Engagement of protection actors in MHPSS: the need for cross-sectoral cooperation

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Fostering the mental health and psychosocial well-being – within a comprehensive protective response – of people affected by humanitarian emergencies requires multi-sectoral action and coordination.

Many people living in areas affected by violence and conflict experience a negative impact on their mental health, and one in five develop a mental health condition, which is much higher than for populations not affected by conflict.[1] Affected people may require focused psychosocial support or clinical mental health and psychological services. First and foremost, however, affected people need supportive social networks and to have their basic needs and security met in ways that preserve their dignity and agency, and uphold their rights.

Over the last decade, supporting the mental health and psychosocial well-being of people affected by conflicts, disasters and public health emergencies has gained recognition as a vital part of the humanitarian response.[2] The 2007 IASC *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* have positioned MHPSS as an interdisciplinary field that requires a collaborative approach between multiple humanitarian disciplines.[3] In 2019, the global leadership for humanitarian response (the IASC Principals) re-affirmed the decision to "treat MHPSS as a cross-cutting issue that has relevance within health, protection, nutrition, education and Camp Coordination and Camp Management sectors/clusters, in all emergencies".[4]

Humanitarian programmes tend to focus on a specific sector while individuals, families and communities in emergency settings often present with multiple problems and needs that cut across sectoral definitions. Since 2007, strong technical tools for specific MHPSS interventions have been developed in areas

such as health, nutrition, education, gender-based violence and child protection. But the whole humanitarian response needs to adopt an MHPSS approach. This implies providing humanitarian assistance in ways that support the mental health and psychosocial well-being of persons of concern even when the primary focus of the intervention is sectoral. In short, promoting and protecting psychological well-being (positive mental health) and delivering MHPSS services must be firmly embedded within sectors and delivered across sectors.

Objectives, resources and structure

Addressing MHPSS requires a clearly defined space for the topic within humanitarian coordination structures. The IASC Principals agreed in their 2019 meeting to "reflect MHPSS indicators in relevant planning documents and establish dedicated budget lines, as well as specific MHPSS codes within financial tracking systems and to support the creation and the work of country-level MHPSS Working Groups in all migration, refugee and humanitarian contexts as crosscutting groups". UN agencies recently re-affirmed these decisions in their Joint Interagency Call for Action.[5]

There are currently 50 multisectoral MHPSS Working Groups (WGs) active in humanitarian settings, serving as platforms where agencies involved in MHPSS programming can discuss programming issues. These are technical forums that work across clusters and sectors – and with focal points in these where relevant – but do not replace the role of clusters and sectors, which retain accountability for activities and reporting. The exact configuration and co-leadership should be decided at country level by the involved MHPSS actors but MHPSS WGs are ideally co-chaired by a health agency and a protection agency to balance diverse and complementary approaches.

Integrating community-based MHPSS approaches into other sectors often involves working in a different way rather than taking on new tasks: providing existing services in an effective way (focusing on dignity, agency and participation of affected populations) rather than requiring stand-alone 'psychosocial programmes' to be developed.[6]

A protective environment

One of the four protection principles in the Sphere Handbook is to "assist people to recover from the physical and psychological effects of threatened or actual violence, coercion or deliberate deprivation".[7] It is essential therefore that all humanitarian

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Internally displaced South Sudanese at the Protection of Civilians site near Malakal, Upper Nile, act out a play addressing the issues of suicide and hopelessness.

actors pay attention to the psychological consequences of human rights violations and to the fact that forced displacement affects people differently depending on age, gender and diversity. Without a protective environment it is impossible to address the MHPSS needs of affected individuals, families and communities. The capacity of people and families to take action to claim their rights is negatively affected by pervasive demoralisation, feelings of depression and anxiety, memories related to past events of violence and loss, and worries about current life circumstances and the future.

Protection concerns can cause or aggravate MHPSS conditions and equally MHPSS conditions can cause or aggravate protection concerns. In emergency settings, the rights of people with severe mental health conditions are often violated – even more pervasively than in stable situations. The capacity of people and families to take actions to claim their rights is negatively affected by the mental health and psychosocial consequences of conflict, violence and disasters. Addressing these consequences contributes to protection by strengthening the agency of people to effectively address their protection issues.

Protection actors need to understand the impact of intersecting characteristics of the affected population, with particular attention to cross-cutting issues and continuity of care across a person's lifespan. They can strengthen MHPSS in their work by:

- improving MHPSS interventions to reach all affected population groups
- including MHPSS within the whole range of protection programmes
- establishing referral mechanisms with MHPSS actors in other sectors
- advocating for the establishment of cross-sectoral MHPSS WGs
- encouraging the use of MHPSS outcome indicators within protection programmes[8]
- promoting the work and encouraging further scale-up of Areas of Responsibility (within the Global Protection Cluster) that have systematically incorporated MHPSS within their programming, notably on child protection, gender-based violence and mine action
- promoting inclusion of MHPSS in protection case management for at-risk individuals and families, for example by training case managers in basic psychosocial skills
- making MHPSS a standing item on the agenda of protection cluster meetings and inter-sectoral coordination meetings
- advocating for MHPSS as a cross-cutting issue in the humanitarian response and in the humanitarian programme cycle such as in Humanitarian and Refugee Response Plans, and Humanitarian Needs Overviews.

Development investment and local responses

Investing in MHPSS services not only contributes to reduced suffering of people in humanitarian settings (which would itself be enough reason to do this) but also fosters and contributes to social cohesion, peace and rebuilding of societies in the long term.[9] This requires, from the onset of an emergency, a longer-term vision to contribute to building sustainable structures. Protection actors and relevant stakeholders should encourage the engagement of development actors in response, in order to ensure complementarity between humanitarian and development action. This often means advocating with Ministries of Finance or Planning for longer-term budget allocation to support the health and psychological well-being outcomes of people living within their territories. Addressing the mental health consequences of forced displacement contributes to durable solutions and including MHPSS considerations in activities for durable solutions increases their effectiveness in assisting affected populations, host communities and government authorities to manage and overcome the consequences of displacement and disaster.

Local NGOs often play only marginal roles in coordination. Few of the MHPSS

WGs are co-chaired by local NGOs. To our knowledge this has only happened in Bangladesh (BRAC), Greece (Babel), Nepal (TPO Nepal) and Uganda (TPO Uganda). There are, however, government line ministries in co-leading roles supporting service provision to affected populations through national systems in Afghanistan, Egypt, Lebanon, North-East Nigeria, Niger, Turkey, Ukraine and Yemen (Aden).

For example, in Afghanistan, the MHPSS WG is co-chaired by the Director of Mental Health and Substance Abuse within the Ministry of Public Health and a full-time national staff member from the NGO Action Against Hunger. The programmes and activities of the WG member agencies contribute to the delivery of the Afghanistan national mental health five-year strategy and the building of mental health systems such as the inclusion of mental health in the Basic Package of Health Services and the Essential Package of Hospital Services. These packages are developed by the Ministry of Public Health and supported by a consortium of donors. The WG is also linked with the national mine action victim assistance programme and with protection actors more broadly, with MHPSS-specific indicators included in the protection sections of the 2021 Afghan Humanitarian Response Plan and Humanitarian Needs Overview.

It is imperative that local actors such as community members, volunteers, religious leaders, youth leaders, district health and social care workers, teachers and service-users are fully involved in the development and implementation of MHPSS responses. This is the only viable strategy for cultural shift, sustainability, preparedness, and continuity of treatment and support when humanitarian and logistical access is a challenge, and funding is limited.

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