

Community-based approaches to MHPSS

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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

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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.

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The opinions expressed in this article are those of the authors and do not necessarily reflect the views of IOM.

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

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