FORCED MIGRATION review

Mental health and psychosocial support

Plus special features on:
**Data and displacement
Missing migrants**

UNIVERSITY OF OXFORD

REFUGEE STUDIES CENTRE

ISSN 1460-9819

From the editors

We had not expected to be publishing yet another issue of FMR under COVID-19 restrictions – and to be welcoming new Co-Editor Alice Philip to the team without even being able to meet in person! But thanks to the collaboration of our authors and donors, we are pleased to be able to present the latest issue with its three features.

The main feature on **Mental health and psychosocial support (MHPSS)** seems particularly timely during the current pandemic when the mental health impacts of displacement are distressingly compounded by the impact of COVID-19. The 15 articles in this feature explore the importance of MHPSS and the challenges inherent in this field, debate MHPSS initiatives and their application in different contexts, and advocate for strengthened collaboration and commitment – and new ways of thinking.

The authors in our **Data and displacement** feature discuss recent advances in gathering and using data, the challenges that remain, and new approaches, including in the face of pandemic-imposed restrictions.

Unknown numbers of migrants die or disappear during their perilous journeys, and their families are often left in limbo. In our **Missing migrants** feature, authors explore initiatives to improve data gathering and sharing, identification of remains, and assistance for families left behind.

This magazine and the accompanying Editors' briefing are available online and in print at **www.fmreview.org/issue66**. They will also be available in Arabic and Spanish. Unfortunately, shortage of funding means we are unable to publish this issue in French.

Forthcoming: Our next issue will include a major feature on Public health and WASH, and a shorter feature on Non-signatory States and the international refugee regime. See **www.fmreview.org/forthcoming**.

With best wishes

Marion Couldrey and Alice Philip
Editors, Forced Migration Review

Front cover image:
Rose Sakouma holds hands with another member of the Women Standing association in Begoua, Central African Republic. When attacks began in her area, she escaped with her daughters and grandchildren: "I was traumatised, seeing killings, bullets and machetes, heads cut off and people strangled. My husband was killed while escaping. Without Women Standing, I wouldn't be alive today. When we meet, we reassure each other."
UNHCR/Adrienne Surprenant

Forced Migration Review issue 66 • www.fmreview.org/issue66

Foreword: No health without mental health

Sigrid Kaag

Mental health and psychosocial support (MHPSS) is vital for our individual and collective well-being, especially now.

"There is no health without mental health." UN Secretary-General António Guterres reaffirmed this simple but powerful message in May 2020.[1] In a timely effort to sound the alarm, he cautioned that a global upsurge in the prevalence and severity of mental health problems as a result of COVID-19 was very likely, and that action and funding were needed urgently to tackle the devastating impact of the pandemic on access to mental health services.

A WHO survey[2] in October 2020 indicated that COVID-19 had partially disrupted mental health services in 93% of countries worldwide at a time when demand for mental health support is rising. Mental health and psychosocial support (MHPSS) is vital for our individual and collective well-being, especially now. MHPSS is even more crucial for the most vulnerable already living on the margins of society: people who have been hit by conflict or disaster, and who have been forcibly displaced or are on the move. Many of them have already lost their homes, communities, loved ones and livelihoods. The pandemic adds further to their distress and precarious circumstances.

The Netherlands strongly advocates recognising the importance of MHPSS for people and communities affected by crisis, and is committed to ensuring an MHPSS-inclusive approach in all humanitarian efforts, as well as in conflict prevention and peacebuilding programming.[3] Together with like-minded countries and humanitarian agencies, we are making progress. In the past few years MHPSS has finally been designated a priority on the international agenda. Indeed, important agreements on including MHPSS as part of any humanitarian response were reached in 2019, with the Mind the Mind Now Conference and its Amsterdam Conference Declaration[4] whereby a coalition of 28 countries and 10 organisations pledged to address the mental health and psychosocial needs of people affected by emergencies.

Integral to this is the need to:
- promote the integration of MHPSS into all crisis response from the outset
- integrate basic psychosocial skills into the training of every humanitarian worker
- attend to the psychosocial well-being of humanitarian staff, first responders and volunteers.

These principles are high on the agenda of the IASC's MHPSS Reference Group,[5] and are also reflected in the December 2019 resolution[6] by the International Red Cross and Red Crescent Movement, which calls for the integration of MHPSS into all aspects of its emergency response.

However, although important steps have been taken, given the increasing levels of poor mental health we urgently need to scale up our investments – in funding as well as in political and policy efforts and in human resources development. In December 2020, at a high-level meeting[7] during the Humanitarian Week, several UN humanitarian agencies issued a joint call for action, urging parties to honour earlier commitments to provide cross-sectoral MHPSS to meet the needs of people affected by emergencies.[8] In January 2021, the Executive Board of the World Health Organization adopted a decision on mental health preparedness and response for public health emergencies.[9] It calls on the World Health Assembly 2021 to endorse the updated mental health action plan, on Member States to allocate adequate funding, and on WHO to strengthen its capacity in the area of mental health.

MHPSS is not a luxury, an afterthought, or an additional burden. It is an effective tool because it helps individuals, families

and communities to release their potential to recover, maintain or regain their resilience and perspective, to rebuild social cohesion, to resume their livelihoods, and to foster reconciliation. Unlocking this potential through MHPSS is essential to alleviating the effects of conflict, natural disasters, displacement and pandemics. And it can be done – provided that we work in close partnership with affected populations, grassroots organisations and civil society groups, making use of and building on existing experience, expertise and tools.

I very much welcome this issue of Forced Migration Review dedicated to MHPSS, relevant for practitioners, policymakers and researchers alike. It is an excellent gateway to a rich body of knowledge and expertise that need to be disseminated. And I call on all governments and actors to work collaboratively and with strengthened commitment to address the mental health needs of displaced people around the

world and to make full use of the potential of MHPSS. Because MHPSS helps to keep both our minds and our societies at peace.

Sigrid Kaag
Minister for Foreign Trade and Development Cooperation of the Kingdom of the Netherlands
MHPSS@minbuza.nl

1. bit.ly/Guterres-mental-health-covid-video

2. WHO (2020) *The impact of COVID-19 on mental, neurological and substance use services: results of a rapid assessment*
www.who.int/publications/i/item/978924012455

3. See 'Enhanced Integration of MHPSS & Peacebuilding', October 2020 bit.ly/MHPSS-peacebuilding-video-Oct2020

4. International Conference on Mental Health and Psychosocial Support in Crisis Situations – Amsterdam, 7-8 October 2019
bit.ly/Netherlands-MHPSSconference-Oct2019
Amsterdam Declaration bit.ly/Amsterdam-Declaration-Oct2019

5. bit.ly/IASC-MHPSS

6. bit.ly/RCRC-MHPSS-Resolution-Dec2020

7. See bit.ly/high-level-MHPSS-crises-Dec2020-video

8. bit.ly/IASC-MHPSS-CallForAction-Dec2020

9. WHO (2021) *Promoting mental health preparedness and response for public health emergencies*
https://apps.who.int/gb/ebwha/pdf_files/EB148/B148(3)-en.pdf

Creative tensions in the framing of MHPSS

Alastair Ager

The tensions and challenges involved in the development over recent decades of the field of practice now known as mental health and psychosocial support (MHPSS) will continue to shape questions of implementation, prioritisation and impact.

The earliest use of the term 'psychosocial' in the context of forced migration that I have found is by Hertha Kraus in a 1939 Special Issue of the *The Annals of the American Academy of Political and Social Science*.[1] Her paper addressed the sources of stress for those resettling in "a strange country" and noted the psychological and social nature of these beyond the legal, political and economic stressors considered by other authors.

The term only came into wider use in the field in the 1990s, however. Barbara Harrell-Bond had written a chapter in her 1986 classic *Imposing Aid* on "the over-socialized concept of man" in which she had taken the humanitarian field to task for its neglect of the psychological experience of forced displacement. In 1993 I was asked by her to

put together a review of the issue of refugee mental health for Harvard's *Global Mental Health* report.[2] However, it made only passing reference to the psychosocial concept, largely to hint at the broader social and cultural context shaping refugee mental health.

A subtle hint was inadequate to address the divisions that developed in this fledgling field later in that decade. The Rwandan genocide and, particularly, the wars following the breakup of the former Yugoslavia brought the human side of conflict and displacement into both public awareness and humanitarian response. However, addressing mental health issues in populations subject to ethnic-political persecution also brought to the surface sharp tensions between normative psychiatric

responses and broader community-based approaches.[3] Derek Summerfield and Pat Bracken were particularly strong critics of the imposition of Western frames of illness on the victims of human rights violations and oppression. A meeting convened in the late 1990s by the American Red Cross to consider appropriate means of response revealed disparate factions with strong ideological and methodological positions. A number of groups attending noted "a lack of consensus on goals, strategies and impacts".

Forging a consensus

As a result, in 2000 Carolyn Makinson brought together a number of leading international NGOs working in this area with academic groups from institutions that had engaged with emerging approaches into a Psychosocial Working Group to develop a shared framing of the field.[4] The group proposed that psychosocial interventions should be defined by an interest in human capital (notably in relation to the impact of mental ill-health on individual well-being), in social ecology (the relationships and broader social fabric disrupted by forced migration), and in culture and values (especially the erosion of rights and cultural norms). The interaction between these three domains was also emphasised. The core challenge of planning appropriate interventions arose in negotiating the provision of supports in these domains for an affected community in a manner that reflected genuine partnership rather than neo-colonial imposition. In presentations to local actors in-country, it was always discussion of this last issue that received the greatest attention.

Subsequently, two members of this working group, Mark Van Ommeren and Mike Wessells, were invited to co-chair an Inter-Agency Standing Committee (IASC) process for the development of what became the IASC *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. This initiative steered a process which focused on practical implementation rather than theory, and on wide local and national consultation in order to address the concerns about imposition that had marked the preceding

decade. The guidelines, published in 2007,[5] succeeded in providing a framework that both integrated diverse disciplinary perspectives and was transparently accessible to diverse actors, local and international. In doing so, it accommodated major tensions within the field that had undermined coherence and collaboration since its inception.

A maturing, evidence-based field

The guidelines were substantially based on emerging best practice, although it was recognised that the evidence base supporting them was comparatively weak. While the subsequent formulation of supplementary guidelines for specific situations, such as the Ebola outbreak, were important, the most significant development in subsequent years has been gathering this much more robust evidence base. This included a major research agenda-setting exercise by Wietse Tol and colleagues[6] that identified a number of priority questions related to modalities of intervention; these were family- and school-based approaches, assessment methods, and indicators for monitoring and evaluation. Other questions related to identifying stressors, problems and protective factors from the perspective of affected populations, sociocultural adaptation of interventions, and whether interventions address locally perceived needs. The team facilitating this consensus exercise observed that the agenda emphasised "the generation of practical knowledge that could translate to immediate tangible benefits for programming in humanitarian settings, rather than addressing the key debates that have dominated the academic literature". While this may be true, these two clusters of research questions show some resonance with a core tension within the MHPSS framing: the former emphasising the identification of effective and generalisable programme interventions, measures and indicators, with the latter emphasising the need for contextualisation.

With sustained support for research studies in the area through programmes such as Elrha's R2HC programme,[7] MHPSS moved from being one of the poorest supported areas of humanitarian action in terms of

evidence to one of the best. Much of the work has focused on documenting the impact of specific intervention approaches that are currently implemented at scale, such as structured activities within Child Friendly Spaces, or that are potentially scalable, such as Programme Management Plus (PM+). This work has contributed significantly to the goal of identifying impactful programmatic approaches, but also often points to the importance of the goal of accommodating the diversity of contexts to which such interventions need to be adapted. The field has thus matured to the point where the focus is on refining and strengthening proven interventions, or finding more effective or efficient modalities for their delivery.

Creative tensions

If, from the turbulence of the 1990s, the field formed in the 2000s and matured in the 2010s, what prospect is there for the field in the next decade? On the research side, there is a new research agenda-setting exercise underway with support from a number of donor agencies and intergovernmental organisations, reflecting the place that MHPSS has secured in humanitarian strategy. This is a consensus-building exercise engaging with diverse national and international stakeholders, whose outcome will not be known until well into 2021. However, there are at least three issues that seem likely to emerge from the exercise, and that will continue to engage practitioners and researchers alike in the next decade.

Scaling, fidelity and contextual adaptation: The challenge of balancing the development of generalisable, effective interventions with the need for cultural adaptation and sensitivity to the agendas of local actors will remain a key feature, if not **the** key feature, of work for some time to come. This is a significant task, reflecting the recurrent MHPSS challenge of combining technical generalisability with contextual understanding and engagement, and scaling interventions for access by a much greater proportion of affected communities while retaining fidelity to the active components of proven

interventions. However, there are some very promising recent examples of contextual adaptation being considered as a task to be undertaken as a step-by-step process rather than as a vaguely stated ambition.

Relieving suffering or driving long-term change: Evaluations that have looked at longer-term impacts of psychosocial interventions have frequently found no major benefits for those in the programmes compared with those not receiving interventions.[8] Typically, this finding is not the result of a 'drop off' in the well-being of those who have attended programming but is rather the result of those who did not attend programming managing to 'catch up' in terms of adjustment. Despite short-term benefits being noted, the intervention is sometimes reported as having no impact. This raises the issue of whether psychosocial programming should be aimed principally at the relief of suffering or at shaping longer-term trajectories of adjustment. Promises of longer-term benefit may reflect an undue capture by a longer-term resilience narrative rather than a relief of suffering narrative. I believe that the positioning of psychosocial interventions as supporting populations in distress rather than demonstrating long-term benefits may be usefully established as the baseline expectation for the field. This is not to say that long-term benefits cannot be secured but it may be appropriate for psychosocial interventions to be judged in the same way that food, shelter and most health interventions are primarily judged – that is, on their amelioration of the suffering and risk in affected populations during an emergency, rather than on long-term trajectories of food security, settlement or physical well-being.

Focused intervention versus strategy of engagement: Finally, I anticipate debates continuing about the relative priority of focused MHPSS intervention programmes – such as tackling severe mental distress and the consequences of gender-based violence – and broader-focused community engagement strategies promoting agency, ownership and peace-building. We can anticipate, however,

the development of clearer framing and theories of change linking these different forms of work. The breadth of influences on well-being reflected in community-based approaches was acknowledged in Kraus's initial use of the term to describe the forces shaping the experience of the resettling refugee and in much literature since; the value of focused, targeted interventions addressing psychological and emotional distress is now also endorsed by a rich literature.

Alastair Ager aager@qmu.ac.uk @AlastairAger
Institute for Global Health and Development, Queen Margaret University; Mailman School of Public Health, Columbia University

1. Kraus H (1939) 'Starting Life Anew in a Strange Country', *The Annals of the American Academy of Political and Social Science*, Vol 203 www.jstor.org/stable/1021890

2. Ager A (1993) 'Mental health in refugee populations: A review', Refugee Studies Programme, University of Oxford, for Project on International Mental and Behavioral Health, Harvard. http://fmo.bodleian.ox.ac.uk:8080/fedora/get/fmo:1082/PDF

3. Ager A (1997) 'Tensions in the psychosocial discourse: implications for the planning of interventions with war-affected populations', *Development in Practice* 7 (4) www.jstor.org/stable/4029006?seq=1

4. Psychosocial Working Group (2002) *Psychosocial Intervention in Complex Emergencies: a Conceptual Framework* bit.ly/PWG-conceptual-framework-2002

5. IASC (2007) *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* bit.ly/IASC-MHPSS-guidelines

6. Tol W et al (2011) 'Research Priorities for Mental Health and Psychosocial Support in Humanitarian Settings' PLoS Med 8(9) e1001096 doi.org/10.1371/journal.pmed.1001096

7. Tol W et al (2020) 'Improving mental health and psychosocial wellbeing in humanitarian settings: reflections on research funded through R2HC', *Conflict and Health* 14 https://doi.org/10.1186/s13031-020-00317-6

8. Panter-Brick C, Dajani R, Eggerman M, Hermosilla S, Sancilio A and Ager A (2017) 'Insecurity, distress and mental health: experimental and randomized controlled trials of a psychosocial intervention for youth affected by the Syrian crisis', *Journal of Child Psychology and Psychiatry* 59 https://doi.org/10.1111/jcpp.12832

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

Sarah Harrison, William S Chemaly, Fahmy Hanna, Nancy Polutan-Teulières and Peter Ventevogel

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

UNHCR/Will Swanson

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.

Sarah Harrison
sahar@rodekors.dk @IFRC_PS_Centre
International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support; former Co-chair of the IASC Reference Group for MHPSS in Emergency Settings

William S Chemaly
chemaly@unhcr.org @WilliamChemaly
Global Protection Cluster Coordinator

Fahmy Hanna hannaf@who.int
Technical Officer, Department of Mental Health and Substance Use, World Health Organization; Co-chair of the IASC Reference Group for MHPSS in Emergency Settings

Nancy Polutan-Teulieres polutan@unhcr.org
Senior Protection Officer, Global Protection Cluster

Peter Ventevogel
ventevog@unhcr.org @VentevogelPeter
Senior Mental Health Officer, Public Health Section, Division of Resilience and Solutions, UNHCR

The authors alone are responsible for the views expressed in this article which do not necessarily represent the views, decisions or policies of the institutions with which the authors are affiliated.[10]

1. Charlson F et al (2019) 'New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis', The Lancet 394 (10194)
bit.ly/Lancet-Charlson-et-al-2019

2. Jones L and Ventevogel P (2021) 'From Exception to the Norm: How Mental Health Interventions Became Part and Parcel of the Humanitarian Response', World Psychiatry 20(1); 2-3
https://onlinelibrary.wiley.com/doi/epdf/10.1002/wps.20808

3. IASC (2007) IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings bit.ly/IASC-MHPSS-guidelines

4. IASC Summary Record and Action Points of Principals Meeting, Geneva, 5 December 2019 bit.ly/IASC-Principals-meeting-05122019

5. Joint Inter-agency Call for Action on MHPSS 2020
bit.ly/MHPSS-joint-interagency-call-2020

6. Horn R, Waade M and Kalisky M (2016) 'Not doing more, but doing differently: integrating a community based psychosocial approach into other sectors', Intervention 14(3)
bit.ly/Horn-Waade-Kalisky-2016

7. https://spherestandards.org/handbook-2018

8. IASC (2017) Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support Programmes in Emergency Settings
bit.ly/IASC-MHPSS-CommonMandEFramework

9. Tankink M and Bubenzer F (2017) 'Building sustainable peace through an integrated approach to peacebuilding and mental health and psychosocial support: a literature review', Intervention 15(3) bit.ly/Intervention-Tankink-Bubenzer-2017

10. This paper is based on Harrison S, Hanna F, Ventevogel P, Polutan-Teulieres N and Chemaly WS (2020) MHPSS and protection outcomes: Why joint action to improve mental health and psychosocial wellbeing of people affected by conflict, violence and disasters should be a priority for all protection actors, Policy Discussion Paper, Global Protection Cluster and IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings
bit.ly/MHPSS-protection-outcomes-2020

Urban mental health and psychosocial support in Egypt

Nancy Baron

In complicated urban contexts, organisations must redesign established models of MHPSS intervention in order to ensure that services are accessible to the most vulnerable and are context-specific. It is not possible merely to move camp-designed interventions to the urban context.

Refugees in Egypt, like those across the world, struggle to find an adequate quality of life. Asylum seekers come to Egypt hoping that their stay will be temporary, they will be cared for by UNHCR and they will be resettled to a Western country. This hope quickly diminishes. UNHCR and its partners have limited resources and financially can assist only a small percentage of the vulnerable. Meanwhile, fewer than 5% are resettled annually.

The Psycho-Social Services and Training Institute in Cairo (PSTIC) concentrates on helping people find what they can do to become self-reliant rather than bemoaning the system's lack of resources. PSTIC targets the most vulnerable of those registered with UNHCR including people who are homeless, hungry, sick and unable to be self-reliant; who struggle due to gender-based, community or family violence; who feel overwhelmed by distress, despair and traumatic experiences; who are marginalised or rejected; and who are chronically ill, disabled or with poor mental health.[1]

During their attempts to assist people to solve problems, PSTIC workers help people manage their feelings of entitlement, dependency, disappointment and anger. PSTIC also concentrates on building families' capacities for self-help; for example, activities are not designed for children alone but rather to build the capacities of families to assist their own children. When there is no family, or the family is unable to help, PSTIC facilitates communities to become responsible for assisting their vulnerable members.

'Of the community'

Migrant groups in urban contexts often establish national, tribal and religious communities which have physical centres with regular activities, designated members and elected leadership. The PSTIC Teams are 'of the community' and can therefore access these communities. Over 160 of PSTIC's 180 workers are refugees, asylum seekers or migrants from the nationalities most represented in Egypt: Eritrea, Ethiopia, Somalia, South Sudan, Sudan, Iraq, Syria and Yemen. The workers live in their communities and have first-hand awareness of issues and can provide practical interventions in accordance with culture and context in the languages spoken by their communities.

PSTIC does not replace but rather supplements community leaders. It respects the authority of elected leaders and their traditional influence to resolve problems. PSTIC workers, however, are trained to manage a range of issues that are often not within the expertise of community leaders. With PSTIC workers and community leaders working together over time, community leaders have gained greater understanding and new skills to manage mental illness, suicide risk, substance abuse, child protection needs and the protection of women. They identify people in need and can assist responsibly or they refer cases to PSTIC and other service providers.

PSTIC's workers are selected in cooperation with their urban communities. Many were community leaders before joining PSTIC. They are a paid team of refugees, trained to offer MHPSS support; they have no offices and provide assistance through home and community visits using a 'desk in a backpack' approach.

These workers have little prior training or experience in MHPSS. They were teachers, IT workers, lawyers, agriculturalists, at-home mothers or house cleaners before being hired. They are chosen because of their personalities,

motivation, compassion and experience in helping in their communities rather than because of their levels of education. They are taught essential knowledge and practical psychosocial support skills and helped to broaden their attitudes to enable them to help anyone in need without discrimination. They learn professional ethics and the application of basic human rights in order to equitably assist women and children and people with special needs including those with differences in gender or sexual identity.

As refugees, PSTIC workers have had few opportunities in Egypt, so most feel grateful for work that not only provides an income but helps those in need and also gains them the respect of their communities. However, working at PSTIC can be challenging and emotionally draining. Though beneficial, the 'of the community' model does create challenges. PSTIC workers must manage sometimes competing community allegiances versus professional ethics. Workers have individual supervision, weekly team meetings and monthly supportive group sessions to share personal and professional challenges. To ensure full transparency, communities also have opportunities to complain about workers and services through helplines and community meetings.

People's problems are not confined to usual office working hours, and services must be delivered when and where they are needed. This requires the cooperation of workers and their agreement that 24-7 response is essential. With this model, serious attention to staff care is critical. Importantly, workers must feel safe if they have to respond at night. At PSTIC, no worker responds to an emergency alone and they are given emotional support during and after, with praise for a job well done.

COVID-19 temporarily restricted the fieldwork of PSTIC workers and forced them to provide assistance by telephone and only respond in person to life-threatening emergencies. During the height of the pandemic, PSTIC workers often called people daily, knowing how stressed they were due to losing control over their ability to be self-reliant, uncertainty of the situation,

Training new PSTIC workers during the COVID-19 pandemic, Cairo.

confinement to home, and loss of work and income. Slowly, PSTIC workers have been able to return to the field, taking precautions to minimise infection. Workers wear masks and arrange with those whom they visit to wear masks during their home sessions. For overcrowded households, workers now offer some support in refugee community-based centres.

'One-stop shop' approach

To meet the needs of the most vulnerable, PSTIC has learned that it must have interventions at all four layers of the IASC MHPSS pyramid of interventions for emergency settings (see below).[2] PSTIC therefore carefully combines the provision of layers of intervention into individualised plans of action and complements services offered by the government and other entities.

