

IASC

Inter-Agency Standing Committee
IASC Reference Group for Mental Health and
Psychosocial Support in Emergency Settings



CAMP COORDINATION
AND CAMP MANAGEMENT
CLUSTER

Mental Health and Psychosocial Support in Emergency Settings:

What Should Camp Coordination and Camp Management Actors Know?



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and Camp Management Actors Know?**

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List of acronyms

CAP	Consolidated Appeal Process
CCCM	Camp coordination and camp management
CFS	Child-friendly space
CERF	Central Emergency Response Fund
GBV	Gender-based violence
HESPER	Humanitarian Emergency Settings Perceived Needs Scale
IASC	Inter-Agency Standing Committee
IFRC-PSC	International Federation of Red Cross and Red Crescent societies- Reference center for psychosocial support
IOM	International Organization for Migration
MHPSS	Mental health and psychosocial support
PFA	Psychological first aid
PTSD	Post-traumatic stress disorder
WASH	Water, sanitation and hygiene
WHO	World Health Organization

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Introduction

1.1 Background

This document is for humanitarian actors within the Camp Coordination and Camp Management (CCCM) cluster, at national and subnational levels, in countries facing emergencies and crises. It is addressed to managers and field staff, and is also relevant to camp management agencies working in situations where the CCCM Cluster has not been activated.

Based on the *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, 2007), this document provides an overview of essential knowledge that humanitarian actors within the CCCM cluster/sector should have about mental health and psychosocial support (MHPSS) in humanitarian emergencies. Relevant agencies should ensure that their staff, in particular camp managers, is oriented on this document, as applicable.

Whenever the CCCM cluster is activated, the CCCM lead agencies are the providers of last resort. Their task is usually to coordinate the operations of the various actors that provide essential services in the camps and are active under their respective clusters (Protection, Health, Shelter, Water, sanitation and hygiene (WASH), Nutrition, Education, Non-food items and so on). This document, while specifically designed for CCCM actors, applies to all humanitarian actors providing services in camps.

The term ‘psychosocial’ denotes the interconnection between psychological and social processes and the fact that each continually interacts with and influences the other. In this document, the composite term ‘mental health and psychosocial support’ (MHPSS) is used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders.

The aim of camp management is to “ensure that standards in the camp are upheld so as to allow the displaced population to enjoy their human rights whilst striving for durable solutions. [It] is a vital form of humanitarian assistance because it coordinates protection and assistance programming, and takes a holistic approach to upholding basic human rights and meeting the needs of the camp population.” (NRC and CMP, 2008)

Including considerations of psychosocial well-being in the general CCCM activities will help protect the dignity of survivors and enhance the general humanitarian response.

1.2 Impact of emergencies

Emergencies create a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies erode protective supports that are normally available, increase the risk of diverse social or psychological problems, and tend to amplify pre-existing problems. While social and psychological problems will occur to variable extents in most groups, it is important to note that every individual will experience the same event in a different manner and will have different resources and capacities to cope with that event.

Psychosocial problems in emergencies are highly interconnected, yet they may be predominantly social or psychological in nature. Significant problems of a predominantly social nature include the following:

- Pre-existing (pre-emergency) social problems (e.g. belonging to a group that is discriminated against or marginalized; political oppression);
- Emergency-induced social problems (e.g. family separation; lack of safety; stigma; disruption of social networks; unemployment and poverty; breakdown of community structures, resources and trust; difficult interactions with the host communities; involvement in survival sex); and

- Humanitarian aid-induced social problems (e.g. overcrowding and lack of privacy in camps; undermining of community structures or traditional support mechanisms; aid dependency).

Similarly, the following are problems of a predominantly psychological nature:

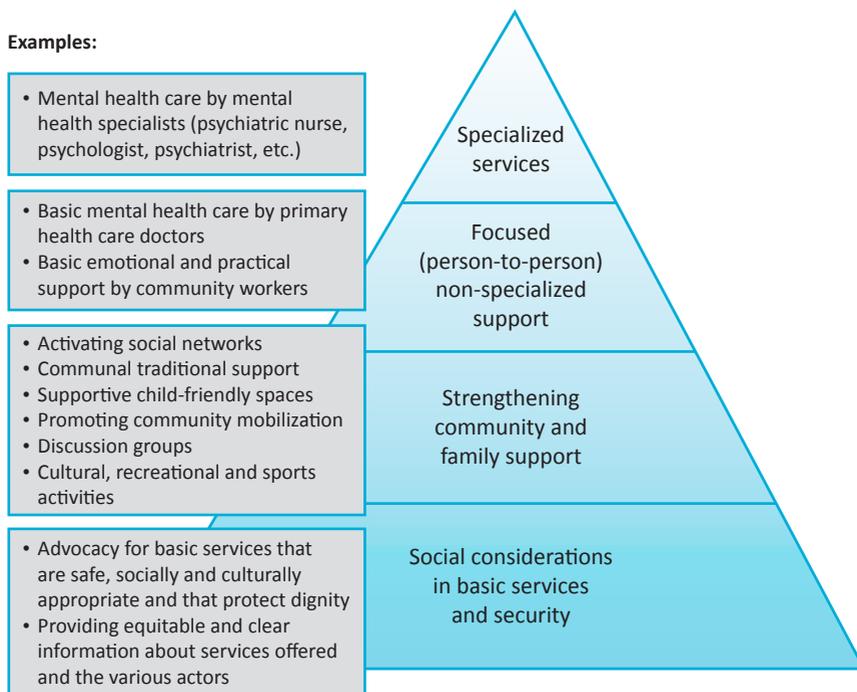
- Pre-existing problems (e.g. severe mental disorder; depression; alcohol abuse);
- Emergency-induced problems (e.g. grief; non-pathological distress; alcohol and other substance abuse; depression and anxiety disorders; sense of disorientation and uncertainty about the future; post-traumatic stress disorder (PTSD)); and
- Humanitarian aid-related problems (e.g. anxiety due to a lack of information about services or about perceived differences in access to aid).

