and establishing mental health units in 16 districts across the country. During the outbreak, these nurses were able to meet the MHPSS needs of many patients (including those referred by people providing PFA), while also supporting Ebola treatment centres and survivors' clinics. These services were an essential element of the provision of care, which was only possible because they were set up in advance, demonstrating the importance of investment in strengthening (decentralized) mental health services to enable efficient and effective action to prevent, prepare, respond and recover. In addition, partners worked during the crisis with local organizations of people living with disabilities to ensure that key public health messages were made available in accessible formats, that barriers to accessing response services were addressed and that people with disabilities participated in planning and coordination, so that their needs and priorities were heard. Recently, the sustainable impacts of these efforts have been demonstrated in response to the COVID-19 pandemic. Thanks in part to these earlier efforts, the health system has been better prepared to respond to the mental health impacts of COVID-19 outbreaks. Contributing to this preparedness was the use of many of the same coordination mechanisms and referral pathways established prior to the Ebola outbreak, as well as the already built capacity of community-based workers. For instance, previously trained mental health nurses have been deployed to quarantine sites to conduct visits and provide support. These actors work side by side with responders such as contract tracers and awareness-raising teams to provide MHPSS and to ensure that resilience and well-being are promoted during the pandemic (For more information on this case study, please see Gray et al., 2021).

Lessons learned

Community acceptance and ownership are essential for successful and sustainable programmes.

DRR strategies and plans must include the voices of vulnerable and at-risk people in decision-making.

Multisectoral and varied stakeholder collaboration is necessary such as between MHPSS actors, DRR actors, government and local at-risk individuals and communities.

MHPSS-related DRR policies and plans should be clear, brief and realistic and should be integrated with pre-existing structures and initiatives.

Advocacy for funding should take place at multiple levels prior to emergencies.

Name recognition and prior working relationships can be crucial to creating buy-in.

Investing in health systems, including emergency and DRM capacities prior to emergencies is essential for reducing risks, building preparedness and strengthening response and recovery efforts.

Culturally adapted and community-led approaches are key to reduce stigma and raise awareness.

Online resource hubs can be effective in raising awareness and increasing prevention and preparedness.

TABLE 6: DOS AND DON'TS WHEN DESIGNING MHPSS-DRR PROGRAMMES

DO

- Emphasize community ownership and acceptance and local contextualization.
- Develop collaborative relationships with varied stakeholders prior to emergencies.
- Design policies and plans with realistic expectations.
- Advocate for DRR- and MHPSS-specific funding and awareness prior to emergencies, based on past lessons.
- Invest in systems and build capacities of sectors, organizations and individuals, and coordination mechanisms.
- Implement context-specific and culturally adapted activity to reduce stigma.
- Disseminate and implement programming that is easily accessed and tailored to local contexts.

DON'T

- Develop programmes without diverse and at-risk or vulnerable stakeholders in leadership roles.
- Wait until after emergencies begin to establish coordination and collaboration.
- Design policies and plans that are comprehensive but unactionable based on local resources.
- Wait until emergencies occur to advocate for funding or to raise awareness.
- Rely on or overemphasize external intervention or human resources.
- Assume local agreement or acceptance of MHPSS approaches or themes.
- Disseminate or implement programming that is non-specific or cannot be tailorabled to contextual risks and hazards.

Appendix A: Glossary

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Comprehensive DRR glossaries are currently available and include the Report of the Open-ended Intergovernmental Expert Working Group on Indicators and Terminology relating to Disaster Risk Reduction, endorsed by the UN General Assembly in February 2016 (UNDRR, 2016), and WHO's Glossary of Health EDRM Framework Terminology (2020). Terms in these glossaries and others in both the MHPSS and DRR fields share conceptual overlap and yet may differ in regard to their definition, scope or practical application. The glossary presented here is therefore intended to assist actors working at the intersection of DRR and MHPSS and to provide guidance on overlap in concept and definition and differentiation between these concepts. Definitions from both of the glossaries mentioned above, and others, have been incorporated here to provide a comprehensive and integrative view.

Acceptable risk

The extent to which a (disaster) risk is deemed acceptable or tolerable depends on existing social, economic, political, cultural, technical and environmental conditions. Note: In engineering terms, acceptable risk is also used to assess and define the structural and non-structural measures that are needed in order to reduce possible harm to people, property, services and systems to a chosen tolerated level, according to codes of "accepted practice" which are based on known probabilities of hazards and other factors (WHO, 2019b).

Anthropogenic hazards

Also known as human-induced hazards, these are hazards induced entirely or predominantly by human activities and choices. This term does not include the occurrence or risk of armed conflicts and other situations of social instability or tension which are subject to international humanitarian law and national legislation (UNGA, 2016).

Biological hazards

Hazards of organic origin or conveyed by biological vectors, including pathogenic microorganisms, toxins and bioactive substances. Examples are bacteria, viruses or parasites, as well as venomous wildlife and insects, poisonous plants and mosquitoes carrying disease-causing agents (UNGA, 2016).

Building back better

Building back better is a term used to describe use of the recovery, rehabilitation and reconstruction phases after a hazardous event to increase the resilience of individuals, communities and countries through both the integration of DRR measures into the restoration of physical infrastructures, societal systems, livelihoods, economies and the environment and the reform of health and mental health systems to scale up health and mental health services and policy (WHO, 2013).

Building better before

Building better before is a term used to describe prevention and preparedness before hazardous events to increase the resilience of individuals, communities and countries by reducing risks in advance of crises. This may involve strengthening systems, including mental health and social systems, livelihoods, economies and environmental protections and addressing social determinants that lead to mental health and psychosocial problems.

Capacity

The combination of all the strengths, attributes and resources available within an individual, organization, community or society to manage and reduce disaster risks and strengthen resilience. Capacity may include infrastructure, institutions, human knowledge and skills, and collective attributes such as social relationships, leadership and management (UNDRR, 2017a).

Capacity assessment

The process by which the capacity of a group, organization or society is reviewed against desired goals, where existing capacities are identified for maintenance or strengthening and capacity gaps are identified for further action (UNDRR, 2015).

Capacity development

The process by which people, organizations and society systematically stimulate and develop their

capacities over time to achieve psychosocial and economic goals. It is a concept that extends the term capacity-building to encompass all aspects of creating and sustaining capacity growth over time. It involves learning and various types of training but also continuous efforts to develop institutions, political awareness, financial resources, health systems, technology systems and the wider enabling environment (UNDRR, 2015).

Climate change

A change in the state of the climate that can be identified (e.g. by using statistical tests) by changes in the mean and/or the variability of its properties and that persists for an extended period, typically decades or longer (IPCC, 2012).