Social support through family, friends or community is essential as a cornerstone

of each individualised plan of action. PSTIC's workers assist people to find a safe system of support and build the capacities and responsibility of this support system. No one asking PSTIC's help is refused. PSTIC workers assist and refer and when no service is possible, they listen and offer kindness. Recognising that the most vulnerable may not know how to ask for help, workers will take the initiative to call or knock on someone's door to offer assistance when they are told there is a problem.

> For example, a person attempts suicide. Her roommate calls a PSTIC refugee worker who goes to her home and does an immediate assessment. The woman cries and says she does not want to die but feels lonely and frightened. Due to COVID-19, she lost her job and cannot pay her rent. The PSTIC worker sits with her and her roommate and makes a plan for support and protection. A psychiatrist is on the phone consulting with the PSTIC worker and does a telephone assessment with the client. All agree she can be safe at home with the protection of her roommate and they set up a psychiatric clinic appointment for the next day. PSTIC helps alleviate her immediate distress by arranging temporary food vouchers and payment of her rent until she can find a new job.

Interventions at Layer 1 of the pyramid offer practical assistance to reduce distress. PSTIC's 24-7 helplines are widely advertised. Helpline staff offer information and referral, and arrange for workers to go immediately to someone's home when needed.

Inaccurate information is often a cause of distress. The Information Sharing Team shares accurate information in informal community settings. To manage the distress caused by COVID-19, PSTIC increased its information sharing through a MHPSS Facebook page sharing information in six languages.[3] A Housing Initiative Team provides emergency response to secure safe affordable housing, mediate conflicts with landlords and teach financial planning. Additionally, a Health Advocacy Medical Team assists refugees to access emergency medical care with nurses also providing home-based health care for people who are confined to bed.

Interventions at the second, third and fourth layers of the MHPSS pyramid include a Psychosocial Team of trained refugees who assess needs, prepare individualised case plans, and provide counselling and conflict mediation, community integration, advocacy, accompaniment and referral. The team offers intensive management for child and family protection, mediators for gang violence, school-based activities for boys to promote non-violent activities, and specialised play groups for children with special needs and their families. This team works to minimise stigma in the community, facilitate community integration and – through home visits – promote compliance with mental health treatment. A Counselling Team of multilingual refugee counsellors offers short-term goal-directed individual, couple and family counselling, while the Mental Health Team of Egyptian psychiatrists acts alongside refugee psychosocial workers to provide psychotherapy and psychiatric treatment in PSTIC clinics for people with serious mental illness.

Urban environments pose many challenges for the provision of mental health and psychosocial support to displaced populations. In such contexts, MHPSS interventions need to be accessible to the most vulnerable and designed for each unique context. The PSTIC 24-7 community-based urban model has gained international recognition and its international training institute, Urban Life,[4] has welcomed trainees from 15 countries to join field-based training. The practices developed by PSTIC to meet urban challenges in Cairo can offer lessons to those working in urban centres elsewhere.

Nancy Baron drnancybaron@pstic-egypt.org
Director, Psycho-Social Services and Training Institute in Cairo (PSTIC) (a programme of Terre des hommes)

1. PSTIC assists about 2,000 cases (8,000 individuals) monthly. http://pstic-egypt.org

2. IASC (2007) *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, pp11–13 bit.ly/IASC-MHPSS-guidelines

3. www.facebook.com/RefugeesTogether/

4. www.urbanlifemhpss.com

Culture bias and MHPSS

Joanne Michelle F Ocampo, Mhd Nour Audi and Mike Wessells

Culture bias can reduce programme effectiveness and potentially cause serious harm to already vulnerable communities.

Mental health and psychosocial support (MHPSS) programmes' effectiveness in alleviating mental health and psychosocial burdens is contingent on multiple factors, including socio-cultural relevance to the local population.[1] Culture bias – which entails interpreting, judging or acting based on one's own cultural standards – can have a negative effect on socio-cultural relevance and can impact all stages of MHPSS programming, including design, implementation and evaluation.

Providing MPHSS services for people affected by the Syrian conflict has been fraught with cultural challenges, including cross-cultural application of trauma screening tools without local validation.[2] Mental health providers in Lebanon viewed refugees' cultures as an 'obstacle' to discovering underlying psychiatric disorders. Also, refugees' strategies to adapt to a discriminatory environment were considered by mental health practitioners as dishonest and manipulative behaviour, and this affected the ability to build trust between mental health practitioners and refugees.[3]

Culture bias in humanitarian MHPSS programmes is not new. During the war in Angola, many Western NGOs focused almost exclusively on Post-Traumatic Stress Disorder (PTSD). During one of the authors' fieldwork in the mid-1990s, child soldiers reported that their main challenge was spiritual contamination by the unavenged spirits of the people they had killed. Although traditional healers had cleansing rituals for this specific problem, psychologists and international NGOs did not work with them to address this spiritual distress or contextualise their own approaches to this local concern, thereby limiting the success of the MHPSS programming. Eventually, the rituals were included in the reintegration programme,

significantly increasing community acceptance of the former child soldiers.

Missed opportunities and harmful effects

While it may be more convenient to implement universalised approaches to MHPSS, this runs the risk of limiting the effectiveness of MHPSS work by disregarding essential contextual elements when addressing problems that are a high priority for the affected people. As a result, MHPSS programmes may miss important opportunities to support the health and well-being of communities. In the Philippines, one of the most disaster-prone countries in the world, humanitarian responses to MHPSS needs are often narrowly focused, with little or no attention given to Filipino idioms of distress or to local and indigenous practices that could complement external support.

Overlooking the need to contextualise MHPSS within local settings can result in an insufficient understanding of the mental health needs of, and forms of resilience among, individuals and family and community members. Outsider approaches may also feel alienating to local people, resulting in low levels of acceptance and uptake of MHPSS supports and services.

More concerningly, culturally inappropriate interventions can cause unintended harm to people. Culture is a defining feature of human identity that confers a sense of meaning and acts as our anchor in the world. When outsiders impose culture biases, people may experience a sense of loss or marginalisation of their dignity and identity, reflecting a damaging colonialist pattern that treats local people and their cultures as inferior.

It is important to recognise that the negative outcomes of culture bias are not necessarily deliberate. Humanitarian actors inevitably bring culture biases into individual

conversations with community members, meetings with grassroots organisations, and conferences with international organisations. This can be exacerbated by the relative power held (and ignored) at times by humanitarian actors. Having little power, and fearing for survival, conflict-affected people may reposition their beliefs or reshape their identities in potentially harmful ways, just to fit within the cultural lens of a humanitarian organisation.

Within MHPSS, culture bias occurs mostly through the imposition of presumed universal categories and through standardised (Western-derived) research and treatments that do not adequately take into consideration other cultures and contexts. Frequently done in the name of evidence-based practice, this approach assumes that MHPSS needs such as depression and PTSD have common interpretations, origins, symptoms and impacts across all cultures and can be treated using the same interventions. This assumption is questionable, and so too is the parallel, often tacit, assumption that culturally defined maladies and stresses do not warrant significant attention. This dominant 'one-size-fits-all' approach is inappropriately generalised for populations within the humanitarian arena.

Addressing culture bias

Systematically attending to and becoming aware of our own and others' cultural beliefs and practices may be important in operationalising the Do No Harm principle. More thoroughly contextualising MHPSS interventions helps to recognise and support people's dignity and identity in times of dire need. While there is no quick fix for reducing culture bias in MHPSS programming, there are some useful strategies.

For an organisation: Firstly, build evidence for the impact of culture bias in MHPSS programming. Assess how culture bias has potentially impacted past and current MHPSS programme implementation and the targeted population. Make use of various knowledge resources, including mental health workers assessment surveys, focus groups with programme participants,

and community advisory groups. Secondly, assess and continuously build MHPSS workers' cultural humility and relevant skills. Prioritise the importance of addressing culture bias – during recruitment and throughout deployment of MHPSS workers – and consider in-depth reflection sessions on this topic when evaluating programmes; include both international and national workers, and be aware of local power differentials and inequities.

For a programme: Enable an iterative process for cultural adaptation of ongoing MHPSS programmes. Support local ownership of MHPSS interventions through all programming stages, engaging with local healers, grassroots organisations and local MHPSS workers.

For an MHPSS worker: Seek to acquire the ability to reflect on problems caused by cultural disrespect and marginalisation. Consider how to systematically improve your programme by including cultural dimensions that are not harmful and that may contribute to well-being and resilience even if they do not fit dominant MHPSS schemes. In general, work with cultural humility. Think appreciatively about the knowledge, resources and understanding that people have of their own culture, the current context and the problems that they face, and reflect on the limits to outsiders' knowledge.

Critical questions

With deep appreciation for cultural differences, we should ponder how to most effectively balance local cultural views and approaches with outsider or universalised approaches within MHPSS. Our quest to find a balance is also likely to be contingent upon available resources, an agency's mandate, the political climate, and a host of other considerations. These complexities, however, can serve as a productive springboard for continuous reflection, learning and adjustment.

Another critical question for MHPSS practitioners is how to avoid causing unintended harm. It is helpful to assume that every culture has a mix of positive and negative aspects that promote or

undermine people's health and well-being. This understanding will help humanitarians to avoid supporting harmful practices and to engage with and strengthen positive cultural resources and practices. Similarly, they should beware of cultural tokenism, by being, for example, sensitive to issues of language and translation while privileging Western approaches and reducing cultural idioms of distress to Western categories without adequate justification.

A third question to consider is how local power structures influence discussions about which local approaches are valuable, or even culturally appropriate. Blindly engaging with cultural interlocutors without appreciating local power dynamics may provide a skewed image of local beliefs and practices. Most important to keep in mind is the reality that international humanitarian actors may interact in a way that itself affects, reflects or shapes local power dynamics and influence. It is essential for external MHPSS workers and their agencies to attempt to understand the nuances of local power structures and to learn from people, including those living at the margins of society, who seldom have a voice or influence key decisions or actions. Action that supports local discriminatory use of power can increase MHPSS needs.

Addressing culture bias has powerful implications for people's dignity, identity and well-being, and affects the quality and implementation of MHPSS programming in humanitarian settings. At a time when there are pressures for decolonisation and also strong donor and institutional pressures urging conformity to standardised (Western) approaches, there remains a great need to improve integration and contextualisation of MHPSS programming into local cultural approaches in a way that delivers better outcomes and boosts our collective commitment to human well-being and humanitarian accountability.

Joanne Michelle F Ocampo
joannemichelle.ocampo@columbia.edu
Doctoral Student

Mhd Nour Audi
nour.audi@columbia.edu @Nour_Audi
Doctoral Student

Mike Wessells mgw2106@columbia.edu
Professor

Department of Population and Family Health, Columbia University

1. Mukdarut B, Chiumento A, Dickson K and Felix L (2017) *The Impact of Mental Health and Psychosocial Support Interventions on People Affected by Humanitarian Emergencies: A systematic review* https://oxfamilibrary.openrepository.com/handle/10546/620214

2. Gadeberg A K and Norredam M (2016) 'Urgent need for validated trauma and mental health screening tools for refugee children and youth', *European Child and Adolescent Psychiatry* 25(8) http://europepmc.org/article/MED/27043846

3. Kerbage H et al (2020) 'Mental Health Services for Syrian Refugees in Lebanon: Perceptions and Experiences of Professionals and Refugees', *Qualitative Health Research* 30(6) https://doi.org/10.1177/1049732319895241

The importance of teacher well-being for student mental health and resilient education systems

Danielle Falk, Paul Frisoli and Emily Varni

Teachers play a paramount role in providing MHPSS to their students and in sustaining resilient education systems – and supporting teachers' own well-being is essential if they are to fulfil this role.

In conflict-affected and forced displacement contexts, education provides life-saving and sustaining skills. Formal and non-formal schools are important sites for delivering mental health and psychosocial support (MHPSS) to affected children and youth, and teachers are at the centre of this work.

Yet teachers in emergency, chronic crisis and early recovery contexts receive minimal if any MHPSS support themselves, nor are they provided with initial and continuous professional development to safely nurture their students. This may be because the idea of teacher well-being remains elusive and

interventions that support teacher well-being are in their infancy, contributing to inadequate MHPSS provision to teachers.

The Education Equity Research Initiative's Conceptual Framework for Teacher Well-being in Low Resource, Crisis, and Conflict-Affected Contexts[1] (referred to in this article as the Conceptual Framework) provides a structure to assess the MHPSS needs of teachers, design policies and programmes that meet these needs, and evaluate the efficacy of such policies and programmes in improving teacher well-being. The Conceptual Framework's accompanying recommendations are actionable steps for policymakers and practitioners to enhance teacher well-being and ensure that education systems are resilient, for the benefit of the MHPSS needs of both teachers and students.

Teacher well-being is context-specific and encompasses how teachers feel and function in their jobs. There are four outcome-based concepts that are critical to consider when measuring teacher well-being – self-efficacy (their belief that they are able to elicit desired outcomes for their students), job stress and burnout, job satisfaction, and social-emotional competence.[2] In our Conceptual Framework we apply a socio-ecological approach to identify four levels of support for teacher well-being: individual, school, community, and national-regional-global. This approach is particularly relevant for teachers working amidst conflict and forced displacement given the different roles they play in and outside school; for example, teachers often act as para-social workers for children and youth, or as leaders in their community given their respected role as educators. A broad socio-ecological framing recognises the interrelated environments, interactions and relationships that contribute to teacher well-being, and can offer guidance on multiple intervention points for practitioners and policymakers to consider when designing and implementing sustainable and contextually appropriate MHPSS programmes and policies that aim to support teacher well-being.

The recommendations below align with the findings underpinning the Conceptual Framework and with the Inter-agency Network for Education in Emergencies Minimum Standards.[3]

Individual support: recognise and value diverse teacher profiles

The factors to consider in terms of teachers' individual characteristics are gender, displacement status, level of education, coping mechanisms, employment status, teaching experience, content knowledge and cultural competence. These factors can guide rapid needs assessments to understand teacher profiles as well as the communities in which they work, and should also inform teacher professional development (TPD) programmes and policies so that these take account of teachers' inherent skills and strengths. Taking an 'asset-based' approach such as this can help build teachers' self-efficacy and job satisfaction, contributing to their overall well-being. This approach is also essential when providing training in MHPSS interventions that teachers will deliver to students, since the efficacy and quality of such interventions will rely, at least partially, on teachers' own well-being. TPD can provide adult-specific tools, such as mindfulness, stress management and self-care strategies that teachers can practise to support themselves, while then adapting the approaches for their students. This approach allows teachers to build on their own social-emotional competence, to reduce their own stress, and to model effective social-emotional behaviours and strategies for students.

School support: invest in peer relationships and protective environments

School culture, safety and resources influence teachers' well-being and ability to provide effective MHPSS to students. The four school-level factors to consider are teacher-student relationships, peer relationships, school leadership and school resources. Policymakers can develop national standards for equitable teacher-student ratios, fair distribution of classes among teachers, and adequate teaching and learning materials for schools. Policymakers and practitioners working together

can ensure these standards are put into practice, particularly in contexts of forced displacement where there may be an influx of students alongside teacher shortages and limited school infrastructure and resources.

The school-level factors also provide guidance for TPD policies and programmes, particularly those for school leaders who play a central role in promoting positive school cultures and peer collaboration. Practitioners can design professional development for head teachers, ministry inspectors and supervisors that includes concrete strategies to create safe and nurturing schools, provides opportunities to demonstrate positive leadership, and supports school leaders to create participatory school management systems that elevate teachers' voices in school decision-making. For head teachers, TPD can focus on strategies for cultivating peer relationships and communities of practice among teachers. Teacher collaboration helps improve outcomes that contribute to well-being while reducing stress and burnout.

Supporting these outcomes, while decreasing stress and burnout, is especially critical given the many additional roles that teachers play for students in forced displacement contexts, such as counsellor and para-social worker. Practitioners and policymakers must recognise these multiple roles and implement school-wide and integrated approaches that equip teachers with the knowledge and skills to identify and respond to signs of distress among students. Practitioners can work across the education and child protection sectors to strengthen referral mechanisms and follow-up for child protection and MHPSS concerns in the school and the community. Policymakers and practitioners must also ensure that school leaders and district education offices are provided with professional development to set up and use referral pathways for teachers and other education personnel and children who require specialised services.

Community support: strengthen partnerships
Context is crucial in understanding and responding to the MHPSS needs of teachers. The three community-level factors – access

to basic needs, respect and recognition, and responsibility and duty – provide guidance for practitioners and policymakers to understand community context and teachers' relationships with community members. Mapping community risks and resources can help to identify formal and informal structures, resources and individuals that may be assets or obstacles for MHPSS. It is particularly important to understand teachers' ability to meet their basic needs for food, water, shelter, transportation and security. In conflict-affected contexts, assessing physical security risks is critical as schools and teachers are often targets of attacks. Real and perceived threats of violence can increase teachers' stress and burnout so efforts should be made to ensure that there are contextually relevant and responsive mechanisms for teachers and students to report threats to their physical, social and emotional well-being.

Teachers' relationships with community members, especially their students' caregivers, are also vital to consider. Building positive relationships is an important, and often under-utilised, approach for meeting teachers' MHPSS needs through enhancing their job satisfaction, social-emotional competence, and decreasing job stress. To enhance these relationships, practitioners can establish and provide training for Parent Teacher Associations and School Management Committees on the importance of education and the role of teachers, and mobilise members to provide support for non-teaching tasks at school.

National-regional-global support: prioritise teacher well-being in policy and practice
The potential to improve teacher well-being as well as to increase teacher retention, improve gender parity, and promote inclusion among under-represented groups in the profession can be increased through interventions relating to five policy-oriented factors: teacher management, the right to work, compensation, TPD and certification.

At the national level, policymakers can include teacher management policies in education sector plans as preparedness measures for responding to crises and

A primary school teacher leads a class at Makpandu refugee camp, Western Equatoria State, South Sudan, where parents have helped build new classrooms for the overcrowded school.

displacement – for example, rapid deployment of teachers or recruitment of contract teachers to high-need areas. These policies should promote gender equity and inclusion of displaced teachers and others from under-represented communities.

The COVID-19 pandemic has amplified the indispensable role of teachers and compounded the risks they face in carrying out their work. Many national governments, particularly those hosting large numbers of refugees and/or internally displaced people (IDPs), have included MHPSS to teachers in their national COVID-19 response plans (such as Uganda, Colombia and Nigeria). In order to operationalise these plans, policymakers and practitioners can use the Conceptual Framework to guide policy conversations, identify intervention points for enhancing teacher well-being, and select evidence-based factors for measuring the impact of interventions.

Beyond COVID-19 response plans, however, policymakers must institutionalise support for teacher well-being and MHPSS in permanent education policies, with collaboration on budgets and financing across Ministries of Education, Health and Finance. For example, these line ministries can collaborate on budget and financing for personal protective equipment and safeguarding measures for schools, alongside training costs for community-based MHPSS assessments or PSS programming in schools. In contexts of forced displacement, the Ministry of Interior should also be included in order to ensure that refugee and IDP teachers have access to the same services as their non-displaced peers. At the regional level, particularly in areas affected by forced displacement, policymakers can strengthen or establish regional frameworks to promote the inclusion of displaced and returnee teachers into national education systems; this will help ensure that displaced teachers have access to compensation and benefits, essential rights, and employee protections, all of which contribute to supporting well-being. One example of a regional policy that prioritises the MHPSS and well-being needs of displaced and host community teachers is the Djibouti Declaration adopted by the Intergovernmental Authority on Development in the Horn of Africa.[4]

At a global level, practitioners, policymakers, donors and researchers must generate more evidence on teacher well-being in conflict-affected and forced

displacement settings and garner increased attention and support to teachers in these contexts. Global education stakeholders should collaborate with teachers who work in these settings to build evidence on good practice for supporting teacher well-being and meeting teachers' MHPSS needs. Finally, education stakeholders must amplify teachers' voices by including teachers in local, regional and international forums where teacher well-being and MHPSS policy and programming are discussed.

Conclusion

Providing MHPSS to teachers, children and youth affected by conflict and forced displacement is the collective responsibility of the global education community. While teachers are the ones tasked with identifying and responding to their students' MHPSS needs, we cannot expect them to do so alone. Prioritising teacher well-being in education policy, practice and research is necessary

if we are to build education systems that promote the socio-emotional health of teachers and students, retain teachers in the profession, and enable teachers to provide safe and equitable education, including MHPSS, for all children and youth.

Danielle Falk *dlf2136@tc.columbia.edu*
Doctoral Student, Teachers College

Paul St John Frisoli *paul.frisoli@lego.com*
Senior Programme Specialist, LEGO Foundation

Emily Varni *evarni@savechildren.org*
Education in Emergencies Specialist, Save the Children US

1. Education Equity Research Initiative (2019) *Landscape Review: Teacher Well-being in Low Resource, Crisis, and Conflict-Affected Contexts* (the visual representation of the Teacher Well-being Conceptual Framework is on p10)
bit.ly/EERI-landscape-review-2019

2. More information on these are in Section 4 (p. 11) of the Landscape Review: see endnote above.

3. www.ineesite.org/en/minimum-standards/translations

4. bit.ly/Djibouti-declaration-2017

Faith-sensitive MHPSS for humanitarian practitioners

Leonie Harsch, Corrie van der Ven and Olivia Wilkinson

Faith and spirituality are part of many people's identities and everyday lives, and faith sensitivity is integral to providing holistic, people-centred MHPSS in humanitarian situations.

Effective mental health and psychosocial support (MHPSS) in response to humanitarian emergencies connects with the worldviews, healing practices and language of the people it aims to assist. Faith is a factor in many individuals' and communities' capacity to cope with psychosocial challenges; for many people, for example, burying their loved ones according to the rituals of their faith is important in order to be able to grieve. This is why the Inter-Agency Standing Committee's *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* call upon humanitarian actors to engage with local religious and spiritual resources, groups and leaders in their regular programming.[1] It is also why the integration of religious leaders and religious

practices into standard operating procedures during the 2014–15 Ebola response in West Africa, for example, was so effective.[2]

Developing faith-sensitive humanitarian response starts with recognising that religious practices, such as praying, can be an element of psychosocial support which should be complemented, rather than replaced, by other forms of MHPSS. Humanitarian practitioners can adopt a faith-sensitive approach regardless of their own or their organisation's identification or non-identification with a faith tradition. Faith sensitivity is about the faith of the people you assist.[3]

Despite major policy commitments[4] many humanitarian and development organisations hesitate to take faith-related aspects sufficiently into account when designing their programmes or to consider

local faith actors as potential partners to collaborate with on MHPSS. Practitioners tend to avoid dealing with faith-related questions out of concern that this might interfere with the humanitarian principles of neutrality and impartiality. Indeed, applying faith sensitivity in practice is not always straightforward. So, how should we approach the bringing together of faith and MHPSS in planning and implementing faith-sensitive psychosocial responses that do not go against the humanitarian principles?

Faith sensitivity in practice
To help MHPSS practitioners overcome some of the barriers and hesitations, an online training tool on faith-sensitive humanitarian response with a focus on MHPSS has been developed to outline opportunities, challenges, and practical steps to take.[5] The training – launched in June 2020 – is a product of collaboration between the ACT Alliance, Islamic Relief Worldwide, the Joint Learning Initiative on Faith and Local Communities, the Lutheran World Federation and the DanChurchAid Learning Lab. The full training only takes approximately two hours to complete.

Adopting a faith-sensitive approach to MHPSS means learning how to understand people's spiritual and religious needs and resources, and the roles of faith communities in responses to humanitarian emergencies. This also involves reflecting on your own and your organisation's positions, understandings and biases regarding faith. Here are five key recommendations for practitioners (in particular for those in international organisations) wishing to make MHPSS more faith-sensitive:

Include faith in assessments: Consider information on religious beliefs, practices, activities of faith groups, and places of worship that are relevant to the mental health and psychosocial well-being of the affected community. How do they see the crisis, how do they explain distress, and in what terms do they speak about coping? What are the spiritual influences on their well-being? What religious concepts are

helpful for them in responding to challenges they face? Resources developed by UNHCR on socio-cultural context, concepts and healing practices concerning mental health and psychosocial well-being of specific refugee communities show how such information can be documented.[6] Conduct such assessments in participatory ways that also include perspectives from local faith communities. Discuss mental health issues with representatives of different faith traditions to understand how theological concepts influence how individuals make sense of and cope with related challenges.

