#NOLOST GENERATION

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MAPPING PHASE II: REPORT

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08 July 2020

MHPSS Programmes for Children, Adolescents, Youth (24-0 years) and Parents/Caregivers in Syria and from Syria and Iraq Crises Affected Countries

NLG MHPSS Task Force

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ACRONYMS

4W
Who's doing What, Where and When

AFS
Adolescent-friendly spaces

CFS
Child-friendly spaces

CP
Child Protection

GBV
Gender-Based Violence

IASC
Inter-Agency Standing Committee

MENA
Middle East and North Africa

MHPSS
Mental Health and Psychosocial Support

MoH
Ministry of Health

MoPH
Ministry of Public Health

MoSA
Ministry of Social Affairs

NLG
No Lost Generation

PFA
Psychological First Aid

PHC
Primary Health Care

PSS
Psychosocial Support

RCT
Randomized Controlled Trial

SEL
Social and Emotional Learning

YFS
Youth-friendly spaces

1 EXECUTIVE SUMMARY

The unabated violence of the Syrian conflict has deeply affected the physical, mental health and psychosocial well-being of children, adolescents, youth and their parents/caregivers. During nearly nine years of conflict, over 5.6 million people have fled to neighbouring refugee hosting countries and beyond.[1] Many of them have witnessed or experienced the death or separation from loved ones, displacement, physical harm, and exposure to violent situations. The psychosocial impact of conflict-related violence, coupled with the stressors of displacement, including the lack of livelihood options, violence, disruption of social networks, traditional ways of coping, and most recently the COVID-19 pandemic, are having an unprecedented negative impact on the mental health and psychosocial well-being of children, adolescents, youth and their families. With the projected impact of COVID-19 on the mental health and psychosocial well-being of populations across the world, the pandemic has strengthened the case for the need of integrated MHPSS services across the Syrian humanitarian response, including for children, adolescents and youth.

The **Mental Health and Psychosocial Support (MHPSS) Task Force of the No Lost Generation (NLG)** was established in March 2019 with the aim to improve the coordination and quality of the MHPSS response for children, adolescents and youth in line with the 3RP programmes. To gain a better understanding of the response at the regional level, the MHPSS Task Force initiated in November 2019 a mapping of MHPSS programmes targeting children, adolescents, youth and their parents/caregivers in Syria and from Syria and Iraq crises affected countries – Egypt, Jordan, Lebanon and Turkey. The first phase of the mapping (November 2019-January 2020) consisted of a survey that was completed by 42 organizations (56% international non-governmental organizations (INGOs); 21% UN agencies; 18% NGOs and five per cent government agencies), and the outcomes included a desk review and a descriptive mapping of MHPSS programmes. This first phase of the mapping was conducted in collaboration with the MHPSS and Child Protection working groups at the national level, which primarily supported the dissemination of the survey. The main caveat of this phase was the limited qualitative information that was collected. The second phase of the mapping (March-May 2020) consisted of a qualitative review of identified MHPSS programmes during Phase I, employing document review and semi-structured interviews. Thirty-nine interviews were conducted with MHPSS staff from 20 organizations.

MHPSS PROGRAMMING

The findings from the survey showed that the majority of MHPSS programmes concentrated on levels two (48%) and three (31%), while 17% and 5% of reported MHPSS programmes were at levels one and four respectively, of the Inter-Agency Steering Committee (IASC) intervention pyramid for mental health and psychosocial support in emergencies. The concentration of activities in levels two and three is in line with the IASC recommendations stating that most of the population in emergency situations will require non-specialized MHPSS services.

Limited common understanding on MHPSS approach across and within organizations

A wide variety of MHPSS programmes, based on different concepts, approaches and resources, require enhancement of the evidence-based approach. While it is acknowledged that MHPSS programmes must remain contextualized, the limited use of harmonized approaches as well as indicators that can monitor and evaluate the impact of the MHPSS interventions, render it difficult to assess their relevance and quality across and within organizations.[2]

1 UNHCR Data as of 27 February 2020.

2 For the purpose of this mapping, MHPSS programmes refer to a broad range of interventions that seek to 'protect or promote psychosocial well-being and/or prevent or treat mental disorders' (IASC, 2007).

Limited number of psychosocial support interventions in formal and non-formal education

Twenty-nine per cent of organizations reported implementing psychosocial support (PSS) programmes in formal and non-formal education, making it one of the least frequent interventions at level two of the IASC intervention pyramid for mental health and psychosocial support in emergencies, as opposed to a larger number of MHPSS interventions around strengthening coping mechanisms or recreational activities for children, adolescents and youth. Organizations recognized that the integration of PSS approaches and programmes in formal education, but also in non-formal education, can be pivotal in supporting children, adolescents and youth's psychosocial well-being, which in turn, may positively contribute to the educational experience. Additionally, investment on the integration of PSS within education is highlighted as a sustainable approach that can benefit children at a larger scale.

Limited engagement with parents/caregivers

Seventy-four per cent of organizations reported implementation of parenting interventions, ranging from awareness raising sessions to more structured programmes, but with a considerable focus on one-off activities. Addressing the psychosocial needs of parents/caregivers, children, adolescents and youth in a holistic way was highlighted as a priority because it can be more effective than addressing their needs in silos.

Fragmented MHPSS response and lack of effective referral pathways

Seventy-nine per cent of respondent organizations provided case management or referral services. Organizations reported that enhanced follow-up on the case management and referral pathways is needed. Some of the key challenges with case management and referrals were the overload of cases, long waiting lists and limited availability of services in some contexts. Additionally, it was reported that overall, referral pathways are more challenging in host communities as opposed to in refugee camps, where there may be stronger coordination in the mapping and referral to adequate services.

Shortage of structures and limited capacity on MHPSS

Respondents noted that the mental health systems inside Syria but also in the refugee host countries are fragile and present significant barriers of access for Syrian refugees. With national mental health systems overstretched and with organizations noting a considerable demand for focused services, there is increasing pressure on the higher levels of the IASC intervention pyramid for mental health and psychosocial support in emergencies. At the same time, organizations noted the limited number of MHPSS trainings that build the capacity of non-specialized staff to provide focused, non-specialized mental health and psychosocial services. The investment on focused, non-specialized services (level three in the IASC multi-layered intervention model for MHPSS) can reinforce the sustainability of interventions by building the capacity of local, non-specialized staff as well as mitigate the pressure on the highest level of the IASC intervention pyramid for mental health and psychosocial support in emergencies. Additionally, respondents noted that it is crucial that the specialized mental health staff providing services to Syrian refugees are aligned with the MHPSS approach and integrated into the overall humanitarian response.

Limited knowledge on the specific needs of adolescents, including on negative coping mechanisms

Organizations reported that adolescents are systematically targeted across the different MHPSS programmes. While adolescents are integrated into the MHPSS response, there is a significant need to enhance the understanding of adolescents from a gender and life course perspectives, acknowledging the different MHPSS needs between younger (10-14 years) and older adolescents (14 years and above), and designing tailored MHPSS programmes that holistically address these needs. Linked to this issue was the dearth of data and interventions addressing negative coping mechanisms such as risk behaviours, self-harm and suicide, increasingly reported among adolescents.

RESEARCH, MONITORING AND EVALUATION

While the majority of MHPSS interventions concentrated at levels two and three of IASC intervention pyramid for mental health and psychosocial support in emergencies, the implementation of evidence-based psychosocial interventions such as Problem Management +, Inter-Personal Therapy, Self-Help Plus is still limited. Greater investment on assessing the quality of community-based psychosocial interventions is critical to ensure the do-no-harm principle, flag harmful practices and identify potentially scalable interventions. Organizations recognized that research, monitoring and evaluation is an area that has seen progress over the years, but that requires further investment, for instance through contextually appropriate and validated indicators as well as research that is rigorous yet adaptable to the needs of complex humanitarian emergencies.

Wide variation of goals, outcomes and indicators

The variation of goals, outcomes and indicators has led to difficulties in demonstrating MHPSS programmes' value or impact. Several organizations highlighted the limitations that pose the sole use of quantitative indicators to measure the effectiveness of MHPSS interventions, which are insufficient to reflect the multi-dimensional effects of the interventions.

Improvement needed on community-based approaches to MHPSS programmes

Community-based approaches were recognized as critical and as an area of improvement, as organizations increasingly invest on this approach. Organizations noted that trust building is essential in community-based approaches and that the participation and engagement of local actors, partners, community leaders, parents, children, adolescents and youth at all stages of the MHPSS interventions facilitate the creation of solid community networks that can support and sustain the effectiveness and sustainability of MHPSS interventions in the long term. While many organizations do employ participatory needs assessments, regularly conduct consultations and garner feedback from individuals, there remains a need for placing greater emphasis on community-led actions and particularly, on the systematic engagement of children, adolescents and youth. This has been an area which has been systematically been identified as key, but also broadly overlooked. Moreover, mixed method approaches that integrate community-based monitoring and evaluation mechanisms as well as observations and assessments with MHPSS users while a programme is implemented, can provide more reliable evidence on the quality and effectiveness of the MHPSS interventions.

Short-term duration of funding

Based on the available information on funding shared by organizations, 76% of MHPSS programmes were funded or had secured funding at the time of the survey, while six per cent of MHPSS interventions were not funded. Organizations recognized that the MHPSS response remains strongly dependent on funding, rendering the delivery of MHPSS services subject to the availability of funds. The short-term duration of funding, the increased competition for depleting resources and donor fatigue represent a constant threat to the sustainability of MHPSS interventions. The nature of funding has created a paradox wherein donors are increasingly demanding sustainable approaches; yet the short-term nature of funding limits the ability to invest on systems strengthening and emphasize maximization of local resources that are key to sustainable approaches.

CAPACITY DEVELOPMENT AND STAFF CARE

Lack of follow-up and supervision for staff trained on MHPSS

Theory-based trainings have been noted as insufficient to build the capacity of staff on MHPSS, and several interviewees noted the need for training programmes that incorporate learning by doing, i.e. practice. Curricula on evidence-based interventions such as Psychological First Aid (PFA), Problem Management Plus, but also MHGAP Humanitarian Intervention Guide, require field practice, as well as regular supervision via on-site visits. Among the key common challenges regarding staffing was the relative high staff turnover, which is intrinsically linked to the short nature of funding and inability to secure positions in the long term. Additionally, the recruitment of Syrian staff posed severe limitations in some contexts as work permit processes are lengthy and often difficult to obtain, limiting the opportunities to involve them in the response.

Limited opportunities for staff care.