Climate change adaptation

In human systems, the process of adjustment to actual or expected climate and its effects, in order to moderate harm or exploit beneficial opportunities. In natural systems, the process of adjustment to actual climate and its effects; human intervention may facilitate adjustment to expected climate and it's effect (IPCC, 2012).

Clusters

Groups of humanitarian organizations, both UN and non-UN, in each of the main sectors of humanitarian action (water, health, shelter, logistics, etc.; WHO, 2019b). Note: Clusters are designated by the IASC and have clear responsibilities for coordination (UNHCR, 2015). Mental health falls within the health cluster.

Collaboration (intersectoral)

The process of joint planning, construction, implementation and monitoring by ministries and authorities belonging to different public sectors, including sharing of resources in order to enable each ministry or body to carry out responsibilities that were mutually agreed upon (WHO, 2020).

Community

Specific group of people, often living in a defined geographical area, who share a common culture, values and norms and are arranged in a social structure according to relationships which have been developed over a period of time. Note: Members of a community gain their personal and social identity by sharing common beliefs, values and norms which have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group and share common needs and a commitment to meeting them (WHO, 2019b).

Community-based disaster risk management

Promotes the involvement of potentially affected communities in DRM at the local level. This includes community assessments of hazards, vulnerabilities and capacities, and their involvement in planning, implementation, monitoring and evaluation of local action for DRR (UNGA, 2016).

Community resilience

The ability of communities exposed to disasters, crises and underlying vulnerabilities to anticipate, prepare for, reduce the impact of, cope with and recover from the effects of shock and stresses without compromising their long-term prospects. Community resilience can be considered a combination of both the collective resilience of community members and group-level structures and organization (IFRC, 2011).

Compensatory disaster risk management

Activities that strengthen the social and economic resilience of individuals and societies in the face of residual risk that cannot be effectively reduced. They include preparedness, response and recovery activities, but also a mix of different financing instruments, such as national contingency funds, contingent credit, insurance and reinsurance and social safety nets (UNGA, 2016).

Context

As applied to emergency risk management, context is described by a number of factors related to the setting, circumstances and environment of risks and events. Note: These include the cultural, social, political, legal, regulatory, financial, technological, economic, natural and competitive environment, whether local, national, regional or international, and those factors related to the governance, organizational structure, roles, accountabilities, policies, objectives and strategies that are in place to achieve those objectives. They also include the capabilities of and relationships between internal and external actors and stakeholders (WHO, 2019b).

Contingency planning

A management process that analyses disaster risks and establishes arrangements in advance to enable timely, effective and appropriate responses. Contingency planning results in organized and coordinated courses of action with clearly identified institutional roles and resources, information processes and operational arrangements for specific actors at times of need. Based on scenarios of possible emergency conditions or hazardous events, it allows key actors to envision, anticipate and solve problems that can arise during disasters. Contingency planning is an important part of overall preparedness. Contingency plans need to be regularly updated and exercised (WHO, 2019b).

Coordination

1) Management processes to ensure integration (unity) of effort. Coordination relates primarily to resources and operates vertically (within an organization) as a function of the authority to command, and horizontally (across organizations) as a function of the authority to control (WHO, 2015a).
2) The way in which different organizations (public or private) or parts of the same organization work or act together in order to achieve a common objective (ISO 22300).

Coping capacity

The ability of people, organizations and systems, using available skills and resources, to manage adverse conditions, risk or disasters. Note: The capacity to cope requires continuing awareness, resources and good management, both in normal times as well as during disasters or adverse conditions. Coping capacities contribute to the reduction of disaster risks (UNGA, 2016).

Corrective disaster risk management

Activities that address and seek to remove or reduce disaster risks which are already present and which need to be managed and reduced now. Examples are the retrofitting of critical infrastructure or the relocation of exposed populations or assets (UNGA, 2016).

Crisis

1) An unstable or crucial time or state of affairs in which a decisive change is impending, especially one where a highly undesirable outcome is distinctly possible (WHO, 2015b).
2) Unstable condition involving an impending abrupt or significant change that requires urgent attention and action to protect life, assets, property or the environment (ISO 22300).

Disability

A limitation in a functional domain that arises from the interaction between a person's intrinsic capacity and environmental and personal factors (WHO, 2011). Note: Disability – or difficulties in functioning – is neither purely biological or purely social or psychological. Disability can occur at three levels: impairments, activity limitations and participation restrictions. An impairment is a problem in body function or structure or in cognitive ability or emotional function; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations (adapted from WHO, 2019b).

Disability-adjusted life years (DALYs)

Population metric of life years lost to disease due to both morbidity and mortality (WHO, 2019b).

Disaster

A serious disruption of the functioning of a community or a society at any scale due to hazardous events interacting with conditions of exposure, vulnerability and capacity, leading to one or more of the following: human, material, economic and environmental losses and impacts. Note: The effect of a disaster can be immediate and localized, but is often widespread and could last for a long period of time. The effect may test or exceed the capacity of a community or society to cope using its own resources, and therefore it may require assistance from external sources, which could include neighbouring jurisdictions, or those at the national or international levels (UNGA, 2016).

Disaster management

The organization, planning and application of measures preparing for, responding to and recovering from disasters. Disaster management may not completely avert or eliminate threats; it focuses on creating and implementing preparedness and other plans to reduce the impact of disasters and to "build back better". Failure to create and apply a plan could lead to damage to life, health, mental health and psychosocial well-being, and assets, and to lost revenue (UNGA, 2016).

Disaster response

Actions taken directly before, during or immediately after a disaster in order to save lives, reduce health impacts, ensure public safety and meet the basic subsistence needs of the people affected (UNGA, 2016).

Disaster risk

The potential loss of life, injury, destroyed or damaged assets, or impairment in psychosocial functioning which could occur to an individual, system, society or community in a specific period of time, determined probabilistically as a function of hazard, exposure, vulnerability and capacity. The definition of disaster risk reflects the concept of hazardous events and disasters as the outcome of continuously present conditions of risk. Disaster risk comprises different types of potential losses, which are often difficult to quantify. Nevertheless, with knowledge of the prevailing hazards and the patterns of population and socioeconomic development, disaster risks can be assessed and mapped, in broad terms at least. It is important to consider the social and economic contexts in which disaster risks occur and that people do not necessarily share the same perceptions of risk and their underlying risk factors (UNGA, 2016).

Disaster risk assessment

A qualitative or quantitative approach to determine the nature and extent of disaster risk by analysing potential hazards and evaluating existing conditions of exposure and vulnerability that together could harm people, property, services, livelihoods and the environment on which they depend. Disaster risk assessments include the identification of hazards; a review of the technical characteristics of hazards such as their location, intensity, frequency and probability; the analysis of exposure and vulnerability, including the physical, social, health, mental health and well-being, environmental and economic dimensions; and the evaluation of the effectiveness of prevailing and alternative coping capacities with respect to likely risk scenarios (UNGA, 2016).