Connect programmes to people's beliefs and practices: When designing MHPSS programmes, build upon local beliefs, practices, rituals and activities that are part of effective coping strategies already in existence in the respective community. This can include prayer, reading scriptures and mourning rituals, including group activity. In Gaza, counsellors from Islamic Relief Palestine use references to the faith of the people participating in psychosocial group sessions as entry points to the topic discussed, if appropriate in light of the participants' relationship with faith. For example, they point out similar effects of meditation and the practice of praying when introducing meditation as a technique to manage stress. Connecting a topic with familiar ideas makes it more relatable.

Collaborate with local faith actors: When engaging with local faith actors, include female and youth leaders (who often have informal roles), and base partnerships on meaningful participation, joint decision-making, and mutual learning and capacity sharing. MHPSS specialists can offer training on key psychosocial principles to local faith leaders, discuss cases where counselling may be helpful on top of spiritual support, or provide information on MHPSS services for referrals. Establishing two-way referral mechanisms can facilitate access to spiritual and religious care through imams, pastors and religious or traditional healers alongside access to psychological

and social care. For example, the American Red Cross runs a Disaster Spiritual Care programme in collaboration with local faith leaders trained in psychological first aid.[7]

Address potentially harmful practices linked to faith: Certain theological understandings can be a basis for ineffective and inappropriate coping or be used to legitimise harmful practices. Examples are confinement as a treatment for mental illness when such illness is seen as a spiritual instead of a health problem, or inappropriately associating disasters with sin or karma. Responding to negative coping mechanisms does not mean separating faith and mental health or trying to convince people to abandon their faith. Rather, actors should involve both leaders and vulnerable people of different genders and ages in assessing the impact of religious beliefs on mental health and in identifying potentially harmful practices. Then, they should promote dialogue between faith leaders, well-informed local religious thinkers and the local community around social norms and interpretations on which they are based, and provide appropriate training and resources to support a process of reflection and change.

Engage with faith in a way that respects humanitarian principles: Faith sensitivity may be viewed as being in conflict with the humanitarian principles of impartiality and neutrality, with neutrality urging against affiliation with faith as it is connected to the politics of conflicts, and impartiality asserting the need to avoid bias, discrimination and proselytisation based on faith affiliation. Yet in neither case does this mean ignorance and avoidance of faith. While asserting the need to remain neutral and impartial, it is possible to sensitively support someone's own beliefs and practices. Support religious practices if a person you assist requests this, such as joining them in prayer (if that is appropriate for you), but do not coerce a religious practice if not requested. Allow space for such requests without forcing the issue.

Towards localised response

A faith-sensitive approach puts people and communities affected by conflict and disaster – and their rights, needs and dignity – at the centre of MHPSS response, as it helps adapt assistance to their specific social and cultural context, of which faith is a part. In addition, collaborating with faith actors and communities can contribute to strengthening the roles of local actors in the humanitarian system, facilitating community-led support and embedding assistance in existing structures. Faith-sensitive programming and partnerships are therefore important aspects of the localisation of aid, and thus of a wider reform process of the humanitarian system too.

Leonie Harsch @*LeonieHarsch*
leonie.harsch@mercator-fellows.org
Former Visiting Fellow, Joint Learning Initiative on Faith and Local Communities (JLI)

Corrie van der Ven
c.vanderven@protestantsekerk.nl
Programme Officer, Kerk in Actie; former Religion and Development Programme Manager, ACT Alliance

Olivia Wilkinson *olivia@jliflc.com* @*OliviaWilk*
Director of Research, JLI

1. IASC (2007) *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* bit.ly/IASC-MHPSS-guidelines

2. Winiger F (2020) '"More than an intensive care phenomenon": Religious communities and the WHO Guidelines for Ebola and Covid-19', *Spiritual Care* 9(3)
https://doi.org/10.1515/spircare-2020-0066

3. See also FMR issue 48 on Faith and responses to displacement www.fmreview.org/faith

4. Such as UNHCR's 2014 *Partnership Note on Faith-based Organizations, Local Faith Communities and Faith Leaders* bit.ly/UNHCR-faith-partnership-note-2014 and the 2018 Global Compact on Refugees www.unhcr.org/gcr/GCR_English.pdf

5. The training can be freely accessed at www.fabo.org/act/fshr. The training builds on: Lutheran World Federation and Islamic Relief Worldwide (2018) *A faith-sensitive approach in humanitarian response: Guidance on mental health and psychosocial programming* bit.ly/IRW-LWF-faith-sensitive-MHPSS-2018

6. Tay A K, Islam R, Riley A, Welton-Mitchell C, Duchesne B, Waters V, Varner A, Silove D and Ventevogel P (2018) *Culture, Context and Mental Health of Rohingya Refugees: A review for staff in mental health and psychosocial support programmes for Rohingya refugees*, UNHCR
bit.ly/UNHCR-culture-MHPSS-Rohingya-2018

7. American Red Cross (2018) *Disaster Spiritual Care* bit.ly/ARC-disaster-spiritual-care-2018

Faith and MHPSS among displaced Muslim women

Kathleen Rutledge, Sandra Iman Pertek, Mohammad Abo-Hilal and Atallah Fitzgibbon

With religious identity, practices and beliefs having a profound impact on mental health, faith sensitivity in aid and MHPSS is essential.

"Prayer was the rope of survival." "Religious needs are my primary needs." "I wish I had been asked." These statements were shared by displaced women in Iraq, Syria, Tunisia and Turkey in three independent, coordinated research studies in 2019 led by University of Birmingham, Queen Margaret University and Syria Bright Future in collaboration with Islamic Relief Worldwide and the Humanitarian Academy for Development. The studies examined the role of faith in coping and recovery of women in forced migration and conflict contexts.[1]

The women in this study, like many forced migrants, suffered unspeakable hardships, experiencing loss of relatives and belongings, war and violence (including sexual and gender-based violence), life-threatening journeys, separation from family, and powerlessness. Having once belonged to a local faith community, now, on the move, they had held onto the religion, faith and spirituality that move with them. Faith resilience and spiritual suffering – often difficult to comprehend

for outsiders – influenced women's well-being in varied ways. Throughout their experiences, religious identity, religious practices and religious beliefs had a profound impact on mental health, both buffering and contributing to psychological distress.

Faith moves with them

The findings from the study indicate that the women drew widely upon their faith narratives to find meaning in their suffering and inform critical decision-making, including decisions regarding divorce and suicide. They employed a variety of faith practices as primary coping mechanisms, and valued guidance from informal and formal, female and male faith leaders and access to religious spaces and resources. Women described their religious practices as providing comfort, as a conduit of protection from danger, as a means to reduce anxiety, and as a pathway to receive direction for decision-making. "It's just like pouring water on fire," shared Jinan, a 51-year-old woman living in an IDP camp in Iraq, referring

Sandra Pertek

A Syrian refugee woman reading the Qur'an at home in Turkey.

to her practices of prayer and reading the Qur'an. Religious beliefs similarly formed a primary framework through which the majority of the women in the three studies interpreted life and sought to understand their experiences. A sense of continuing spiritual intimacy with God helped women to persevere through their ongoing struggles.

The women in camps and shelters, however, struggled with logistical barriers to practising their faith, including the lack of privacy and lack of a dedicated space for prayer in their crowded accommodation. In countries of transit and refuge, some felt too tired or preoccupied with daily stresses to perform their individual worship, and lacked opportunities to exercise communal faith practices. They had lost or had to leave behind religious accessories such as sacred texts, prayer beads and prayer mats. Some lost mobile phones in which they kept religious applications or were unable to charge their phones to access religious applications.

Some intimated that their religious practices had declined as a result of their struggle to reconcile their experiences with their belief in God. For some, the decline in their faith was only temporary but for those who were unable to resolve the dissonance between their experiences and their faith, or to restore the stability of their former practice, the decline was linked with symptoms of anxiety and depression. They needed reassurance from sacred knowledge – which felt out of their reach – to help process internalised beliefs associated with abuses they had experienced, as well as self-blame.

Disrupted support

Some of the women in the study shared the desire to speak about spiritual struggles in a formal counselling setting but felt that they were not meant to talk about faith issues. One respondent in Iraq shared: "It is clear, because when they talk to us they never mention anything about religion." Similarly, a study participant from Syria said that she wished that "religious sayings and examples…can be used in treatment, because my personality is inclined to faith and religion."

International and local service providers tended to avoid engaging with religion and did so only when explicitly requested by the women. However, staff attitudes and organisational policies shaped what the women considered safe to disclose. For instance, the religious profile of migrants crossing borders in Tunisia was often assumed based on their appearances, and accounting for religious needs was not embedded in reception screening procedures, nor in medical checks or psychosocial support activities. Most women across the four countries spoke of a desire for a broader type of aid engagement focused on increasing or restoring access to external supports related to faith that had been severely disrupted. Many wished for access to spaces where they might gather with other women to pray as they had done before. For women in transit, the locations of prayer spaces or faith leaders were unknown or remote and, unable to locate spiritual leaders, many were left with unresolved emotional turmoil.

The support that was accessible to the women from aid and MHPSS providers largely did not account for the impact of faith on psychological distress nor the relevance of facilitating access to faith resources for coping, instead assuming local faith leaders would take responsibility for such needs. The reasoning was frequently linked to concerns for neutrality and impartiality. In many of these contexts however – transit towns, detention centres, camps and resettlement locations – the women had limited access to such persons or resources, or had been overlooked or estranged from support due to their gender. Those with a humanitarian mandate who could have brokered equal access did not ask the women in the study about their needs related to faith and avoided discussion of faith in assessments and response plans. As a result, many of the women in this study lacked external support for their coping strategies.

Faith-sensitive MHPSS with Muslim women

While marginalising faith concerns of displaced populations can create harm,

over-emphasising the importance of faith to a population or making assumptions about faith needs based on the majority religion may also create harm. Aid should be responsive to persons who both do and do not wish to be engaged in any way with faith. Thus faith sensitivity in aid and MHPSS begins with asking the displaced population: what they believe the causes of their problems are, what they feel the solutions should be and what role, if any, they would like for faith language, faith actors and spiritual practices to be a part of that process.

The foundations for faith sensitivity in MHPSS are rooted in the principles and directives set forth in the IASC *Guidelines on MHPSS in Emergency Settings*.[2] These provide guidance on engaging religious supports and on undertaking assessments that take faith issues and actors into account, and emphasise the importance of building on available resources and capacity, participation, integrated support systems and human rights. Further practical guidance on faith sensitivity in MHPSS was developed in 2018.[3] Drawing on this guidance and the data in this study, we offer a number of recommendations for working specifically with Muslim women.

MHPSS and other aid actors should take responsibility for assessing, facilitating and monitoring equal access to faith resources and spaces for women and men, working closely with formal and informal faith leaders, and recognising that access to religious resources is gendered. It is important to identify informal female faith leaders in the local context to whom other women turn for spiritual and emotional support. Engage those women in PSS programme design and implementation, including in Psychological First Aid trainings.

MHPSS staff should be made aware of the existence and relevance of key faith teachings and local proverbs that are utilised for coping by individuals and communities. In addition, identification with Prophets and female role models in faith narratives can be a source of comfort as they too experienced displacement, persecution and loss. Heightening staff awareness of these coping methods may enhance the effectiveness of the programmes.

Mental health tools should take into account local idioms of distress that often infuse faith language into descriptions of symptoms of mental health disorders; for example, in Iraq "tired soul" was used to describe the experience of depression.

The role of adverse experiences related to religious identity should be considered when assessing root causes of distress, especially for populations exposed to war atrocities and religious persecutions, and religious and racial discrimination. Increased understanding of the positive and negative functions of local beliefs regarding guilt and divine punishment, and their impact on distress levels and coping mechanisms, can help providers tailor effective care responses.

Women's peer-to-peer psychosocial support groups designed and led by women can be particularly potent in improving well-being, especially when integrated with educational and income-generation projects. These initiatives may also include religious coping activities such as providing peer support to re-establish rituals and space for discussion related to faith and other concerns.

Kathleen Rutledge *KRutledge@qmu.ac.uk*
Humanitarian response director; doctoral researcher, Queen Margaret University

Sandra Iman Pertek
S.M.Pertek@pgr.bham.ac.uk
Gender consultant; doctoral researcher, University of Birmingham

Mohammad Abo-Hilal *Mahilal3@gmail.com*
Syrian psychiatrist; founder of Syria Bright Future

Atallah Fitzgibbon
Atallah.Fitzgibbon@irworldwide.org
Faith Partnerships Advisor, Islamic Relief Worldwide

1. Involving 246 women, most Muslim (96%), with the remainder Christian, ages ranging from 18-64. The study also included 22 interviews with humanitarian and MHPSS practitioners.

2. IASC (2007) *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* bit.ly/IASC-MHPSS-guidelines

3. Islamic Relief Worldwide and Lutheran World Federation (2018) *A faith-sensitive approach in humanitarian response: Guidance on mental health and psychosocial programming.* bit.ly/IRW-LWF-faith-sensitive-MHPSS-2018

Roles and responsibilities of cultural mediators

Emilie Venables, Katherine Whitehouse, Caterina Spissu, Lilian Pizzi, Ahmad Al Rousan and Stefano di Carlo

Cultural mediation is critical to optimising both access to and quality of mental health services.

There is increasing recognition of the need for cultural mediation – an approach that goes beyond purely providing translation and interpreting services – to meet the needs of migrants, asylum seekers and refugees.[1] Cultural mediators work with a wide variety of organisations including NGOs, hospitals, health centres and the police, and provide assistance to displaced populations in areas including medical and para-medical services, health promotion, psychological services and legal advice.

Médecins Sans Frontières (MSF), which has provided a range of support to migrants throughout Italy since 1999, conducted a study to understand the role of cultural mediation in facilitating mental health provision and the challenges faced by those providing cultural mediation services, and to learn more about the experiences and support needs of cultural mediators themselves.[2] Twenty-five in-depth interviews were conducted with cultural mediators, MSF staff and key informants from academic institutions and organisations who were experts in the use of cultural mediation with displaced populations.[3]

Pivotal role of cultural mediators

Communication and translation are the main tasks of any cultural mediator's work, enabling meaningful exchange and helping to build trust. The three-way communication that occurs between cultural mediators, their clients and other team members (such as psychologists) is an extremely important triangular relationship which helps beneficiaries to access and benefit from essential services. This relationship helps to build trust between the cultural mediator and the client, in turn improving communication between the client and the service-provider.

Cultural mediators are often the first point of contact that people have with mental health services. The mediators are often able to facilitate a more adequate and earlier understanding of needs and prevent mistakes being made or avoid missed opportunities for timely access to care and services. This initial contact was beneficial in assessing the immediate needs of displaced populations, particularly relating to acute psychological distress.

Some cultural mediators assist clinicians or mental health staff during individual consultations, or work with survivors of torture and women who have been trafficked. Others work with legal and security agencies, providing information and translation during legal hearings. They translate both words and concepts between clients and service providers, ensuring that the client is understood and can access the care and support they need.

Emotional and challenging work

The work is also challenging for the mediators themselves. Often they are drawn from the refugee community and many of them

MSF/Sara Creta

An MSF cultural mediator working with displaced people in Italy.

have been through similar, often traumatic, migration journeys and experiences as the people they are trying to support; it is more difficult therefore for them to establish a proper, objective and professional distance. Where they have been through a difficult asylum process in Italy themselves, they can be unsure if – or how – they should share these experiences with their clients. They are sometimes accused of bias or are asked to lie or conceal information, which puts them in a very difficult position.

On the other hand, as an MSF staff member said, the fact that some of the cultural mediators had travelled the same way and were in a stable situation "was a positive message for the people… the very fact of being there, even sometimes without speaking, was already of added value in this situation, to decrease the tension, the fear…"

Clients do not always want assistance from, or close proximity to, a cultural mediator, and do not always want to speak their home language during psychological or clinical sessions. As one expert in cultural mediation explained, "it's the language of their torturers". Some prefer expressing themselves in French or English without a cultural mediator to assist with translation. Although MSF clients already have the right to decline the support of a cultural mediator during their sessions, more work is needed to inform (and thereby reassure) them about codes of conduct and confidentiality to help in deciding whether or not to have the assistance of a cultural mediator.

While familiarity with their experiences provides reassurance for clients, the shared experience between cultural mediators and those whom they assist makes their work emotionally challenging and the risks for them of vicarious trauma and burnout are extremely high. Cultural mediators may adopt personal coping strategies, but well-integrated psychological support and supervision are necessary to fully protect cultural mediators, particularly those exposed to extremely sensitive issues around mental health, violence or torture.

Regular meetings between cultural mediators and their counterpart colleagues – such as psychologists, physiotherapists or clinicians – need to take place before and after interactions with clients. However, as many cultural mediators do not work full time, or may be working with different organisations simultaneously, such meetings can be challenging to attend. In addition, this precarious employment status adds further to the challenges they face.

Timely access to mental health services for refugees and asylum seekers is a fundamental component of essential medical provision, in Italy as elsewhere. Cultural mediators are essential to this but the pressures on them in that role are many. A greater focus on training and skills development for cultural mediators and for those staff working with them would also help ensure an improved clarity of roles and quality of service provision, and would reduce the potential for increased trauma.

Emilie Venables *emiliecvenables@gmail.com*
Luxembourg Operational Research Unit, Médecins Sans Frontières (MSF) Luxembourg; Division of Social and Behavioural Sciences, School of Public Health and Family Medicine, University of Cape Town

Katherine Whitehouse
kitwhitehouse@gmail.com
Luxembourg Operational Research Unit, MSF Luxembourg

Caterina Spissu *caspissu@gmail.com*
Italy Mission, MSF

Lilian Pizzi *lilian.pizzi@gmail.com*
Italy Mission, MSF

Ahmad Al Rousan
ahmad.alrousan@rome.msf.org
Italy Mission, MSF

Stefano di Carlo *ste.dicarlo@gmail.com*
Italy Mission, MSF

GBV and mental health among refugee and host community women in Lebanon

Alina Potts, Rassil Barada and Angela Bourassa

Underlying gender and power imbalances that put displaced women and girls at risk of gender-based violence (GBV) are exacerbated by vulnerabilities related to legal status, economic security, access to services, and living conditions.

ABAAD, a Lebanese organisation working on all aspects of GBV prevention and response,[1] and the US-based Global Women's Institute (GWI)[2] conducted a survey of Lebanese, Palestinian and Syrian refugee women in Lebanon in order to understand their experiences of GBV and mental health and psychosocial support (MHPSS) provision. The survey was undertaken in May 2019 in collaboration with Lebanese GBV and MHPSS service providers and academics. It was complemented by qualitative data collected through focus group discussions with community leaders, GBV and MHPSS practitioners, and community members to further understand both their perceptions of well-being and any barriers to and factors supporting coordinated services across these two sectors.[3]

Of the 969 women interviewed, 90% reported having serious problems due to one or more environmental vulnerabilities: food insecurity (71%), physical health (62%), being separated from family (56%), and safety and security where they live (50%). Participants in focus group discussions identified lack of access to financial resources as the main cause of these vulnerabilities among both host and refugee communities. GBV is common among this population; over one-third of women indicated having been married before the age of 18 and over three-quarters of women who had or had had a partner reported having experienced intimate partner violence (IPV), about half within the previous year. Eight in 10 women who experienced IPV met the criteria for severe distress.[4] Coercive control is also an important risk factor for psychological distress. Forced or child marriage was one of the largest factors for psychological distress with immense pressure

on girl brides, affecting their relationship to the spouse and their future children.

More Syrian women than Lebanese women met the criteria for severe psychological distress. This difference was explained in focus groups as stemming from pressure or worry (expressed in Arabic as *daghet*) resulting from financial and family stress, uncertainty about the present and future, family separation, and stigma associated with refugee status. Having a serious problem in even just one dimension of environmental vulnerability was associated with a significantly higher rate of severe psychological distress compared with those who had no serious problems. The number of vulnerabilities causing serious problems was significantly associated with increased rates of severe psychological distress.

Both Lebanese and Syrian women mentioned the mutually reinforcing nature of physical health and mental health, and how having chronic illnesses or physical ailments can prevent them from taking care of themselves, as well as how mental health can manifest as physical symptoms.

Women's responses

More Syrian women sought services in response to violence, primarily psychosocial support or mental health services, whereas Lebanese women sought more education and vocational training. The primary barrier to seeking services was that women simply did not know services were available, followed by the belief that they did not need services to address violence. Similarly, the primary supporting factor for seeking help was to have services clearly targeted to people of their background or status, particularly for the Syrian women. This

relates to how services are advertised, where they are located (for example, whether they are located in town centres or close to the settlements where refugees live), and how they are structured (for example, whether offered as standalone centres or within government-run 'one-stop' centres alongside a number of other service providers).

Most of the women looked for comfort in their religion to cope with violence. Prayer was the only common coping mechanism among survey and focus group participants. One woman described her experience in using spirituality to cope with daily experiences: "I go up to the edge of the valley, and I talk to God. I sit down, drink a cup of herbal tea, smoke a cigarette, scream my lungs out, and then go back."

Coping mechanisms reported as helpful were finding employment, engaging community leaders responsible for security in the informal tented settlements, and using pain relief or other medication. About three-quarters reported seeking advice about what to do and found emotional support from people close to them helpful. Crying or letting it out were described as "of no use" because the "sorrow remains inside."

Anecdotal evidence from ABAAD's staff suggests that vulnerabilities have significantly increased among all residents of Lebanon since data collection in May 2019, with many losing their income, and women reporting higher rates of GBV and psychological distress. This has been further exacerbated since the explosion in Beirut on 4th August 2020 and the outbreak of the COVID-19 pandemic, which accelerated Lebanon's economic collapse, isolated GBV survivors with their perpetrators, and created physical barriers between affected persons and their support systems. In addition, many services have been suspended or adapted during the pandemic, leaving survivors with limited access.

The focus group discussions yielded words such as *daghet*, which can be loosely translated as pressure or worry, and *ghadab*, anger or fury, as feelings associated with poor mental health. While in English these terms may not indicate mental health

struggles, in this context people tend to understate their symptoms because of stigma and social pressure to "stay strong" or "pull oneself together" (*shedde halik*).

Recommendations

Service providers should seek to provide holistic, low- or no-cost GBV and MHPSS services, with support for referrals, in safe locations, and co-locating them as appropriate (to reduce transport costs). Safe transportation and childcare should be provided whenever possible. Referral pathways between GBV and MHPSS providers can be further augmented by ensuring age-appropriate services. Services such as psychosocial support were often available for younger and middle-aged adults, but were not always accessible to children, adolescents and older people.

Focus group participants referred to the immense stigma related to seeking mental health services, the lack of qualified service providers, and absence of confidential safe spaces in the camps as barriers to care. Novel approaches, such as mobile services with safe, confidential physical space for service provision, may address these concerns.

Awareness sessions are needed to address victim-blaming (blaming survivors of GBV for their experience – which further negatively impacts their mental health and also perpetuates stigma) and to target not only community members but also service providers themselves. GBV actors should continue to conduct community-level awareness sessions on gender and GBV, as well as recognising and responding to psychological distress, and offer supportive coping mechanisms. Trainings should include prevention and response to sexual exploitation and abuse, especially given the current economic crisis. GBV actors should continue to conduct awareness sessions on the negative physical, psychological and social effects of forced and early marriage. Community-based campaigns should undertake to de-stigmatise conversations about mental health using locally relevant terms. The terms used to describe mental health (or ill-health) among this population deviate from the mainstream

terminology (such as depression, *ikti'eb*). Many participants in the focus groups understated their experiences with mental health by using softer terms or euphemisms (such as *daghet*) to describe more severe symptoms, for example of severe anxiety.

Ensuring services are clearly accessible to all can help address barriers to host community members, refugees and migrant domestic workers' access to services; many will have limited knowledge of such services and/or believe that they do not target their demographic.