While 57% of organizations reported the existence of staff care policies, greater emphasis and investment on staff care was highlighted together with the need to institutionalize a culture that is supportive of staff care and that allows MHPSS staff to maximize the services and resources available. Additionally, it was recognized that frontline staff, especially refugee outreach volunteers or workers, are particularly at risk of compassion fatigue and vicarious trauma when confronted with challenging environments – which they may themselves be facing in their personal lives – and high-risk cases, requiring additional support to mitigate the effects of stress and burnout. Several respondents noted that the creation of peer-to-peer support groups present the opportunity to provide guidance and support and can contribute to a culture of self-care.

RECOMMENDATIONS

Based on the findings of this mapping, 15 recommendations were developed. Consensus around their prioritization and feasibility was obtained through consultation and validation with the NLG MHPSS Task Force members. Against the backdrop of the COVID-19 pandemic, which has rendered the MHPSS response ever more relevant, below are the **top priority recommendations.**

MHPSS Programming	Advocate for holistic and comprehensive MHPSS interventions that address children, adolescents and youth's broader social environments, including socio- economic and educational barriers, as well as parents/caregivers' psychosocial well-being.
	Invest in the integration of psychosocial support in formal and non-formal education settings by building the capacity of teachers, counsellors, and other care-workers with periodic, relevant and structured trainings, to deliver PSS as an integral component of the curriculum and other activities, in addition to specific PSS activities.
	Ensure that the voices and perspectives of children, adolescents and youth - boys, girls and the most marginalized - but also of parents/caregivers and community members are systematically taken into consideration. Mechanisms must be developed and implemented so that they have an opportunity to take a more active and leading role at all stages of the MHPSS programming, including in the monitoring and evaluation mechanisms.
	Promote multi-layered, MHPSS approaches focusing on adolescents, including on parent-adolescent relationship. The impact of the Syria crisis, now amplified by the socio-economic impact of COVID19-, has deeply affected young people's psychosocial well-being and hope for the future.
Research, Monitoring and Evaluation	Gain a better understanding of the MHPSS needs of specific groups, namely adolescents and youth engaging in negative coping mechanisms like suicide and self-harm. While anecdotal evidence accounts for a surge on this issue among adolescents and youth, a better understanding of suicide-related behaviours, at-risk-groups and cultural approaches to suicide and self-harm must be gathered to enable the design of interventions that can address these specific needs. It is therefore crucial to generate more age and gender disaggregated data that can help better understand the specific needs of adolescents and youth, providing age and gender-sensitive interventions to their mental health and psychosocial well-being. Similarly, other groups for which there is considerable dearth in data are children with disabilities, street children and unaccompanied children.
Sustainability	Advocate for longer-term funding that can support the undertaking of more research on evidence-based programmes as well as longer-term capacity development plans. These two areas can contribute to improving the quality of service delivery and at the same time, contribute to developing more sustainable interventions.
Capacity Development and Staff Care	Invest in longer-term capacity development tailored to the specific contextual needs and learning needs of MHPSS staff, as well as strengthen the mainstreaming of MHPSS approaches with staff across the humanitarian response. Trainings on MHPSS interventions must include regular and systematic supervision, on-site coaching and field practice. It is recommended that organizations conduct assessments on their capacity development gaps and needs and build their capacity development plans accordingly, combining practical and theoretical approaches and exercises that enhance the learning. For frontline staff, systematic supervision and coaching must be strengthened.
	Increase investment on staff care, including self-care. Organizations should commit to the institutionalization of staff care by mitigating internal stressors, establishing transparent, equitable and supportive management systems, fostering a culture supportive of staff care, including for instance, the establishment of peer-to-peer support groups, and providing opportunities for staff to make use of the services when needed. This must be expanded for frontline workers during COVID-19.

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2 INTRODUCTION

There is an emerging consensus in the humanitarian community responding to the Syria and Iraq crises that an effective humanitarian response must incorporate mental health and psychosocial support approaches and services. It is widely recognized that children, adolescents and youth are particularly vulnerable groups in times of conflict, and that the detrimental effects extend well beyond their physical health and survival. The exposure to the traumatic events, violence and displacement that conflict generate, can limit children, adolescents and youth's ability to cope and function with everyday life, destroy the sense of normalcy and safety, while heightening a sense of fear and eroding protective services and supportive environments that may normally be available to serve them and their communities. The loss and separation from parents/caregivers, family members, peers and community at large may lead to feelings of loneliness, grief and anxiety. Furthermore, the conflict can create new, or intensify pre-existing mental health and psychosocial problems for parents/caregivers, which in turn, may physically and mentally affect children, adolescents and youth, further exacerbating their vulnerabilities. The protracted interruption of normalcy that children, adolescents and youth endure, takes away important and healthy developmental opportunities that may have detrimental consequences throughout their life course.

At the same time, children, adolescents and youth in the Syria and Iraq crises have demonstrated strong resilience. In normal situations, peers, family members and the community can provide much of the support and care that this young people need. However, humanitarian crises diminish the ability of individuals as well as protective services and infrastructures to respond to young people's needs for care and support. Often, parents/caregivers are in much need of support themselves. The necessity to develop and foster supportive and protective environments, equip individuals and communities with mental health and psychosocial support services, and strengthen positive coping mechanisms is evident.

An increasing number of humanitarian organizations provide a wide range of MHPSS programmes[3] to populations affected by the conflicts in Syria and Iraq, as well as to those who have fled to neighbouring refugee hosting countries in the region – Egypt, Jordan, Lebanon and Turkey. The Mental Health and Psychosocial Support Task Force of the No Lost Generation (NLG) was established in March 2019 with the aim to improve the coordination and quality of the MHPSS response for children, adolescents and youth. To gain a better understanding of the response at the regional level, the MHPSS Task Force initiated a mapping of MHPSS programmes targeting children, adolescents and youth and their parents/caregivers in Syria and from Syria and Iraq crises affected countries – Egypt, Jordan, Lebanon and Turkey. The first phase of the mapping took place between November 2019 and January 2020. It consisted of a survey to map the organizations implementing MHPSS programmes for children, adolescents, youth and their parents/caregivers in the NLG countries. This first phase of the mapping was conducted in collaboration with the MHPSS and Child Protection working groups at the national level, who supported namely the dissemination of the survey. The survey explored the type of programmes and their funding status, and the capacity building and staff care services for MHPSS staff. Forty-two organizations responded to the survey (56% INGOs; 21% UN agencies; 18% NGOs and five per cent government agencies) and the outcomes included a desk review and a descriptive mapping of MHPSS programmes. Phase I provided a clear, regional overview of the MHPSS response. However, several limitations were identified. The most important caveat from Phase I was the limited qualitative information, highlighting the need to further explore the quality and effectiveness of existing programmes.

3 For the purpose of this mapping, MHPSS programmes refer to a broad range of interventions that seek to 'protect or promote psychosocial well-being and/or prevent or treat mental disorders' (IASC, 2007).

3 PURPOSE AND OBJECTIVES

The purpose of Phase II was to produce a **qualitative assessment of MHPSS programmes in Syria and from the Syria crisis affected countries** (Egypt, Iraq, Jordan, Lebanon and Turkey) for children, adolescents, youth and their parents/caregivers. The findings from Phase II served to complement the mapping launched in Phase I, which provided a descriptive, regional overview of MHPSS programmes.

The specific objectives of Phase II were to:

1. Assess the MHPSS programmes identified during Phase I to identify best practices and highlight key barriers.
2. Assess the capacity building and staff care services for MHPSS staff.
3. Produce recommendations based on the findings from Phases I and II.

The geographic focus of Phase II was on the NLG countries – Egypt, Iraq, Jordan, Lebanon, Syria and Turkey, and on programmes identified during Phase I.

4 METHODOLOGY

4.1 The Method

Phase II of the mapping was based on a qualitative methodology, employing document review and semi-structured interviews to collect data.

The 42 organizations that participated in Phase I of the mapping were contacted via email and followed up individually to participate in Phase II (March-April 2020). Additionally, the Child Protection and MHPSS working groups in the NLG countries were informed about the second phase of the mapping and encouraged to disseminate the information among organizations which may have not participated to Phase I.

In total, 20 organizations were interviewed, out of which 17 were organizations which participated in Phase I of the mapping and three organizations were implementing partners from these organizations. Additionally, two organizations from Phase I provided documentation but were not interviewed.

Thirty-nine semi-structured interviews were conducted with persons involved in the delivery of MHPSS interventions at different levels: programmatic, technical and field. The breakdown of respondents' profile is presented below.

FIGURE 1: No. of interviews by country

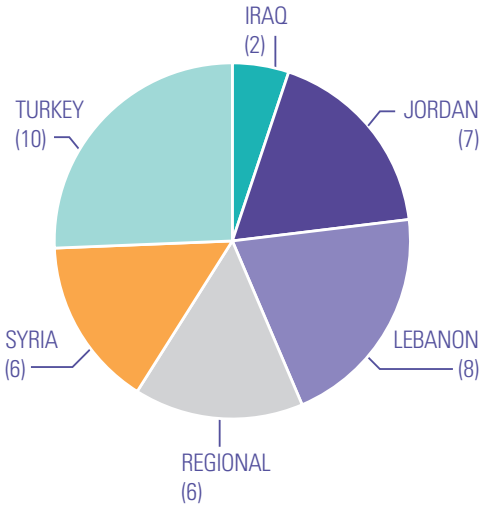


FIGURE 2: No. of interviews by professional discipline

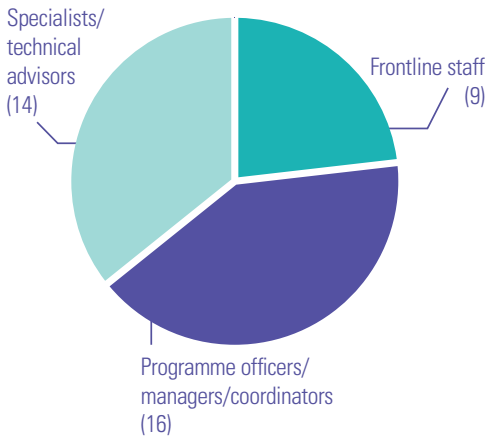
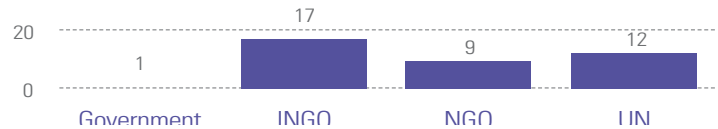


FIGURE 3: No. of interviews per organization type



The semi-structured interviews were transcribed and analysed using thematic analysis, combining a hybrid approach of deductive and inductive coding. A preliminary codebook was developed based on the interview guides (deductive coding). The interview transcripts were coded employing this codebook and during the process, new codes emerged from the data (inductive coding). The coding of interviews was reviewed based on the final codebook and themes were generated based on similar codes and patterns. The identified themes during this process shaped the structure of this report. The coding of interviews was conducted on NVivo 11.