Disaster risk information

Comprehensive information on all dimensions of disaster risk, including hazards, exposure, vulnerability and capacity, related to persons, communities, organizations and countries and their assets. Disaster risk information includes all studies, information and mapping required to understand the disaster risk drivers and underlying risk factors (UNGA, 2016).

Disaster risk governance

The system of institutions, mechanisms, policy and legal frameworks and other arrangements to guide,

coordinate and oversee disaster risk reduction and related areas of policy. Note: Good governance needs to be transparent, inclusive, collective and efficient to reduce existing disaster risks and avoid creating new ones (UNGA, 2016).

Disaster risk management (DRM)

Disaster risk management is the application of disaster risk reduction policies and strategies to prevent new disaster risk, reduce existing disaster risk and manage residual risk, contributing to the strengthening of resilience and reduction of disaster losses. Disaster risk management actions can be divided between prospective disaster risk management, corrective disaster risk management and compensatory disaster risk management, also called residual risk management (UNGA, 2016).

Disaster risk management plan

These plans set out the goals and specific objectives for reducing disaster risks together with related actions to accomplish these objectives. They should be guided by the Sendai Framework for Disaster Risk Reduction 2015–2030 and considered and coordinated within relevant development plans, resource allocations and programme activities. National-level plans need to be specific to each level of administrative responsibility and adapted to the different social and geographical circumstances that are present. The timeframe and responsibilities for implementation and the sources of funding should be specified in the plan. Linkages to sustainable development and climate change adaptation plans should be made where possible (UNGA, 2016).

Disaster risk reduction (DRR)

Disaster risk reduction (DRR) is aimed at preventing new and reducing existing disaster risks and managing residual risk, all of which contribute to strengthening resilience and therefore to the achievement of sustainable development. Note: Disaster risk reduction is the policy objective of disaster risk management, and its goals and objectives are defined in DRR strategies and plans (UNGA, 2016).

Disaster risk reduction strategies and policies

Strategies and/or policies that define goals and objectives across different timescales and with concrete targets, indicators and timeframes. In line with the Sendai Framework for Disaster Risk Reduction 2015–2030, these should be aimed at preventing the creation of disaster risk, the reduction of existing risk and the strengthening of economic, social, health and environmental resilience. DRR strategies are planning tools that provide vision and long-term perspective, identify goals and actions decided by a high-level authority at national or local level or a multi-stakeholder mechanism with the appropriate authority, building on the country context (governance structure, political and economic priorities), on an understanding of disaster risk (prevailing hazards, risk vulnerability, exposure, perception of risk and existing coping capacities of society) and on an evaluation of current DRR systems and capacities at country level. DRR strategies should be closely linked with development plans so that underlying factors of risk and resilience-building can be fully addressed (UNDRR, 2019a).

Disaster vulnerability

The conditions determined by physical, social, economic and environmental factors or processes which increase the susceptibility of an individual, a community, assets or systems to the impacts of hazards (UNGA, 2016).

DRR plans

A plan/action plan/roadmap/framework is a document that provides operational orientation for implementation of the strategy by defining priority actions, timeframes, budget and resources and roles and responsibilities of various entities in delivering results, identifying indicators and modalities for review and monitoring progress. It may be developed as one comprehensive national DRR plan, as a risk-sensitive development plan, as sector-specific plans or by addressing specific hazards (UNDRR, 2019).

Early warning system

An integrated system of hazard monitoring, forecasting and prediction, disaster risk assessment, communication and preparedness activities, systems and processes that enables individuals, communities, governments, businesses and others to take timely action to reduce disaster risks in advance of hazardous events. Note: Effective "end-to-end" and "people-centred" early warning systems may include four interrelated key elements: 1) disaster risk knowledge based on the systematic collection of data and disaster risk assessments; 2) detection, monitoring, analysis and forecasting of the hazards and possible consequences; 3) dissemination and communication, by an official source, of authoritative, timely, accurate and actionable warnings and associated information on likelihood and impact; and 4) preparedness at all levels to respond to the warnings received. These four interrelated components need to be coordinated within and across sectors and at multiple levels for the system to work effectively and need to include a feedback mechanism for continuous improvement. Failure in one component or a lack of coordination across them could lead to the failure of the whole system (UNGA, 2016).

Emergency

1) A type of event or imminent threat that produces or has the potential to produce a range of consequences, and which requires coordinated action, usually urgent and often non-routine.
2) The term "emergency" is sometimes used interchangeably with the term "disaster" as, for example, in the context of biological and technological hazards or health emergencies, which, however, can also relate to hazardous events that do not result in the serious disruption of the functioning of a community or society. Note: Emergencies have effects that may be considered on a continuum from local emergencies with limited consequences to wide area disasters with catastrophic consequences. "Incidents" or "events" are often referred to as "emergencies", with the terms used interchangeably, but not all incidents or events are emergencies (UNGA, 2016).

Emergency management

This is a term used, sometimes interchangeably, with the term disaster management, particularly in the context of biological and technological hazards and for health emergencies. While there is a large degree of overlap, an emergency can also relate to hazardous events that do not result in the serious disruption of the functioning of a community or society (UNGA, 2016).

Emergency response plan

A document that describes how an agency or organization will manage its responses to emergencies of various types. Note: It provides a description of the objectives, policy and concept of operations for the response to an emergency, and the structure, authorities and responsibilities for a systematic, coordinated and effective response. In this context, emergency plans are agency- or jurisdiction-specific, and detail the resources, capacities and capabilities that the jurisdiction, agency or organization will employ in its response (WHO, 2017).

Emergency (risk) management agency or organization

An organization, often a government agency, specifically mandated to provide a single point of accountability for the coordination of multisectoral and interagency emergency activities, including risk assessment, prevention, mitigation, preparedness, response and recovery activities within a particular area (WHO, 2015a).

Emergent risk

The term "emergent risk" is used to describe risks that are poorly understood but are expected to grow greatly in significance. Unlike other risks, emergent risks do not have a track record which can be used to estimate likely probabilities and expected losses (UNDP, 2020).

Environmental degradation

Environmental degradation is the deterioration in environmental quality from ambient concentrations of pollutants and other activities and processes such as improper land use and natural disasters (UN, 1997). Environmental degradation also includes habitat destruction, species extinction, loss of biodiversity and other environmental damage caused by air pollution.