Economic empowerment activities are important to counteract the effect of environmental vulnerabilities. Such programmes should actively minimise the risk of GBV resulting from the challenge that a woman's income may pose to dominant gender roles by undertaking a thorough gender and GBV assessment to inform programme design, monitoring and evaluation, with technical guidance from GBV actors.

Finally, it is important to recognise that refugees have specific vulnerabilities,

and may be more comfortable seeking support from service providers of a similar background when possible. Engaging Syrian members of humanitarian organisations in outreach or other services, or working with informal Syrian service providers or community leaders to build trust with refugee community members, could help address this.

Alina Potts *apotts@gwu.edu @alina_potts*
Research Scientist, Global Women's Institute

Rassil Barada *rbarada@gm.slc.edu*
Protection from Sexual Exploitation and Abuse and Gender-Based Violence Consultant, ABAAD-MENA

Angela Bourassa
abourassa@gwu.edu @ABourassaMPH
Research Associate, Global Women's Institute

1. See also www.fmreview.org/detention/anani

2. Research institute based at the George Washington University https://globalwomensinstitute.gwu.edu/

3. Peer-reviewed publication of full results forthcoming.

4. The K6+ assessment tool was used to measure psychological distress. See Segal S P, Khoury V C, Salah R and Ghannam J (2018) 'Contributors to Screening Positive for Mental Illness in Lebanon's Shatila Palestinian Refugee Camp', *The Journal of Nervous and Mental Disease* 206(1) https://pubmed.ncbi.nlm.nih.gov/28976407

Community-based approaches to MHPSS

Dmytro Nersisian, Marine Ragueneau, Heide Rieder and Guglielmo Schinina'

The limits of operating within humanitarian contexts do not always allow for sufficient time and resources to be devoted to the participatory processes that are vital to establishing community-based approaches to MHPSS.

People's sources of stability – such as individual and group identity, sense of place and belonging, and legal and social status – can be undermined by displacement and its associated stressors. Mental health and psychosocial support (MHPSS) can restore a sense of normality, mend collective wounds and support the transformation of individual and collective identities.

Humanitarian responses, however, are commonly structured within inequitable power relations. Thematic expertise is valued over local knowledge and at times imposed. Often those most impacted by programming are not engaged in designing, implementing

and evaluating programmes, while organisations are accountable to donors rather than purely to the crisis-affected communities they serve. In the domain of mental health, cultures, belief systems and power dynamics have great impact in conceptualising illnesses, including symptomatology, and in shaping responses, including treatments and psychological interventions. There is therefore an inherent risk that MHPSS programmes in humanitarian settings may replicate the problematic dynamics of humanitarian interventions and mental health care alike by a) focusing on the vulnerabilities of those forcibly displaced, disregarding their

resiliencies and agency; b) understanding reactions to adversity through a bio-medical approach and therefore risking pathologising MHPSS programme participants; and c) creating systems of reliance on assistance that perpetuate inequitable power dynamics.

One way to overcome these risks and instead support crisis-affected communities in constructing their own responses to adversity is to use community-based approaches – that is, approaches based on the understanding that communities can be drivers for their own care and change and should be meaningfully involved in all stages of MHPSS responses.

Community-based approaches to MHPSS are characterised by:

- understanding the importance of collective reactions to adversity and of social cohesion in determining individual and social well-being
- activation of context-specific, multi-disciplinary support systems that build on existing strengths of affected communities, rather than merely provision of services to respond to the deficits created by the emergency
- participatory engagement of communities in all phases of projects
- the objective to restore and/or strengthen the collective structures and systems essential to daily life and well-being.[1]

The International Organization for Migration (IOM) has identified seven different levels of community engagement in MHPSS programmes.[2] In the first three levels, where communities do not have decision-making power, information is either shared with communities or gathered from them, or they are merely consulted. The next two levels are firstly where communities are involved in activity planning but their power remains limited (known as 'functional' community engagement) and secondly where communities are completely involved in decision-making processes ('interactive' engagement). The last two levels are characterised as community ownership, in which communities control decision-

making and agencies act as facilitators; and empowerment, where communities are able to respond to existing needs with limited external support. While MHPSS programmes should always aim for empowerment levels of community engagement, staff should be clear about their limitations.

A community-based approach in Bangladesh and South Sudan

IOM programmes in Bangladesh and South Sudan demonstrate the necessity of continuous participatory assessment and the importance of working alongside civil society and government stakeholders in the MHPSS sector in order to build capacity to deliver services and to enable knowledge sharing that will last beyond any single MHPSS intervention.

In Bangladesh, where an estimated 720,000 Rohingya are displaced, IOM MHPSS teams work with community volunteers from both Rohingya and host communities and engage with, among others, traditional healers and religious leaders. As coping strategies identified by the communities included relying on family and social support and religious practices, the teams focused on facilitating collective activities centring on cultural preservation and rituals and celebrations. These activities included creating collective kitchens, facilitating family dialogues, holding healing ceremonies and creating a Cultural Memory Center (CMC). The kitchens and family dialogues provided safe spaces to discuss pressing issues; in addition, gathering informally for a traditional activity fostered a sense of community. Healing ceremonies had a strong inter-generational component and allowed community members to engage with their historical narratives and cultural and community identities, and also increased opportunities for social connection. The CMC, through the collection, production and exhibition of traditional arts and crafts, offered a participatory platform for Rohingya community members to preserve a sense of identity and cultural heritage, and also to ensure its continuity in younger generations.

Preserving collective identity and cultural heritage proved to be indispensable

components in restoring and maintaining mental health and psychosocial well-being of individuals and the wider Rohingya community.

MHPSS programmes often emphasise sustainability through strengthening health and social service systems. In South Sudan, where 7.5 million are in need of humanitarian assistance, including 1.3 million of the total 1.6 million IDPs in the country, large portions of the population cannot be reached through existing mental health services. IOM's programme therefore focuses on strengthening family and community structures and support, in partnership with existing health and social service providers. Alongside offering direct services to displaced communities in camp-like settings, the programme widened its scope of interventions in 2017 to include capacity building for government stakeholders and to serve host communities. Through a collaboration with the Ministry of Gender, Child and Social Welfare the programme currently includes 35 social workers from the State ministry in Wau in Western Bahr el Ghazal, complementing the IOM MHPSS staff. This has contributed to the professionalisation and practical experience of this particular group through on-the-job training combining social work and MHPSS skills such as case management, Psychological First Aid, basic counselling, and referral.

The social workers focus on building the self-reliance and agency of community members. Through their continuous presence and engagement, the social workers have gained the trust of community leaders and members, enabling discussion of critical topics such as early pregnancy, drug abuse and youth violence, and referrals to relevant services if necessary.

Social workers and MHPSS staff also jointly facilitate inter-generational dialogue sessions in host communities and areas of return, working either directly or in collaboration with national NGOs. Youth and the elderly are given equal space to express their grievances, such as the elderly's experiences of lack of respect and connection inside the family system and youth's experience of neglect. This process requires time and repeat visits to the same families and communities by staff in order to be successful. Working with social workers and other health-care and social services staff sets the foundation for empowerment-driven community engagement in MHPSS programming, thereby transferring resources to and exchanging knowledge with national actors who will continue delivering services once humanitarian partners have left.

A community-based approach to MHPSS is essential in supporting individuals' and communities' resilience and agency in displacement contexts; in providing ethical, culturally appropriate and sustainable MHPSS for people of varying backgrounds; and in addressing individual and community psychosocial well-being within the wider social, political and economic structures affecting displaced people's lives. While emergency contexts and the general humanitarian architecture often do not encourage community-based approaches to MHPSS, community-based support remains possible if actors engage with communities and ensure that programming reflects the needs and resources of the communities themselves.

Dmytro Nersisian *dnersisian@iom.int*
MHPSS Programme Manager, Bangladesh

Marine Ragueneau *contactpss@iom.int*
Consultant, Mental Health, Psychosocial Response and Intercultural Communication Global Section

Heide Rieder *hrieder@iom.int*
MHPSS Programme Manager, South Sudan

Guglielmo Schinina'
contactpss@iom.int @metonimia
Head, Mental Health, Psychosocial Response and Intercultural Communication Global Section

International Organization for Migration (IOM)

1. IASC *Community-Based Approaches to MHPSS Programmes: A Guidance Note* bit.ly/IASC-MHPSS-community-based

2. IOM (2019) *Manual on Community-Based MHPSS in Emergencies and Displacement* www.iom.int/mhpsed

Physical activity, mental health and psychosocial support

Simon Rosenbaum, Alastair Ager, Leslie Snider, Ajwang Warria, Holly Collison, Sabrina Hermosilla and Davy Vancampfort

Physical activity (including sport) is an evidence-based yet under-recognised strategy for protecting and promoting MHPSS among displaced populations.

Globally, recognition of the relationship between physical health, mental health and psychosocial well-being is rapidly increasing. As mental health, just like physical health, is a cross-cutting issue, a large number of sectors, agencies and actors thus play a role in achieving optimal outcomes in this area for forcibly displaced populations. Increasingly, in both high- and low-resource settings, dedicated physical activity practitioners with mental health training are being integrated into multidisciplinary teams that promote mental health and psychosocial well-being. Similar opportunities must be considered for displaced populations in order to maximise the potential impact of physical activity as a MHPSS strategy.

Physical activity[1] is often seen as the cornerstone of non-communicable disease prevention and treatment, but the most vulnerable populations around the world, including those living in displacement, women and people with disabilities, are often the least likely to have access to targeted physical activity programmes, infrastructure or opportunities. Yet there is clear value in embedding physical activity interventions as a routine component of mental health care – such as the provision of MHPSS – to displaced populations.

Physical activity is a proven strategy for both preventing and treating mental disorders, for promoting well-being and social connection, and for fostering a sense of community. This includes reducing the burden of mental disorders by reducing symptoms of depression, anxiety, schizophrenia, post-traumatic stress disorder and substance use disorders.[2] Evidence indicates that in terms of mental health benefits, the type or intensity of physical activity is less critical than the overall time spent. Another key factor is prioritising enjoyment, fostering self-efficacy (an individual's belief in their capacity to achieve specific performance goals), and personal preference, which are all predictors of long-term engagement in physical activity.

Physical activity and sport should be considered across layers 2-4 of the IASC Pyramid,[3] including as part of community and family support (layer 2), as a focused non-specialised support (layer 3), and as a component of specialised MHPSS care.[4] Migrants' indigenous games and physical activities can be an important part of their past and contribute to preserving culture and connecting to future narratives of pain and healing. Sport and physical activity can play an important role in the integration of displaced people in communities.

In addition to reducing symptoms of mental disorders, emerging evidence shows that physical activity is protective against future episodes of poor mental health. Among children exposed to adverse childhood events, team sports participation is protective against future mental disorders. Similarly, sport participation is recognised as critical to the five 'C's of positive childhood development: competence, confidence, character, connections and compassion/learning. This is in addition to contributing to social and emotional development of children at all ages in relation to conflict resolution, principles of fairness, development of initiative, leadership and non-violent communication.

Physical activity, MHPSS and humanitarian contexts

Rohingyas in Bangladesh: A rapid assessment conducted in Cox's Bazar in 2019 found that the Rohingya refugees identified physical activity as a psychosocial strategy which helped to relieve 'tension', a local expression for distress.[5] Lack of resources (including space and equipment) was the biggest barrier to participation despite strong support for physical activity from community leadership. Access was also limited for specific groups including people with disabilities, older adults and – due to security fears and cultural attitudes – women. The report provides recommendations for MHPSS providers including promoting cultural-friendly games and activities, ensuring MHPSS staff are trained in and aware of the benefits of physical activity, and using woman- and child-friendly spaces to deliver tailored physical activity programmes for those groups.[6]

ClimbAID: ClimbAID is a non-profit, sport-for-development organisation that uses climbing as a mental health and psychosocial intervention. Their programme in Lebanon

encompasses the 'Rolling Rock', a mobile climbing wall that brings MHPSS-informed climbing and other physical activities to children and youth from the local population and the refugee community. Preliminary results of an evaluation of the ClimbAID programme highlight its contribution to fostering better relationships between refugee and host communities, challenging gender biases and increasing self-efficacy.

Surf therapy: Surfing is being used in vulnerable populations around the world to promote health, empowerment, mentorship, and community inclusion and partnership. The principles and learning from surf therapy programmes and the establishment of the International Surf Therapy Organization[7] provide a foundation for developing, evaluating and scaling physical activity programmes with mental health aims.

Arsenal Football Club and Save the Children: Coaching for Life, a partnership between a professional football team and an NGO, was developed in response to research conducted by Save the Children as a MHPSS strategy to address the negative consequences of prolonged exposure to

ClimbAID/Jameson Schultz

ClimbAID PSS-informed climbing session in Saadnayel, Bekaa Valley, Lebanon.

stress in children. The project was piloted in Jordan and Indonesia and uses football to help children develop skills in managing emotions, communication, decision-making, self-esteem and conflict management.

Competition versus participation in Uganda:

Not all sport-for-development programmes have a positive impact on mental health and psychosocial outcomes. A competitive football league in northern Uganda was found to have had a negative impact on the mental health of participating boys. The resulting recommendations highlight the need to improve local capacity and resource provision for non-competitive recreational physical activity, and the importance of integrating MHPSS training for coaches and sporting professionals.[8]

The Olympic Refuge Foundation (ORF):

The ORF was founded in 2017 by the International Olympic Committee (IOC) in order to support the protection, development and empowerment of children and youth in vulnerable situations through sport. The *Sport for Protection Toolkit: Programming with Young People in Forced Displacement Settings*[9] was the product of a multi-agency collaboration between UNHCR, the IOC and Terre des Hommes to develop a practical resource for practitioners working with sport to improve outcomes for young people living in displacement. It includes both theoretical and step-by-step practical guidance.

Following the successful development of the *Toolkit*, the ORF Think Tank was launched in July 2020. This aims to enhance the visibility of the role of sport as an evidence-based MHPSS strategy, while supporting the generation of evidence and resources. The ORF Think Tank includes representatives of diverse fields including international development and emergency contexts, clinical disciplines (psychiatry, psychology, physiotherapy, exercise physiology), child protection, education and post-conflict programming. This diversity provides an opportunity to break down many of the traditional sectoral silos that exist in humanitarian contexts and will help to achieve tangible outcomes with a high potential for impact.

Integrating physical activity as core MHPSS

MHPSS and sports practitioners working with displaced communities can maximise the potential of physical activity to protect and promote mental health and psychosocial well-being in a variety of ways. Firstly, MHPSS practitioners should be trained in basic principles of physical activity promotion and, similarly, professionals providing physical activity and sports programmes should at a minimum be trained in basic psychosocial support principles and skills, including psychological first aid. Secondly, a basic level of infrastructure is required to deliver physical activity and sports programmes and ensure that those who are most vulnerable are not left behind. Thirdly, thinking beyond able-bodied young men and expanding physical activity services to safely and appropriately include women and people with disabilities is essential. Lastly, physical activity – and team sports in particular – can provide an opportunity for mentorship and pathways to livelihoods that should be considered in developing physical activity programmes with an MHPSS purpose.

Simon Rosenbaum
s.rosenbaum@unsw.edu.au @simon_rosenbaum
Associate Professor, School of Psychiatry, UNSW Sydney

Alastair Ager *aager@qmu.ac.uk @AlastairAger*
Professor, Institute for Global Health and Development, Queen Margaret University

Leslie Snider *les@redbarnet.dk @LeslieMSnider*
Director, The MHPSS Collaborative, hosted by Save the Children Denmark

Ajwang Warria *ajwang.warria@wits.ac.za*
Senior Lecturer, University of the Witwatersrand

Holly Collison *H.Collison@lboro.ac.uk*
Senior Lecturer, Institute for Sport Business, Loughborough University London

Sabrina Hermosilla
shermosi@umich.edu @HermosillaSabri
Research Investigator, University of Michigan

Davy Vancampfort *@DavyVancampfort*
davy.vancampfort@kuleuven.be
Assistant Professor, KU Leuven Department of
Rehabilitation Sciences and University Psychiatric
Centre KU Leuven

1. Physical activity refers to any bodily movement and includes sport and exercise.

2. Ashdown-Franks G et al (2020) 'Exercise as Medicine for Mental and Substance Use Disorders: A Meta-review of the Benefits for Neuropsychiatric and Cognitive Outcomes', *Sports Medicine* 50(1) https://link.springer.com/journal/40279/volumes-and-issues/50-1

3. IASC (2007) *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* pp11–13 bit.ly/IASC-MHPSS-guidelines

4. Stubbs et al (2018) 'EPA guidance on physical activity as a treatment for severe mental illness: a meta-review of the evidence and Position Statement from the European Psychiatric Association (EPA), supported by the International Organization of Physical

Therapists in Mental Health (IOPTMH)', *European Psychiatry* doi: 10.1016/j.eurpsy.2018.07.004

5. Wells R et al (2019) 'Physical activity as a psychosocial intervention among Rohingya refugees in Bangladesh: a rapid ecological community assessment', *Intervention* 17(2) bit.ly/Intervention-Wells-et-al-2019

6. Ahmed M S et al (2019) 'Sports and physical activity in psychosocial interventions with adolescent groups of the Rohingya community in Bangladesh: potential, limitations and critical factors for success', *Intervention* 17(2) bit.ly/Intervention-Ahmed-et-al-2019

7. https://intlsurftherapy.org

8. Richards J et al (2014) 'Physical fitness and mental health impact of a sport-for-development intervention in a post-conflict setting: randomised controlled trial nested within an observational study of adolescents in Gulu, Uganda', *BMC Public Health* 14(1) bit.ly/BMCPublicHealth-Richards-et-al-2014

9. bit.ly/Sport-for-protection-toolkit-2018

Adaptation of MHPSS in camps in the context of COVID-19

Jordan Balletto, Hannah Bergbower, Alice Tang and Fernando Ona

The pandemic has placed significant additional mental and emotional burdens on forced migrants. MHPSS interventions must be adapted to meet this challenge and not be overlooked in the wake of containment and mitigation efforts.

The IASC intervention 'pyramid' for mental health and psychosocial support (MHPSS) in emergencies promotes the need for a layered system of complementary support that meets the needs of different groups during emergencies.[1] The recommendations here reflect these layers of intervention, and focus on the importance of establishing collective care and mutual aid networks that integrate the cognitive, affective, spiritual and social realities of displaced persons living in camp settings in the context of COVID-19.

Basic services and security

Decisions made by host countries during the pandemic response, including lockdown measures and travel restrictions, have disproportionately affected forced migrants, who are experiencing increased barriers to meeting their basic needs when they may already be traumatised and emotionally strained. Advocacy must continue for their **inclusion in national responses** and to maintain access to aid delivery and physical access for aid workers, as well as

to ensure that migrants' movements are not unnecessarily restricted in ways that discourage them from seeking routine health care and mental health support.

Outside groups and minorities have become targets for blame as failed containment responses exacerbate ethnic and religious divides, with refugees, IDPS and asylum seekers in particular often portrayed as competing for access to diminishing resources. The risk of disease outbreaks in camps creates further feelings of justification among host governments and populations for inhumane treatment and lockdown measures. **Anti-stigma campaigns** will be essential for creating an accepting environment where forced migrants feel confident enough to seek treatment, self-isolate and identify as having COVID-19 without fear of social or legal repercussions.

Religious and cultural leaders within both the host community and the camp populations can be effective in spreading the message that religion, ethnicity or any other identifying factor does not determine

whether or not someone is more likely to contract and carry the virus.[2] Sharing the importance of seeking health care when individuals fall ill and advocating for systems where those affected can be cared for without social or legal repercussions will also be essential to the MHPSS response.

Displaced populations living in camp settings have expressed the fear of starvation, of common illnesses caused by deteriorating living conditions, and of interruptions to standard aid delivery is taking precedence over fear of contracting the virus. Focused MHPSS interventions are unlikely to achieve full potential for success unless people have consistent **provision of basic needs and essential health services**, in order to feed their children, receive pre-natal care, manage chronic health conditions, and receive preventive services and treatment for common illnesses in camp settings. In addition, incorporating psychosocial stabilisation techniques and spiritual care practices may help strengthen emotional and spiritual well-being during the stressful experiences that refugees are coping with on a daily basis.

Community and family support

Being able to turn to immediate and distant social networks is often more vital to healing and survival than any humanitarian programming – and this is directly threatened by the nature of the COVID-19 pandemic.[3] Transferring **support networks** to phone messaging apps for the duration of the pandemic may be one option for safely maintaining social ties both within and outside camp boundaries. Rearranging in-person networks for groups who are more prone to isolation and have less access to technology (such as women, girls and young children) to take place in safe physically distanced spaces may also be an effective solution.

By **involving forced migrants in the COVID-19 response**, aid agencies can offer people who have been cut off from their previous occupations the opportunity to be active and engaged again. This may require supporting training of community health workers, of contact tracing and surveillance teams, or of teachers in providing COVID-adapted education. People can also be involved in sewing groups for cloth mask production, sanitising teams for public spaces, and helping with home distribution of food and medicine for people in isolation.

For people in isolation, maintaining social contact outside the home and camp through telephone calls and messaging can reduce feelings of isolation and thereby **support their mental health**. Distribution of inexpensive entertainment items for children that can be used in isolation – such as books, games, colouring supplies, music, and meditation apps – can provide calming activities that support well-being. In contrast, much exposure to negative information and frightening imagery regarding the virus can stoke fears and be detrimental to positive coping and mental health. Reducing exposure to TV news and reducing the amount of time spent seeking information on the virus can help reduce feelings of isolation-induced anxiety, fear and depression.[4] Spiritual care practices and interventions may be useful complements to MHPSS programming.

Focused non-specialised supports

All humanitarian workers and community health workers (CHWs) from the local camp population can play a role in reducing stress associated with the virus by delivering evidence-based information in plain language through universally accessible channels. This can also help prevent anxiety by reducing the spread of rumours and misinformation. **Delivering specific advice** in a way that is empathetic and clear, without the use of potentially threatening or ambiguous language (for example, giving clear instructions to avoid physical contact with others rather than talking of 'social distancing'), is something that can be done by most non-specialised workers with very little training and supervision.[5]

There are **mental health considerations for people in quarantine** who may be feeling social and psychological stress after a COVID-19 diagnosis, including shame, fear, anxiety and depression. Care should be taken to ensure that people in quarantine

are not exposed to excessive amounts of reporting of negative or frightening aspects of the pandemic. Having MHPSS staff and non-specialised teams of CHWs present and accessible for people in quarantine, either in-person or through remote services, will be essential to support the fluctuating needs of patients and their families.[4]

CHWs from the camp population need to be prepared to deal with heightened levels of distress and anxiety. While **Psychological First Aid (PFA)** does not constitute professional psychiatric treatment or counselling, PFA training is designed so that any worker can feel equipped to provide a humane, supportive response to a person who is showing signs of distress and suffering. Since World Health Organization guidelines indicate that successful PFA training can be completed in one day, widespread implementation seems feasible, especially if trainings can be adapted to remote online learning.[6] Current evidence of the effect of PFA on psychosocial outcomes indicates that it improves retention of knowledge and strengthens capacity for providing psychosocial support in humanitarian crises.[7]

Specialised mental health services

Clinical psychiatric care is overwhelmingly unavailable to displaced populations who are in desperate need of such services.[8] The COVID-19 pandemic has further reduced access to the already far from sufficient provision of high-level mental health care to displaced populations due to movement restrictions, elimination of group programming to reduce transmission risk, and understaffing as humanitarian agencies are forced to pare down operations. **Expansion of telepsychiatry** can mitigate this issue by providing health care remotely. It is also possible that telepsychiatry programmes will expand the available pool of psychiatrists, as trained clinicians from locations all over the globe could opt to accept remote patients in camp settings.