4.2 Tools

For the purpose of this mapping, two semi-structured interview guides were developed. The 'best practices' interview guide focused on exploring the effectiveness, relevance and sustainability of MHPSS interventions as well as the extent of research and evidence, participation and engagement, and coordination. As the mapping was undertaken during the COVID-19 outbreak, it was decided to incorporate an additional section to map the response plans and adaptation of MHPSS interventions. The 'capacity building and staff care' interview guide explored the availability, quality and gaps of capacity building and staff care services for MHPSS staff.

4.3 Limitations

The mapping presented several limitations which must be taken into consideration when reviewing the results.

- **COVID-19**

The launch of Phase II coincided with the COVID-19 outbreak and the subsequent movement restrictions. Initially, country missions to collect data about MHPSS users' experiences of MHPSS programmes were planned. Given the movement restrictions, it was decided to conduct all data collection remotely and focus the mapping on the qualitative assessment of MHPSS interventions as well as the capacity building and staff care services for MHPSS staff. It must be noted that several tools, particularly the WHO-UNCHR Assessment Toolkit[4] already exist and may be used by organizations interested in collecting MHPSS users' perspectives. Another that emerged was a delay in the undertaking of data collection. The initial data collection phase was extended three additional weeks to accommodate to organizations' schedules that were affected by COVID-19.

- **Number of Participating Organizations**

The number of participating organizations presented in this mapping is by no means exhaustive and there may be more organizations implementing MHPSS programmes than what this mapping was able to capture. However, this mapping provides an indication of the organizations that are implementing MHPSS programmes in the NLG countries and presents a qualitative assessment of identified interventions. It must also be noted that many of the organizations participating in this mapping operate with implementing partners.

- **Definition of 'Best Practice'**

For something to be a 'best practice', there must be evidence that the practice has achieved its stated aims, and this is typically measured with an evaluation. Considering the limited number of evaluations that exist for MHPSS programmes for children, adolescents, youth and parents/caregivers in the context of the Syria and Iraq crises, the selection of 'best practices' presented in this mapping was based on malleable criteria. The criteria employed for this mapping is based in the Organisation for Economic Cooperation and Development (OECD) Development Assistance Committee (DAC) guidelines, namely on the criteria of effectiveness, relevance and sustainability, as well as on the IASC guidelines. Throughout the document, examples of 'best practices' are highlighted in coloured boxes. While some of the selected practices have been evaluated or tested, others are cases that may not have been evaluated but that provide a good example on a specific theme or issue.

4 WHO and UNCHR (2012)

5 MHPSS PROGRAMMING

Findings from Phase I revealed a concentration of MHPSS programmes in levels two and three of the IASC intervention pyramid for mental health and psychosocial support in emergencies while interventions in level four represented around five per cent of the total number of identified interventions. The table below summarizes the levels in which organizations reported implementation of MHPSS programmes. The organizations highlighted in purple participated in the second phase of the mapping.

Organization	Level 1	Level 2	Level 3	Level 4
Action Against Hunger (ACF)	X	X	X	X
Association of Assistance, Solidarity and Support for Refugees and Asylum Seekers (MSYD-ASRA)	X	X	X	X
Catholic Relief Services (CRS)		X		
Cordaid	X	X	X	
Danish Church Aid (DCA)	X	X	X	
GIZ	X	X		
Finn Church Aid	X	X		
Heartland Alliance International	X	X	X	X
Humanity & Inclusion	X	X	X	
Humanity & Inclusion - Syrian Mission			X	
International Medical Corps (IMC)	X	X	X	X
International Organization for Migration (IOM)	X	X	X	
International Rescue Committee (IRC)	X	X	X	X
INTERSOS Jordan	X	X	X	
Jesuit Refugee Service (JRS)	X	X	X	X
MARAM	X	X	X	
Medair	X	X	X	
Médecins Du Monde (MdM) France	X	X	X	
Ministry of Heath, Iraq	X	X	X	X
MSF		X	X	
Norwegian Church Aid (NCA)	X	X	X	X
Norwegian Refugee Council (NRC)	X	X	X	

Oum el Nour	X	X	X	
Plan International Lebanon		X		
Psychosocial Services and Training Institute in Cairo (PSTIC) / Programme of Terre des hommes	X	X	X	X
Relief International	X	X	X	
René Moawad Foundation	X	X	X	
Save the Children (Egypt)	X	X	X	
Save the Children (Jordan)	X	X	X	
SEED FOUNDATION	X	X	X	X
Syria Bright Future[5]	X	X		
Un Ponte Per	X	X	X	
UNHCR	X	X	X	X
UNICEF[6] (Iraq)	X	X	X	
UNICEF (Syria)	X	X	X	
UNICEF (Turkey)		X	X	
UNRWA	X	X	X	
UOSSM	X	X	X	X
War Child		X	X	
WFP	X	X		
WHO (Iraq)	X		X	X
World Vision (Iraq)	X	X	X	X

Activities under level one concentrate on community awareness and information dissemination on mental health and psychosocial support. Similarly, organizations conduct outreach activities to identify and reach vulnerable populations, including through mobile units.

Activities under levels two and three were the most implemented activities, which is in line with the available 4Ws and the IASC recommendations indicating higher needs for non-specialized services for the large portion of the population. At level two of the IASC intervention pyramid for mental health and psychosocial support in emergencies, a broad range of activities aiming to strengthen family and community supports as well as to increase communities' resilience and coping mechanisms are being implemented, including support to community-based structures and groups; community mobilization for support for vulnerable groups; community-based child protection committees; parenting skills and awareness sessions; structured psychosocial support activities for children and youth; life skills and youth initiatives. In terms of spaces, several organizations run or support child-friendly spaces, youth-friendly spaces and women's centres. Organizations have noted that activities in these spaces are important entry points for the identification of cases that may require more case-based support.

5 During the interview conducted in Phase II, the organization informed that activities had been suspended for 2019 due to funding.

6 It is known that UNICEF has MHPSS interventions in the other NLG countries; however, the mapping was not able to obtain details on their activities in the remaining countries.

5.1 Strengths and Challenges of MHPSS Programming

Limited common understanding on MHPSS approach across and within organizations
A wide variety of MHPSS programmes, based on different concepts, approaches and resources, which are not necessarily evidence-based or structured, are being implemented. While it is acknowledged that MHPSS interventions must remain contextualized, the absence of harmonized indicators that can monitor and evaluate the impact of the MHPSS interventions, render it difficult to assess their relevance and quality across and within organizations. Respondents noted it would be beneficial to have some level of minimum standards and standardization across MHPSS programmes with sufficient space for contextualization based on the needs of the population.

SYRIA

In Syria, UNICEF has noted the challenges in working with various implementing partners that employ a variety of manuals, particularly when it comes to monitoring and assessing the impact of the interventions. Before the COVID-19 outbreak, plans were underway for the development of a national PSS manual that would unify the PSS programmes delivered to children in Syria.

TURKEY

In Turkey, UNICEF delivered PSS programmes employing a variety of manuals up until 2018, rendering it difficult to fully assess the progress and outcomes. The decision was made to adopt the **Children's Resilience Programme Manual by Save the Children Denmark and the IFRC Reference Centre for Psychosocial Support,** review it and contextualize it to the Turkish case. Implementing partners have been trained on the manual and are now delivering a standard and harmonized PSS package.

Limited number of psychosocial support interventions in formal and non-formal education
Education in the context of emergencies and humanitarian settings is recognized as foundational for children, adolescents and youth's, development and well-being. Continuity of education or attendance of informal education may not only positively contribute to the educational experience, but it can provide a sense of normalcy and a space for socialization with peers. Organizations recognize that the integration of psychosocial support approaches and interventions in formal and non-formal education can be pivotal in supporting children, adolescents and youth's psychosocial well-being, which in turn, may positively contribute to the educational experience. The training of teachers, school counsellors and other school-based staff on PSS and social emotional learning (SEL) can equip them with the knowledge and skills to better deal with their students, creating a more nurturing environment, which in turn, enhances the learning environment for students. Additionally, teachers may be better able to manage classrooms and better prepared to identify cases that may require additional support and provide it or refer them when specialized services are required.

Findings from Phases I and II highlighted however the limited number of organizations providing psychosocial support in formal and informal education settings, as well as limited provision of training for teachers. Among the 42 organizations that participated in the mapping, 12 provided PSS in formal education and 12 organizations provided PSS in non-formal education settings. While these figures may be affected by the fact that PSS delivery through education programmes may have not been captured through this mapping, this gap has been noted in previous national mappings, for instance in the 4WS for Jordan in 2017.

The Better Learning Programme (BLP) by NRC first developed in 2007 in collaboration with the University of Tromsø, was introduced through NRC Palestine education programming in 2012, and over the last eight years, it has reached all NRC's Middle East programmes, including Iraq, Jordan, Lebanon, Libya and Syria.

- **Aims:** The programme aims to improve the learning conditions for children and adolescents that have been exposed to conflict and displacement by offering PSS and SEL.

- **Target groups:** the BLP is delivered to school-aged children (6-15 years) and it involves the capacity building of teaching/non-teaching staff in formal as well as non-formal educational structures, and the activation of the caregivers' role to support their children.

- **Activities:** BLP consists of three components: i) BLP 1 is a general, classroom-based support approach that provides basic psychosocial support to children; ii) BLP 2 is the component that targets a smaller group of children who are underachievers and iii) BLP 3 is based on a clinical approach to address trauma-induced nightmares. The programme has developed a set of manuals and a monitoring and evaluation (M&E) package which include pre and post-tests. Additionally, the programme requires the adaptation and contextualization to reflect the local needs.

- **Effectiveness:** The BLP programme has been evaluated in Palestine and in Jordan (implementation in camps and host community). The results of the evaluation have demonstrated that the programme has been functional when it comes to improving the well-being and participation of children, equipping them with skills for coping with fear, stress and anxiety. It has also supported conditions for children to better succeed in school by improving their ability to focus, strengthen connections with parents and teachers, and improve their ability to complete their academic tasks. However, the actual contribution that it may have to learning outcomes has been harder to assess. To better study the associations between the programme and its outcomes, there are plans underway for further research with the University of Tromsø and the University of Auckland.

- **Key challenges** that have been reported are the extent of scalability of the programme beyond NRC's engagement in light of Ministries of Education formal agreements to institutionalise the BLP.