Environmental hazards

Hazards that may include chemical, natural and biological hazards. They can be created by environmental degradation or by physical or chemical pollution in the air, water and soil. However, many of the processes and phenomena that fall into this category may be termed drivers of hazard and risk rather than hazards in themselves, such as soil degradation, deforestation, loss of biodiversity, salinization and sea-level rise (UNGA, 2016).

Epidemic

The occurrence in a community or region of cases of an illness, specific health-related behaviour or other health-related events clearly in excess of normal expectancy. Note: The community or region and the period in which the cases occur are specified precisely. The number of cases indicating the presence of an epidemic varies according to the agent, size and type of population exposed, previous experience or lack of exposure to the disease, and time and place of occurrence (WHO, 2001).

Evacuation

Moving people and assets temporarily to safer places before, during or after the occurrence of a hazardous event in order to protect them. Note: Evacuation plans refer to the arrangements established in advance to enable the moving of people and assets temporarily to safer places before, during or after the occurrence of a hazardous event. Evacuation plans may include plans for the return of evacuees and options to shelter in place (UNGA, 2016).

Geological or geophysical hazards

These originate from internal Earth processes. Examples are earthquakes, volcanic activity and emissions, and related geophysical processes such as mass movements, landslides, rockslides, surface collapses and debris or mud flows. Hydrometeorological factors are important contributors to some of these processes. Tsunamis are difficult to categorize: although they are triggered by undersea earthquakes and other geological events, they essentially become an oceanic process that is manifested as a coastal water-related hazard (UNGA, 2016).

Hazard

A process, phenomenon or human activity that may cause loss of life, injury or other health impacts, property damage, social and economic disruption or environmental degradation. Note: Hazards may be natural, anthropogenic or socionatural in origin. Natural hazards are predominantly associated with natural processes and phenomena. Anthropogenic, or human-induced, hazards are induced entirely or predominantly by human activities and choices. This term does not include the occurrence or risk of armed conflicts and other situations of social instability or tension which are subject to international humanitarian law and national legislation. Several hazards are socionatural, in that they are associated with a combination of natural and anthropogenic factors, including environmental degradation and climate change (UNGA, 2016).

Hazardous event

The manifestation of a hazard in a particular place during a particular period of time. Note: Severe hazardous events can lead to a disaster as a result of the combination of hazard occurrence and other risk factors (UNGA, 2016).

Hazard monitoring function

Activities to obtain evidence-based information on hazards in a defined area used to make decisions about the need for public warning (ISO 22300).

Health emergency

A type of event or imminent threat that produces or has the potential to produce a range of health consequences, and which requires coordinated action, usually urgent and often non-routine. Note: A health emergency may pose a substantial risk of significant morbidity or mortality in a community (WHO, 2015a).

Health emergency and disaster risk management

The systematic analysis and management of health risks, posed by actual or potential hazardous events, including emergencies and disasters, through a combination of hazard, exposure and vulnerability reduction to prevent and mitigate risks, preparedness, response and recovery (WHO, 2019b).

Health policy

A general statement of understanding to guide decision-making that results from an agreement or consensus among relevant partners on the issues to be addressed and on the approaches or strategies to deal with them (WHO, 2011).

Health promotion

The process of enabling people to increase control over and to improve their health. Note: Health promotion represents a comprehensive social and political process: it not only embraces actions directed at strengthening the skills and capabilities of individuals but also actions directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health (WHO, 1998).

Health sector

Organized public and private health services (including health promotion, disease prevention, diagnostic, treatment and care services), the policies and activities of health departments and ministries, health-related nongovernmental organizations and community groups, and professional associations (WHO, 1998).

Health system

The people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve, while responding to people's legitimate expectations and protecting them against the cost of ill-health through a variety of activities whose primary intent is to improve health (WHO, 2011).

Hydrometeorological hazards

Hazards that are of atmospheric, hydrological or oceanographic origin. Examples are tropical cyclones (also known as typhoons and hurricanes); floods, including flash floods; drought; heatwaves and cold spells; and coastal storm surges. Hydrometeorological conditions may also be a factor in other hazards such as landslides, wildland fires, locust plagues, epidemics and in the transport and dispersal of toxic substances and volcanic eruption material (UNGA, 2016).

Local and indigenous peoples' approach to DRM

The recognition and use of traditional, indigenous and local knowledge and practices to complement scientific knowledge in disaster risk assessments and for the planning and implementation of local disaster risk management (UNGA, 2016).

Mental health and psychosocial support

Any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental health condition. Note: Traditionally, the term mental health care has been used by health professionals to describe specialized interventions to treat individuals diagnosed with mental health conditions. Psychosocial support and psychosocial interventions are terms used by a broader range of workers in the emergency response field to refer to activities that support both the psychological and social health of individuals and communities as a whole rather than focusing specifically on treating mental health conditions. Mental health and psychosocial support (MHPSS) is a composite term that the majority of organizations

have agreed to use in reference to "any type of local or outside support that aims to protect or promote psychosocial wellbeing and/or prevent or treat mental health conditions" (IASC, 2007).

Mental health outcome

A change in the mental health status of an individual, group or population which is attributable to a planned intervention or series of interventions (adapted from WHO, 1998).

Mental health promotion

Mental health promotion activities involve the creation of individual, social and environmental conditions that enable optimal psychological and psychophysiological development. Such initiatives involve individuals in the process of achieving positive mental health, enhancing quality of life and narrowing the gap in health expectancy between countries and groups. It is an enabling process, done by, with and for people. Prevention of mental health conditions can be considered one of the aims and outcomes of a broader mental health promotion strategy (Jané-Llopis, Barrry, Hosman & Patel, 2005).

Mental health stigma

Misunderstanding or prejudice surrounding mental health problems based on an unfounded belief that individuals with mental health conditions are untreatable, difficult, not intelligent or incapable of making decisions, despite the existence of effective treatments for these conditions. This perception leads to social stigma, which can then lead to abuse, rejection and isolation and exclusion of people from health care or support (WHO, 2019a).

Mitigation

The lessening or minimizing of the adverse impacts of a hazardous event. The adverse impacts of hazards, in particular natural hazards, often cannot be prevented fully, but their scale or severity can be substantially lessened by various strategies and actions. Mitigation measures include engineering techniques and hazard-resistant construction as well as improved environmental and social policies and public awareness. It should be noted that in climate change policy "mitigation" is defined differently, and is the term used for the reduction of greenhouse gas emissions that are the source of climate change (UNGA, 2016).

Multihazard

A term that means 1) the selection of multiple major hazards that a country faces, and 2) the specific contexts where hazardous events may occur simultaneously, cascadingly or cumulatively over time, and taking into account the potential interrelated effects (UNGA, 2016).