Task-sharing of psychological support between clinicians (whether on-site or remote) and CHWs can be effective in improving social function, reducing

depression and disability, and improving access to mental health care. Task-sharing can increase the availability of mental health care and help achieve the most efficient allocation of mental health specialists' time.[9]

Jordan Balletto *jordan.balletto4@gmail.com*
Program Monitor, Louisiana Department of Health, Shots for Tots Coalition

Hannah Bergbower *@hannahbergbower*
hannah.bergbower@tufts.edu
Nurse–Midwife/Nurse Practitioner and Clinical Practice Director, Delkab OB GYN Affiliates; Adjunct Associate Professor, Tufts University Department of Public Health and Community Medicine

Alice Tang *alice.tang@tufts.edu*
Professor of Public Health and Community Medicine, Tufts University Department of Public Health and Community Medicine

Fernando Ona *fernando.ona@tufts.edu*
Clinical Associate Professor of Public Health and Community Medicine, Tufts University Department of Public Health and Community Medicine

1. IASC (2007) *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* pp11–13 bit.ly/IASC-MHPSS-guidelines

2. See World Health Organization communication guidance for avoiding harmful language: WHO (2020) *Social Stigma associated with COVID-19* bit.ly/WHO-covid19-stigma-guide

3. Kim J, Maxwell D and Robillard S (2020) 'COVID-19 compromises social networks: What this means for people in humanitarian crises', The Conversation bit.ly/Conversation-KimMaxwellRobillard-2020

4. UNHCR (2020) *Emerging Practices: mental health and psychosocial support in refugee operations during the COVID-19 pandemic* bit.ly/UNHCR-COVID-emerging-practices-2020

5. UNSDG (2020) *Policy Brief: COVID-19 and the Need for Action on Mental Health* bit.ly/UNSDG-COVID-mental-health-2020

6. WHO, World Trauma Foundation and World Vision International (2011) *Psychological first aid: Guide for field workers* bit.ly/WHO-psych1stAid-2011

7. Sijbrandij M et al (2020) 'The effect of psychological first aid training on knowledge and understanding about psychosocial support principles: A cluster-randomized controlled trial', *International Journal of Environmental Research and Public Health* 17(2) www.ncbi.nlm.nih.gov/pmc/articles/PMC7013432/

8. Okasha A, Karam E and Okasha T (2012) 'Mental health services in the Arab world', *World Psychiatry* 11(1) www.ncbi.nlm.nih.gov/pmc/articles/PMC3266748/

9. Sijbrandij M et al (2017) 'Strengthening mental health care systems for Syrian refugees in Europe and the Middle East: integrating scalable psychological interventions in eight countries', *European Journal of Psychotraumatology* 8(2) www.ncbi.nlm.nih.gov/pmc/articles/PMC5687806/

From place to space: field insights on adapting child-friendly spaces during COVID-19

Janna Metzler, Aimyleen Gabriel, Frieda Mwebe and Kevin Savage

While COVID-19 is not currently perceived as a serious disease threat to children, its indirect effects on their lives and psychosocial well-being may be profound. Child-friendly spaces may therefore be all the more important, particularly in fragile contexts of displacement.

Child-friendly spaces (CFS) – one of the most widely used humanitarian interventions to support, care for and protect refugee and displaced children – provide physical places that are safe and stable environments for children to thrive and reach developmental milestones. The primary aims of CFS are to promote the psychosocial well-being of children, to serve as a protective mechanism against abuse, exploitation and violence, and to mobilise communities towards the support, care and protection of children.[1] Although mobile versions exist, CFS are often static; they provide a range of structured and free-play activities that encourage children to form meaningful attachments with peers and adults, foster functional literacy skills, and improve psychosocial well-being.

Traditional models for mental health and psychosocial support (MHPSS) programming, however, have not been designed for contexts of epidemics, such as Ebola or the COVID-19 pandemic, in which life-saving public health measures to reduce transmission of infectious diseases impose drastic restrictions on movement, social interaction and the delivery of services.

In the midst of the coronavirus pandemic, as interventions such as CFS are forced to halt due to risk of transmission, practitioners are challenged as never before by how best to support the social and emotional well-being of children – primarily through remote means. We have been asking ourselves how we can translate the original premise of these place-based service delivery models for the context of COVID-19. How can we shift the physical place to a conceptual space that would stay true to the original aims and proven results[2] of CFS? Is it possible to promote positive mental health and psychosocial

outcomes for children, while also mitigating the risk of COVID transmission?

We began exploring these questions in CFS programming in the refugee response in West Nile, Uganda, within a randomised controlled trial started in 2018. With the declaration of the pandemic in March 2020, the Ugandan government ordered the closure of all education institutions including CFS. Only services deemed essential and life-saving were allowed to continue. We are now drawing on our existing work to determine how best to adapt CFS to address the current mental health and psychosocial support needs of children and their families as a result of and within the context of COVID-19. From this experience we have developed four sets of recommendations for the adaptation of CFS programming and the identification of different learning modalities in use or accessible to children within communities.[3]

Caregivers' well-being

Over one third of children and caregivers surveyed reported new stressors for caregivers or related to caregiving in the context of the COVID-19 pandemic. Some of these include closed churches, closed borders (restricting movements back to South Sudan), economic insecurity, lack of material goods to support basic needs, lack of support from relatives, and fear of the coronavirus itself. New COVID-related stressors were also reported for caregivers where children's exposure to friends was reduced. The two most frequently reported stressors related to lack of food and education.

In West Nile, local staff had already organised mobile activities that enable them to reach caregivers and their children in the camps while adhering to safety measures and

social distancing. Caregivers are provided with positive parenting sessions following the Ugandan Ministry of Gender, Labor and Social Development's Parenting Manual and World Vision's Parenting Module. When caregivers and children were asked what learning method they preferred for education during the COVID situation, radio was most mentioned, although books and printed materials were also overwhelmingly reported. Radio broadcasts may therefore be a wide-reaching and helpful medium to promote positive parenting messaging and to dispel any stigma or misinformation related to COVID. Radio broadcasts can feature information on COVID, violence prevention, self-care and mindfulness, self-directed sports and physical exercise, and functional literacy and numeracy activities. Given that only roughly a quarter of participants own a radio in the household, distribution of radios and a related maintenance programme would be vital. Existing campaigns to provide radios to child-headed households can be expanded to further support the aims of CFS for all children in the settlement camp. These campaigns can also provide direct materials to households, such as information, education and communication materials or psychosocial play kits to accompany facilitator-led activities during the broadcasts.

UNHCR/Esther Ruth Mbabazi

With schools closed in Uganda because of the pandemic, teachers have set up home-learning classes to keep refugee children engaged.

Community-based support for families

With access to the community now more difficult due to COVID-19 restrictions, several community-based groups have been leading efforts to reduce disease transmission and identify families in need of general psychosocial and specialised mental health support. Trained health workers and community volunteers have been working together to support dissemination of COVID messaging. This initiative can be extended to develop and disseminate child-friendly MHPSS messaging and capacity-strengthening efforts for community groups, child protection committees (CPCs) and faith leaders already working to provide information to prevent the spread of the virus and address stigma and other misconceptions.

Case workers and CPC members have been working together to identify and refer high-risk mental health cases and mobilise additional support for children with a disability. Traditional methods of case management have been adapted to provide remote support using mobile phones to monitor cases, and regularly checking in with caregivers, particularly those with identified high-risk cases. However, very few households have access to mobile phones. In this void, CPC members have been playing an important role as intermediaries between the case worker and caregivers. Strengthening the capacity of CPC members in Psychological First Aid as a key component of a broader toolkit can improve their understanding of how best to respond to those in distress, leading to appropriate screening and referral of high-risk mental health cases. A recent study following the Ebola outbreak in Sierra Leone noted that even a one-day training was effective, though those trained should receive ongoing refresher training with skilled trainers to ensure those skills are applied correctly.[4]

Children and youth clubs

Overwhelmingly, children surveyed reported not being able to go back to school – and be with friends – as the primary source of their concern. Prior to the closure of CFS within the settlement, children and youth clubs (CYCs) were able to bring children together and to promote social cohesion, peacebuilding and child protection, and were also useful for enabling child-led advocacy. In the absence of CFS, these smaller CYCs have thrived outside the confines of their formerly place-based home. Facilitated by community groups and faith leaders, activities include opportunities which they would normally have in the CFS. The groups follow a set of sessions adapted from a child-led peacebuilding curriculum. Child club members trained in journalism have also been helping with COVID response activities through promoting child-friendly information on coronavirus prevention and personal hygiene, either face to face or through mobile phones, sharing information on child protection through the radio and during community meetings, and promoting children's safety from violence. Members of the clubs also reach out to child-headed households to provide basic child protection and psychosocial support messages.

While not recommended during the health response surge of an outbreak, these CYCs can prove a useful vehicle for child-led response efforts including the development and dissemination of life-saving MHPSS and child protection information. These small groups can further be supported by community members and volunteers to adapt existing psychosocial curricula (such as the CFS Activity Catalogue) for socially distant small group or peer-to-peer exercises.[5] Finally, a newly developed World Vision infectious disease module can be used to help CYCs tailor mental health and psychosocial messaging and materials in child- and adolescent-friendly ways.

Advocating for MHPSS and child protection as essential services

The closure of the CFS by the government as a non-essential service meant that the most needed child protection and MHPSS support were inaccessible. Through the advocacy efforts of the CFS programme and in collaboration with the local Task Force on Child Protection, child protection and MHPSS services were gradually re-introduced through case workers, trained health workers, teachers and community leaders. The modalities of service provision as described above were quickly adapted in consultation with communities, including children. High-risk mental health and child protection cases were identified by working closely with the various groups and sectors in the camps. The child protection coordination groups frequently engage with local authorities to share new and emerging assessment information to support advocacy and encourage improved response on gaps in child protection and MHPSS services.

Conclusion

Evidence from past epidemics shows that children in such contexts may face increased risk of violence, neglect, abuse and exploitation, and the interruption or breakdown of services including systems of protection, making programming such as MHPSS even more critical.[6] Since humanitarian operations around the world have been significantly affected by COVID-19, adaptation of programming has become a key focus for agencies: how can tools and approaches be adapted to maintain equally essential services and humanitarian support?[7] We hope our insights will prove useful to others as they try to answer this question and make adaptations in the coming years as we continue to grapple with this and future pandemics. World Vision is now prioritising learning and adaptation of its core tools and approaches to COVID-19 and is seeking collaboration and partnerships to do so, particularly in child protection and MHPSS.

Janna Metzler *jlm2200@cumc.columbia.edu*
Adjunct Assistant Professor, Mailman School of Public Health, Columbia University

Aimyleen Gabriel
aimyleen.gabriel@worldvision.org.uk
Senior Child Protection Programme Adviser, World Vision UK

Frieda Mwebe *frieda_mwebe@wvi.org*
Child Protection in Emergencies Specialist, World
Vision International (WVI)

Kevin Savage *kevin_savage@wvi.org*
Humanitarian Research Director, WVI

1. Global Education Cluster, Global Protection Cluster, INEE and
UASC (2011) *Guidelines for child friendly spaces in emergencies*
https://inee.org/resources/guidelines-child-friendly-spaces-
emergencies

2. Hermosilla S, Metzler J, Savage K, Musa M and Ager A (2019)
'Child friendly spaces impact across five humanitarian settings: a
meta-analysis', *BMC Public Health* 19(1): 576
https://doi.org/10.1186/s12889-019-6939-2; Metzler J, Savage K,
Yamano M and Ager A (2015) *Evaluation of Child Friendly Spaces:
An inter-agency series of impact evaluations in humanitarian
emergencies* DOI: 10.13140/RG.2.1.2745.4807

4. Sijbrandij M et al (2020) 'The Effect of Psychological First Aid
Training on Knowledge and Understanding about Psychosocial
Support Principles: A Cluster-Randomized Controlled Trial',
International Journal of Environmental Research and Public Health
17(2) www.mdpi.com/1660-4601/17/2/484

5. https://app.mhpss.net/?get=49/cfs-activity-catalogue.pdf

6. World Vision International (2020) *COVID-19 Aftershocks:
Secondary impacts threaten more children's lives than disease itself*
bit.ly/WVI-C19Aftershocks-2020

7. ACAPS (2020) COVID-19 Impact on humanitarian operations:
Quick survey bit.ly/ACAPS-covid-impact-survey-April2020

Therapy in Uganda: a failed MHPSS approach in the face of structural issues

Costanza Torre

While the combination of therapy and livelihood creation may appear to be beneficial for refugees' mental health, the reality in Uganda has been rather different.

The past 30 years have seen an unprecedented rise in attention towards the mental health of conflict-affected populations. The World Health Organization (WHO) estimates that the burden of mental disorder among conflict-affected individuals may be as high as 22% and to be particularly prevalent among refugees and forced migrants.[1] This is certainly the case in Uganda, where the mental health needs of the large number of displaced people have been described as dire and largely unmet, despite MHPSS interventions being a common part of the humanitarian response.

In Palabek, a settlement of more than 54,000 South Sudanese refugees in northern Uganda, programmes range from psychoeducation sessions[2] targeting large groups to the prescription of medication for the most severe individual cases. However, as in most humanitarian settings where resources are scarce and qualified professionals few, mental health assistance in Palabek largely consists of brief psychological interventions targeting common mental disorders such as anxiety, depression and post-traumatic stress disorder.

By far the most common among these interventions is a brief form of Cognitive Behavioural Therapy (known as CBT-T), with at least six different NGOs delivering it in Palabek refugee settlement alone.

CBT-T offers important advantages in severely resource-poor contexts like Palabek, despite the fact that its therapeutic effects have been found to be questionable.[3] CBT-T consists of ten sessions that can be delivered to groups on a weekly basis by minimally trained local staff. In Palabek the therapeutic component is often accompanied by a livelihoods component, focused on entrepreneurship. In Uganda, whose national refugee policy is dominated by a self-reliance narrative, CBT-T is a perfect fit as it allows for the confluence of two powerful discourses: the moral imperative to alleviate refugees' (psychological) suffering, and 'helping refugees help themselves', which sees entrepreneurship as the best way towards from emergency assistance. However, these interventions can have detrimental effects on refugees' mental health when carried out without carefully considering the context of their implementation.[4]

CBT-T in practice

In Palabek, NGOs offering CBT-T primarily target women, selecting those who meet the criteria for common mental disorders after undergoing a diagnostic test. The groups are taken through ten sessions of CBT-T, after which the refugees undertake a one-day financial training where they are taught the basic skills necessary for running a small business. After the training, the group of women is given a small sum of money which they are encouraged to use to start a joint business activity among themselves. Some groups choose to start raising poultry or goats, while others prefer selling sugar, soap and other everyday items. The succession of the steps – that is, receiving therapy before receiving funds – is non-negotiable, and no one can request to partake in the livelihood creation part of the intervention unless they have been through the CBT-T part. The reason, as given by a CBT-T trainer, is that: "We give them CBT so they can forget the past. […] You cannot give money to someone who is traumatised, because they will just throw it away."

NGO workers leading the CBT-T sessions are adamant that CBT-T is the main part of the intervention and that the refugees are eager to receive therapy. However, interviews with several women from different cohorts of the programme suggest that this view is not necessarily shared by refugees: "They told us when they first came [to recruit us] that they would give us money, and that that could make us forget about the past and change our lives. That is why I went, because my children needed clothes and I have no money at all." This hints at a fundamental and often overlooked issue in the delivery of psychological interventions in contexts characterised by extreme poverty; while CBT-T – an intervention firmly rooted in Western notions of personhood, suffering and healing – places the cause of the suffering inside the individual, participants in countries such as Uganda will often view their distress as a consequence of socio-economic hardship. They will therefore seek a solution to it not so much in the form of self-help techniques but rather in an actual change in their circumstances.

Does it work?

The assumption underlying CBT-T interventions delivered in Palabek refugee settlement is that after undergoing therapy the women will be firmly on the path towards recovery from their psychological distress and be ready to become independent and successful economic actors. This was unfortunately not the case for most of the women interviewed during the course of this study. For example, women from three different CBT-T groups reported that none of their groups had been able to successfully open and run a business, despite the fact that the majority had at least some level of experience in trading and business in South Sudan before fleeing to Uganda. To understand why this approach failed – and, furthermore, had detrimental effects – it is necessary to look at the wider context of Palabek settlement, taking into account the structural challenges that refugees face in this setting.

Palabek is located in one of the poorest rural districts in Uganda. The plots that Uganda assigns refugees for cultivation are too small to allow for anything more than small-scale and subsistence farming, and the rocky nature of the land frequently prevents even that. Kitgum Town, the nearest economic centre in a region still struggling with the heavy and long-lasting socio-economic impact of a recent and bloody civil war, is 40km away and expensive to reach (and the roads are often impassable). In this sense, refugees living in the settlement are significantly cut off from the lively economic market that characterises other areas of the country. Even after undertaking the cost of travel and of purchasing merchandise in Kitgum, the women were faced with the exceptionally slow-paced economic reality of the settlement. In the words of one woman:

"I went to Kitgum and bought sugar and lacere [small fish] to sell. But there was no one to buy it... We tried to sell, but people have no money here."

Even the groups that were able to sell all the produce they invested in found that the profit was too small, and business too slow to justify pursuing. Most importantly, however, they had more pressing needs to

attend to. The refugee emergency in Uganda is greatly under-funded so food and other basic needs are never adequately met. The women were unlikely to make enough to do more than meet their immediate needs – with no opportunity to build capital.

As for their mental well-being, none of the women interviewed reported an improvement in their psychological distress, while some added that they felt even more hopeless than before undergoing CBT-T.

"They told us they would help us forget, but they gave us even more problems. […] The money they gave us was too little, and now I keep thinking that I cannot do anything."

Another bluntly stated:

"The programme made my life worse. I took the money and bought food and clothes for my children, but I could only buy for some of them; the others have been angry at me since."

A third commented:

"They said we could change our lives […]. They treated us like fools."

What is refugees' mental health really about?

The experiences of these women constitute a call for a critical re-think of the design and implementation of brief psychological interventions in extremely resource-poor settings. In particular, a few key features of mental health interventions based on self-help techniques need to be recognised as deeply problematic. By establishing a straightforward connection between mental health and the achievement of economic independence, they run the risk of medicalising conditions of poverty. And by focusing solely on individual responsibility (both through teaching self-help psychological techniques and through their emphasis on entrepreneurship), they fundamentally ignore the structural and wider issues faced by people living in protracted displacement.

Those participating in CBT-T interventions in Palabek claimed that the amount of money they received was too small to meaningfully affect their lives; if anything, the realisation of how insufficient the sum they were given was led to an increased sense of frustration and hopelessness. It heightened their sense of precariousness and only made planning effectively for the future a less realistic possibility. Mental health assistance such as this needs to be fundamentally re-thought, with an explicit focus on the structural barriers that keep refugees from planning and working towards their future, and on the negative impact of social justice issues on individuals' and communities' well-being.

Costanza Torre *c.torre@lse.ac.uk*
PhD Candidate, London School of Economics and Political Science

1. Charlson F et al (2019) 'New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis', *The Lancet* 394(10194) www.sciencedirect.com/science/article/pii/S0140673619309341

2. Providing education and information to those seeking or receiving mental health services.

3. Bangpan M et al (2016) *The impact of mental health and psychosocial support programmes for populations affected by humanitarian emergencies: a systematic review protocol* bit.ly/Bangpan-et-al-MHPSS-review-2016

4. Findings based on interviews with participants in CBT-T interventions during 13 months of ethnographic fieldwork in Palabek refugee settlement 2019–20.

Data and evidence on forced displacement: reflections on progress and challenges

Ewen Macleod

In recent decades substantial advances have been made by the humanitarian and development communities in terms of gathering and using data to underpin programming. Significant challenges and gaps remain, however, requiring new approaches and partnerships.

When the Sustainable Development Goals (SDGs) and Agenda 2030 were adopted in New York in September 2015, their ambition to "leave no-one behind and "reach the furthest behind first" reflected a renewed global solidarity around further poverty reduction. While the SDGs themselves contained no specific provisions for displaced and marginalised populations, it seemed clear that their inclusion would be a priority if this specific aim was to be fulfilled. Less obvious was how the generation of data and evidence to demonstrate development progress among such populations would be accomplished. In particular, how could the advances in data and digital technology be harnessed to reach those countries and people seemingly trapped in a protracted spiral of conflict, exclusion and poverty?

The SDGs' detailed provisions included a helpful, if ambitious, set of targets and indicators to measure progress across Agenda 2030.[1] These were partly inspired by the rapid advances in technology and digital capabilities that had enabled the expanded and more efficient capture of data during the previous two decades. The need for more accurate data and evidence was also given prominence in the two Global Compacts on Refugees and for Migration respectively.

Due in large measure to the efforts of the Expert Group on Refugee and Internally Displaced Statistics (EGRIS) established under the aegis of the UN Statistical Commission in 2016, a specific indicator for inclusion of displaced populations has since been developed.[2] It augurs well for the more systematic inclusion of these groups within national statistical and data collection efforts. It also brings momentum to much needed reflection on the many definitional issues around displacement that still require resolution.

Notwithstanding progress at the normative level, a number of familiar challenges quickly emerged. Insecurity, conflict and violence inhibited accurate and secure data collection in many of the world's poorest countries. Poverty was increasingly concentrated in these same States where government capacities to generate national statistics were weak. In consequence, there were insufficient data to allow the analysis that was needed. Among the 1.5 billion people most prominently at risk of exclusion from the promise of Agenda 2030 were the estimated 79 million displaced in and outside their country.[3]

By their very nature, displacement and mobility produce practical and political economy issues that can inhibit the inclusion of refugees, migrants, stateless persons and internally displaced persons (IDPs) within national census and vital registration exercises. In the case of refugees and migrants, many host governments are unwilling to devote resources to collecting detailed data on citizens of another country. Security, access, mobility and political will frequently impede prioritising data collection on IDPs. And, notwithstanding the efficiency gains associated with technical innovation, there are protection and confidentiality issues that make the collection of information by states on vulnerable and marginalised populations more complex and sensitive.

Traditionally data collection on displaced populations has mostly been undertaken by humanitarian agencies and government counterparts during emergencies. It has

focused primarily on gathering quantitative information and assessing critical essential needs. Over time, the reach, quality and delivery of these assessments have improved significantly. Disaggregated data on vulnerability has become a standard feature of humanitarian surveys.

The application of digital technology has also had an important impact on agency infrastructure, personnel and efficiency. The rapid collection of data and its more systematic incorporation into programme design and budgeting have benefited implementation and resource use. The use of mobile technology for the efficient delivery of cash transfers is one obvious example. These positive developments represent substantial advances in humanitarian practice.

Risks, challenges and concerns

Yet significant issues and gaps remain, due partly to the proliferation of data systems and applications themselves, and partly to the rise in the number of protracted crises. Claims for the transformative potential have occasionally been exaggerated, while risks related to the collection, storage and transmission of data have sometimes been overlooked in the rush to embrace digital capabilities.

The ready availability of new informatics technology has also produced new and different challenges for both aid providers and recipients. The potential advantages of inter-operable biometric data, for example, may be evident for a country's citizens. But such systems can lead to both legal and security concerns for refugees and represent practical obstacles to inclusion if they are established in parallel to national models.

The potential efficiency gains from using digital technology coincided with an increase in donor States' emphasis on value for money and accountability. At the same time, the more widespread use of data technology requires greater investment in capital and equipment, personnel and specialised training. Larger volumes of available data also imply higher level of effort in processing and reporting. In addition, in the absence of agreed principles and standard operating procedures for data production, collection

A South Sudanese refugee is registered at the Aru transit centre, Ituri province, Democratic Republic of the Congo.

and transmission, there have been growing concerns over data quality and security.

As the number of surveys and assessments has increased, so has the need for greater coordination over content and delivery to avoid duplication and interview fatigue. Significant imbalances between the volume of newly generated data and the ability to analyse it in depth or to convert it into policy and programmatic substance have occurred. Greater ownership and access by displaced people themselves to data and information has partly disrupted the relationship with aid providers and prompted new thinking around inequality and accountability.

Yet technology in itself will not necessarily transform inequalities or automatically reduce vulnerabilities. On the contrary, it can reinforce and deepen asymmetrical power relations at organisational, local, household and individual levels. The digital divide has a gender, ethnic and racial dimension to it too. Addressing such imbalances requires political commitments to greater inclusion, to enabling policies and to supportive implementation arrangements.