Thus, mental health and psychosocial needs in emergencies encompass far more than psychological conditions like PTSD or disaster-induced depression. A selective focus on these two problems is inappropriate because it overlooks many other MHPSS needs in emergencies. Moreover, it focuses on deficits, ignoring individual, family and community resources.

Men, women, boys and girls have assets or resources that support mental health and psychosocial well-being. A common error in MHPSS programming is to ignore these resources and to focus solely on deficits – the weaknesses, suffering and alleged pathology – of the affected group. It is important to acknowledge the problems, but also the nature of local resources and the extent to which affected people can access them.

1.3 Principles

Figure 1: Intervention pyramid for MHPSS in emergencies



Source: IASC, 2008.

Note: For an explanation of the different layers, see IASC, 2008, pp. 12–13.

In emergencies, people are affected in different ways and require different kinds of support. One of the key principles is ensuring the availability of complementary types of support. MHPSS services require a layered system of complementary and interconnecting kinds of support that meet the needs of different groups (see Figure 1). All layers of the pyramid are important and should ideally be implemented concurrently, with the aim of keeping the affected persons at the lowest possible level of service-care.

Another key principle is that in the early stages of an emergency, it is important to build local capacities, to support self-help and to strengthen

existing resources. Whenever possible, humanitarian actors should build both government and civil society capacities. At each layer of the intervention pyramid, key tasks are to identify, mobilize and strengthen the skills and capacities of individuals, families, communities and society.

Activities and programming should be integrated, as much as possible, into wider systems (e.g. existing community support mechanisms, formal/non-formal school systems, general health-care services, general mental health services and social services). The proliferation of stand-alone services or programmes, such as those dealing only with rape survivors or people having a specific diagnosis, tends to be problematic because it can fragment support systems. Activities that are integrated into wider family, community and governmental systems and humanitarian assistance in camps reach more people, are usually more sustainable and carry less stigma.

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Coordination

MHPSS activities should be coordinated within and across clusters, as they are integral components of each sector (e.g. CCCM, Health, Protection, Education). It is important to include MHPSS projects in relevant chapters (e.g. CCCM, Health, Protection, Education) of flash appeals, Consolidated Appeal Processes (CAPs) and Central Emergency Response Fund (CERF) applications. Such documents should not have a separate MHPSS chapter. Accountability for MHPSS activities remains within the relevant clusters, and MHPSS should not be established as a separate cluster. However, it is important that MHPSS activities are coordinated and in line with the Inter-Agency Standing Committee (IASC) Guidelines on MHPSS. A suitable and contextually appropriate mechanism should be implemented for actors from different sectors to meet regularly to coordinate their MHPSS plans and actions.

The IASC Guidelines on MHPSS recommend establishing a single, intersectoral, inter-cluster MHPSS coordination group. It is appropriate to establish an MHPSS coordination group where many MHPSS actors are present. The coordination group needs to have terms of reference. Key inter-cluster operational issues should be addressed by the inter-cluster coordination group, where it exists. When few MHPSS actors are present, intersectoral MHPSS coordination may not be appropriate. In that case, it is important to organize regular meetings among MHPSS actors from different sectors or to establish a system of MHPSS focal points from within the various relevant clusters that meet regularly.

Of note, politically and practically, it is often best to have the MHPSS coordination group co-chaired by a couple of agencies from different sectors. In camp settings, it can be ideal for the group to be co-chaired by a CCCM agency. Lead organizations should be knowledgeable in MHPSS and skilled in inclusive coordination processes (e.g. avoiding dominance by a particular approach and sector). Coordination is enhanced by the development, evaluation and modification of an MHPSS strategic plan across sectors.

In practical terms, the CCCM cluster should have a psychosocial focal point for the sector. Ideally, the psychosocial focal point should be part of the core support staff of the cluster. Otherwise, an agency active in the CCCM sector that has capacity in the domain should be appointed to act as such.

For CCCM, the focal point will take on the following responsibilities:

- a. Provide advice to the CCCM cluster agencies on how to best mainstream MHPSS considerations into camp design, set-up and management in that specific crisis situation.
- b. Organize inductions in psychological first aid (PFA) and ‘do no harm’ rules (i.e. guidelines to avoid emotional harm to beneficiaries) for camp managers and other staff providing direct assistance in camps. Indeed, camp managers often deal with people severely affected by a crisis. While psychosocial assistance requires specialized skills, camp managers should be aware of how to avoid emotional harm to beneficiaries and be able to identify urgent needs for psychosocial assistance in the camp.
- c. Report the needs and requirements of the CCCM agencies at the MHPSS coordination group meetings and vice versa, making sure that the offer for MHPSS services matches the demand for services in camps, that no duplication exists, and that identified gaps in social supports by the MHPSS actors in camps are referred to the CCCM cluster for action.
- d. Depending on the agreed-upon coordination structure, the resources available and the local situation, the CCCM psychosocial focal point may also co-lead the IASC coordination group.

3 Essential MHPSS activities, considerations and knowledge related to CCCM

During conflicts and following natural disasters, populations are often forced to leave their homes and many flee to safer areas. The displacement process involves different forms of deprivation, protection risks and emotional challenges at every step. Loss of home and loved ones, insufficient nutrition, loss of security due to armed attacks, abuse and environmental threats are often among the reasons for leaving. While travelling, especially across borders, people may be subject to: legal identity issues; fatigue and unhealthy conditions; environmental risks; family separation, including an increase in the number of separated and unaccompanied children; heightened risk of sexual and gender-based violence (GBV); trafficking; attacks from armed groups; and discrimination. Upon arrival at a new location, hardship, loss of social role and recognition, loss of sense of agency, stigma, marginalization, further discrimination and harassment, and boredom may add to the sources of distress and affect the social and family life of the individuals.

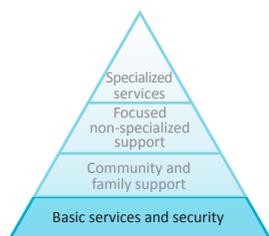
First, the population living in camps should be helped to find proper responses to the eventual distress that the various interrelated factors mentioned above may provoke.