Multihazard early warning systems

These address several hazards and/or impacts of similar or different type in contexts where hazardous events may occur alone, simultaneously, cascadingly or cumulatively over time, while taking into account the potential interrelated effects. A multihazard early warning system with the ability to warn of one or more hazards increases the efficiency and consistency of warnings through coordinated and compatible mechanisms and capacities, involving multiple disciplines for updated and accurate hazard identification and monitoring for multiple hazards (UNGA, 2016).

Natech (natural hazard triggering technological disaster)

A chemical accident, including spills of oil and oil products, triggered by a natural hazard or natural disaster (such as extreme temperatures, high winds, floods, storms, earthquakes or wildfires) (OECD, 2015).

National disaster management agency (or authority)

The national government agency that is responsible for coordinating disaster or emergency management policy and practice. Note: There is no common definition for this agency or organization as the name and scope of functions vary across countries and are usually defined by national legislation or policies (WHO, 2020).

National platform for disaster risk reduction

A generic term for national mechanisms for coordination and policy guidance on DRR that are multisectoral and interdisciplinary in nature, with public, private and civil society participation involving all concerned entities within a country. Note: Effective government coordination forums are composed of relevant stakeholders at national and local levels and have a designated national focal point. For such mechanisms to have a strong foundation in national institutional frameworks, further key elements and responsibilities should be established through laws, regulations, standards and procedures, including clearly assigned responsibilities and authority; building awareness and knowledge of disaster risk through the sharing and dissemination of non-sensitive disaster risk information and data; contributing to and coordinating reports on local and national disaster risk; coordinating public awareness campaigns on disaster risk; facilitating and supporting local multisectoral cooperation (e.g. among local governments); and contributing to the determination of and reporting on national and local disaster risk management plans and all policies relevant for disaster risk management (UNGA, 2016).

Natural hazards

Predominantly associated with natural processes and phenomena (UNGA, 2016).

Non-structural DRR measures

Non-structural measures are measures not involving physical construction which use knowledge, practice or agreement to reduce disaster risks and impacts, in particular through policies and laws, public awareness-raising, training and education (UNGA, 2016).

People living with disabilities

Those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (UNCRPD, 2006).

Preparedness

The knowledge and capacities developed by governments, response and recovery organizations, communities and individuals to effectively anticipate, respond to and recover from the impacts of likely, imminent or current disasters. Preparedness is based on analyses of disaster risks and good linkages with early warning systems and includes both physical preparedness (e.g. preparing emergency kits) and psychological preparedness (e.g. understanding what to expect). Note: Preparedness action is carried out within the context of DRM and aims to build the capacities needed to efficiently manage all types of emergencies and achieve orderly transitions from response to sustained recovery. Preparedness is based on a sound analysis of disaster risks and good linkages with early warning systems, and includes activities such as contingency planning, the stockpiling of equipment and supplies, the development of arrangements for coordination, evacuation and public information, and associated training and field exercises. These must be supported by formal institutional, legal and budgetary capacities. The related term "readiness" describes the ability to quickly and appropriately respond when required (UNGA, 2016).

Preparedness plan

A plan that outlines procedures for reacting to crises and establishes arrangements in advance to enable timely, effective and appropriate responses to specific potential hazardous events or emerging disaster situations that might threaten society or the environment (UNGA, 2016).

Prevention

Activities and measures to avoid existing and new disaster risks. Note: prevention (i.e. disaster prevention) expresses the concept and intention to completely avoid potential adverse impacts of hazardous events. While certain disaster risks cannot be eliminated, prevention aims to reduce vulnerability and exposure in such contexts where, as a result, the risk of disaster is removed. Examples include dams or embankments that eliminate flood risks, land use regulations that do not permit any

settlement in high-risk zones, seismic engineering designs that ensure the survival and function of a critical building in any likely earthquake and immunization against vaccine-preventable diseases. Prevention measures can also be taken during or after a hazardous event or disaster to prevent secondary hazards or their consequences, such as measures to prevent the contamination of water. (UNGA, 2016). In public health, primary prevention aims to prevent disease or injury before it occurs by preventing exposures to hazards that cause disease or injury, altering unhealthy or unsafe behaviours that can lead to disease or injury, and increasing resistance to disease or injury should exposure occur. Secondary prevention aims to reduce the impact of a disease or injury that has already occurred by detecting and treating it as soon as possible to halt or slow its progress, encouraging personal strategies to prevent reinjury or recurrence, and implementing programmes to return people to their original health and function to prevent long-term problems. Tertiary prevention aims to soften the impact of an ongoing illness or injury that has lasting effects by helping people manage long-term, often complex health problems and injuries (e.g. chronic diseases, permanent impairments) in order to improve as much as possible their ability to function, their quality of life and their life expectancy (WHO, 2020).

Prevention in mental health

Applied to mental health and psychosocial well-being, preventative measures aim to reduce risk factors for mental health problems and promote factors that protect mental health and psychosocial well-being, as well as prevent the occurrence of disasters or adverse situations that initiate or exacerbate mental health problems (adapted from WHO, 2014).

Prospective disaster risk management

Activities that address and seek to avoid the development of new or increased disaster risks. They focus on addressing disaster risks that may develop in the future if DRR policies are not put in place. Examples are better land use planning or disaster-resistant water supply systems (UNGA, 2016).

Public health

The science and art of promoting health, preventing disease and prolonging life through the organized efforts of society (Acheson, 1988).

Public health event

1) Any event that may have negative consequences for human health and mental health. Note: The term includes events that have not yet led to disease and/or injury in humans but have the potential to cause disease and injury through exposure of humans to hazards or as a result of direct or indirect consequences of other hazardous events (adapted from WHO, 2017).
2) A manifestation of disease or an occurrence that creates a potential for disease (WHO, 2016).

Public health risk

A likelihood of an event that may affect adversely the health and mental health of human populations. Note: In the context of the International Health Regulations, there is an emphasis on an event which may spread internationally or may present a serious and direct danger (WHO, 2016).

Psychological vulnerability

The factors that increase susceptibility to developing a mental health problem. Psychological vulnerability can be determined by a number of factors, including individual differences, such as personality, cognitive style or emotional disposition; social factors, such as available social support networks, poverty, social disadvantage or discrimination; or situational factors, such as current or cumulative stress.

Readiness

The ability to quickly and appropriately respond when required (UNGA, 2016).

Reconstruction

The medium- and long-term rebuilding and sustainable restoration of resilient critical infrastructures, services, housing, facilities and livelihoods required for the full functioning of a community or a society affected by a disaster, aligning with the principles of sustainable development and "building back better", to avoid or reduce future disaster risk (UNGA, 2016).