Inclusive education is central to **UNRWA's** education programme and in this regard, there has been awareness raising and capacity development of the agency's teachers, school counsellors, school principals, and all its professional support cadre, to better enable them to identify and address the needs of students. An inclusive education approach entails creating an environment where the psychosocial needs of all children are recognized and addressed.

UNRWA works to ensure that PSS is provided to all children by providing a safe and stimulating environment within the classroom, but it recognises that some children may require additional support, where the school will plan for school-based additional support measures for the child. Similarly, there will be some children who require extensive PSS, which is beyond the capacity of the school and this requires the school to seek alternative support from appropriate external organisations.

Three key studies help to further strengthen inclusive practices within UNRWA education: the triennial classroom observation study which assesses teaching and learning practices in the classroom, and the extent to which these practices promote an inclusive learning environment; the monitoring of learning achievement which measures students' performance with regards to the equity of learning outcomes, and includes targets to narrow the gap between the high and less high performers; and the perception survey which explores the perceptions of teachers, children and parents regarding the implementation of inclusive education practices in schools. In addition to the data and understanding that these studies generate, the UNRWA Education Management Information System (EMIS) helps to monitor that student with disabilities and additional needs are being supported accordingly.

IRAQ

In Iraq, **Catholic Relief Services (CRS)** has focused on **building the capacity of teachers** to improve learning environments and quality of teaching. Teachers have received capacity building on social emotional learning; integration of PSS in classrooms; and classroom management. Additionally, they have established teacher learning groups that come together to reflect on the challenges they face as well as to come up with solutions. Teachers' observations also take place to support teachers in the implementation of concepts learned during the trainings.

Enhancing the integration of MHPSS and gender-based violence services

Respondents reported the strong linkages that exist between MHPSS and gender-based violence (GBV), and several organizations have integrated MHPSS services within their GBV response. As noted by respondents, the experiences of GBV survivors can be very distressing and as part of the response, they require MHPSS services that can promote their psychosocial well-being as well as prevent or treat mental health disorders. For example, UNHCR noted that MHPSS is integrated in its broader protection programming through community-based protection, child protection and GBV. For the latter, GBV survivors are provided with multi-layered, comprehensive packages.

LEBANON

In Lebanon, ABAAD has a network of 18 women and safe spaces that provide holistic GBV services, and in which MHPSS are fully integrated. Services that are available at the centres include structured PSS activities aiming to build knowledge, skills, confidence and self-esteem of women and adolescent girls; emotional support groups; group and individual counselling. ABAAD also engages men through the men centres, where support is provided at the individual, community, family and couples level.

Limited engagement with parents/caregivers

Results from the survey showed that 74% of organizations provided activities aiming to strengthen parenting/family/caregivers' support. Interviewees remarked that children, adolescents and youth's mental health and psychosocial well-being is intrinsically linked to parents/caregivers' own well-being; therefore, holistic approaches can provide positive results for children, adolescents, youth and their parents/caregivers. Positive parenting strategies are difficult to maintain when parents/caregivers are experiencing trauma, loss, severe stress and daily stressors related to poor living conditions and uncertainty about the future, thus highlighting the needs to support parents/caregivers who can in turn, provide care and support for their own children. Several respondents noted gaps and challenges in working with male parents/caregivers; very limited services for parents/caregivers of adolescents as much of the programmes focus on parents/caregivers of younger children; as well as limited parenting support for parents/caregivers of children with disabilities.

The IRC programme 'Families Make the Difference (FMD) is a group-based intervention that aims to improve the well-being of children by improving parenting practices and reducing harsh punishment. FMD is based on IRC's previous experience with parenting programmes, initially developed for post-conflict settings and now adapted to humanitarian contexts. In the MENA region, the programme is being implemented in Syria and Lebanon.

- **Aims:** the programme aims to improve children's well-being and reduce violence and insecurity that children may face at the hands of parents, namely harsh parenting.
- **Target Groups:** parents and caregivers of children.
- **Effectiveness:** In Lebanon, the programme has been subject to a mixed methods study (qualitative and pre and post), which revealed that the intervention is feasible and acceptable. Pre and post test results revealed improvements with regards to the use of physical punishment; traumatic stress symptoms and parental warmth/affection. For children, the largest change was in depression symptoms. However, the programme would require further research to look in-depth into the effects.
- **Key challenges are that further research, including randomized controlled trials (RCTs), is required to attribute effects.**

The Caregiver Support Intervention (CSI) by War Child Holland is an evidence-based parenting programme that was originally developed in Gaza and is now being implemented in Lebanon.

› **Aims:** the programme aims to strengthen parenting by reducing stress and increasing psychosocial well-being among parents/caregivers of children as well as by promoting positive parenting.

› **Target Groups:** mothers and fathers of children aged 3 to 12.

› **Activities:** the programme consists of nine psychosocial interventions for parents affected by conflict and displacement. It is implemented by trained community members. The first four sessions of the programme give participants with tools and techniques to manage their frustrations while stress management and relaxation techniques are practiced throughout the programme and incorporated into the positive parenting.

› **Effectiveness:** The programme has been subject to a pilot RCT with Syrian refugees in northern Lebanon, and results suggested that the participation in the intervention resulted in improvements in caregiver well-being as well as strengthened parenting skills. Finally, it also showed some improvements in the psychosocial well-being among children.

Limited knowledge on the specific needs of adolescents, including on negative coping mechanisms

Interviewees noted a significant gap on adolescent-focused interventions. Respondents stressed that while adolescents are indeed incorporated in their MHPSS activities, there is a real need for enhancing the understanding of adolescents from a gender and life course perspective, acknowledging the different needs between younger (10-14 years) and older adolescents (14 years and above), and designing tailored MHPSS interventions that holistically address their needs, particularly at levels two and three of the IASC intervention pyramid. Furthermore, challenges exist regarding the identification, recruitment and retention of adolescents on MHPSS programmes, which include restrictive mobility norms, especially for adolescent girls; competing responsibilities that may impede them for attending MHPSS programmes, for instance work, especially for adolescent boys,; and lack of interest when interventions are not adequately responding to their needs.

Additionally, interviewees noted a dearth of data and interventions addressing negative coping mechanisms such as risk behaviours, self-harm and suicide, increasingly reported among adolescents.

LEBANON

In Lebanon, **Plan International** developed its own **PSS package for adolescents** aged 10-17 years. The need for this package was identified through a review of existing PSS programmes as well as consultation meetings with adolescents and their parents/caregivers. While structured PSS packages were available, the organization identified a need for a package that was specifically tailored to adolescents. The package incorporates modules to address the specific needs of adolescents, including sexual and reproductive health and rights as well as modules on gender equality and planning for the future. On the first session of the programme, adolescents are invited to discuss and select 13 out of 31 sessions included in the package that are most relevant to their needs. The adolescent package is accompanied by a similar parenting package with a holistic approach in mind. Parents of the adolescents enrolled in the programme receive sessions on the same topics but addressed to their needs as parents. The objective is to facilitate parents-adolescent interactions as well as to provide parents with the necessary skills and knowledge to support adolescents. In terms of monitoring and evaluation, the package has pre and post test tools, observation tools and a self-evaluation tool for the facilitator.

Key challenges have been noted in the systematic collection of data as the package is being delivered through several partners; however, this is an area where work is underway.

The **Youth Empowerment Programme (YEP),** implemented by IMC is a structured PSS group intervention for adolescents. The aim of the programme is to improve the wellbeing of adolescents by increasing their confidence, self-esteem, resilience and social support networks, as well as to collaborate in a community service project. In the MENA region, the programme has/is being implemented in Jordan, Syria and Turkey.

Groups of 10 same-sex adolescents gather for 16 sessions over 16 weeks to discuss a particular topic. Some of the topics that are introduced are building and identity; communication and talking to parents; self-esteem; relationships; youth and the community; and the development of a youth project at the end of the programme. The adolescents are assessed at the start and end of the programme on a number of measures linked to the sessions that were conducted, for e.g. sense of connectedness with the community.

Fragmented MHPSS response and lack of effective referral pathways

Organizations providing multi-layered services and internal referral mechanisms noted that their capacity to provide holistic services facilitated the work and allowed them to monitor the quality of services. In contrast, organizations that referred cases reported having limited capacity to follow up on the provision and quality of services that individuals may receive once they have been referred. Beyond ad hoc follow up, organizations reported limited circulation of feedback or information on the outcome of referred cases.

Some of the key challenges with case management and referrals were the overload of cases, long waiting lists and limited availability of services, which in turn create delay in the provision of services and feelings of frustration among MHPSS users. Several respondents also noted that when case workers have limited training and capacity on MHPSS, there is a tendency to over-rely on the referral

of cases to specialized mental health services, creating bottlenecks at the highest level of the intervention pyramid, and overlooking the potential for these cases to be addressed through non-specialized mental health care providers. It was reported that overall, referral pathways are more challenging in host communities as opposed to in refugee camps, where there may be stronger coordination in the mapping and referral to adequate services.

Shortage of structures and limited capacity on MHPSS

Respondents noted that the mental health systems inside Syria but also in the refugee host countries are fragile and present significant barriers of access for Syrian refugees. With national mental health systems overstretched and with organizations witnessing a surge in cases requiring more specialized mental health services, there is increasing pressure on the higher levels of the IASC intervention pyramid for mental health and psychosocial support in emergencies. At the same time, organizations noted the limited number of MHPSS trainings that build the capacity of non-specialized staff to provide focused, non-specialized mental health and psychosocial services. The investment on focused non-specialized services (level three in the IASC multi-layered intervention model for MHPSS) can reinforce the sustainability of interventions by building the capacity of local non-specialized staff as well as mitigate the pressure on the highest level of the IASC intervention pyramid for mental health and psychosocial support in emergencies. Additionally, respondents noted that it is crucial that the specialized mental health staff providing services to Syrian refugees are integrated into the overall MHPSS approach and response.

An intervention highlighted as successful is the **Mental Health Gap Action Programme (mhGAP) by the World Health Organization**, where available, local specialists and psychiatrists are identified, trained through training of trainers and supported to conduct mhGAP trainings and supervision for primary health care staff as well as other professional staff, for e.g. social workers, and paraprofessionals, so that they can provide comprehensive mental health care. This approach builds the capacity of non-specialized staff that is often the first point of contact with individuals, to assess their mental health situation and directly manage cases that do not require more specialized services.

5.2 Barriers to Implementation

Respondents discussed the below barriers that affect the implementation of MHPSS programmes.