More efficient and more extensive data capture also raises the stakes with respect to security and confidentiality. The potential escape or leakage, accidental or otherwise, of personal and private information presents particular risks to vulnerable populations and humanitarian assistance providers in insecure operating environments. The convergence of interests between private sector data

companies and States in the area of security and intelligence gathering also raises a number of red flags for humanitarian aid organisations.

Still, the growing number of countries trapped in protracted crises has highlighted the pressing need to reduce vulnerability and dependence on short-term emergency programmes and funding. As is widely acknowledged, these are unsustainable and can discourage the growth of national capabilities. Rising costs have also driven new commitments to support greater cooperation and complementarity among humanitarian, development and peace and conflict resolution actors; an important component of these is a shared interest and commitment to generating reliable data and evidence.

More detailed data on household consumption, assets and income sources are required to plan appropriate policies and programmes to combat poverty and promote socio-economic development. In displacement settings, such surveys should include all affected populations in order to underpin social cohesion and ensure parity. Significantly greater effort, time and resources are required to design and implement such exercises. Yet without this investment, the foundation for more equitable and longer-term support will be missing.

The scale of the Syrian crisis highlighted the need to assess the social and economic impacts not only on displaced populations but also on host country economies and populations. It also revealed important gaps in the global data collection system, definitions and methodologies deployed essentially for humanitarian objectives. Addressing these requires not just increased technical investment in generating data. In many crisis-affected countries, it also involves overcoming many practical obstacles such as poor infrastructure, weak connectivity, restricted access and unpredictable security conditions. Last but not least, converting data into evidence that can drive change in policy and in institutional and implementation capabilities is not achieved through purely technical processes. It must be accompanied by astute diplomacy and political skill that encourage and incentivise change.[4]

When the SDGs were launched, statistics on global displacement were often based on initial emergency registration exercises or derived from secondary sources.[5] There were almost no individual datasets or instruments that captured the socio-economic effects of long-term displacement on the development prospects of affected populations. Since then, there has been a marked increase in the number of studies, surveys and assessments conducted in a wide range of countries, many of them delivered through national systems.[6] These still remain modest in coverage so the need to scale up remains pressing. But progress has been encouraging and more countries are recognising the opportunities provided through obtaining accurate and comparable data.

National capacities for statistics and data collection in countries affected by violent conflict are in urgent need of institutional development and strengthening. Expanding digital capacities and installing appropriate infrastructure and connectivity are vital to support broader national and human development objectives. The Global Compact on Refugees specifically highlights the need for greater resources to be mobilised to support such requirements in displacement settings.

In addition, there are still important policy obstacles to the inclusion of displaced people. Beyond practical issues related to access and resources, there are also concerns around ethnic or religious demography and the potential use of data and evidence for political and security purposes. In such contexts, the undoubted development benefits of investing in new digital technology have also to take into proper account the potential misuse of data, especially in regard to personal information. This concern needs to take fuller account of the political and security context, governance framework and methodologies and protocols that data providers are operating. For displaced persons, messaging services can be empowering sources of information and mobile phones can be efficient enablers of cash transfers and provide useful means of sourcing information on welfare conditions for aid agencies when access is constrained. But for governments

seeking to control or discourage mobility, they can also reveal critical data about movements, locations and intentions.

In worst-case scenarios, States' use of advanced digital technology provides enhanced capabilities for surveillance and intelligence gathering that can be operationalised to apprehend, detain and exclude groups and individuals. Governments' power over the discretionary use of information requires attention to the terms and conditions of data sharing on the part of development and humanitarian partners.

There are important ethical issues around the collection and sharing of personal information extracted from vulnerable populations, particularly refugees and migrants (who may not be protected by national laws on data protection and security). These issues range from gaining consent for the collection and use of such data from the selected individuals, to formally committing to the secure protection, storage and transmission of data, and to the systematic anonymising of all personal identifiers that could compromise the safety of individuals.

Over the last decade, the proliferation and rapid evolution of digital technology has propelled considerable innovation in both applications and equipment. But it has also generated fragmentation around the collection and use of data in humanitarian settings, in part attributable to the increased number of participants. In response, the production of data protection protocols, data-sharing agreements and overall ethical and technical guidance seeking to regulate the domain has also grown appreciably.

Collectively these represent a considerable body of good practice with real potential to extend the essential humanitarian principle of 'do no harm' to the digital space. This itself reflects greater awareness among practitioners of the need to temper enthusiasm for data technology with greater discretion as to its ethical application and its use. Given the dynamic nature of the sector, perhaps what is needed, however, is a distillation of some core principles into a Code of Conduct or set of Minimum Standards that all stakeholders should commit to upholding.

A joint approach to strengthening capacity

It was in response to the growing interest in socio-economic evidence and in strengthening the global data system related to protracted displacement that the World Bank and UNHCR agreed to combine their efforts and resources to establish the Joint Data Center on Forced Displacement (JDC) in Copenhagen. A particular focus was to support complementary humanitarian and development approaches towards the production and use of primary data by a broad range of stakeholders engaged in countries affected by conflict and violence.

Four main objectives for the JDC were established: i) encouraging a more systematic collection of socio-economic data collection on displaced people, ii) enabling open access to forced displacement data while ensuring anonymisation and safeguards that meet legal data protection requirements, iii) supporting innovation to enhance data collection and iv) strengthening the sustainability of global data collection systems.

The initial phase of the JDC's four-year work programme coincided with the current COVID pandemic. Understandably this has restricted efforts to support data collection in the field through face-to-face interaction – a primary aim – but it has also served to reinforce the critical significance of including displaced and marginalised populations in public health and social protection programmes. A recent JDC-supported study offers some important insights into COVID's impact on displaced populations. It also provides an early example of how combining innovative data collection, accurate sample design and rigorous analysis can offer actionable insights even in adverse operating environments.[7]

Through its work and partnerships, the JDC aspires to make the medium- to long-term socio-economic circumstances of displaced populations more visible and accessible and to strengthen the capabilities of interested stakeholders to enable progress

in improving outcomes for them. The articles in this special feature in Forced Migration Review provide insights into some of the main pathways and methodologies that the JDC will pursue and encourage in future.

Ewen Macleod ewen.macleod@gmail.com
Former UNHCR Director of Resilience and Solutions and Special Adviser to the High Commissioner

1. SDG 17 https://sdgs.un.org/goals/goal17

2. bit.ly/Eurostat-IRRS

3. World Bank (2017) *Forcibly Displaced : Toward a Development Approach Supporting Refugees, the Internally Displaced, and Their Hosts*, Chapter 1 bit.ly/WB-10986-25016

4. See Read R, Taithe B and Mac Ginty R (2016) 'Data hubris? Humanitarian information systems and the mirage of technology', *Third World Quarterly* 37(8) bit.ly/TWQ-37-8-Read-et-al

5. See UNHCR Global Trends: Forced Displacement in 2015 bit.ly/UNHCR-Global-Trends-2015 and IDMC Annual Report 2015 www.internal-displacement.org/publications/annual-report-2015

6. See for example, Verme P and Schuettler K, 'The Impact of Forced Displacement on Host Communities: A Review of the Empirical Literature in Economics' bit.ly/JDC-Verme-Schuettler-2019

7. www.jointdatacenter.org

Aligning humanitarian surveys with international statistical standards

Felix Schmieding

There are huge benefits to be gained from producing statistics that are familiar to, and usable by, governments and other development partners.

When the Kenya National Bureau of Statistics published labour force statistics from its 2015–16 integrated household survey, it found that 72% of working-age Kenyans were employed.[1] In Turkana County, the rate was 62%. However, this national survey excluded refugee camps. A survey commissioned by UNHCR and the World Food Programme in 2016 found that only 16% of households in Kakuma refugee camp – located in Turkana County – reported having at least one employed person in the household.[2]

These two statistics are hard to compare for several reasons. The national survey asks about employment at an individual level, the refugee survey at a household level. And while the national survey, implemented with technical support from the World Bank, aligns with the definitions relating to labour statistics as prescribed by international bodies and standards, the refugee survey asks the simple question 'How many in the household have work?', making comparison even more difficult.

While implementation of both surveys was technically robust overall, this example illustrates how surveys implemented by humanitarian organisations are often developed with a specific humanitarian purpose in mind – in this case, to explore options for targeting humanitarian assistance. In pursuing these valid objectives, international statistical standards and best practices are all too often forgotten or discarded as not applicable or overly complex.[3]

However, satisfying the primary humanitarian purpose of a survey while at the same time aligning it with statistical standards comes with huge benefits. In fact, at a time where both the importance of national leadership and of humanitarian–development collaboration in addressing forced displacement is widely acknowledged, and where protracted situations constitute the vast majority of forced displacement, every humanitarian survey that does not 'speak the language' of government and development partners reflects a missed opportunity.

Benefits of alignment

Aligning humanitarian survey work with international statistical standards and best practices will allow the insights produced from the data to be used more effectively in policy dialogue and advocacy, because the survey statistics will be based on concepts that decision-makers are familiar with. Moreover, collecting data in a way that is

aligned with national/official survey methods allows for some degree of comparison between forcibly displaced and national or local host communities, even if the latter are not explicitly included in the survey sample. Furthermore, applying tried and tested (and readily available) statistical standards can reduce the cost and complexity of survey design. Finally, the use of internationally established and recognised measurement practices can increase the attractiveness of the data to researchers for secondary use, thereby enhancing the impact of and return on any investment in data collection.[4]

Concerns that using these standards in humanitarian survey work could be burdensome or impracticable in light of resource and capacity constraints are understandable but ultimately unfounded in most cases – especially when it comes to contexts of protracted displacement (as opposed to emergencies). Since these international standards have been carefully developed to apply in contexts as diverse as Norway and the Central African Republic, and across the full socioeconomic spectrum within these countries, they are also robust in forced displacement settings. The standards are well supported by useful documentation and usually come with guidance material aimed at data practitioners from a variety of backgrounds. And finally, since the marginal cost of expanding an interview by a few questions is negligible in most cases, their application often does not increase survey costs in any notable way.

Good practice in Kenya

UNHCR, in collaboration with the World Bank, conducted two further household surveys in Kenya's Kalobeyei and Kakuma refugee camps, in 2018 and 2019 respectively.[5] This time, the survey questionnaire was modelled largely on the national integrated household survey, which in turn aligns with a wide variety of statistical standards. The results from the surveys allow for direct comparison of the camps' population with their national hosts. We now know that at the time of the surveys 37% of the working-age population in Kalobeyei camp were

employed, compared with 62% in Turkana County and 72% in Kenya overall. We also learned that 58% of refugees in the camp live below the national poverty line, as compared with 72% of the population of Turkana County and 37% across Kenya.

The governor of Turkana County, Josphat Nanok, welcomed the comparable statistics with the words "government now has data!", and outlined how they would be used to inform national and sub-national policymaking, including in incorporating refugees and asylum seekers in the national education system. The governor also stressed that the Kalobeyei survey would inform the national statistical office's decision to extend its national household survey to the refugee camps.[6]

The decision to better align humanitarian surveys with international statistical standards is hardly a trade-off at all, especially in protracted situations. The returns far outweigh the concerns. As more humanitarian surveys incorporate these standards, the methodological divide between humanitarian surveys and their government and development equivalents will shrink. In parallel, learning from humanitarian survey work will increasingly feed into the development and refinement of the survey standards themselves.

Felix Schmieding *schmiedf@unhcr.org*
Senior Statistician, World Bank–UNHCR Joint Data Center on Forced Displacement

1. KNBS (2018) *Labour Force Basic Report, 2015/16 Kenya Integrated Household Budget Survey* bit.ly/KNBS-survey-746

2. UNHCR/WFP/Kimetrica (2016) *Refugees Vulnerability Study Kakuma, Kenya* bit.ly/UNHCR-WB-Kimetrica-Kakuma-2016

3. Such as those developed under the auspices of the UN Statistical Commission or those specified in SDG indicator metadata sheets.

4. Humanitarian agencies are increasingly moving towards an 'open microdata' approach. For example, UNHCR in 2020 launched its Microdata Library, where much of the survey microdata it collects is available to external data users in anonymised form. https://microdata.unhcr.org

5. UNHCR/World Bank (2020) *Understanding the Socioeconomic Conditions of Refugees in Kalobeyei, Kenya: Results from the 2018 Kalobeyei Socioeconomic Profiling Survey*
bit.ly/UNHCR-WB-Kalobeyei-2018
Report for the Kakuma survey report forthcoming in March 2021.

6. Speech delivered at Global Refugee Forum 16 December 2019. Audio recording at: bit.ly/GRF-recording

Including refugees and IDPs in national data systems

Natalia Krynsky Baal

The recent endorsement of international statistical recommendations on refugees and IDPs will help systematise the inclusion of these vulnerable groups in national policy and development agendas. Much work needs to be done, however, to move the recommendations from paper into practice.

In March 2020, days before COVID-19 put New York into lockdown, the UN Statistical Commission (UNSC) unanimously endorsed the world's first International Recommendations on IDP Statistics.[1] These recommendations provide a framework to help countries to better define IDPs and to capture higher-quality, more comparable, nationally owned statistics on this vulnerable population.[2] They reflect years of hard work by the UNSC-mandated Expert Group on Refugee and IDP Statistics (EGRIS) and build on the success of the 2018 International Recommendations on Refugee Statistics (IRRS).[3]

The drive to improve the quality and comparability of, and trust in, data necessarily involves tackling several basic challenges such as establishing clear definitions, transparent methodologies, political will and national capacity. This is especially the case when it comes to population groups such as IDPs who are often excluded or inadequately captured in national statistical systems. The two sets of recommendations represent significant achievements for policymakers and practitioners addressing forced displacement as, although purely technical in focus, they include several ground-breaking steps forward from a policy/political perspective.

The IRRS provide clear definitions and a complete statistical framework for refugees and related populations (that is, encompassing persons in need of international protection, persons with a refugee background, and persons returning to their country after seeking international protection abroad). If countries and other stakeholders can align their own definitions with the IRRS, data between countries can be more easily compared and confusions between different reporting systems will be

significantly reduced. The IRRS also give advice to countries on how the (re)integration of refugees into society should be measured and analysed, providing a framework for this purpose. A further achievement of the IRRS pertains to the agreed recommendations for coordinating official statistics on refugees which in practice can be a complex matter that misses many opportunities for better inclusion of refugees.

Equally, the International Recommendations on IDP Statistics (IRIS) are a potential game-changer. Following a similar structure but tackling a topic where no definitive legal framework exists, the IRIS faced a more difficult challenge but succeeded in providing a statistical framework that standardises key terminology and classifications. For example, they clarify that children born to IDP parents after displacement should not be included in the definition but instead classified as an 'IDP-related' population category, and recommend that the total IDP population is divided into three sub-categories (IDPs in locations of displacement, locations of return and other settlement locations).

Regarding the complicated issue of determining when an IDP should no longer be defined as such, the IRIS also makes significant headway. They build on the eight criteria outlined in the widely accepted IASC Framework for Durable Solutions for IDPs as well as on work undertaken by another inter-agency group of experts[4] to distinguish between two measures: firstly to judge progress towards durable solutions and secondly to determine when key displacement-related vulnerabilities have been overcome so that displaced persons can be taken out of the official population statistics. The IRIS provide

a clear framework for these measures but more work is needed to complete the development of these measures – work which is currently being undertaken by EGRIS with support from the WB-UNHCR Joint Data Center on Forced Displacement (JDC).

The IRIS also provide recommendations for how to enhance statistical coordination efforts at the national and international level. These include recommendations to strengthen connections to national statistical systems, establish technical coordination platforms and ensure quality control of IDP data. They take into consideration the role of both national and international stakeholders in this process.

Taken together, these recommendations tackle both politically sensitive and operationally challenging issues that reoccur in many displacement-affected contexts that are frequently beset by incoherent definitions of durable solutions, competing reports on displacement figures and limited transparency on data production methods.

Progress across the world

Since the IRRS and IRIS were endorsed, support and recognition within and beyond the statistical community have been growing. For example, the Global Compact on Refugees includes a few paragraphs on data and evidence that reference the IRRS directly.[5] The High-Level Panel on Internal Displacement has explicitly included data collection, analysis and use in its scope of work and is increasingly interested in the achievements of EGRIS.[6] And at the institutional level, many organisations are actively identifying opportunities to integrate the IRRS and IRIS into their own data workstreams and efforts to support country-level implementation. At the JDC, for example, we are working with governments and National Statistical Offices to incorporate specific elements of the recommendations into data collection activities and have made this an explicit criterion for funding.

Numerous countries are also taking steps to implement the recommendations, though there is still a long way to go. A brief look at some of recent examples helps to identify learning and inform/prioritise further action and support needed.[7]

Data collection: In **Kenya**, refugees were included in the 2019 national census, and the National Bureau of Statistics is setting up a technical working group to advance practice and monitor progress made on both refugee and IDP statistics in the country. In **Morocco**, as part of the government's national strategy on migration and forced displacement, data on refugees and related populations are collected through a specific survey; additionally, however, question modules from the IRRS on identifying refugees are being included in thematic surveys, such as the labour force survey. In **Ethiopia**, the Central Statistics Agency is working to align and integrate the Socio-economic Survey on Refugees in Ethiopia into the national Household Welfare Statistics Survey and to incorporate key elements of the IRRS in the process. Similar efforts are ongoing in the **Central African Republic** with regard to the IDP population being included in the sampling strategy for a planned national poverty survey, building on several parts of the IRIS. In Europe, **Georgia** is also planning a series of activities to implement the recommendations, including an assessment of various administrative data sources to identify their potential to produce IDP statistics and enable linkages between them.

Coordination: Through more effective coordination between national and international stakeholders, linkages between forced displacement statistics and national data systems are being clarified (or created); meanwhile, connections with National Strategies for the Development of Statistics (NSDS) and new legal frameworks are being cemented. In the **Ukraine**, the State Statistics Service is working with members of the Technical Working Group on IDP Statistics and UNHCR to develop a joint roadmap for the roll-out of the IRIS; this will include improvements to the national IDP registry, incorporation of complementary data sources, and inclusion in the national framework for monitoring progress towards the country's SDG targets. In **Cameroon**, a new statistics law and the NSDS for 2020-25 were endorsed in 2020; the strategy aims to

strengthen statistical capacity and includes for the first time an explicit focus on forced displacement in the country. Meanwhile, in **Colombia**, coordination between the Victims' Unit and the national statistical office has been enhanced in order to improve the quality and usefulness of IDP statistics, and statistical methodologies are being improved (informed by the EGRIS process).

What next?

Momentum is building but much more needs to be achieved if refugees and IDPs are to be more systematically and effectively included in national data systems. Experiences shared by members of EGRIS highlight a few priority areas:

Awareness raising and strategic advocacy: Many countries hosting refugees or IDPs have adequate statistical capacity to start implementing the recommendations. However, they need to be encouraged – through more awareness-raising and advocacy efforts (including showcasing early signs of impact) – to make progress.

Investment in national statistical capacity: Where statistical capacity is weak and/or over-burdened, sustained investment is needed, such as in developing national capacity to monitor progress towards the SDGs and to include refugee (and when relevant IDP) data in broader migration statistics.

Improved financing for forced displacement data: The most accessible funding for data on forced displacement is still largely derived from humanitarian aid budgets which are, by design, short-term and focused primarily on informing humanitarian interventions. This pattern must change in order to support both sustained capacity development and longer-term development data initiatives, including national household surveys and enhanced administrative data systems.

Embracing new methods and alternative data sources: Although both the IRRS and IRIS include recommendations on appropriate methods and data sources, they focus less on new methods or alternative data sources. Rapidly advancing technologies and alternative approaches to collecting data offer opportunities that should be pursued. These efforts have become even more urgent due to the COVID-19 pandemic which has fundamentally challenged traditional data collection methods.

Many of these avenues are currently being explored as part of EGRIS's third phase, 2020–24. A UNSC-endorsed term of reference commits the Group to supporting implementation of the IRRS and IRIS in a coordinated fashion over the next three to five years.[8] With financial support from the JDC and growing interest from countries and institutions, this platform has huge potential. If the international community can combine efforts towards this common goal, significant progress can be made in the space of a few years. Improved official statistics on refugees and IDPs will bear fruit relatively quickly, furthering the inclusion agenda. The challenges are many but the building blocks are there.

Natalia Krynsky Baal
nbaal@worldbank.org @NataliaBaal
Senior Strategy and Policy Officer, World Bank–UNHCR Joint Data Center on Forced Displacement

1. bit.ly/Reliefweb-IRIS

2. For background, see Levakova D et al 'Using collaborative approaches to improve internal displacement data', *Forced Migration Review* 65 bit.ly/FMR65-Levakova-et-al

3. bit.ly/Eurostat-IRRS

4. See https://inform-durablesolutions-idp.org; see also Beyani C, Baal N K and Caterina M (2016) 'Conceptual challenges and practical solutions in situations of internal displacement', *Forced Migration Review*
www.fmreview.org/solutions/beyani-baal-caterina

5. www.unhcr.org/5c658aed4

6. www.un.org/internal-displacement-panel/content/what-we-do. See also EGRIS written submission to the HLP:
bit.ly/EGRIS-submission-HLP-Feb2021

7. All examples were presented by representatives of national organisations during the JIPS-EGRIS conference in 2020 on statistical capacity building:
www.jips.org/jips-publication/jips-egris-conference-2020-report/. Two exceptions are Ethiopia and Central African Republic which are activities supported by the JDC: bit.ly/JDC-filling-data-gaps

8. *Terms of Reference for the Expert Group on Refugee and IDP Statistics (EGRIS): Third Phase/Implementation of Recommendations* (2020-2024): bit.ly/EGRIS-TOR-2020-24

The pitfalls and potential of high-frequency phone surveys during COVID-19

Jeffery C Tanner

Phone surveys can be particularly useful in times – such as during the current pandemic – when it is difficult to conduct face-to-face surveys, but can present challenges.

The COVID-19 pandemic has torn through lives and livelihoods across the globe. Forcibly displaced people are among the most vulnerable but there is little robust data to provide insights into how their needs are evolving through the pandemic.[1] Health considerations limit options for gathering data during this challenging period, with traditional face-to-face data collection efforts halted out of concern for enumerator and public health, and because of travel restrictions, lockdowns and social distancing. One alternative is the use of mobile phone surveys. This approach has proven useful in gathering data in risky environments, in remote areas, in areas where enumerator safety is a concern, where responsiveness to new and changing data needs is important, and in contexts where monitoring unfolding situations is needed. They have also been found to yield high-quality data and to be cost-effective.[2]

In the face of the COVID-19 pandemic, the World Bank rolled out robust high-frequency (that is, multi-round) phone surveys (HFPS) to collect socioeconomic data in some 100 countries.[3] In collaboration with the World Bank, UNHCR and national statistical offices, the World Bank–UNHCR Joint Data Center on Forced Displacement[4] is supporting the integration of booster samples of displaced people in at least two rounds of ongoing and planned COVID-19 HFPS in 12 or so of those countries. This will enable a better understanding of changes in welfare, vulnerabilities and prospects for displaced people as a result of the COVID-19 pandemic, and enable better responses to be designed.[5]

Although HFPS can generate crucial data during the pandemic, there are challenges in applying this method, particularly in the context of displacement. The main challenges can be classified as threats to the robustness of the sample and limitations to the information collected. Fortunately, with foresight and careful planning there are also ways to overcome those challenges.

Sampling

A statistically sound survey should be representative of a defined population and have a large enough sample to have the statistical power to detect meaningful differences between groups or across time. Because phone coverage is uneven – due to ownership (affected by demographic and economic factors), network coverage or electric power availability, for example – HFPS samples may not be representative of the target displaced population, thus skewing the analytical results. Similarly, bias can occur when some groups are more or less likely to be selected to be surveyed ('undercoverage' or 'differential coverage') or when some respondents refuse to participate ('non-response') or refuse to continue in subsequent rounds ('attrition').