Recovery

The restoring or improving of livelihoods, health and mental health, as well as economic, physical, social, cultural and environmental assets, systems and activities, of a disaster-affected community or society, aligning with the principles of sustainable development and "building back better", to avoid or reduce future disaster risk (UNGA, 2016).

Rehabilitation

The restoration of basic services and facilities for the functioning of a community or a society affected by a disaster (UNGA, 2016).

Residual risk

The disaster risk that remains even when DRR measures are in place, and for which emergency response and recovery capacities must be maintained. The presence of residual risk implies a continuing need to develop and support effective capacities for emergency services, preparedness, response and recovery, together with socioeconomic policies such as safety nets and risk transfer mechanisms, as part of a holistic approach (UNGA, 2016).

Resilience in DRR terminology

The ability of a system, community or society exposed to hazards to resist, absorb, accommodate, adapt to, transform and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions through risk management (UNGA, 2016).

Resilience (personal/individual, community)

There are no universally accepted definitions of resilience. Instead, resilience may be viewed as a fluid concept that may be more useful when contextualized to specific situations or circumstances to define healthy adaptations.

Risk factor

Any attribute, characteristic or exposure of an individual that increases the likelihood of them developing a disease, injury or mental health condition or of experiencing the exacerbation of a condition or psychosocial distress. Note: Risk factors can include any element of behaviour or lifestyle, environmental exposure or genetic characteristic that is associated with a particular outcome (adapted from WHO, 2019b).

Risk register

Record of information about identified risks (ISO 22300).

Structural DRR measures

Structural measures are any physical construction to reduce or avoid possible impacts of hazards, or the application of engineering techniques or technology to achieve hazard resistance and resilience in structures or systems. Note: Common structural measures for DRR include dams, flood levees, ocean wave barriers, earthquake-resistant construction and evacuation shelters. Common non-structural measures include building codes, land use planning laws and their enforcement, research and assessment, information resources and public awareness programmes. Note that in civil and structural engineering, the term "structural" is used in a more restricted sense to mean just the load-bearing structure, while other parts such as wall cladding and interior fittings are termed "non-structural" (UNGA, 2016). Strong arguments have been made for the consideration of MHPSS in structural measures (see Galappatti & Richardson, 2016).

Sustainable development

Development that meets the needs of the present without compromising the ability of future generations to meet their own needs (Brundtland, 1987).

Systemic risk

A systemic risk is a risk that is endogenous to, or embedded in, a system that is not itself considered to be a risk and is therefore not generally tracked or managed, but which is understood through systems analysis to have a latent or cumulative risk potential to negatively impact overall system performance when some characteristics of the system change (UNDRR, 2019a).

Tabletop exercise (TTX)

A facilitated discussion that uses a progressive simulated scenario, together with a series of scripted interjections to encourage participants to consider the impact of a potential emergency on existing plans, procedures and capacities. Note: A TTX simulates an emergency situation in an informal, stress-free environment. It is a discussion around an exercise scenario or narrative of an emergency situation which, guided by a facilitator, is designed to elicit constructive discussion between participants; to identify and resolve problems; and to refine existing operational plans (WHO, 2017).

Technological hazards

These originate from technological or industrial conditions, dangerous procedures, infrastructure failures or specific human activities. Examples include industrial pollution, nuclear radiation, toxic wastes, dam failures, transport accidents, factory explosions, fires and chemical spills. Technological hazards also may arise directly as a result of the impacts of a natural hazard event (UNGA, 2016).

Underlying disaster risk drivers

Processes or conditions, often development-related, that influence the level of disaster risk by increasing levels of exposure and vulnerability or by reducing capacity. Underlying disaster risk drivers – also referred to as underlying disaster risk factors – include poverty and inequality, climate change and variability, unplanned and rapid urbanization and the lack of disaster risk considerations in land management and environmental and natural resource management, as well as compounding factors such as demographic change, non-disaster risk-informed policies, the lack of regulations and incentives for private DRR investment, complex supply chains, the limited availability of technology, unsustainable uses of natural resources, declining ecosystems and pandemics and epidemics (UNGA, 2016).

Vulnerability

The conditions determined by physical, social, economic and environmental factors or processes which increase the susceptibility of an individual, a community, assets or systems to the impacts of hazards (UNGA, 2016).

Vulnerable group

Individuals who share one or several characteristics that are the basis of discrimination or adverse social, economic, cultural, political or health and mental health circumstances and that cause them to lack the means to achieve their rights or otherwise enjoy equal opportunities (ISO 22300).

Appendix B: Considerations for MHPSS Assessments during COVID-19

1. Background

The COVID-19 pandemic has severely impacted the mental health and psychosocial well-being of people globally.[16] In this context, understanding the stressors that communities, families and individuals face, the supports available to them and their ability to cope is crucial for developing an effective response.

2. Purpose of this note

This appendix provides practical guidance on conducting mental health and psychosocial support (MHPSS) assessments in the context of COVID-19. This guidance supplements resources for conducting MHPSS assessments in emergency settings[17–19] and addressing MHPSS needs during COVID-19.

3. Practical tips for conducting MHPSS assessments during COVID-19

The approach to conducting MHPSS assessments will vary depending on the context and purpose of the assessment. In general, MHPSS assessments in emergency settings should be aimed at 1) providing an understanding of the situation from an MHPSS perspective; 2) analysing problems and peoples's ability to cope; and 3) analysing resources to inform the response required.[17-19] The following "dos and don'ts" can be used to effectively design an assessment in order to address these aims in the context of COVID-19.