The very way camps are coordinated and managed affects the well-being of the population living in camps. The manner in which a camp is designed and set up, how the basic services are organized, offered and communicated, and the extent to which the sense of agency of the residents is promoted or disregarded all contribute towards the well-being of camp residents, and can mitigate or enhance the distress provoked by their recent past experiences.

A number of minimum responses need to be implemented. The IASC Guidelines on MHPSS identify 11 domains of intervention. However, they do not encompass a dedicated section on CCCM. This chapter will try to address this gap by highlighting selected responses from the IASC Guidelines and adding new ones specific to CCCM operations.

These actions and considerations follow the framework of the MHPSS intervention pyramid, whereby camp coordination, site selection, planning and set-up, implementation of activities, and closure–relocation are considered at each level.

3.1 Basic services and security level



Several considerations should be taken into account to protect the mental health and psychosocial well-being of camp residents, while providing for their basic needs and security. Often, services are provided without considering the emotional and cultural impact that their delivery may have on individuals, family dynamics, gender relations and traditional household roles. This generally undermines the dignity of the residents and disorients them, harming them further.

3.1.1 Include specific social and psychological considerations in the provision of food and nutritional support (Action Sheet 9.1 of the IASC Guidelines)

This includes measures granting dignity, consideration of cultural practices and food habits, and consideration of household roles in determining who should be the first recipient of the help provided in a family, and in which fashion help should be given in order to protect the dignity of beneficiaries in a specific culture. Ignoring these interactions can cause harm, result in programmes that require people (including elderly, pregnant women and the differently abled) to queue for long hours, treat aid recipients as dehumanized and passive consumers, create conditions for violence in and around food deliveries or undermine existing household and community roles, putting aid recipients in embarrassing situations in front of their family and peers.

Key actions:

- Assess psychosocial factors related to food security, nutrition and food aid.
- Maximize participation of women and men in the planning, distribution and follow-up of food aid.
- Maximize security and protection in the implementation of food aid.
- Implement food aid in a culturally appropriate manner that protects the identity, integrity and dignity of primary stakeholders.
- Stimulate community discussion for long-term food security planning.

3.1.2 Include specific social considerations in site planning (Action Sheet 10.1 of the IASC Guidelines)

This includes envisaging assistance that is safe, dignified, and culturally and socially appropriate. The organization of sites can have a significant impact on well-being, which is reduced by overcrowding and the lack of privacy in camps. Mental health and psychosocial problems may arise when people are isolated from their own family and group, or are forced to live surrounded by people they do not know.

Key actions:

- Use a participatory approach that engages communities, including women and men of all ages, children, elderly and those people at risk in site selection and planning.
- Choose sites that protect security and minimize conflicts with permanent residents, and that grant, as much as possible, access to basic services out of the camp (schools, health facilities and places of worship).
- Include communal safe spaces in site design, including child-friendly spaces (CFSs), community spaces, spaces for women and youth, and places of worship wherever possible. Additionally, spaces for emergency health clinics, nutrition centres, schools and psychosocial support should be envisaged, if there is no possibility for referral outside the camp.

- Maximize privacy, ease of movement and social support. This includes preferring family-sized tents and shelters to multifamily ones.
- Organize shelter with the aim of keeping family members and communities together.
- Use traditional housing systems within the affected community as a point of reference. Use to the extent possible locally available materials to allow the community to take care of eventual maintenance and reduce the distress due to dependence on external aid.

Textbox 1

In Haiti, the term *lakou* defines both the extended family and the courtyard around which extended families live, and is central to Haitian life. Whenever possible, camps were organized following *lakou* lines in Haiti, both in terms of the position of the tents around an internal courtyard instead of in corridors, and in the selection of people who should live around those courtyards. Wherever this was possible, residents felt safer and less isolated, and they felt that they could better help each other in taking care of the elderly, the children and the vulnerable members of the *lakou*.

3.1.3 Include specific psychosocial considerations in the provision of water and sanitation (Action Sheet 11.1 of the IASC Guidelines)

This includes the provision of dignified, safe and culturally appropriate access. In camp settings, the provisions of access to clean drinking water and to safe and culturally appropriate hygiene and sanitation facilities are high priorities. These are not only survival measures but also key factors in restoring a sense of dignity. In some camps, poorly lit and unlocked latrines have become sites of sexual attacks and GBV; in others, conflict over water sources has become a significant cause of distress. Part of the stress experienced in relation to WASH is context-specific, and relates to what is possible and suitable within a given culture.

Key actions:

- Facilitate participation in the assessment, planning and implementation of WASH facilities, engaging women and people at risk. Ensure the creation of gender-balanced committees.
- Promote safety and protection in all WASH activities. This includes ensuring the accessibility and closeness of relevant facilities, reducing waiting times as much as possible, and securing and illuminating latrines and bathing facilities (e.g. by appointing guards and using torches). For further information, see *The Sphere Handbook* (The Sphere Project, 2011) at: www.sphereproject.org/resources/download-publications/?search=1&keywords=&language=English&category=22.
- Promote personal and community hygiene, including provision of sanitary materials for women and girls as well as private bathing and washing areas, encouraging clean-up and hygiene campaigns, and distributing soap and other supplies informed by the advice received by the community.

3.1.4 Provide information to the camp population on humanitarian efforts and available services in camps (Action Sheet 8.1 of the IASC Guidelines)

The lack of information on who is doing what in camps can provoke disorientation and lack of trust in the camp population. Lack of accurate and credible information on available services and their operating mechanisms and future perspectives may create rumours and unnecessary distress in the population.

Key actions:

- Envisage ways to present and introduce the different actors in the camp to the community.
- Promote and facilitate regular meetings between the community and the service providers operating in the camp.
- Coordinated case management may encourage the development of trust and provide a sense of ongoing security.