Identifying specific sources of potential bias is critical in data collection exercises to maximise the ability to a) prevent bias through design, b) correct for it through cleaning, reweighting and analysis and c) identify the direction of bias in order to facilitate use of the data in policymaking. Integral to the value of survey data is the correct identification and implementation of a robust sampling frame, sampling strategy, and analytical weights – the primary tools for overcoming sample bias. If bias persists in HFPS data, it is most likely to be biased upwards, meaning that the data may indicate that the population is better off than it is. Even if this is so, HFPS data are still useful for policymaking if outcomes

observed in the data are low enough to indicate that intervention is merited.

In general, three approaches can be used to build a sampling frame: using a representative survey, using a list, and using random digit dialling.[6] The first two rely on the existence of comprehensive information at a time not long prior to starting the phone survey. Some countries are fortunate to have had a national data collection effort that included collecting data and phone numbers on displaced populations, from which a representative sample can be drawn. In other instances, UNHCR registration data can be used, so long as the registry data – particularly phone numbers – are valid and current; however, unregistered populations would be missing. Typically, personal information may be used to help elicit a balanced sample but (to help mitigate data protection concerns) only the phone numbers need to be passed to the enumeration team. The third approach – random digit dialling (using randomly generated phone numbers) – is seldom cost-effective or feasible when surveying displaced persons but may be appropriate in certain cases.

All three of these methods are used in current JDC-supported survey activities. In Chad, a nationally representative survey from 2018 that included refugees for the first time is being used as a sampling frame. In Djibouti and Ethiopia, UNHCR registration data are being used. And in Ecuador the survey team will partner (as they have done previously) with a local telecommunications firm to determine the geographic areas and collections of phone numbers most likely to belong to Venezuelans in refugee-like situations in the country.

If appropriate complementary data are available, 're-weighting' can be used to help correct sample data to recover underrepresented parts of the true population. This process is complex and challenging but if properly applied can overcome issues of attrition, non-response and partial coverage to make the sample a useful approximation of the actual population.

Preventing a biased sample is of course better than correcting for one – and

incentives can help. The World Bank survey in Ecuador on the impact of COVID-19 on host and refugee populations provided airtime credit that met or exceeded the time spent on the survey. Outside an epidemic, there are other incentive options, such as direct provision of mobile phones or small solar charging stations.[7]

Instrument design and implementation

There are various practical considerations to bear in mind relating to potential limitations on what and how much can be collected.

Surveys need to be kept short to limit respondent fatigue, particularly when repeated interactions are planned, and this inevitably limits the potential depth and breadth of data gathering. Moreover, question complexity tends to reduce data quality, particularly in phone surveys. There are three options to mitigate these constraints to at least some degree. Different respondents can be randomly assigned a different module of questions while answers from a common set of modules are used to impute data for the randomly missing modules. Alternatively, modules that are asked of the entire sample can be rotated in and out from one round of the survey to the next, as was done in Ethiopia by including a module on locust swarms in the second round of that HFPS. This approach works best when more dynamic outcomes (such as food security and employment) are included in all rounds, and more static outcomes (for example, demographics or histories) are rotated. Finally, in some cases it is possible to use a smaller set of questions from a long module to impute an overall outcome score (as with consumption poverty).

Some topics are difficult to cover by phone survey. In general, topics that are challenging to survey face to face are even more difficult over the phone, although the impersonal nature of a phone survey may make it easier for some respondents to discuss certain topics (such as those involving social stigma like mental health, domestic abuse, xenophobia or sexual behaviour).

The evidence base on the reliability of phone surveys compared with face-to-face

surveys for displaced populations is still quite nascent. However, several studies have found no difference between mobile phone and landline surveys or mobile phone and face-to-face surveys.[8] It is hoped that planned JDC-supported work in Jordan might be able to offer insights into this question, as the respondent sample is split between face-to-face and phone surveys.

Despite these challenges, phone surveys are generally better suited to collecting socioeconomic microdata than other remote data-collection options. SMS options may have slightly better coverage and initial compliance but questionnaires generally need to be limited to fewer than five questions to avoid respondent fatigue. Paper-based surveys pose significant logistical challenges in a setting without postal addresses or a functioning postal system. Internet-based surveys generally suffer worse sample bias than phone surveys as they require even more technology and developing a robust sampling frame is far more challenging. And all these options assume a fairly high functioning level of literacy, which is not an issue for HFPS.

There are several practical guides on implementing a phone survey – guides that cover topics including the paramount importance of data protection and collaboration with the national statistical office (NSO).[9] Such collaboration may appear time-consuming during a crisis but is important in order to help build capacity,

encourage the inclusion of displaced populations in regular national data collection efforts, and build buy-in for the statistics generated to be used in designing a national COVID-19 response and recovery plan that includes displaced people. Phone surveys are not appropriate in all instances, but with a sound sampling strategy and instrument they can produce reliable data.

Jeffery C Tanner jtanner@worldbank.org
Senior Economist, World Bank–UNHCR Joint Data Center on Forced Displacement

1. World Bank (2020) 'Highly Vulnerable Yet Largely Invisible: Forcibly Displaced Populations in the COVID-19 Induced Recession' bit.ly/JDC-Paper-series-No1

2. Dabalen A, Etang A, Hoogeveen J, Mushi E, Schipper Y, von Engelhardt J (2016) *Mobile Phone Panel Surveys in Developing Countries: A Practical Guide for Microdata Collection*, World Bank https://openknowledge.worldbank.org/handle/10986/24595

3. See World Bank COVID-19 High Frequency Monitoring Dashboard bit.ly/WB-C19-HFdashboard

4. A World Bank–UNHCR joint initiative established 2019 www.jointdatacenter.org

5. Most surveys include modules on one or more of the following topics: health; education; financial access; food security; consumption (use of goods and services); labour market outcomes (e.g. employment status and sector, changes in labour income); WASH/health habits; COVID knowledge and behaviours, including compensating mechanisms; and aid/assistance. To that, the JDC has frequently added a module on displacement histories and, where possible, attitudes towards host/displaced populations.

6. Himelein K et al (2020) *High Frequency Mobile Phone Surveys of Households to Assess the Impacts of COVID-19: Guidelines on Sampling Design*, World Bank Group bit.ly/WorldBank-Himelein-et-al-2020

7. Etang A and Himelein K (2020) 'Monitoring the Ebola Crisis Using Mobile Phone Surveys', *Data Collection in Fragile States; Innovations from Africa and Beyond* https://link.springer.com/book/10.1007%2F978-3-030-25120-8

8. See endnote 2.

9. See for example UN ESCAP (2020) 'Engaging with development partners to stand-up COVID-19 rapid assessment surveys: Five tips for National Statistical Offices', Stats Brief Issue 25 bit.ly/UNESCAP-stats-brief-25; UNICEF (2020) 'MICS Plus; A Step-By-Step Guide to Implementation' bit.ly/UNICEF-MICS-guide-2020; WFP (2017) 'Conducting Mobile Surveys Responsibly' bit.ly/WFP-mobile-surveys-2017

Datasets to be publicly available

JDC-supported datasets (and accompanying documentation) on displaced populations from roughly 12 countries will be de-identified and published alongside the corresponding data on national (host) populations. These will be publicly available in the World Bank microdata library with links in the UNHCR microdata library at https://microdata.worldbank.org.

Briefs on the trends found in these data will be used in dialogue with host governments to illustrate the challenges that these vulnerable populations face during the pandemic.

JDC Literature Review updates and database

The World Bank-UNHCR Joint Data Center on Forced Displacement (JDC) publishes monthly literature review updates. These are added to a literature review database and also to a compilation product, searchable under 13 themes. www.jointdatacenter.org/resources

Measuring migrant deaths and disappearances

Andrea Garcia Borja and Julia Black

There are many challenges that hinder documentation of migrant deaths and disappearances but also much that can be done to improve the coverage and completeness of such data.

People trying to migrate to other countries drown in sewage canals; they freeze to death in remote forests; they die of dehydration and starvation after their vehicles break down in the middle of the desert. Documenting migrant deaths and disappearances helps to counter the invisibility of these tragedies, while collection, analysis and dissemination of such data are also valuable for advocacy campaigns, to inform evidence-based migration policies, and to improve operational planning.

However, collecting information on fatalities during migration is challenging for several reasons. The lack of safe and legal options for migration forces people to travel on irregular migration routes to evade detection. As a result, deaths either go unreported or without witnesses. Remote, harsh topography also makes it difficult to find people's remains; the remains of countless people who die on irregular migration journeys – especially those who go missing at sea – are never recovered.

There are additional, though more surmountable, issues involved: firstly, the difficulties of agreeing an operational definition of a 'missing migrant' and, secondly, the lack of reliable, accessible data sources. In the context of the COVID-19 pandemic, data collection has become increasingly challenging, with additional obstacles posed by reduced media coverage of migrant deaths, inability to reach migrants to collect testimonies, and border closures pushing migrants to more invisible routes.

Who is a missing migrant?

The International Organization for Migration's Missing Migrants Project (MMP) is a global, open-access dataset tracking deaths of people along mixed migration routes worldwide.[1] Since it was created in

2014, the project has recorded 40,505 deaths and disappearances during migration.[2] There is no agreed definition of 'missing migrant' but clearly an operational definition is needed in order to produce an evidence base.

MMP's definition refers to a person who died (or who went missing and is presumed to be dead) in the process of migration towards an international destination, regardless of the person's legal status. Migrants who die or go missing outside the process of migration – for example, when a migrant is residing in a foreign country – are not included in the database. MMP also excludes deaths that occur in immigration detention and settlements such as refugee camps, and deaths after deportation. This definition was designed specifically to identify the risks linked to irregular migration journeys.

 A category of missing migrant that is absent from MMP's definition relates to the many migrants who lose contact with their loved ones. These people may be alive but in situations where they are not able to contact their families, or they may choose not to for fear of deportation or other consequences.

Though adopting a definition is necessary for starting data collection on any topic, it can also have negative consequences. For example, the exclusion of deaths that occur in migrant shelters, refugee camps or in detention can lead to the perception that migrants in such spaces are safer than those on the move. It can also lead to underestimating the scope and scale of migrant deaths by those who are not aware of MMP's methodology. This is especially problematic when MMP's figures are used in the media with limited background information and when death rates are shown without an explanation about how they were calculated.[3]

In addition, establishing when a death happened 'in the process of migration' is

particularly problematic. In general, the notion of transit implies temporariness but it says nothing about the length, direction or continuity of the migration journey. In the MMP methodology, it is assumed that transit is generally continuous; in reality, migrants often pause or re-route their journeys to regain strength and financial resources, and their completed journeys may take months or years. If a migrant dies or goes missing during one of their stopovers, their death would not be counted by MMP. The result is that many incidents are excluded from the database because it could not be established that the migrant was in transit.

Likewise, migrants are often forced to pause their journeys because of government policies that restrain their movement. In 2020 mobility restrictions imposed to contain the spread of COVID-19 have been of particular concern, leaving thousands of migrants stranded in dangerous situations where humanitarian support, including access to health care, may be unavailable.

> An Ivorian teenager died on board a quarantine ship in Italy one month after being rescued from the Mediterranean. Reportedly, the lack of access to adequate health care on the ship caused his health to deteriorate and eventually his death.[4] Had he had access to better health care immediately after his sea journey, his life might have been saved.

Sources of data

Few official sources collect and publish data on migrant deaths, and the available data are sometimes inaccurate or incomplete. The few official data that are available are typically collected by border agencies and forensic examiners. To address the issue that many missing migrants are not captured in government data, MMP relies on other sources, such as social and news media, NGOs, civil society, international organisations, and migrants themselves.

> In its efforts to help the families of missing migrants, the Pima County Office of the Medical Examiner in Arizona examines unidentified remains found in its jurisdiction and determines

which ones could be coded as 'undocumented border crossers'. The criteria they use include whether the body was recovered in a known migration corridor, whether the person's belongings match the items typically carried by migrants, and whether those supplies came from Mexico. This simple classification translates into an invaluable record of migrant deaths along a border with one of the highest fatality rates. Since 2001, they have recorded over 3,398 migrant deaths.[5]

Media reports are one of the most frequently used sources by MMP. However, very often the information that the media provide about migrant fatalities is inaccurate, incomplete or misinterpreted and exaggerated.[6] In addition, where deaths occur in large numbers and on well-known routes, such as the Mediterranean route, these are more likely to be reported by the media and this can bias MMP data. This problem is further exacerbated when a large part of the media coverage focuses on just a few issues. In 2015, when there was wide media coverage of the Bay of Bengal crisis, our data saw a substantial increase. MMP documented 577 Rohingya migrants' deaths at sea that year. In contrast, in 2020, MMP has only recorded 165 such deaths, even though NGOs have declared that well over a thousand Rohingya have been stranded at sea for months, indicating that the death toll might well be higher.

MMP also uses other sources of information such as migrant surveys and survivors' testimonies. The more recent crackdown on NGOs that carry out search and rescue operations and offer lifesaving support to migrants – such as those active in the Mediterranean and at the southern US border – not only puts migrant lives at risk but also hampers our ability to collect evidence. Lastly, MMP uses maritime departure data to identify possible incidents involving migrant deaths or disappearances on overseas routes.

> In 2020, the sea passage from the northwestern coast of Africa to Spain's Canary Islands saw a significant increase in migration flows compared with 2019. Information about the sex and age of people who go missing on this route and the precise location of their death or disappearance

is scarce. In 2020, at least 849 people lost their lives on this route. Several incidents potentially involving hundreds of deaths are still to be verified and recorded by MMP but evidence is difficult to obtain. MMP has consequently started to collect data on departures from the Senegalese coast; this information can then be compared with that on arrivals in the Canary Islands to account for potential shipwrecks.

Recommendations

Though there are many challenges that hinder documentation, much can be done to improve the coverage and completeness of data on missing migrants, as the following recommendations suggest.

Data must represent the lived experiences of people taking migration journeys. Actors using operational definitions, such as MMP's, should develop guidelines on how to adapt their methodologies to the evolving realities of migration journeys.

All actors working in spaces where migrant deaths and disappearances occur should collect and share data. Also, actors collecting missing persons reports should disaggregate these data so that disappearances linked to migration can be identified.

Data on missing migrants should be shared among actors, regardless of definition. Data on missing migrants tend to be scattered and fragmented, and there is great value in bringing disparate sources of data together for comparison and verification.

States must urgently start collecting data on migrant deaths within their territories. Official actors are likely already to collect data about deaths within their jurisdiction. Local, national and regional authorities that collect such data should disaggregate it by migratory status and publish it in accordance with data protection standards. This includes collecting information – in a sensitive way – from migrants about deaths or disappearances of fellow migrants that they have witnessed.

NGOs, international NGOs and civil society should collaborate to resolve cases and

generate evidence. Data collection efforts led by non-governmental actors working directly with people on the move can provide new information and increase the likelihood that data can be verified, particularly in cases where migrants' bodies are not recovered. Collaboration with and between families of the missing should also be encouraged, as their involvement can both provide crucial information and help families cope with the uncertainty of the loss that they face.

The media should use existing guidelines for reporting on migrant deaths. Media reports can be the first indication that a migrant death or disappearance has occurred, and as such can play a vital role in data collection. Details on the people involved in such an event should be included whenever possible, while giving due consideration to the deceased and their families' interests. Beyond this, news reports should mention the limitations of any data published, so as to avoid inaccuracies or misinterpretations, and should endeavour to portray the people behind the numbers.

Andrea Garcia Borja
agarciaborja@iom.int @agarciaborja
Data Analyst

Julia Black *jblack@iom.int @_Julia_Black*
Project Officer

IOM Missing Migrants Project

1. https://missingmigrants.iom.int

2. Figure covers period from 1 January 2014 to 30 January 2021.

3. Dearden K, Sánchez Dionis M, Black J and Laczko F (2019) 'Calculating "Death Rates" in the Context of Migration Journeys' bit.ly/IOM-GMDAC-Dearden-et-al-2019

4. *Agenzia Italia* (2020) bit.ly/3neBlXF (Italian only)

5. Map of Migrant Mortality bit.ly/35ajDhC

6. White A and Singleton A 'Mixed messages: Media coverage of migration and fatalities', chapter 3 in IOM (2017) *Fatal Journeys, Volume 3, Part 1: Improving Data on Missing Migrants* bit.ly/2Us5nKQ

thematic listings

Protection at Sea
Take a look back at earlier articles published by FMR focusing on this topic, brought together in our thematic listing on Protection at Sea.
www.fmreview.org/thematic-listings

Tackling DNA data-sharing challenges

Sara H Katsanis, Diana Madden, Courtney C Siegert, Eduardo Canales and Kate Spradley

Administrative and ethical barriers to DNA data sharing for identification of migrants found along the US–Mexico border exemplify the need for long-term solutions and sustainable processes.

Inherited and unchanging throughout life, DNA is a powerful metric for identifying human remains. Technical improvements in using it have advanced over the decades; however, ethical, administrative and bureaucratic barriers restrict its use, particularly for transnational identification. This is apparent in US border states, where unidentified human remains (UHR) thought to be those of migrants are buried without DNA sampling or left to languish unnamed for years.

Since 2008, over 800 UHR have been found in Brooks County, over 70 miles north of the Texas border with Mexico.[1] Such unexplained deaths are subject to investigation which in most places includes an autopsy with DNA sampling; in South Texas, however, the relevant laws and practices were not followed prior to 2013, meaning that DNA samples were not taken. Graves are now being exhumed to collect DNA and other anthropological data to investigate the identities of the deceased. So far, 34 of 163 long-term deceased have been identified and more graves await exhumation. Due to the historic lack of case tracking in the region, we do not know how many more nameless or unmarked graves might contain the remains of missing people.[2]

Identification often takes years. Usually, UHR are sent to a medico-legal authority for identification where, in most cases, an autopsy will be performed, including DNA sampling. DNA data can be uploaded to the federal DNA data system, the Combined DNA Index System (CODIS). These data will be compared with the missing persons index and with an index of relatives of missing persons. The theory of DNA-based identification via CODIS is that at some point family members will report the missing person and provide 'family reference' DNA samples (FRS). Any jurisdiction in the US can take a missing person report and an FRS, then submit that FRS to a CODIS DNA laboratory.

Need for cooperation and collaboration

For migrant families, however, multiple barriers limit identifications. CODIS was designed for criminal casework, not for missing persons identifications. It is designed to protect the quality of the data and includes restrictions on access that create heavy paperwork burdens for FRS and UHR submissions. Moreover, crime laboratories prioritise casework where a person's life or liberty might be at stake; this means UHR and FRS processing might be delayed. CODIS laboratories also require a missing person case report number from a US jurisdiction, which might not be possible if the report is filed outside the US.

Most importantly for transnational missing cases, it is a federal requirement of CODIS that FRS be collected by law enforcement personnel. However, relatives of the missing might be unwilling or unable to provide FRS to law enforcement, perhaps fearing deportation of themselves or their family members. Further, public awareness of a missing person report can endanger the lives of the family and that of the migrant. Family members reporting a missing person often face extortion.

Numerous governmental and non-governmental efforts to improve search and recovery, identification processes, and communication and repatriation processes are ongoing. For example, some jurisdictions have begun sending UHR and FRS to a private DNA laboratory that does not require FRS be obtained in the presence of law enforcement, and this has contributed to the identification of many individuals. A private laboratory can also accept UHR and FRS from other countries. However,

An unknown migrant's grave in the Sacred Heart cemetery in Brooks County.

most UHR are in CODIS, and some are in a private database, while most FRS are in a private database and not in CODIS. This has created two DNA data systems that are disconnected from one another and individually under-populated, resulting in missed opportunities for identifications.

Over the years, various stakeholder groups have convened to address these and other DNA identification challenges. Stakeholders include all levels of law enforcement, Justices of the Peace, medico-legal officials, consulates, intergovernmental organizations, humanitarian organizations, migrant family advocates, forensic anthropologists, database stewards, DNA experts, governmental officials and human rights experts. Some improvements have emerged from these efforts, such as: improved communication among stakeholders; a new humanitarian database to enable comparison of FRS data not in CODIS with the UHR data in CODIS; and that consular officials are now allowed to collect FRS for CODIS.[3]

One of the roles academics can play is to provide unbiased research approaches to examine the policy gaps and differing perspectives that restrict progress. Our team drew up a research strategy focusing on the use of DNA data for identifications, and in March 2020 we held a symposium for professional stakeholders to debate policy options (we also plan to bring together families of transnational missing persons). This enabled us to chronicle the specific challenges identified by stakeholders and consider the priorities and proposals of each stakeholder group.

Different missions, different priorities

Despite the good intentions of all stakeholders, political pressures and stark differences in mission-based priorities lead to disagreements and miscommunications on policy matters. For example, a criminal justice unit has an interest in maintaining the integrity of a missing person case that could be a homicide. Similarly, border security has an interest in learning the identities of migrants and their affiliates in order to investigate gang and smuggling rings. In contrast, humanitarian organisations advocate for a family's right to know and for the repatriation of their loved ones regardless of their involvement in illegal activity. Each of these missions holds intrinsic value – but the differences create friction.

Much of the information surrounding a transnational missing person is highly sensitive. Geographic data on where remains are found are useful both for finding more people and for investigating smuggling routes. Names of family members of the missing can be exploited by smugglers or

kidnappers or used to investigate immigration violations in the US. DNA data from the missing and from family members can also be used to investigate criminal activity. Given these sensitivities, distrust between stakeholder groups is high. Understanding the processes at play and the interests of stakeholders is the first step toward progress, and at this stage in our research certain key areas for improvement can be noted.

Shift the narratives surrounding the unidentified: Many assumptions cloud perceptions of the circumstances of missing persons at the border. One assumption is that they are all migrants; many are, but not all. Another is that the migrants are all from Mexico and countries in Central America. Increasingly, migrants from around the world are travelling to South America to go north to the US. Another assumption is that the challenges to DNA-based identifications are unique to missing migrants. In reality, many of the data-sharing and funding restrictions apply to all types of missing persons investigations. We have adjusted our language recently from 'missing migrants' to 'transnational missing persons' to more accurately reflect the fact that the challenges are not unique to migrants or to particular regions of the world and to highlight the issues specific to US–Mexico cross-border identifications.

Improve communications: Misunderstandings percolate through organisations, particularly when so many stakeholders are involved. Transparency is essential in implementing current policies, formulating new policies and communicating between organisations.

Leverage creative solutions: The most promising outcomes of our research are ideas that could improve the status quo. For example, many of the stakeholders expressed general support for the use of 'rapid DNA' instruments for quick DNA data analysis of UHR or FRS. Such instruments can be used by non-experts, can process samples in 90 minutes, and are relatively portable. There

was also strong agreement on the need for a mechanism for training and certifying non-law enforcement personnel as FRS collectors.

Though the precise policy mechanisms needed to enable improvements remain unclear, every single stakeholder with whom we have interacted agrees that current practices must be reformed. We hope that building a policy framework based on priorities and stakeholder-driven solutions can aid the construction of sustainable solutions.

Sara H Katsanis
sara.katsanis@northwestern.edu @GxJustice
Research Assistant Professor, Pediatrics, Feinberg School of Medicine, Northwestern University; Ann & Robert H Lurie Children's Hospital of Chicago

Diana Madden *dimadden@luriechildrens.org*
Behavioral Research Coordinator, Ann & Robert H Lurie Children's Hospital of Chicago

Courtney C Siegert *csiegert@txstate.edu*
PhD Candidate, Department of Anthropology, Texas State University

Eduardo Canales
ecsouthtexashumanrights@gmail.com
Founder and Director, South Texas Human Rights Center

Kate Spradley *mks@txstate.edu @kate_spradley*
Professor, Department of Anthropology, Texas State University

1. Although Brooks County is not located along the border, it handles many migrant deaths due to the presence of a US Customs and Border Patrol checkpoint.

2. Spradley M K and Gocha T P (2020) 'Migrant deaths along the Texas/Mexico border: a collaborative approach to forensic identification of human remains', *Forensic Science and Humanitarian Action: Interacting with the Dead and the Living*
https://doi.org/10.1002/9781119482062.ch34

3. Budowle B, Bus M M, Josserand M A and Peters D L (2020) 'A standalone humanitarian DNA identification database system to increase identification of human remains of foreign nationals', *International Journal of Legal Medicine* 134(6)
https://link.springer.com/article/10.1007/s00414-020-02396-9

What about those left behind?