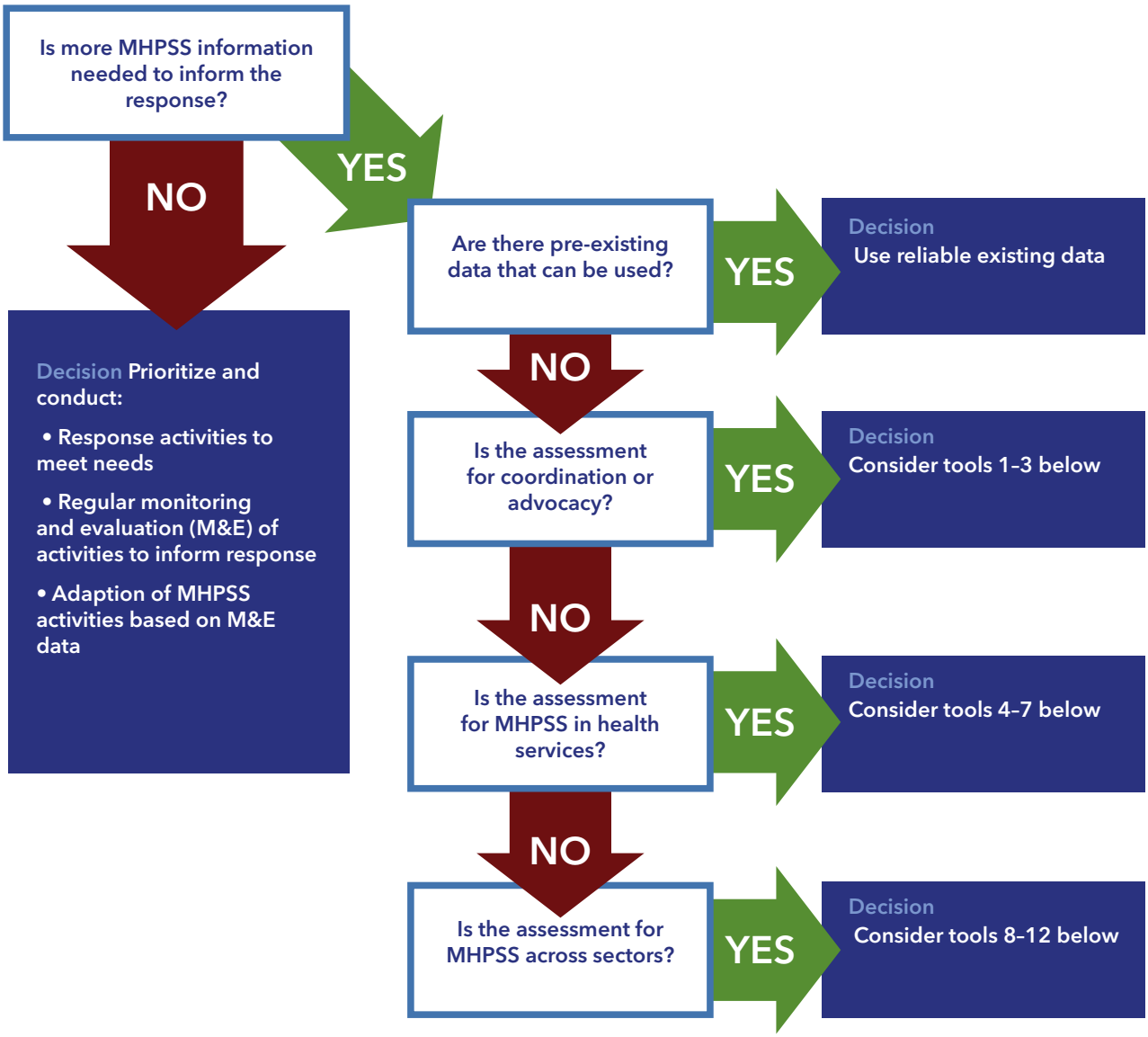
16 - United Nations Secretary-General. UN Policy Brief: COVID-19 and the Need for Action on Mental Health, (2020). (https://unsdg.un.org/sites/default/files/2020-05/UN-Policy-Brief-COVID-19-and-mental-health.pdf).
17 - IASC Reference Group on MHPSS in Emergency Settings. IASC Reference Group MHPSS Assessment Guide, 2012 (https://interagencystandingcommittee.org/system/files/iasc_rg_mhpss_assessment_guide_.pdf).
18 - WHO & UNHCR. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings, 2012 (https://apps.who.int/iris/bitstream/handle/10665/76796/9789241548533_eng.pdf?sequence=1).
19 - International Medical Corps. Toolkit for the Integration of Mental Health into General Healthcare in Humanitarian Settings: Step 1. Assess & Plan for Mental Health Integration (https://www.mhinnovation.net/collaborations/IMC-Mental-Health-Integration-Toolkit).

DO	DON'T
Rely on existing data from all sectors, when possible. For example, existing data can inform prevalence estimates of MHPSS issues in Humanitarian Needs Overviews.[20-21]	Duplicate assessments or collect data that are unnecessary, will not add new information or are unsafe and may cause harm to those involved
Prioritize critical activities and proceed with extreme caution if conducting in-person assessments	Carry out low-priority or high-risk activities if these can be delayed until the situation is safer
When new data are required, carry out rapid assessments of the situation, needs and resources to inform response	Carry out complex studies, such as population-based studies, which are impractical in emergencies
Protect people and staff by prioritizing safety and adapting to avoid unnecessary contact	Put people at risk of contracting COVID-19 by engaging in unnecessary in-person contact
Ensure confidentiality, privacy and consent in assessment	Put people at risk of harm or stigma from others
Link assessment to action and advocacy by analysing, sharing and acting on data collected	Collect data without using them or with unrealistic promises about how data will be used
Tailor assessment tools to the context and situation	Implement a "one-size-fits-all" approach
Carry out participatory and inclusive assessments as opportunities to build trust and engage vulnerable groups[22]	Exclude or overlook vulnerable groups or those with limited access (e.g. without remote access)
Integrate MHPSS within both multisectoral and single-sector assessments to inform a holistic MHPSS response	Exclude MHPSS questions in other sectors or assume that MHPSS is not relevant
Coordinate MHPSS assessments across sectors	Carry out fragmented MHPSS assessments

20 - Charlson F, van Ommeren M, Flaxman A, Cornett J, Whiteford H & Saxena S. New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis. The Lancet, 2019, 240-248. doi:10.1016/ S0140-6736(19)30934-1
21 - Rogers JP, Chesney E, Oliver D et al. Psychiatric and neuropsychiatric presentations associated with severe coronavirus infections: a systematic review and meta-analysis with comparison to the COVID-19 pandemic. Lancet Psychiatry. 2020, 7(7):611-627. doi:10.1016/S2215-0366(20)30203-0
22 - IASC. COVID-19: How to include marginalized and vulnerable people in risk communication and community engagement, 2020 (https://interagencystandingcommittee.org/covid-19-how-include-marginalized-and-vulnerable-people-risk-communication-and-community-engagement).

4. Selecting tools for MHPSS assessments

The following decision tree can be useful for quickly determining the most appropriate approach for gathering MHPSS data. This approach, along with the tools selected, must be adapted to the local context.



5. Tailoring MHPSS assessment tools to COVID-19[23]

MHPSS assessments in the context of COVID-19 will require many adaptations similar to those necessary for MHPSS operations and interventions generally.[24] Likewise, assessment teams must receive adequate training in adapting assessment approaches or using adapted tools that are currently available.[25] When carrying out MHPSS assessments during COVID-19, the following priority questions may be particularly relevant. The list below details specific adaptations that may be useful for the recommended assessment tools.