- Identify key information gaps and key information for dissemination.
- Disseminate information in multiple ways.
- Organize information points and community messaging in relation to the available services.
- Coordinate messages to be passed along to the population with all key actors.
- In case camps have been in existence prior to the current emergency, make use of trusted informants, such as people who have been residing in the camp for a long time, and organize welcoming and orientation teams of different ages, gender and cultural background.
- Constantly monitor the situation and identify information gaps to be covered. This is particularly important in crucial moments of camp life, such as during the initial months, during periods when relocation/repatriation is discussed, and on the brink of camp closure.

Textbox 2

In Haiti, specific psychosocial teams were created to assess perceptions and misperceptions in relation to the relocation of the population of some of the camps. The results of the assessment were crucial to address rumours and misperceptions with information campaigns, and to consider other emotional issues in the organization and implementation of relocation.

3.1.5 Maximize security and facilitate reports of abuse

Distress in camps may be caused by numerous factors, including fear for the safety of oneself and loved ones, lack of privacy and lack of control. These fears in emergency-affected populations may be based in reality when there is lack of security and can be augmented by having been exposed to extreme stressors in their recent past.

Legal and medical support for survivors should be available to all, and reporting systems need to be made safe, accessible, culturally appropriate and confidential. Measures to support those affected by incidents of violence in camps need to be considered, including measures to counteract the tendency among new arrivals to not report such events. Particular attention should be paid to the establishment of safe and

confidential reporting channels and compliant handling mechanisms for women and girls.

3.1.6 Promote self-sufficiency and sense of agency

Envisage, at the earliest stage, programmes like food for work and more sustainable forms of full or partial self-sustainment, including, wherever possible and appropriate, communal gardening, cottage markets, and art and crafts markets.

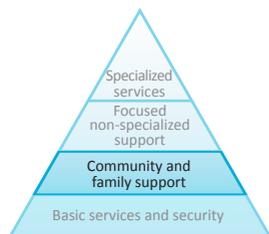
3.1.7 Organize orientation and training of aid workers in basic psychosocial support and ‘do no harm’ rules

Aid workers play a key role in the provision of MHPSS during emergencies. Orientation should prepare workers to provide the necessary emergency response and to not involuntarily harm the beneficiaries further from an emotional point of view, while providing basic social support. The orientation content may have similarities across emergencies, but it must be modified in each emergency to suit the specific culture, context, needs and capacities. Essential teaching may be organized through brief orientation seminars, followed by ongoing support and supervision.

Key actions:

- CCCM core staff should organize, directly or through an agency, MHPSS inductions for camp managers and other humanitarian workers.
- In each camp, core staff in direct contact with beneficiaries across sectors should receive orientation on: basic MHPSS knowledge and ‘do no harm’ rules, such as an introduction to common psychosocial consequences and issues in camps and ways to respond to them, cultural specificities and what to do to avoid further distress while providing assistance. It may be helpful to use PFA orientation materials as part of the session. For PFA, the tool to be considered is the inter-agency-approved guide, *Psychological First Aid: Guide for Field Workers*, available from http://whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf. For other subjects, training tools can be obtained by the CCCM cluster leads from www.mhps.net.

3.2 Community and family support level



The camp situation may encompass many different, often newly formed, types of households, due to deaths, separations and the fact that some family members have been left behind. Beyond family groups composed of parents and children, a camp population encompasses multiple-generation families, single adults and young people, single-parent households, child- or adolescent-headed households, groups who have formed family-like bonds on the basis of a shared journey. The variety of relationships needs to be recognized. The process of responding to an emergency in camps should be owned and controlled as much as possible by the population at these camps, who should make use of their own support structures as much as possible. Camp life should be guided by participation and existing self-help and coping mechanisms.

3.2.1 Facilitate conditions for community mobilization, ownership and control of life in camps (Action Sheet 5.1 of the IASC Guidelines)

Key actions:

- Identify existing community-based mobilization processes (community's structures, formal and informal leaders, mechanisms to support each other).
- Facilitate the participation of marginalized people in committees and planning and monitoring systems, from an age, gender and diversity perspective.
- Support planning discussions and the dissemination of information.
- Promote community mobilization processes, which include discussion groups, collective reflections on priority issues, and facilitation of activities and workshops connecting the population's previous history, the actual conditions of the present, plans for the future and the operationalization of current and planned activities.
- Use culturally appropriate ways of engaging communities (see Textbox 3).

Textbox 3

In Haiti, psychosocial mobile teams in camps organized workshops and events based on interactive theatre for the community. Whenever a group of residents identifies a problem, if they feel so inclined, they are helped to create an open-ended theatre performance, where the problem is presented without a resolution. The performance is shown twice to the community. At the second showing, community members could go on stage to substitute for the actors, give them directions, or discuss what they would do to find a solution to the problem. The solutions announced on stage that elicit consensus become proposals for change that are then discussed with the camp management. Issues of security, sexual harassment, lack of education facilities, and water and sanitation have been discussed and resolved in this fashion.

3.2.2 Facilitate community self-help and social support (Action Sheet 5.2 of the IASC Guidelines)

Key actions:

- Select, as much as possible, human resources in the local community, without discrimination and with equal representation across groups.
- Support traditional coping mechanisms (e.g. rituals, festivals, sports activities, informal women’s and men’s groups, and peer-to-peer youth activities) that helped the community in the past to cope with the situation.
- Encourage community-owned initiatives that provide family and community support, especially to the most vulnerable.
- Strengthen mechanisms that enable families to extend their support to vulnerable members, such as people with physical and mental impairment. These may include provision of food for work or cash support for the member of the family who takes care of a vulnerable member.
- Facilitate conflict management sessions and train staff in conflict management skills. In some situations, groups within the camp may have suffered from persecution or violence at the hands of individuals

of similar background to other people in the camp. Issues of forgiveness and reconciliation may rise, which could lead to conflict.

- Facilitate good collaboration with the host community, especially where resources are in competition.