- **Economic hardship and social exclusion** are considered some of the major daily stressors for individuals and communities affected by the Syria crisis. Contextual factors – the social, political and economic environments – and ongoing daily stressors can support or inhibit the resilience of children, adolescents and youth, as well as parents/caregivers' ability to care and support their children. Several respondents noted the importance in strengthening cross-sectoral coordination between MHPSS and livelihood programmes for instance, as addressing socio-economic sources of distress may contribute to strengthening the resilience of individuals and at the same time, considering the mental health and psychosocial needs of individuals can contribute to their access to livelihood opportunities.

- **Gender and socio-cultural norms** can affect access to MHPSS. Adolescence is a critical period where gender and socio-cultural norms unfold and set many of the attitudes and practices for the future. Restrictive mobility, namely for adolescent girls, may prevent them from accessing MHPSS services, while MHPSS services that are not particularly sensitive towards adolescents may discourage them from accessing services. Similarly, challenges remain in engaging males,

especially male parents/caregivers in parenting programmes, due to issues such as limited understanding of MHPSS services; conflicting schedules as they may be working or looking for work; but also limited tailoring of services that specifically address male parents/caregivers' needs.

- **Limited understanding about MHPSS services as well as potential stigma** associated with the interventions may lead to parents/caregivers preventing their children to access MHPSS. Some respondents noted that parents/caregivers may perceive community-based activities as little more than 'recreation and relaxation' and place larger value on interventions that they consider more beneficial, for e.g. on education. Additionally, taboos around mental health issues may lead to potential discrimination or bullying, especially in case-focused services. Organizations commented that this is where community-based approaches are fundamental to gain community acceptance and buy-in. Moreover, technical terms and jargon must be avoided, and the services must be explained and implemented in ways that are culturally relevant and meaningful.

- **Limited prioritisation of MHPSS interventions.** Some respondents noted that MHPSS may not be viewed as a priority in the context of crisis situations by government counterparts in some countries, and some level of scepticism may emerge on the potential impact of these interventions.

- **Access to hard-to-reach populations and locations** can constrain organizations' ability to provide MHPSS services to children, adolescents, youth and parents/caregivers who may be in acute need of them.

- **In-country existing capacity and capacity building needs, and the state of national healthcare systems** are varied across the NLG countries.

6 EFFECTIVENESS

The importance of the integration of MHPSS into the humanitarian response is increasingly recognized, and growing body of evidence has been demonstrating the positive effects of MHPSS interventions on individuals. However, further investment is required on research, monitoring and evaluation to demonstrate the value or impact of MHPSS programmes, including contextually appropriate and validated indicators as well as research that is rigorous yet adaptable to the needs of complex humanitarian settings.

6.1 Research, Monitoring and Evaluation

Research, monitoring and evaluation were not addressed during Phase I, but emerged as an important issue during Phase II, which focused on the quality and effectiveness of interventions. While the majority of MHPSS interventions concentrate at levels two and three of IASC intervention pyramid for mental health and psychosocial support in emergencies, there is limited evidence on the impact of interventions at these levels. With limited evidence, it becomes difficult to identify and scale up programmes that prove to yield positive results. Respondents acknowledge that scalable interventions remain challenge. The challenge of scaling up is intrinsically linked to the gap in evidence. With limited rigorous evidence on the impact of interventions, it becomes difficult to roll out interventions at scale, as this may compromise the quality and potentially cause harm if the interventions are inappropriate or ineffective. Respondents also acknowledged the complexities of conducting rigorous research and evaluations, including RCT, in humanitarian settings. Despite this inherent challenge, there is a need to strengthen flexible and innovative research that can support the generation of evidence and be adaptable to complex settings.

Wide variation of goals, outcomes and indicators

The wide variation of goals, outcomes and indicators for the many MHPSS programmes being implemented has led to difficulties in demonstrating their value or impact, as well as challenges in comparing tools and measures. Several organizations highlighted the limitations of quantitative indicators only to measure the effectiveness of MHPSS interventions, which are insufficient to reflect the multi-dimensional effects of the interventions. Instead, mixed methods approaches combining quantitative and qualitative indicators as well as monitoring of activities such as visits, observations and assessments with MHPSS service users while a programme is being implemented, can provide more reliable evidence on the quality and effectiveness of the MHPSS interventions.

TURKEY

In Turkey, UNICEF is investing on improving on building evidence around its PSS programmes and is now implementing standardized pre and post-tests through its implementing partners. A crucial point is not only to have standardized approaches and tools to monitoring, but also build the capacity of partners in the use of these tools. **In Syria, UNICEF** has developed a set of qualitative indicators and also employs pre and post-tests in order to be able to measure the quality of PSS programmes, an issue where evidence has been particularly weak.

A practice highlighted by respondents is the **STRENGTHS Project**, that trains Syrian refugees in the use of **Project Management (PM)+**, an evidence-based, scalable psychological intervention that has been developed by WHO. In individual and group format, PM+ provides individuals with skills to improve their management of practical problems and associated common mental health problems. PM+ consists of five, 90-minute sessions that can be delivered by trained, non-mental health professionals. The intervention has been subject to RCTs. The STRENGTHS project is further translating, adapting and testing a version for adolescents, **EASE**. EASE, in collaboration with War Child, is now being tested in Lebanon. The programme focuses on children between the ages of 10 and 14, and is constituted of seven sessions with adolescents and three sessions with the parents/caregivers. EASE is being rolled using master trainers who train trainers, who in turn, train facilitators. The training and intervention materials have been adapted and revised so that the intervention can be applicable to the context.

6.2 Sustainability

Based on the available information on funding shared by organizations, 76% of MHPSS programmes were funded or had secured funding at the time of the survey, while six per cent of MHPSS interventions were not funded.[7] The second phase of the mapping focused on key challenges regarding funding mechanisms of MHPSS interventions as well as broader sustainable approaches.

Short-term duration of funding

All respondents recognized that limited and short-term nature of funding is a constant threat to the survival of the MHPSS interventions, acknowledging that the response remains strongly dependent on funding, rendering the delivery of the MHPSS response subject to the availability of funds. The short-term nature of funding, which in some cases can be of one year or less, compounded with the increased competition for depleting resources and donor fatigue, represent a constant threat to the sustainability of MHPSS interventions.

7 Funding information was not specified for 18% of reported MHPSS interventions.

Investing on local structures and resources

Several respondents noted the importance of designing sustainable, flexible MHPSS interventions from the onset to avoid the risk of having high-cost interventions that may disappear when funding ends. Low-cost MHPSS interventions with sustainable approaches that maximize and build on local capacity and resources are needed, especially in a context of depleting resources for the Syria crisis.

Long-term impact and sustainability of MHPSS interventions ultimately requires community uptake, building on local structures and resources, and the strengthening of national mental health policies and systems. As noted by a respondent, the emphasis continues to be on shorter-term responses and there are limited efforts to systems strengthening. Similarly, it is important to build on existing resources and structures to avoid creating parallel systems that may become unsustainable.

The nature of funding has created a paradox wherein donors are increasingly demanding sustainable approaches; yet the short-term nature of funding limits the ability to invest on systems strengthening and emphasize maximization of local resources that are key to sustainable approaches.

JORDAN

In Jordan, GIZ, in collaboration with the Ministry of Health and JUST University, conducted a study on the MHPSS needs for adolescent Syrian refugees (12-17 years). Based on the results from the study and incorporated into the Ministry of Health's (MoH) work plan, a the project was launch that focuses on the capacity development for professionals working in the health sector for the MoH, NGOs and CBOs in locations with high concentration of Syrian refugees – Mafraq, Sahab and Zarqa. Staff from CBOs, school counsellors and selected teachers, health centres as well as parents receive structured training to improve their psychosocial services in the community. After the initial training, participants are followed up and coached in the field for several months. This initiative is part of a broader framework that seeks to provide holistic MHPSS services to refugee school children and adolescents in Jordan, and which includes the delivery of PSS in schools; the availability of specialized services in health centres; and the involvement of parents by providing them with intrafamily psychosocial support.

One of the highlighted strengths of this project has been the strong cooperation with the different actors that would typically be involved in delivering MHPSS services to children and adolescents, and the clear understanding of what each actor can contribute with to improve the psychosocial well-being of children and adolescents.

7 COMMUNITY-BASED APPROACHES TO MHPSS PROGRAMMES

Community-based approaches are grounded on the understanding that communities are best positioned to drive their own care, provide support to one another and be active participants at all stages of the MHPSS response.[8] Respondents recognized the critical importance of community-based approaches, an area in which organizations have been increasingly investing. A plethora of resources have been produced on this; however, the ways in which participation and engagement of communities and especially of children, adolescents and youth are practiced and understood, remains relatively diverse.

Organizations noted that trust building is essential in community-based approaches and that the participation and engagement of local actors, partners, community leaders, parents, children, adolescents and youth at all stages of the MHPSS interventions facilitate the creation of solid community networks that can support and sustain the effectiveness and sustainability of MHPSS interventions in the long term. Community-based approaches clearly outlined that community participation and engagement must be obtained from the start, involving them in the assessment of needs; design, implementation, monitoring and evaluation of MHPSS interventions. This process ensures that interventions are culturally appropriate, increases trust and ownership from communities.

The IASC guidelines recommend that assessments are conducted with the local community to identify needs prior to the design and implementation of programmes, ensuring that the response fits with actual needs and local values. Organizations recognized that community-based approaches in the **identification of needs** are fundamental. Several respondents commented that these are systematically done in consultation with communities and that the specific cultural and social norms are considered in the design and adaptation of programmes. Furthermore, participatory assessments and engagement of communities from the design of the MHPSS interventions are part of the minimum standards of several organizations. On the other hand, some respondents noted that the contextualization and adaptation of MHPSS resources could be improved and the participation and engagement of communities enhanced.

During programme implementation, several respondents highlighted the feedback mechanisms that are set up to garner MHPSS users' views and experiences, including field visits, FGDs and complaint box mechanisms. An area where participation and engagement remain limited is in the research, monitoring and evaluation processes, including in the design and implementation of evaluation with communities. Moreover, the nature of participation and engagement remains at the consultative and collaborative levels.

While many organizations do employ participatory needs assessments, regularly conduct consultations and garner feedback from individuals at different stages of the MHPSS programmes, there remains a need for placing greater emphasis on community-led actions and particularly, on the systematic engagement of children, adolescents and youth.

8 IASC Community-based Approaches to MHPSS Programmes: A Guidance Note.

TURKEY

In Turkey, IOM adheres to its community-based approach manual for the implementation of its MHPSS programmes. Community consultations are held with community members to understand the local needs and better understand the ways in which programmes need to be contextualized to the local realities. An important component of the community-based approach to MHPSS in Turkey has been the **strengthening of the social cohesion of communities,** acknowledging that both refugee and host communities may face similar MHPSS challenges. Rather than targeting Syrian populations only, the services have sought to address the vulnerabilities and MHPSS needs that both Syrian and Turkish communities may face. MHPSS programmes are delivered through **mobile PSS teams** that target geographical areas with particularly vulnerable population that may otherwise not have access to services.