COVID-19 priority questions

- What are the needs? Clarify how the pandemic has impacted communities' needs, including those of potentially vulnerable groups (e.g. women, children, parents, caregivers), and if these needs are being met.
- How are services adapting? Review existing local responses plans and changes in services across sectors in order to identify gaps and opportunities to further integrate MHPSS.
- What MHPSS services are available? Understand current access to MHPSS services across sectors, within all levels of the MHPSS intervention pyramid and for vulnerable groups.
- Is MHPSS coordinated among actors? Determine if there is an active MHPSS working group.
- What is the capacity to adapt? Assess if MHPSS actors have the capacity to provide adapted services (e.g. remote services) and identify areas where increased capacity is required to continue services.
- What safety precautions are necessary? Identify safety needs to inform budgeting and planning.
- Are human rights being protected? Identify any needs for advocacy to ensure that all persons, including those with mental health conditions and in institutions, are considered in prevention and mitigation plans.
- How have community and family supports changed? Determine changes in community support networks, practices or structures (e.g. school closures) and impacts on coping in the context of COVID-19.
- What are the local perceptions, myths and rumours involving COVID-19? Gauge community attitudes towards COVID-19 and those who are ill.
- Are remote tools used and available? Determine if affected communities use and have equal remote access to inform service adaptation and identify where MHPSS may be integrated.

23 - IASC MHPSS RG. IASC Common Monitoring and Evaluation Framework for MHPSS Programmes in Emergency Settings, 2017 (https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-common).
24 - For further guidance, please visit: https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-resources-covid-19
25 - A resource group to share MHPSS assessment tools for COVID-19 is available on MHPSS.net. For more information, please visit: https://app.mhpss.net/groups/current-mhpss-emergency-responses/novel-coronavirus-international-health-emergency-2020/covid19-assessment/

IASC AND WHO-UNHCR ASSESSMENT TOOLS[26]		COVID-19 PRIORITY ADAPTATIONS
COORDINATION AND ADVOCACY	**1. Who is Where, When, doing What (4ws) in mental health and Psychosocial Support**	• Assess service availability and adaptations required during COVID-19 based on local measures and identify gaps • Revise codes and subcodes to include activities adapted for COVID-19 and relevant to the local context • Assess training on remote service provision and remote access, such as in Sheet 2 – Columns S, U or V
	2. WHO-UNHCR Assessment schedule for serious Symptoms in Humanitarian Settings	• Decide whether there is a need to implement this tool to assess new problems related to COVID-19 or rely on existing data • If implemented, conduct remotely and develop a plan for ensuring access to vulnerable groups or remote locations
	3. Humanitarian Emergency Setting Perceived Needs Scale (HESPER)	• Conduct remote interviews and ensure that staff are trained in conducting remote assessment where possible • Consider creating surveys or adapting physical spaces to allow for safe distancing if remote tools are not available
MHPSS THROUGH HEALTH SERVICES	**4. Checklist for site visits at institutions (e.g. hospitals, care homes, other stay facilities)**	• Determine if inpatient units for mental health are included in plans for COVID-19 prevention and mitigation • Determine if precautions are in place to protect persons in institutions if someone is infected with COVID-19
	5. Checklist for integrating mental health in primary health care (PHC)	• Assess capacity of facilities to adapt MHPSS services and access to remote means, if necessary, including in assessing worker competency (Section 2), impact of the emergency (Section 6) and social indicators (Section 7) • Review the files of all service users and prioritize care for people with severe conditions or distress to minimize health visits. Include number of estimated service users in relevant areas (e.g. Section 5) • Assess plans to integrate MHPSS into COVID-19 care, such as quarantine units
	6. Neuropsychiatric component of the Health Information System (HIS)	• Adapt the HIS to consider remote consultations and other adapted service delivery, if relevant locally
	7. Template to assess mental health system resources	• Assess number of facilities with capabilities for remote services • Assess number of personnel with experience of providing remote services or available for home visits, if safe and feasible

26 - WHO & UNHCR. Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings, 2012 (https://apps.who.int/iris/bitstream/handle/10665/76796/9789241548533_eng.pdf?sequence=1).

IASC AND WHO-UNHCR ASSESSMENT TOOLS		COVID-19 PRIORITY ADAPTATIONS
MHPSS THROUGH DIFFERENT SECTORS, AND THE COMMUNITY	**8. Checklist on obtaining general information from sector leads**	• Assess adaptations across sectors due to COVID-19 and impacts on access to various services (e.g. school closures) • Identify opportunities to integrate MHPSS within adapted services
	9. Template for desk review of pre-existing information relevant to MHPSS	• Review internal and external documents, guidance notes or recommendations related to the COVID-19 response and concerning health, protection, risk communication and community engagement in the local context • Assess access to and acceptability of technologies (e.g. Internet, cell services, cultural acceptance of technology)
	10. Participatory assessment: perceptions of general community members	Prioritize vulnerable groups, such as older persons, persons with health issues or pre-existing mental health conditions, women and children, persons with limited access to services or support, or persons who themselves or whose family members have been infected with COVID-19 and may be staying in quarantine or isolation
	11. Participatory assessment: perceptions of community members with in-depth knowledge of the community	• Include targeted questions that ask about COVID-19 in Section C, such as "How are people who are infected treated?" and "What do people think causes COVID-19?" to assess perceptions of the pandemic and at-risk groups • Assess potential protection issues that may increase due to movement and other restrictions
	12. Participatory assessment: perceptions of severely affected people	• Assess participants' knowledge, fears, concerns, coping and needs regarding COVID-19 • Assess continued access to social support or unique barriers to seeking support, such as in Question 2.2

Appendix C: UNDS Socio-Economic Response to COVID-19 Streams of Work

FIVE PILLARS OF UNDS RESPONSE	DOMAIN OF MHPSS-DRR ACTION
Pillar 1: Health First: Protecting health services and systems during crises	Capacity development
	Preparedness
	Adaptation and provision of essential MHPSS services and activities
	Policies, strategies, legislation
Pillar 2: Protecting People: Social protection and basic services	Inclusive practices and approaches
	Integration of MHPSS considerations across sectors and services
	Advocacy and awareness raising
	Promotion of human rights and rights-based approaches
Pillar 3: Economic Response and Recovery: Protecting jobs, small and medium-sized enterprises and informal sector workers	Mental health prevention and promotion
	Rebuilding and reforming systems
Pillar 4: Macroeconomic Response and Multilateral Collaboration	Risk and needs assessments
	Organizational polices and planning
	Mental health prevention and promotion
Pillar 5: Social Cohesion and Community Resilience	Community mobilization and engagement
	Re-establishment of social networks, supports and community
	Facilitation of appropriate communal practices
	Inclusive early warning systems

Note, Adapted from UN Framework for the Immediate Socio-Economic Response to COVID-19

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