Textbox 4

In Damak, Nepal, refugees were trained as community psychosocial workers and classroom-based intervention facilitators. Their interventions were particularly efficacious due to their knowledge of the local context and culture and of the needs of their peers.

3.2.3 Facilitate conditions for communal cultural, spiritual and religious healing practices (Action Sheets 5.3 and 6.4 of the IASC Guidelines)

In emergencies, people may experience collective cultural, spiritual and religious stresses that may require immediate attention. Survivors of disasters or wars, for instance, may feel significant stress due to their inability to perform culturally appropriate burials. Similarly, people may experience intense stress if they are unable to engage in normal religious practices. Moreover, religious practices may help to ease tension, distress and sense of disorientation in part of the camp population.

Key actions:

- Make sure that space for prayers and religious rituals is available and culturally adequate, and that religious leaders within and outside the camp population are mobilized.
- Provide religious leaders with basic training on MHPSS and encourage their role as a source of community-based social support by working with them on ways they might incorporate psychosocial support considerations in their religious practices, messages and community activities.
- Make sure that all differences are taken into consideration and no religious discrimination takes place in camps in terms of provision of rituals and venues for praying.

- Facilitate conditions for appropriate healing practices, including commemorative rituals agreed upon with religious leaders, which may act as a substitute for burial ceremonies.
- Consider ensuring that important passages of life in camp life are ritualized and celebrated, according to the culture of the communities living in the camp and in a fashion decided by them. These important passages can include anniversaries, religious festivities, national festivities in the place of origin and in the host community, refugee day, relocations/departures of groups of inhabitants, and camp closure.
- Because some local practices cause harm (for example, in contexts where spirituality and religion are politicized), humanitarian workers should think critically and support local practices and resources only if they fit with international standards of human rights.

3.2.4 Facilitate activities for cohesion and socialization

These activities take into consideration cultural sensitivity and the wills and desires of the community, and are better organized following an assessment with the camp population. These activities could also include reactivating children's groups and youth groups that existed before the crisis but were disrupted by the events.

3.2.5 Facilitate support for children and their caregivers

In emergencies, the well-being of children depends to a large extent on their family and community situation. Secure and ongoing attachments for children are essential. They require not only direct support to children, but also support to caregivers to enhance their ability to provide children with a safe and protective environment.

Key actions:

- Rapidly organize CFSs where children can play and participate in structured, supportive activities, and where children and adults can receive or mobilize psychosocial support. In CFS training, orientation can be provided for parents and caregivers, and activities should be

organized for very young children and infants. For more guidance, refer to the *Guidelines for Child-Friendly Spaces in Emergencies, Field-testing version* (UNICEF, 2011), available at: [http://intranet.unicef.org/emops/emopssite.nsf/0/5DD41E5748B5AB4F852579B50078C492/\\$FILE/4.-Child-Friendly-Spaces-Guidelines-for-Field-Testing1.pdf](http://intranet.unicef.org/emops/emopssite.nsf/0/5DD41E5748B5AB4F852579B50078C492/$FILE/4.-Child-Friendly-Spaces-Guidelines-for-Field-Testing1.pdf).

- CFSs should always be supported by referral services for responding to protection gaps, issues of violence, mental health issues and psychosocial support.
- Support family unity. Wherever family unity could not be granted and a child could not be reunified with his/her parents, facilitate alternative care arrangements. These should include placing the child under the care of members of the extended family or other solutions based on the child's best interest within the local cultural context. Refer to the *Inter-Agency Guiding Principles on Unaccompanied and Separated Children* available at www.unhcr.org/cgi-bin/texis/vtx/refworld/rwmain?page=search&docid=4113abc14.
- Avoid as much as possible multiple foster families and arrange for a family that could permanently take care of the child. (For more information, see Action Sheet 5.4 of the IASC Guidelines.)

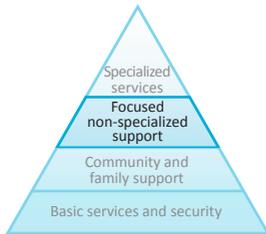
3.2.6 Strengthen access to safe, inclusive and quality education

In emergencies, education is a key psychosocial intervention – it provides a safe and stable environment for learners and restores a sense of normalcy, dignity and hope by offering structured, appropriate and supportive activities.

Key actions:

- Rapidly organize education for all school-age children in a safe learning environment.
- Prepare and encourage educators to support learners' psychosocial well-being.
- Strengthen the capacity of educators to support learners experiencing psychosocial and mental health difficulties.

3.3 Provision of focused non-specialized services



Thanks to the actions and considerations implemented in the previous levels of intervention, well-being will be protected and promoted in the majority of a camp's population. However, certain groups and individuals may require specific attention. It is not under the direct responsibility of the camp management agency to provide these services, but it is recommended that the camp managers link with agencies providing the following services to ensure that they are available in the camps:

- Basic, low-intensity psychological interventions for people with psychological problems.
- Basic mental health care by general health staff (WHO, 2010), including brief, motivational interventions for people suffering from alcohol or substance use problems.
- Focused support to promote the social integration of vulnerable individuals or marginalized groups.
- Facilitation of self-help groups and discussion groups on specific topics of concern for individuals and groups.
- Focused counselling and referral services for victims of GBV.

In a camp setting, multidisciplinary psychosocial teams comprised of community workers, social workers, educators, artists and psychologists could be utilized. They can facilitate community and family support at the focused/non-specialized services level, and create a system of internal referral to psychologists for people requiring specialized support. In doing this, it is important to follow these strategies:

- Integrate services as much as possible and avoid separate services for separate categories.
- Avoid debriefing and non-sustainable care paths.
- Avoid non-specific 'trauma counselling'.