8 COORDINATION

MHPSS coordination mechanisms and working groups exist in all NLG countries and interviewed organizations noted their regular attendance. Interviews commented that the core strength of these coordination mechanisms is information sharing, allowing different organizations to better understand the operations of others. They were also seen as platforms were bottlenecks and harmful practices can be flagged and where global standards can be promoted. In Turkey, a respondent commented that the working group has been effective and that participating organizations rely on the information that is being shared to identify gaps in service delivery as well as levels of accessibility.

Conversely, some interviewees noted the shortcomings of the coordination mechanisms. Findings suggested that while information sharing is a strength, there were often duplication of efforts, especially when conducting needs assessments. Instead of maximizing the availability of existing data and assessments prior to the undertaking of new ones, organizations tend to conduct their own assessments, but not necessarily address existing information gaps. Another challenge with regards to coordination is the limited common understanding of what MHPSS is and what the basic requirements. The development of minimum standards would allow for strengthened coordination.

With regards to cross-sectoral coordination and integration of MHPSS across other sectors, several respondents noted that more efforts must be done to increase awareness and understanding of the importance of MHPSS as well as enhance systematic integration of MHPSS programmes and approaches across the humanitarian response. To support this integration, several respondents suggested investment in the capacity building of humanitarian staff on the basic principles of MHPSS across other sectors, which would strengthen the buy-in for an integrated MHPSS response as well as enhance the nature and quality of MHPSS service delivery.

One respondent noted that when looking at the Whole of Syria response, the work of the MHPSS working group for North-West Syria has demonstrated some good practices with regards to coordination. For example, they jointly developed self-care policy guideline and a hotline for MHPSS staff, based on the identified needs through a survey with MHPSS workers.

9 CAPACITY DEVELOPMENT AND STAFF CARE

9.1 Capacity Development

Key considerations are that qualified and trained staff with the adequate technical and contextual understanding for the job requirements are crucial in the delivery of effective MHPSS responses. Findings suggested that organizations invest on a broad range of trainings for their staff and that capacity building must be an ongoing process that requires long-term planning and investment. Unfortunately, long-term capacity building is difficult within the short nature of funding that MHPSS programmes are subject to. **The lack of long-term capacity building plans for MHPSS staff as well as the limited tailoring of trainings** to the specific needs of staff and contexts were noted as key barriers. Some respondents noted that the trainings being offered were not tailored to their specific learning needs and contextual challenges that they face.

Lack of systematic follow up and supervision of staff

Respondents acknowledged that **supervision and coaching** are essential for frontline staff. It allows them to build on their skills and contributes to the delivery of quality services. Supervision and coaching were noted to be particularly critical when dealing with high-risk cases, where advanced technical skills are required to manage the case. In terms of the provision of supervision and coaching, there were significant variations among organizations. While some organizations have established systematized supervision pathways, others noted that supervision and coaching was rather subject to the supervisors' own initiatives. Respondents engaged in the supervision of frontline staff highlighted that they often joggle between managerial and administrative responsibilities, and technical support to their staff. However, when faced with an overload of work, systematic technical supervision may get overlooked. Several respondents engaged in case management recognized that this is an area where more systematic coaching and supervision must take place to ensure the quality of services being delivered. More technical skills must be developed in areas such as case management and referral pathways to ensure continuum of care for children, adolescents and youth, especially for the more complex cases. In cross-border operations and areas with limited access, the remote nature of coaching and supervision adds an additional layer of challenges to overcome.

IRAQ

In Iraq, the SEED Foundation has created parallel lines of management and technical supervision for frontline staff. Technical supervisors provide frontline staff support with the clinical and more technical aspects of the implementation of their activities – community-based MHPSS, mental health and case management – and also conduct field visits to support front line staff with issues they may face.

SYRIA

In Syria, the Norwegian Church Aid (NCA) in collaboration with its implementing partners, identified the capacity building needs in Syria with regards to GBV case management. The assessment and lessons learned from previous projects revealed that frontline staff required a more sustained approach to capacity building and not only a one-off-training. To address those needs, along with a series of trainings on multiple topics covering GBV and MHPSS, an online help desk was established for case workers to seek advice and support on the management of their cases. This practice helped not only provide ongoing support to the case workers, but it also acted as a monitoring mechanism to identify the most common challenges faced by case workers.

Insufficient specialized and practice-oriented trainings and resources

While all organizations conduct trainings for their staff, the duration, follow up and outcomes of these trainings varied. Some respondents commented being satisfied with the level of training and support that they received, while others noted that their organizations provided limited trainings or if they did, they did not have much follow up or refresher trainings afterwards. Overall, trainings were short in duration and typically one-off trainings with limited or no follow up. Some respondents commented that they were not adequately supported in the application of what was being learnt. With regards to training modalities, respondents advocated for the integration of more real case scenarios and 'learning by doing' approaches that would enhance the learning experience. Theory-based trainings have been noted as insufficient to build the capacity of staff on MHPSS, and several interviewees noted the need for training programmes that incorporate learning by doing, i.e. practice. Curriculum on evidence-based interventions such as Psychological First Aid (PFA), Problem Management Plus, but also mhGAP Humanitarian Intervention Guide, require field practice, as well as regular supervision via on-site visits.

E-learning and access to online resources for continuing professional development were available to most respondents. While frontline staff commended the availability of these resources, they noted limitations regarding content, language barriers and time availability to benefit from these resources. Findings suggested that there is a need for specialized content, for example on PSS, SEL as well as on the case management of high-risk cases. Lack of opportunities and time to make use of the e-learning services, as well as language barriers for some staff when many of the resources are in English, but not in Arabic or Turkish, were noted. Some respondents noted challenges in the translation of MHPSS concepts into Arabic, where variations in the translation can impact the content that is delivered.

High staff turnover and heavy reliance on funding for staffing

Investing on the capacity building of national organizations and systems as well as on national staff capacity is a critical point for the successful implementation of MHPSS programmes, contributing to sustainable approaches. Staffing is intrinsically linked to funding availability, and the short nature of funding makes it difficult to adequately train and maximize on this capacity building by retaining staff. High staff turnover is a key challenge for many organizations, largely affecting smaller, local organizations but also larger ones. Compared to larger organizations, smaller organizations have limited resources to retain staff during funding gaps. The high staff turnover can have a negative effect on the quality of the MHPSS response and increases the workload of staff that must be constantly recruiting and building capacity of new staff. Additionally, the recruitment of Syrian staff, which contributes to building sustainability, posed severe limitations in some contexts as work

permit processes are lengthy and often difficult to obtain, limiting the opportunities to involve them in the response. In Turkey, language barriers are a significant challenge, as organizations strive for qualified staff on MHPSS that can work in Arabic and Turkish.

TURKEY

In Turkey, IOM has addressed the staffing availability issues it faces by building the capacity of Turkish and Syrian social workers. IOM launched a certificate programme that trained 25 social workers from the community on MHPSS, who have then joined the mobile PSS teams.

9.2 Staff Care

The survey showed that 57% number of organizations reported the availability of staff care policies. During Phase II, all interviewed organizations had some level of staff care policies and initiatives in place. **Findings suggested that there must be greater emphasis and investment on staff care.**

Information about the availability of staff care and services was mixed, with some respondents noting that they had received little information about the availability of services and wished they had been duly informed about the support they can access from the start. This is particularly important for organizations that may not have formal structures and referral pathways, where staff can feel disoriented regarding where to seek support. An important issue was that some frontline staff will be hesitant to speak about staff care issues with their direct line manager as they feel that this will reflect on their performance.

Larger organizations typically have structured staff care policies that are integrated into their human resource policies. For example, the International Medical Corps (IMC) has institutionalized staff care into its programmes. In contrast, smaller organizations have fewer in-house capacity and resources to invest on staff care, depending on contracted services when funding allows, and often, relying on the ad hoc staff care support that managers can provide to frontline staff. In these cases, several respondents stressed that managers require enhanced capacity building on staff care as well as support themselves. Staff care must not consist of a one-off training but rather, be an ongoing process. One respondent commented receiving training on how to provide staff care to its team.

For organizations with implementing partners, respondents highlighted the importance of incorporating staff care and capacity building around staff care into the work plans, especially for those that may not have systems in place. This is one of the ways to ensure that staff care takes place at all levels.

For frontline staff, the most common staff care services were individual counselling, either face-to-face or remotely, and organized well-being activities. Respondents commented that while organizations are increasingly more supportive about staff care and self-care, feelings of lack of time and opportunities to benefit from staff care persist.

Additionally, it was recognized that frontline staff, especially refugee outreach volunteers or workers are particularly at risk of compassion fatigue and vicarious trauma when confronted with challenging environments – which they may themselves be facing in their personal lives – and high-risk cases, and may require additional support to mitigate the effects of stress and burnout. Finally, the short-term nature of many contracts and uncertainty around the continuity of position are sources of stress as well as factors that can demotivate staff.

9.3 Self-care

The notion of self-care was reported as important and as an area where there needs to be stronger emphasis on cultivating a culture of self-care across and within organizations. Some respondents commented that while there is increasing emphasis on self-care at the organization level, in practice, there is little or no time to practice self-care. Findings suggested that self-care is an area that could benefit staff and that investment is needed in the provision of trainings, resources and tools that can build awareness around self-care and facilitate its practice. For instance, one respondent noted that the training on self-care had provided the tools to better deal with stress management from and outside work, significantly enhancing the well-being after receiving it. Some other staff noted that their understanding of self-care was limited, but that after having been provided with trainings, tools, they were in a better position to support themselves as well as peers.

Finally, several respondents stressed that the creation of peer-to-peer support groups have the opportunity to provide guidance, support and contribute to a culture of self-care.

JORDAN

LEBANON

PALESTINE

In Jordan and Lebanon (and Palestine), NRC has launched the Supporting the Supporters Initiative. This is a concise package of PSS and self-care modules and materials that are provided to NRC staff operating in crisis context and for the BLP programme. It is a capacity-building phased approach. In the first phase, NRC staff was trained on the package, and in the second phase, MHPSS service providers staff that have been collaborating on the BLP with NRC, will be trained on it. Staff that participated in the first phase felt overall positive and confident about the approach, although they highlighted the potential difficulties in providing peer-to-peer support.