Marta Sánchez Dionis and Kate Dearden

The disappearance of people on migration journeys has reverberating effects on their family and community.

Families of people who go missing on a migration journey either do not know how to seek government support or are sceptical of doing so, and States have done almost nothing to address this issue. There appears to be little understanding and appreciation of the obstacles that families face in the search for answers about the fate of their missing loved ones and of the impact of such a situation on their well-being and livelihoods.

In December 2018, 152 states endorsed the Global Compact on Migration and resolved to "save lives and establish coordinated international efforts on missing migrants", to "facilitate communication with affected families" and to "[e]stablish transnational coordination channels and designate contact points for families looking for missing migrants."[1] Yet families experience multiple structural constraints, ranging from their own circumstances to the lack of adequate institutional and policy frameworks that take into account the particular dynamics of deaths and disappearances on migration journeys. Constraints also result from complex interactions shaped by class, migration status and gender, while efforts to trace relatives have been further complicated by the COVID-19 pandemic.

Laila's brother suddenly disappeared from the lives of his family and community. Overnight, all contact was lost. *"He called from a beach, and he said he would sleep there and leave the next day."* But he never called again.

In 2020, the International Organization for Migration (IOM) carried out research in Ethiopia, Spain and the UK to learn how people with missing migrant relatives could be better supported in their search and in dealing with the impacts of loss.[2] The study is not representative of the experiences of all migrant families. Nevertheless, it provides insight into how people are impacted by the loss of a loved one on migration journeys.

The families' experiences

There is a clear gap between the approach and knowledge of governments and the needs of families. Families in all countries suffer a sense of uncertainty over where to start their search when they realise there is a lack of protocols or entities who can support the process. If families approach authorities, those authorities often say they do not have jurisdiction over missing migrants' cases, alleging that the disappearance did not take place within their territory.

There is also a clear perception that authorities approach cases of missing migrants first and foremost as an issue of anti-smuggling/trafficking or immigration control. Families are pressurised to provide details of the smuggling facilitators who were involved, and are often told that they should not have let their relative undertake such a migration journey in the first place. People who have been migrants themselves, and especially those who have insecure migration status, feel that approaching any authority (or even any organisation that they perceived might share information with authorities) would jeopardise their stay in the country. Furthermore, community advocates who contact authorities on families' behalf are questioned regarding their ties to families and are accused of being connected to migrant smuggling groups or involved in facilitating migrant smuggling.

Families therefore rely mostly on informal channels, contacting friends and family members in different countries and reaching out to people who had travelled with their relatives, such as other migrants and smuggling facilitators. For example, in Ethiopia smuggling facilitators – who are themselves often members of the

community – were frequently willing and able to access contacts and information that could establish or help determine the whereabouts of a missing person.

Many families rely on community-based groups and migrant and refugee associations and advocates, who are often migrants themselves, fluent in the languages of the families, and with an intimate understanding of the specific contexts of the families and their communities.

> In Spain, Laila received support from a network of migrant advocates who assist families in their searches. We spoke with Amira, who is helping Laila search for her brother, and she told us: *"When a family contacts me or someone in the group, we start the process of seeking information through a network of informal, unofficial contacts…We look for them in hospitals, then in detention centres and prisons… and eventually at the morgue…"*

Families use social media in the search, posting short descriptions and photos of the missing person, and screening groups for information about missing or dead migrants. However, many of them lack internet or computer access at home, and their only way to conduct online searches is at community organisations. Limited access to technology, already an issue, has been exacerbated during the COVID-19 pandemic, as many previous points of access, such as internet cafés, community centres or libraries, have been closed.

Other vulnerabilities add difficulties

Engaging in a search can often be costly and a lack of financial resources creates an extra barrier. Filing reports, meeting with authorities, travelling to locations where a person was last seen or trying to track his or her steps can generate significant costs – not to mention the scams or extortion in exchange for information. Furthermore, in countries of migrant transit and destination, such as Spain and the UK, many families have unstable and low-paying employment and poor housing conditions, which severely limits the ability to start a search. In places of migrant origin, like Ethiopia, families are often left without the

One of our research participants showing us the last photo he has of his missing older brother.

Marta Sánchez Dionis

economic support that their missing family member was expected to provide if their journeys had been successful. Many also face the responsibility of covering the significant debt that their loved one incurred to cover the costs of their journey. This particularly affects women and older relatives left behind.

Legal disenfranchisement is another vulnerability that shapes families' options. The fear of starting a search before having attained favourable immigration status regularly leads to postponement of efforts, and therefore to the loss of valuable time to collect information and/or evidence. Visa restrictions may also limit search options.

The IOM research also provides evidence of how a disappearance can exacerbate and reinforce long-standing forms of inequality based on gender. Since most missing migrants were men, it was often the wives, sisters and mothers who drove the search, and who carried a disproportionate amount of social and financial responsibility. The women are simultaneously expected to continue the search for the missing person and to care for their children and older family members.

Conclusions

While some policy implications from the IOM research are context specific, they echo previous findings and recommendations made by the Missing Migrants Project and other organisations, such as the ICRC.[3]

All efforts to assist people who have missing migrant family members should recognise the expertise, knowledge and well-being of families and put them at the centre. This means addressing their needs, rather than focusing on the security and criminal aspects of how the person went missing. The definition of family in cases involving missing migrants should be flexible, taking into account emotional dependency, and be in line with cultural and other contexts.

Community-based groups and grassroots advocates, NGOs, mainstream civil society organisations and other organisations who support families of missing migrants are of critical importance in the absence of appropriate laws, policies and safeguards that allow people to approach and to receive support from authorities. A working group of these relevant actors and families of missing migrants in each country could be formed to help with information sharing both to families and to relevant government agencies. While such cooperation could start at the country level, the aim should be to build networks with other actors regionally and beyond – both to share best practices and to help resolve particular missing persons cases.

The issue of missing migrants is not adequately addressed by policies or laws.

A starting point would be for each country to create a protocol that would enable a uniform approach to the implementation of existing national and international legal provisions that protect the rights of families of missing migrants. Such a protocol should include instructions for efficient collection, preservation and sharing of data, and for cross-sectoral collaboration on missing persons cases. The protocol would act as a guide for families, as well as for community groups, organisations and government bodies trying to help them, on how they can search for their loved one and access support.

Marta Sánchez Dionis
msanchez@iom.int @msdionis
Project Officer, IOM's Missing Migrants Project

Kate Dearden *kdearden@iom.int*
Project Officer, IOM's Missing Migrants Project

1. www.iom.int/global-compact-migration

2. Missing Migrants Project www.missingmigrants.iom.int Research team included Gabriella Sanchez, Danish Institute for International Studies; Carlos Arce, University of Córdoba; Tekalign Ayalew Mengiste, Addis Ababa University; and Samuel Okyere, University of Bristol.

3. For example, in the Five Point Action Plan in IOM's *Fatal Journeys* Volume 2 (2016) https://publications.iom.int/fr/system/files/fataljourneys_vol2.pdf and the draft 'Principles on stakeholder interaction with families of missing migrants' being prepared by ICRC's Missing Persons Project www.icrc.org/en/draft-principles-stakeholder-interaction-families-missing-migrants

The search for truth, justice and closure during the pandemic

Danai Angeli

The pandemic has posed additional challenges for bereaved migrant families who mourn the death or disappearance of their loved ones. There are practical ways, however, to assist them.

Bereaved families have the right to truth, to justice and to closure. These fundamental rights are recognised under international human rights law, including under the right to dignity, the right to life and the right to family and private life.[1] At a minimum, States must ensure that bereaved migrant families have the opportunity to be informed about the fate and whereabouts of their

missing or deceased relative, to claim and repatriate their remains, and to lay them to rest (Mytilini Declaration of 2018[2]).

National responses to the COVID-19 pandemic have had severe implications for the ability of bereaved migrant families to exercise the above rights. Containment measures to halt the spread of the virus have often failed to take into consideration the

specific needs of bereaved migrant families and have raised additional legal and practical barriers. Drawing on the experiences of migrants in eight countries (Greece, Germany, France, Italy, Mexico, South Africa, the US and Zimbabwe) during the pandemic, we seek to demonstrate that there are practical and realistic ways in which States – in line with their international obligations – can assist bereaved migrant families without undermining public health responses.[3]

Understanding the cause of death
Lingering questions and doubts over the circumstances of the confirmed or presumed death of a loved one can weigh heavily on the surviving family. International human rights law recognises that the emotional pain and anguish endured may even amount to inhuman and degrading treatment. States are therefore under an obligation to investigate suspicious deaths, hold those responsible accountable and keep the family informed.

The seemingly mysterious nature of the new virus and the spread of conspiracy theories have amplified uncertainties among migrant communities. To begin with, official data on the transmission- and death-rate of COVID-19 among migrants are largely unavailable. Many States, including most European States and the US, do not publish COVID-19 statistics disaggregated by nationality, nor do they report separately on the situation of migrants.

Uncertainty is further exacerbated not only by the different ways in which COVID-19 deaths are verified but also by the amount of information shared with the next of kin. In certain countries (such as Germany), the cause of death is a confidential part of the death certificate which is passed to the relevant statistics office but not readily made available to the next of kin due to personal data protection laws. In New York, death certificates stating COVID-19 as the cause of death have been met with distrust by many families, especially where the person was previously in good health and if access to medical records or any further information about the cause of death is not available. For families located abroad, it

may be even harder to obtain information about the circumstances of death because of restrictions on travel and on who has the right to access relevant paperwork.

Migrants – especially undocumented migrants – have faced increased difficulties in accessing health care since the outbreak of the pandemic for a number of reasons. As a result, an unknown number of COVID-19 cases and other medical conditions have been untreated, and an unknown number of non-hospital deaths have gone undiagnosed. Releasing official and transparent data on the transmission- and death-rate among migrants may help put to rest suspicions and speculations, and assist families seeking truth, justice and accountability.

In Mexico, for instance, the authorities release on a daily basis full open data on COVID-19 cases, hospitalisations and deaths. In addition to tracking variables such as age, sex, location and co-morbidities, Mexico also includes information on nationality, migration status and country of departure. In addition, Mexico has been releasing weekly epidemiological reports on COVID-19 among migrants, including the total number of suspected and confirmed cases, countries of origin, hospitalisations and deaths. Although the official statistics do not account for the full extent of the death toll (given that Mexico has one of the lowest testing rates), the government has nonetheless taken an important step towards making official data fully available to the public in an open and downloadable format.

Procedures for requesting death certificates and obtaining further information about the circumstances of death should be accessible and should take into consideration the additional difficulties faced by bereaved families located abroad. Civil society organisations, migrant associations and support groups can help bereaved families navigate administrative procedures; it is essential that such actors remain operational and accessible throughout the pandemic.

Awareness raising is needed not only on how to contain the spread of the virus but also to provide comprehensive and accessible information about access to health care, the

prospects in case of a positive diagnosis and the reasons for containment measures directly affecting migrant communities. Engaging refugee and migrant communities, grassroots organisations and other support groups to share this information can offer an effective way to overcome deep-rooted distrust towards the authorities.

Laying to rest

International law recognises the human right to bury and honour one's deceased relatives. Ensuring respect for funeral preferences and rituals has become particularly problematic during the pandemic, with limitations on attendance and on handling bodies. The pandemic has also exacerbated time-related and financial constraints. The increasing lack of space in morgues has led to expedited funeral procedures, limiting options for destitute families who need more time to raise funds and constraining their ability to transport remains elsewhere. International travel restrictions have placed additional barriers. The situation is even more complicated where the remains are unidentified or where the family has doubts about the identity.

Forensic protocols should expressly address how post-mortem and ante-mortem data relevant for future identification should be collected and preserved. An important example has been set by Mexico's COVID-19 forensic protocols on the treatment of unidentified remains. These protocols describe how bodies should be handled and how data should be collected and stored in light of the pandemic. The protocols also prohibit the cremation of unidentified remains. In the event of the need for mass management, all unclaimed bodies – whether identified or unidentified – must be buried in individual graves for COVID-19 remains, and the attorney's office and forensic services must record where the remains have been buried.

Funeral expense assistance could be included in the financial assistance provided by States to ease the effects of the pandemic. An important step in this direction has been made by New York City's burial assistance programme to which migrant families – including those with undocumented status – can apply.

Establishing a national visa for funeral and/or identification purposes is an effective and practical way to support bereaved migrant families living abroad. In Germany, for instance, the family visa – which has been maintained throughout the pandemic – allows family members, including extended family members, to visit Germany on a temporary basis to attend a funeral.

Hospital and funeral services protocols should show flexibility to accommodate funeral rites where possible. In Germany, although relatives are not allowed to take the body home, they are allowed in certain circumstances or locations to perform funeral rituals in the hospital room. In Zimbabwe, live streaming of funeral services is available for families (and other members of the community) who are unable to attend in person.

Repatriating remains

For bereaved families, bringing the deceased relative home is essential for closure. Even before the pandemic, the repatriation of human remains was a complex and costly procedure. Since the pandemic, these procedures have become more costly and more bureaucratic, as many States have placed additional restrictions to avoid contagion. At the same time, the suspension of consulate services in many countries combined with travel restrictions have made it more difficult for families living abroad. It is not uncommon, therefore, for bereaved migrant families not to pursue the repatriation option or to find unorthodox ways to achieve it. In Greece, for instance, many migrant families opt to repatriate the bones only, which are made available to the next of kin three to five years after burial. In New York, Mexican families may choose to cremate the relative, against their beliefs, as repatriation of such remains is easier. All this can weigh heavily on the surviving families. There is an urgent need for better national regulations and international coordination in order to more effectively facilitate repatriation procedures.

Bereaved migrant families cannot be left to grieve alone. Providing proper assistance is not only a moral duty; it is also a legal obligation grounded in well-established human rights norms.

Danai Angeli *Danai.angeli@bilkent.edu.tr*
Assistant Professor, Bilkent University; Consultant, Last Rights Project

1. Last Rights (2019) Extended Legal Statement and Commentary bit.ly/Last-Rights-2019-legal-statement

2. The Mytilini Declaration for the Dignified Treatment of all Missing and Deceased Persons and their Families as a Consequence of Migrant Journeys, adopted 11 May 2018, http://lastrights.net/LR_resources/html/LR_mytilini.html

3. Last Rights (2021) *Every Body Counts: Death, Covid-19 and Migration. Understanding the Consequences of Pandemic Measures on Migrant Families* bit.ly/Last-Rights-2021-EveryBodyCounts

Missing migrants and their families: a call for greater international cooperation

Sylvie van Lammeren and Florian von König

A strengthened commitment to coordination and collaboration is essential if actors are to be more effective in locating missing migrants and assisting their families. New initiatives offer a path forward.

The search for missing migrants is a transnational, even transcontinental, undertaking requiring cooperation among a broad range of actors.[1] A global intergovernmental framework for such cooperation had been lacking, but this changed with the inclusion (at ICRC's instigation) of Objective 8 in the Global Compact on Migration. With this, more than 150 States committed to establishing coordinated efforts on missing migrants, including by standardising the collection and exchange of information and establishing transnational coordination for identification and communication with families.

Translating political commitments into action, however, requires information in order to quantify and analyse the problem. This is a notorious challenge as reliable numbers of missing migrants are hard to come by, due, among other things, to the often clandestine nature of migration. Moreover, perceptions of the issue are often distorted, reflecting a focus in both media reporting and public attention on the Mediterranean or Central American contexts, thus neglecting the vast extent of intra-African, Asian or Middle Eastern migration flows. Initiatives such as the Missing Migrants Project of the International Organization for Migration (IOM) or the African Union's recently created African Observatory for

Migration and Development are therefore critical to create a baseline for policy and provide much needed analysis.

At the same time, concrete frameworks are needed to coordinate the efforts of relevant actors along migratory routes to prevent[2] and resolve cases of missing migrants including by collecting, compiling, sharing and comparing information from different sources. Examining existing practices and providing guidance on how to achieve this is an objective that the ICRC's Missing Persons Project (MPP) has pursued since its launch in 2018.[3]

Bringing stakeholders together

Building on its longstanding experience in this area, the ICRC established the MPP to assemble a global community of stakeholders to jointly develop guidance to improve the response.[4] In discussions at an expert workshop in 2019,[5] some 60 practitioners representing States, organisations and families of missing migrants confirmed some major obstacles: the absence of established practices and standards in the area of information collection, challenges to protect sensitive personal information, and poor forensic practices. Participants also stressed the specific challenges faced by families of missing persons, such as the difficulty of accessing information held

Fragkiska Megaloudi

ICRC staff takes a tracing request from a Somali woman. Leros Island, Greece.

in another country, lack of trust in state authorities, and bureaucratic, legal and linguistic barriers. In view of the resources and expertise brought by non-State actors and the importance of involving families in the search, there was broad agreement that a multi-stakeholder model for coordination was most likely to deliver results.

To transform these findings into action, participants proposed that the MPP develop three specific outputs. Firstly, we have worked on a draft dataset to harmonise information relevant to the search for missing migrants.[6] Building on, rather than seeking to replace, existing practices ranging from Interpol forms to those used by the Red Cross and Red Crescent Movement, this document contains standardised questions covering information such as personal details of the missing migrant, physical characteristics and circumstances of disappearance. A second output is the publication of *Principles on Stakeholder Interaction with Families of Missing Migrants*.[7] This addresses the abovementioned challenges faced by families and provides guidance for actors on how to engage with them, emphasising the families' central role in any search process.

The third and arguably most complex document is a set of *Guidelines on Coordination and Information Exchange Mechanisms for*

the Search for Missing Migrants.[8] These mechanisms – designed to clarify the fate and whereabouts of missing migrants, both dead and alive – comprise a flexible network of different types of stakeholders who cooperate in exchanging and analysing information along a migratory route and whose respective roles and relative importance can vary depending on the context. Our document sets out key elements of such a mechanism: a shared understanding of roles and responsibilities; a coordinated approach to information management that may include inter-operable tools; clearly defined information-sharing pathways; and legal agreements that underpin all of these. The draft guidelines also describe preliminary steps that need to be taken at the national level such as the harmonisation and centralisation of data collected by different actors. Given the sensitivity of the migratory context, the document stresses the need to vigorously protect personal data.[9]

In line with the project's commitment to basing recommendations, wherever possible, on existing practices, the guidance document builds on a set of guidelines currently under adoption by the Regional Conference on Migration in the Americas. This is the first regional inter-governmental framework to set out concrete modalities for cooperation on the

missing migrant issue. In the same vein, the *Guidelines* illustrate specific recommendations with reference to existing practices.

What else is needed?

The discussions we have held with experts and practitioners leave us in no doubt that efforts to implement Objective 8 need to be reinforced and coordinated. While some countries are reporting on measures taken at national level – such as strengthening national forensic systems – such efforts are bound to be insufficient without coordinated international action. More determined and coordinated action by governments is a pressing need.

In the absence of decisive action by governments, civil society and other non-State actors have stepped up to fill the void in many parts of the world. However, often their action is limited in scope, and lacks resources and support from relevant authorities. We are therefore convinced that a stronger role for international actors such as the ICRC is required in order to assist States to act upon their commitments in complementarity with the aforementioned efforts. Such a role may need to go beyond convener and technical advice functions to the provision of concrete support – such as in relation to data and information management – to enable cooperation among States and others. As an example, the ICRC is currently developing a digital platform that will allow authorities and other actors to share and manage data and information on missing persons securely both nationally and transnationally.

Moreover, developing investigation and identification methodologies and processes that can use this information effectively and that can be tailored to a broad range of contexts and available resources remains a significant challenge.[10] Long-

term efforts and investments to ensure cooperation and information exchange along migratory routes are essential, however, if we are to provide answers to families searching for missing loved ones.

Sylvie van Lammeren *svanlammeren@icrc.org*
Adviser, Missing Persons Project, International Committee of the Red Cross

Florian von König *fvonkoenig@icrc.org*
Deputy Head, Missing Persons Project, International Committee of the Red Cross

1. There is no international legal definition of 'missing migrants'. The ICRC understands missing persons as individuals whose whereabouts are unknown to their relatives and/or who, on the basis of reliable information, have been reported missing as a result of armed conflicts, other situations of violence, disasters or migration.

2. For ICRC policy recommendations on preventing migrants from going missing, see ICRC (2017) *Missing Migrants and their Families*, Recommendation 1
bit.ly/ICRC-missing-migrants-recommendations-2017

3. www.icrc.org/en/publication/4375-missing-persons-project

4. Through a virtual platform, the MPP brings together experts, family representatives and other stakeholders to stimulate discussion, build consensus on best practices, promote existing technical standards and develop new ones where needed. To join this global community of practice, please contact one of the authors.

5. Organised jointly by ICRC, the IOM Missing Migrants Project and the Argentine Forensic Anthropology Team. See ICRC (2020) *Clarifying the fate and whereabouts of missing migrants: Exchanging information along migratory routes* bit.ly/ICRC-clarifying-fate-2019

6. Draft dataset open for public consultation until 15 April 2021: www.icrc.org/en/document/draft-minimum-standard-dataset-search-missing-migrants

7. Draft document open for public consultation until 15 April 2021: www.icrc.org/en/draft-principles-stakeholder-interaction-families-missing-migrants

8. Draft document open for public consultation until 31 May 2021: www.icrc.org/en/document/guidelines-coordination-missing-migrants

9. See ICRC (2020) *Handbook on Data Protection in Humanitarian Action*, 2nd Edition
bit.ly/ICRC-Handbook-data-protection-2nd-edition

10. For an example of how to undertake such work, see: ICRC (2020) *The Missing and Deceased Migrants and their Families Program in South Africa and Zimbabwe* bit.ly/ICRC-Southern-Africa-2020

Loss, hope, action

Many migrants attempting to cross the Mediterranean do not survive the journey. Others just disappear. With every migrant who goes missing, there is a family longing for closure.
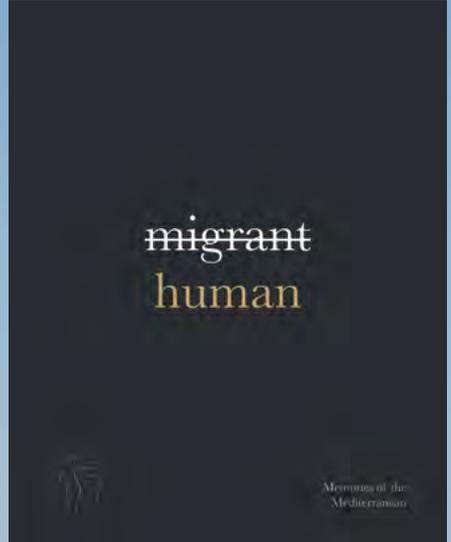
"There's not an event or holiday where we don't think of him. Even walking the streets outside I seem to always see his shadow."

La Terre Pour Tous is an advocacy organisation based in Tunis which works to address the plight of missing migrants and the injustices faced by their families. They work mainly through legal advocacy and awareness campaigns to change policies to enable identification of bodies that have been recovered.

La Terre has also worked with University of Michigan students to visualise the narratives of missing migrants' families, seeking to humanise missing migrants and to demand changes in policies. Visit the online exhibition at **https://missingmigrants.org**

Imed Soltani (*association_laterrepourtout@yahoo.com*), La Terre Pour Tous, Tunis; Odessa Gonzalez Benson (*odessagb@umich.edu*) and Vadim Besprozvany (*vbesproz@umich.edu*), with co-authors Elena Godin, Antonio Siciliano and Bader AlBader, University of Michigan

Read more about missing migrants in this FMR issue.

migrant
human

Memories of the
Mediterranean

Poster design: Malcolm Maturen (University of Michigan student)

OXFORD DEPARTMENT OF INTERNATIONAL DEVELOPMENT

Refugees on the shore of Lesbos, having arrived in an inflatable boat. UNHCR/Ivor Prickett