3.4 Specialized services



Populations in camps include people with pre-existing mental disorders. Worldwide, severe mental disorders account for 4 of the 10 leading causes of disability, and to an estimated baseline of 2 to 3 per cent of the population. In emergencies, the percentage of people with severe mental disorders seems to increase by 1 per cent over the baseline. Moreover, the percentage of people with so-called mild to moderate mental disorders, whose baseline is estimated to be about 10 per cent, may increase by an additional 5 per cent in emergencies. In the vast majority of situations, however, natural recovery over time (i.e. healing without outside intervention) occurs for most survivors. In order to assess and assist people with mental disorders, the camp management organization should facilitate access to clinical mental health care, whether delivered within or outside camps. Preferably, such services are attached to general health or social services (for adults) or to schools (for children). Yet, a subset of the people with mental disorders need specialized care. While it is understood that the provision of mental health services does not lie within the responsibility or capacity of the camp management agency, some key actions are nevertheless identified (see Action Sheet 6.2 of the IASC Guidelines):

- In order to assess, respond to and assist people with severe mental disorders, the camp management organization should refer to a specialized agency that can provide services within or outside camps.
- Various humanitarian actors in camps should be instructed so that they can confidentially identify and signal people who seem very confused, disoriented, incoherent, unable to care for themselves, or who have attempted suicide. The collection of information should be dignified, confidential and subject to further assessment by a health professional trained in mental health.
- Make sure that people with specific needs are protected by family members or neighbours, and referred immediately to health providers in the camp or outside the camp.

- Mental health providers in camps should be encouraged to learn about and, where appropriate, collaborate with local, indigenous and traditional healing systems.
- Support holistic mental health-specialized care in camps when needed, avoiding single-service mental health centres. In particular, clinical mental health care, when made available, should not merely focus on emergency-induced mental health problems, but should also cover pre-existing mental health problems.
- Favour the engagement of mental health agencies, which could grant sustainable midterm therapeutic paths.
- Privacy and confidentiality should be granted in the provision of mental health services.
- If specialized mental health services are provided outside of the camps, safe and dignified transportation should be organized.

3.5 Some aspects of concern and principles of work in developing MHPSS services in camps

- MHPSS needs and resources of the host communities in areas surrounding camps should be noted and addressed.
- While camps should be considered a last resort, and a temporary solution when sustainable solutions have yet to be found, some camps may have already existed before the onset of the current emergency. In these situations, the population of the camp is likely to be composed of long-term, short-term and newly arrived camp residents. MHPSS issues among these groups may be quite different, and what is considered to be a normal reaction in the immediate aftermath of an event may be not considered as such by long-term residents. Therefore, special attention should be given to the different subgroups in assessment, responses and concerns.
- In certain situations, people cannot be accommodated in camps on immediate arrival due to logistical and security considerations. Measures to support those outside the camps need be considered.
- Especially when people flee across borders, language problems may increase significantly, creating difficulties in dealing with MHPSS concerns in the camp, since the languages spoken by the camp

population may differ among groups and from the language of the helpers and the host community. Using interpreters from within the camp population is therefore important. However, the subcultural, gender and political differences within the same language groups in camps should not be underestimated.

- Camps often comprise people of different nationalities, cultures, clans and/or tribes, who are required or forced by circumstance to live together in often crowded conditions. Different groups may hold very different beliefs and operate under different social systems and cultures. Beliefs about mental well-being may also vary. Respecting and mediating between the spectrum of beliefs and systems in camps is therefore paramount to avoid discrimination, isolation and disorientation.
- MHPSS initiatives to be implemented in the camp setting should be evaluated for effectiveness according to the outcome defined as desirable in that setting and for that community.
- The quality of MHPSS offered within the camp needs to be determined in considering both new and existing initiatives. Evaluation can assist in determining effectiveness and also aid in modifications to enhance programmes.

4 Operational challenges

Experience from many emergencies indicates that some actions are advisable, whereas others should typically be avoided. The camp manager should be familiar with these dos and don'ts and may use them as a checklist for programme development, implementation and monitoring.

Table 1: Dos and don'ts

Dos	Don'ts
Establish one overall coordination mechanism or group on MHPSS.	Do not create separate groups on mental health or on psychosocial support that do not talk or coordinate with one another.
Support a coordinated response, participating in coordination meetings and adding value by complementing the work of others.	Do not work in isolation or without thinking how your own work fits with that of others.
Collect and analyse information to determine whether a response is needed and, if so, what kind of response.	Do not conduct duplicate assessments or accept preliminary data in an uncritical manner.
Tailor assessment tools to the local context.	Do not use assessment tools not validated in the local, emergency-affected context.
Recognize that people are affected by emergencies in different ways. More resilient people may function well, whereas others may be severely affected and may need specialized support.	Do not assume that everyone in an emergency is traumatized, or that people who appear resilient need no support.
Ask questions in the local language(s) and in a safe, supportive manner that respects confidentiality.	Do not duplicate assessments or ask very distressing questions without providing follow-up support.
Pay attention to gender differences.	Do not assume that emergencies affect men and women (or boys and girls) in exactly the same way, or that programmes designed for men will be of equal help or accessibility for women.
Check references in recruiting staff and volunteers, and build the capacity of new personnel from the local and/or affected community.	Do not use recruiting practices that severely weaken existing local structures.
After training on MHPSS, provide follow-up supervision and monitoring to ensure that interventions are implemented correctly.	Do not use one-time, stand-alone training or very short training without follow-up if preparing people to perform complex psychological interventions.
Facilitate the development of programmes owned, managed and run by the community.	