10 COVID-19

COVID-19 has profoundly transformed the way we live, deeply affecting children, adolescents and youth's daily lives. Quarantine measures and movement restrictions have disrupted young people's access to education as well as socialization with peers. It has also fractured the ability of individuals to access protective and supportive services that may otherwise be available. The COVID-19 pandemic has brought a new set of challenges and stressors to the populations already affected by conflict and displacement of the Syria crisis. Organizations recognized that the pandemic may be increasing levels of stress and anxiety among children, adolescents, youth and parents/caregivers, and that the provision of MHPSS services can help populations understand, adapt and cope with the situation. Organizations also acknowledged that COVID-19 has strengthened the case for integrated MHPSS interventions across all sectors of the humanitarian response. The pandemic has also made a strong case for the importance of MHPSS community-based approaches and the stronger engagement of community members. In times of crisis as the one presented by COVID-19, communities-based protection networks are best placed to provide support.

- **Socio-economic impact of COVID-19**
  The already precarious situation of many Syrian refugee families in the NLG countries is likely to deepen. Some organizations noted that they have and continue to implement their cash-assistance programmes yet reaching populations in the context of mobility restrictions is challenging and poses the risk of populations losing access to vital support. The economic depletion of resources is projected to become a key source of distress, which in turn can have a negative impact on the mental health and psychosocial well-being of populations.

- **Rising levels of violence**
  Pre-existing factors contributing to violence in the household, coupled with the additional socio-economic stressors related COVID-19, and the restricted movement and social isolation measures, can lead to exponential increase of violence and abuse. At the same time, those affected may struggle to access the services that they would normally be able to.

- **Rising levels of distress**
  There have reportedly been increased levels of anxiety among children, adolescents and youth. Parents/caregivers, who are themselves experiencing the challenging situation, have expressed frustration in the lack of access to support and resources that can in turn, help them support their children. For adolescents who have grown up in conflict and displacement, the COVID-19 pandemic may exacerbate feelings of hopelessness and may lead to an increase in negative coping mechanisms, including self-harm and suicide.

10.1 MHPSS Interventions During COVID-19

In terms of the delivery of MHPSS interventions during COVID-19, respondents agreed that the crisis has pushed everyone to think 'outside of the box'. It has also shown that innovative approaches can be employed to continue the delivery of services, including the employment of remote support. Organizations have adapted their MHPSS interventions, shifting mainly to remote delivery and focusing on key services.

- **Information dissemination** is being carried out through multiple platforms – social media, messaging apps (e.g. Whatsapp), radio, telephone. Where feasible, community outreach is being done through networks of volunteers in the communities. Messaging is focused on raising awareness on hygiene and social distancing practices during COVID-19, in collaboration with health and WASH sectors; on violence prevention; as well as basic psychosocial support and practices that children, adolescents, youth and parents/caregivers can adopt.

- **Case management services** are mainly being handled remotely. In more complex cases and depending on the movement restrictions, face-to-face support is provided. The continuity of case management has been placed as a priority, especially for high-risk and existing cases. Respondents highlighted the difficulties in conducting remote case management, especially with new cases.

- **Parenting resources,** addressing topics such as how to manage stress and how to support their children's mental health and psychosocial well-being, are being disseminated through various platforms, including social media, messaging apps (e.g. Whatsapp), pre-recorded and streaming videos.

- **Child-friendly resources,** including child-friendly messaging on COVID-19 and on how to cope with the situation, as well as MHPSS activities that can be conducted at home are being disseminated to parents/caregivers and their children.
- **Structured PSS activities** are being delivered remotely by several organizations. For e.g. NRC

has adapted its classroom based BLP to remote mode while other organizations have adapted their structured PSS activities to be delivered through Whatsapp.

- **Online individual and group counselling** are being delivered remotely – for e.g. by telephone, Skype, Whatsapp. For example, Abaad in Lebanon has established e-emotional support groups on Whatsapp.

- **Telephone hotlines** have been established to provide psychological support (including PFA) and other basic services to beneficiaries. Respondents referred to the IFRC guidelines for delivering remote PFA during COVID-19. Other organizations, for e.g. IMC, have established hotlines in collaboration with other sectors like GBV to provide case management and remote PFA simultaneously.

- **Offline resource packages**, including PSS activities and materials to be conducted by parents and their children at home are being prepared in some contexts. However, organizations are facing challenges on the actual delivery of these packages in most contexts. Respondents reported that many families with lack of resources are facing challenges to keep the children occupied, noting the need for psychoeducational materials that children and families can use offline.

- Organizations providing **case-focused services** at levels three and four of the intervention IASC intervention pyramid for mental health and psychosocial support in emergencies are striving for the continuum of care.

- Several organizations are preparing for **remote capacity building** of community volunteers, staff from community centres and teachers on how to better integrate MHPSS into their work and support children, adolescents and youth.

10.2 Challenges in Delivering MHPSS During COVID-19

All respondents agreed that COVID-19 has created a paradigm shift and has resulted in multiple challenges that affect the continuity of MHPSS services.

- **Limited access to populations**
  The most immediate and obvious challenge has been the loss of physical access to populations. Most MHPSS interventions that would typically aim to strengthen family and community support have been suspended. While remote service delivery has been made possible in some cases, remote service delivery comes with its own set of limitations. The concern lies particularly in continuing to provide case and support for high-risk cases and particularly vulnerable individuals, including separated/unaccompanied children and others.

- **Limited access to remote services**
  The delivery of remote MHPSS interventions assumes at a minimum, access to the Internet, and many of the remote MHPSS interventions may require smartphone devices. As such, populations who do not have access to this, may face exclusion from services. To mitigate this, some organizations have provided beneficiaries with Internet access, but this remains overall a challenge.

- **Ethical principles and practices on remote services: trust, privacy and confidentiality**
  The provision of remote MHPSS interventions raises several ethical principles, which must be considered to avoid doing harm. In case management, respondents remarked that individuals, especially adults, have reported feeling weary about this mode of intervention. Respondents highlighted that it is challenging to build the necessary relations of trust and privacy that case

management requires over the telephone or online. Respondents noted that follow up of existing case management services remotely has been easier compared to the opening up of new cases, where individuals may be much more uncomfortable of addressing their case remotely and with individuals they have never met. For GBV cases for instance, the person may lack the privacy and space to discuss as the perpetrator may be in the same space. Respondents reported that children, adolescents and youth are overall more accepting of remote support, but that parental trust and buy-in is still needed.
The confidentiality of information is another issue of concern with the use of remote services, and populations may be more distrustful of participating in remote group or individual sessions due to concerns over confidentiality.

Respondents highlighted that key questions that emerge with the provision of MHPSS services remotely are the ways in which informed consent, privacy and confidentiality can be ensured; the methods that are being employed; and finally, how can populations that cannot access remote services be supported. In one organization for instance, it was decided to include moderators in all the Whatsapp communications to flag any malpractices but also to identify cases that may need additional support.

- **Consequences of remote MHPSS services**
  The possibility of continuing MHPSS interventions remotely was positively remarked by respondents. At the same time, several respondents noted that remote modalities do implicate that the full range of services cannot be provided in the same way and that potentially, the effects may be different. For example, one respondent noted that when it comes to case management, it is extremely difficult to provide a full care plan. Instead, the adaptation of remote case management has consisted of providing a basic care plan and ensuring that individuals remain healthy. An important point that was raised by several respondents is the issue of monitoring and evaluation of the quality of remote services.

10.3 Staff-Care during COVID-19

Respondents agreed that similar to a stronger case for the need for integrated MHPSS across all sectors, COVID-19 has also raised awareness about the importance of staff care and self-care. Overall, respondents noted that organizations have been reactive with the provision of information regarding COVID-19 and the changes to their work. In one organization, staff is now able to access a COVID-19 online library, including resources on stress management; and hold weekly remote meetings with staff care personnel. In another organization, self-care resources are being provided regularly to the frontline staff. Respondents noted that case workers conducting remote case management may feel particularly overwhelmed, as they are handling the increased distress expressed by their cases and which in turn, may exacerbate stress and burnout.

11 RECOMMENDATIONS

Based upon the findings of this mapping, 15 recommendations were developed. Consensus around their prioritization and feasibility was obtained through consultation and validation with the NLG MHPSS Task Force members. Against the backdrop of the COVID-19 pandemic, which has rendered the MHPSS response ever more relevant, below are the **top priority recommendations,** followed by recommendations considered of medium priority.

Top Priority Recommendations

MHPSS Programming	**Advocate for holistic and comprehensive MHPSS interventions that address children, adolescents and youth›s broader social environments,** including socio- economic and educational barriers, as well as parents/caregivers' psychosocial well-being.
	Invest in the integration of psychosocial support in formal and non-formal education settings by building the capacity of teachers, counsellors, and other care-workers with periodic, relevant and structured trainings, to deliver PSS as an integral component of the curriculum and other activities, in addition to specific PSS activities.
	Ensure that the voices and perspectives of children, adolescents and youth - boys, girls and the most marginalized - but also of parents/caregivers and community members are systematically taken into consideration. Mechanisms must be developed and implemented so that they have an opportunity to take a more active and leading role at all stages of the MHPSS programming, including in the monitoring and evaluation mechanisms.
	Promote multi-layered, MHPSS approaches focusing on adolescents, including on parent-adolescent relationship. The impact of the Syria crisis, now amplified by the socio-economic impact of COVID-19, has deeply affected young people's psychosocial well-being and hope for the future.
Research, Monitoring and Evaluation	**Gain a better understanding of the MHPSS needs of specific groups, namely adolescents and youth engaging in negative coping mechanisms like suicide and self-harm.** While anecdotal evidence accounts for a surge on this issue among adolescents and youth, a better understanding of suicide-related behaviours, at-risk-groups and cultural approaches to suicide and self-harm must be gathered to enable the design of interventions that can address these specific needs. It is therefore crucial to generate more age and gender disaggregated data that can help better understand the specific needs of adolescents and youth, providing age and gender-sensitive interventions to their mental health and psychosocial well-being. Similarly, other groups for which there is considerable dearth in data are children with disabilities, street children and unaccompanied children.
Sustainability	**Advocate for longer-term funding that can support the undertaking of more research on evidence-based programmes as well as longer-term capacity development plans.** These two areas can contribute to improving the quality of service delivery and at the same time, contribute to developing more sustainable interventions.

Capacity Development and Staff Care	**Invest in longer-term capacity development tailored to the specific contextual needs and learning needs of MHPSS staff, as well as strengthen the mainstreaming of MHPSS approaches with staff across the humanitarian response.** Trainings on MHPSS interventions must include regular and systematic supervision, on-site coaching and field practice. It is recommended that organizations conduct assessments on their capacity development gaps and needs and build their capacity development plans accordingly, combining practical and theoretical approaches and exercises that enhance the learning. For frontline staff, systematic supervision and coaching must be strengthened.
	Increase investment on staff care, including self-care. Organizations should commit to the institutionalization of staff care by mitigating internal stressors, establishing transparent, equitable and supportive management systems, fostering a culture supportive of staff care, including for instance, the establishment of peer-to-peer support groups, and providing opportunities for staff to make use of the services when needed. This must be expanded for frontline workers during COVID-19.