Dos	Don'ts
Build local capacities, supporting self-help and strengthening the resources already present in affected groups.	Do not use a charity model that treats people in the community mainly as beneficiaries of services.
Learn about and, where appropriate, use local cultural practices to support local people.	Do not organize support that undermines or ignores local responsibilities and capacities.
Use methods from outside the culture where it is appropriate to do so.	Do not assume that all local cultural practices are helpful or that all local people are supportive of particular practices.
Build government capacities and integrate mental health care for emergency survivors in general health services and, if available, in community mental health services.	Do not assume that methods from abroad are necessarily better or impose them on local people in ways that marginalize local supportive practices and beliefs.
Organize access to a range of support types, including PFA, for people in acute distress after exposure to an extreme stressor.	Do not create parallel mental health services for specific subpopulations.
Train and supervise primary/general health-care workers in good prescription practices and in basic psychological support.	Do not provide one-off, single-session psychological debriefing for people in the general population as an early intervention after exposure to conflict or natural disaster.
Use generic medication that is on the essential drug list of the country.	Do not provide psychotropic medication or psychological support without training and supervision.
Establish effective systems for referring and supporting severely affected people.	Do not introduce new, branded medication in contexts where such medications are not widely used.
Develop locally appropriate care solutions for people at risk of being institutionalized.	Do not establish screening for people with mental disorders without having in place appropriate and accessible services to care for persons identified to have such disorders.
Use agency communication officers to promote two-way communication with the affected population as well as with the outside world.	Do not institutionalize people unless an institution is temporarily an indisputable last resort for basic care and protection.
Use channels such as the media to provide accurate information that reduces stress and enables people to access humanitarian services.	Do not use agency communication officers to communicate only with the outside world.
Seek to integrate psychosocial considerations, as relevant, into all sectors of humanitarian assistance.	Do not create or show media images that sensationalize people's suffering or put people at risk.
	Do not focus solely on clinical activities in the absence of a multisectoral response.

5

Post-emergency recovery activities by CCCM actors

Camps are to be considered a last resort and a temporary solution. Durable solutions should be envisaged as early as possible within the humanitarian assistance framework. However, in some cases camps are kept active for prolonged periods of time and MHPSS initiatives already in place may provide a valuable resource both at the time of new emergencies and in the post-emergency recovery period.

Moreover, the knowledge and best practices elaborated during the emergency, even after camp closure, can contribute to create a preparedness system in the country and new capacities.

Some possible initiatives include the following:

- 1. Development of policies:** Policy development ensures coordination and effective allocation of resources. Hence, agreement on policy is vital among stakeholders. Policies that support effective, community-based practice need to be in place. After the emergency phase, assessments, best practices and lessons learned should be identified, evaluated and harmonized for the use of local and national authorities, as well as the global CCCM cluster, in their policy revision and emergency preparedness plan.
- 2. Knowledge dissemination:** Likewise, identified best practices, training and assessment should be harmonized and made available digitally at the local, national and global levels, and inform new training protocols for humanitarian staff active within the CCCM cluster and national civil protection mechanisms.
- 3. Integrating mental health and psychosocial capacity-building into sustainable training mechanisms:** Build on the lessons learned and the gaps identified to develop capacity in the MHPSS issues of teachers, educators/animators, civil protection specialists, firemen, social workers, health and psychosocial professionals, and all workers in contact with beneficiaries in various fields who will be involved in relief operations, especially CCCM operations, in the affected countries (destination, transit and origin).

- 4. Working with both civil society and government structures to provide MHPSS:** For example, develop community-based MHPSS that is complemented by local or national government-provided social and mental health services. Simultaneously, increase government outreach and strengthen the knowledge and skills of civil society with regard to MHPSS concerns. In countries prone to emergencies, emergency preparedness and disaster management should be a priority. Efforts towards this end could include integrating psychosocial issues into emergency response policies and structures and ensuring that emergency personnel are trained in and understand MHPSS.
- 5. Strengthening livelihoods and supporting the implementation of community and economic development initiatives:** These key transitional initiatives build hope and enable people to take on appropriate, meaningful roles. Hence, the transition to, and integration of, community development practices with emergency measures in camps are key to securing the long-term sustainability and relevance of the services provided. This is particularly true for long-standing camps, like those in Dadaab, which are subject to periodic emergency situations.
- 6. Developing inter-agency efforts to document good practices, identifying harmful practices and systematically assessing which interventions are most effective:** In many areas, psychosocial support is less easily identified, or appropriate measurable outcomes are harder to find than within mental health services. Good practices would encompass not only programmes of care but also means of integration of MHPSS across sectors.
- 7. Making sure that the MHPSS needs of people and the responses that have been provided can, to a certain extent, be met and maintained during relocation/integration and the eventual repatriation process.**

6

Human resources

6.1 Recruitment

Agencies may recruit psychosocial programme managers. The programme manager will have the following qualifications:

- Advanced degree in behavioural and/or social sciences, including psychology, sociology, pedagogy, psychosocial support, social work and other relevant disciplines;
- Field-based experience in programme management, camp management and community-based psychosocial support in humanitarian settings in emergencies;
- Field-based experience in working with humanitarian agencies (CCCM, Health and Protection) in emergencies in low- and middle-income countries;
- Relevant language knowledge;
- Good knowledge of MHPSS as an emergency response;
- Understanding of cultural diversity and cultural diversity competence;
- Knowledge of United Nations and non-governmental organization humanitarian community, including IASC, clusters, CAP, CERF and similar mechanisms.

Action Sheet 4.1 of the IASC Guidelines gives detailed advice on identifying and recruiting any staff or volunteers. CCCM programme managers should seek to recruit psychosocial support providers who have knowledge of, and insight into, the local culture and appropriate modes of behaviour. Local staff should deliver any direct person-to-person psychosocial support. The programme manager should use available criteria to carefully evaluate offers of help from individual foreign psychosocial professionals who are deployed to offer their services (see IASC Guidelines, pp. 72–73).

6.2 Orientation and training of aid workers in MHPSS services

Inadequately oriented and trained workers without the appropriate attitude and motivation can unintentionally harm affected populations. To prevent harm and support effective action, one can organize brief orientation and training seminars (see Action Sheet 4.3 of the IASC Guidelines).