Medium Priority Recommendations

MHPSS Programming	**Promote effective ways of cross-sectoral collaboration including MHPSS to the COVID-19 response,** by looking into innovative approaches and best field practices in remote support taking into consideration logistics, telecommunication needs and safeguarding measures.
	Promote task-shifting in psychosocial interventions by building local capacity of MHPSS non-specialists on low-intensity, evidence-based psychosocial interventions, such as Problem Management Plus or Inter-personal therapy, to mitigate the reliance and shortage of mental health professionals, and address the most common psychosocial distress affecting children, adolescents and youth and their parents/caregivers, particularly in contexts of displacement.
Research, Monitoring and Evaluation	**Encourage the implementation and monitoring and evaluation of mental health and psychosocial support programmes** by the adoption of a minimum set of indicators as part of good humanitarian and programming practice. It is also vital to expand the incorporation of qualitative methodologies into the monitoring and evaluation of MHPSS interventions. Monitoring and evaluation mechanisms that rely on quantitative methods are not adapted to fully assess MHPSS interventions. Organizations should emphasize mixed methods approaches that can be better suited to assess and evaluate the quality and effectiveness of MHPSS interventions.
	Encourage research with a systemic focus on low-intensity psychosocial support that engages in the evaluation of interventions with the potential for large scale up.
Coordination	**Advocate for a stronger integration of MHPSS across the different sectors of humanitarian response,** emphasizing on the interrelated influences of the cultural and social environment on children, adolescents and youth as well as parents/caregivers' mental health and psychosocial well-being.
	Enhance the role of national and regional MHPSS coordination groups as dynamic platforms where joint actions can take place, flagging harmful practices and promoting global standards, and through which duplication of efforts can be avoided. In a similar way, organizations should maximize the availability of existing data and assessments prior to the undertaking of new ones, which should serve to address information gaps.
	Promote harmonized approaches and common understandings of MHPSS within and across organizations, with the enhanced implementation of minimum standards, aligned with global guidance, and adapted to different contexts across organizations.

12 BIBLIOGRAPHY

IASC (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.

NLG (2019a). NLG MHPSS Desk Review Report: MHPSS Programmes for Children, Youth (0-24) and Parents/Caregivers in Syria and from Syria and Iraq Crises Affected Countries.

NLG (2019b). NLG MHPSS Mapping Report: MHPSS Programmes for Children, Youth (0-24) and Parents/Caregivers in Syria and from Syria and Iraq Crises Affected Countries.

WHO and UNHCR (2012). Assessing mental health and psychosocial needs and resources: toolkit for humanitarian settings.

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13 ANNEXES

13.1 Interview Guide: Assessment of MHPSS Interventions

N.B. This interview guide is meant to guide a semi-structured discussion around the key highlighted themes/topics.

General Information

Sex: Male ☐ **Female** ☐
Nationality:
Age:
Organization:
Job title/area of work:
Years of experience:
Region where you work:
Educational level:

Introduction

1. Can you please briefly describe the MHPSS programme(s) that you are currently providing?
2. Can you please indicate where these programmes are being implemented?
3. Who are the main targets of these programmes?
   a. Can you please describe in terms of age, sex and other criteria?

Evidence

4. How were the MHPSS programmes designed and selected?
5. Are the programmes designed based on research or conceptual framework?
6. Have needs assessments been conducted prior to the implementation of these MHPSS programmes?

7. How has the collected evidence and information been integrated into the MHPSS programmes?

8. Have the voices of the community, children and youth been incorporated into the evidence/ assessments that are conducted?
   a. If yes, can you please tell me more about this.

9. In your opinion, how does evidence support the implementation of the programme?
   a. What worked well?

   b. What could be improved?

10. What are the monitoring and evaluation mechanisms that are being used for your MHPSS programmes?

Relevance

11. In your opinion, how have the norms, values and culture of the population been considered in the planning and implementation of the programmes?

    a. What worked well?

    b. What could be improved?

12. How was the targeted population identified?

13. How were the needs of this targeted population identified?

Effectiveness and Impact

14. Can you please summarize the objectives of the MHPSS programmes?

15. What have been the concrete results of your MHPSS programmes?

16. What have been some of the main obstacles that you have faced in the implementation of the MHPSS programmes?

17. In your opinion, what has worked well to achieve the objectives? What could be improved?

18. Have these results been assessed? If yes, how?

19. In your opinion, how have the results benefited the targeted population? Has there been any unintended consequences?

Sustainability

20. Does the intervention capitalize and strengthen existing, formal and informal local support structures? If yes, can you please tell me more about it.

21. Does the intervention build or feed into government or local civil society plans and capacity?

22. What is the funding status of the programme?
    a. To what extent was it easy/difficult to obtain/secure funding?

23. What are the financial plans to ensure continuity?

24. What are the financial barriers to its sustainability?

25. In your opinion
    a. What has worked well to ensure sustainability of the intervention?

    b. What could be improved?

Participation and community engagement

26. Does the practice involve participatory approaches?
    a. If yes, what are these?

27. Does the intervention involve the participation of local community?
    a. If yes, what are these?

28. Do the programmes engage community stakeholders? How?

Multi-layered and integrated support

29. Do your MHPSS programmes intervene across multiple layers?

30. Are the activities of your MHPSS programmes integrated into wider existing systems?

Coordination and inter-sectoral approaches

31. Are your MHPSS programmes integrated into other sectors? (for e.g. with child protection, health and education) If yes, with which sectors and how?

32. What collaboration mechanisms support your MHPSS programmes?

    a. What has worked well?

    b. What could be improved?

COVID-19

33. How have your MHPSS programmes been affected by the COVID-19 outbreak?

34. What is your response plan to COVID-19?

Concluding remarks

35. Is there anything else you would like to add?

13.2 Interview Guide: Capacity Building and Staff Care

N.B. This interview guide is meant to guide a semi-structured discussion around the key highlighted themes/topics.

General Information

Sex: Male ☐ **Female** ☐
Nationality:
Age:
Organization:
Job title/area of work:
Years of experience:
Region where you work:
Educational level:

Introduction

1. Can you please tell me what your position consists of?

2. Can you please tell me what academic and professional training you have?

Capacity Building Opportunities

3. What capacity building opportunities does your organization offer?

4. How are these capacity building opportunities accessed and delivered (for e.g., online, face-to-face)?

5. Who delivers them (for e.g., in-house or outsourced?)?

6. Have you participated in any capacity building opportunities offered by your organization?
   a. Can you please tell me in which ones and when?

b. How was your overall experience?

7. Did you find the capacity building opportunities useful for your work?

8. Was there any follow up to the capacity building you received? (supervision?)

9. In your opinion, what are the gaps in capacity building?

Quality and Access of Capacity Building

10. In your opinion, is the capacity building offered by your organization relevant and effective?

11. In your opinion, what could be improved in terms of quality and access of capacity building?

12. In your opinion, what are some of the opportunities and challenges that your organization faces with regards to capacity building?

13. How are the capacity building opportunities monitored and followed up?

14. In your opinion, what are the most effective capacity building opportunities? Why?

Other Capacity Building Opportunities

15. Besides the capacity building offered by your organization, do you access any other opportunities?
    a. Which ones, when and how?

    b. Have you found them useful? Why?

16. What sort of capacity building/trainings would you like to have access to?
    a. Why? How?

Staff Care and Self-care

Staff care policies

17. What are the staff care policies and other care services of your organization?

18. How did you find out about these staff care policies and services?

19. How do you access these services?

20. To what extent have you accessed these services?

21. How would you describe/rate the quality of the services?

22. In your opinion, what are some of the challenges faced by your organization regarding staff care services?

23. In your opinion, what could be improved regarding staff care?

Self-care

24. In your opinion, what is self-care?

25. What are some of the self-care strategies that you use?

26. Do you think that your organization facilitates/supports self-care?
    a. If yes, how?

27. Do you think self-care is important and needed in your line of work?

28. Do you think self-care helps you deal with stress and overcome difficulties? Why/why not?
    a. If yes, how?

Concluding remarks

29. Is there anything else you would like to add?

13.3 Participating Organizations

Organization	Phase I	Phase II
ABAAD (NCA partner)		X
Action Against Hunger (ACF)	X	
Association of Assistance, Solidarity and Support for Refugees and Asylum Seekers (MSYD-ASRA)	X	
ASAM (UNICEF Turkey partner)		X
Catholic Relief Services (CRS)	X	X
Cordaid	X	
Danish Church Aid (DCA)	X	X
GIZ	X	X
Finn Church Aid	X	
Heartland Alliance International	X	
Humanity & Inclusion	X	
Humanity & Inclusion - Syrian Mission	X	
International Medical Corps (IMC)	X	X
International Organization for Migration (IOM)	X	X
International Rescue Committee (IRC)	X	X
INTERSOS Jordan	X	X
Jesuit Refugee Service (JRS)	X	X
MARAM	X	
Medair	X	
Médecins Du Monde (MdM) France	X	
Ministry of Heath, Iraq	X	
MSF	X	
Norwegian Church Aid (NCA)	X	X
Norwegian Refugee Council (NRC)	X	X
Oum el Nour	X	X[9]
Plan International Lebanon	X	X
Psychosocial Services and Training Institute in Cairo (PSTIC) / Programme of Terre des hommes	X	
Relief International	X	

9 No interviews were conducted but documentation was shared.

René Moawad Foundation	X	X
Save the Children (Egypt)	X	
Save the Children (Jordan)	X	
SEED FOUNDATION	X	X
Syria Bright Future[10]	X	X
Un Ponte Per	X	
UNHCR	X	X
UNICEF[11] (Iraq)	X	
UNICEF (Syria)	X	X
UNICEF (Turkey)	X	X
UNRWA	X	X
UOSSM	X	
War Child	X	X[12]
WFP	X	
WHO (Iraq)	X	
World Vision (Iraq)	X	

10 During the interview conducted in Phase II, the organization informed that activities had been suspended for 2019 due to funding.

11 It is known that UNICEF has MHPSS interventions in the other NLG countries; however, the mapping was not able to obtain details on their activities in the remaining countries.

12 No interviews were conducted but documentation was shared.

For more information please visit *www.nolostgeneration.org* or contact *menaronolostgeneration@unicef.org*