- Orientation seminars (half- or full-day seminars) should provide immediate basic, essential and functional knowledge and skills relating to psychosocial needs, problems and available resources to everyone working at each level of response. Possible participants include all aid workers in all sectors.
- Training seminars promote learning of more extensive knowledge and skills and are recommended for those working on focused and specialized MHPSS (the top two layers of the pyramid in Figure 1). Local trainers or co-trainers with prior experience and/or knowledge of the affected location are preferred when they have the essential knowledge and skills. The length and content of training seminars vary according to trainees' needs and capacities. Inexperienced staff will require longer periods of training. The timing of seminars must not interfere with the provision of emergency response. The use of short, consecutive modules for cumulative learning is recommended because: (a) this limits the need to remove staff from their duties for extended periods; and (b) it allows staff to practise skills between training sessions. Each short module may last only a few hours or days (according to the situation) and is followed by practice in the field with support and supervision, before the next new module is introduced in a few days or weeks. Seminars involving skills training should always be complemented by field-based support and/or supervision. Providing advanced training in psychosocial skills without organizing a system for follow-up is irresponsible. Action Sheet 4.3 of the IASC Guidelines provides key guidance on organizing orientation and training (e.g. selection of trainers, learning methodologies, content of sessions and challenges in organizing training of trainers).

6.3 Well-being of staff and volunteers

In emergency settings, staff members and volunteers often work long hours under pressure and within difficult security constraints. For many workers, the greatest stress comes from insufficient managerial and organizational support. Moreover, confrontations with horror, danger and human misery are emotionally demanding and potentially affect the mental health and well-being of workers. Action Sheet 4.4.2 to 4.4.2 of the IASC Guidelines describes key actions to facilitate a healthy working environment and address potential day-to-day work-related stressors.

- Psychological debriefing is no longer recommended. Staff who have experienced or witnessed extreme events (critical incidents, potentially traumatic events) need to have access to basic psychological support, including PFA.
- When survivors' acute distress is so severe that it limits their basic functioning (or they are judged to be a risk to themselves or others), they must stop working and receive immediate care from a mental health professional. An accompanied medical evacuation may be necessary. Organize mental health professional contacts for all staff members who have survived a critical incident one to three months following the event. The mental health professional should assess how the survivor is functioning and feeling and refer for clinical treatment those with substantial problems that have not healed over time (Action Sheet 4.4.6 and 4.4.7).

7

Assessment

Assessment is fundamental to planning and providing care in a camp setting.

Assessment of mental health and psychosocial issues comprises two equally important components: needs assessment and mapping of existing services and resources.

The mapping of existing services and resources can be conducted using 'the 4Ws' tool (Who is doing What, Where and until When) endorsed by the global IASC Reference Group on MHPSS (2012). This tool is useful for gathering more information on all MHPSS activities in different sectors. Mapping is usually conducted at the national or regional level, but it could be useful for camp managers to facilitate mapping of MHPSS services available in and around their respective camps for their own use and to additionally contribute to national mapping. It is recommended that this exercise is conducted every month at the onset of a major crisis, since the number of actors and the scope of activities tend to vary to a large extent during the first few months. In case this is not possible, it is advisable to keep the mapping process as an open process where matrixes can be modified constantly. The 4Ws tool is available online at www.mhps.net/4ws.

MHPSS needs assessments may serve many functions, including the following:

- Provision of baseline information on the needs of the camp population that may serve to better plan responses and to provide a basis for the future evaluation of the effectiveness of support programmes;
- Determination of needs and vulnerabilities in the camp community, as well as existing coping strategies and agencies;
- Assessing the perceived levels of well-being within the camp community.

The IASC Reference Group Mental Health and Psychosocial Support Assessment Guide can be obtained by the group chairs from www.mhps.net/groups (see Assessment, Monitoring and Evaluation group and/or the IASC Reference Group Working Space).

In addition, different MHPSS needs assessment tools have been elaborated by various agencies, and used for inter-agency assessments in the past. These tools include:

- *The Humanitarian Emergency Settings Perceived Needs Scale (HESPER)* by the World Health Organization (WHO); available from http://whqlibdoc.who.int/publications/2011/9789241548236_eng.pdf.
- *Psychosocial Needs Assessment in Emergency Displacement Tools* by the International Organization for Migration (IOM); available from www.iom.int.

Wherever possible, a good way to proceed would be to add relevant MHPSS questions and requests for data in the general CCCM registration and profiling tools. In Haiti, for example, questions regarding the identification of people with pre-existing mental disorders or those so distressed that they were unable to function were included in the registration tool for a number of selected camps. The relevant registration tool can be obtained from the global CCCM cluster and from WHO / United Nations High Commissioner for Refugees (www.who.int/mental_health/emergencies/en/).

When conducting MHPSS assessments in camps, the following considerations should be made:

- Identifying a clear objective for the assessment and evaluating its relevance to the given situation is paramount. Organizations should first determine what assessments on MHPSS have already been done and design further field assessments only when necessary.
- Assessments should have a clear, practical and programmatic scope and aim. Avoid research conducted for the sake of research in these contexts.

- Assessments should be conducted in an ethical and participatory manner. Assessments should be, as much as possible, a collaborative process with affected populations and should also involve those groups that can be more vulnerable or marginalized (children, women, minorities).
- The means of assessment should be suitable for the required use. Quantitative data may provide outcomes in terms of establishing baselines on initial indications of need. Qualitative data can offer more value in terms of understanding the experience and capacities of camp populations and groups within the camp. Combining both methods of assessment can provide a more comprehensive picture.
- Avoid duplication. Try to harmonize the different assessments that are being conducted and avoid repeating the same questions to the same people. Ideally, include various indicators in the general CCCM mapping and profiling tools. Ensure the assessment interviews do not overburden the respondents by asking questions whose answers can be derived from existing reports or plans. Coordinating MHPSS assessments is a high priority.
- Important factors that ensure effective assessment are the skills of the interviewer in addressing the misperceptions of the respondent as to the purpose and requirements of the assessment process, as well as his/her skills in avoiding fear, paranoia, stigma, compliance that may introduce bias to results, disregard for the circumstances of the most vulnerable versus those of the most vocal, and so on. In this respect, the MHPSS assessment should be conducted or led by an experienced assessment team and involve training for the interviewers and use language that is understandable and appropriate in the local sociocultural context.
- The assessment results should be shared in a timely manner with the CCCM and other relevant coordination groups and the communities.
- Assessment procedures and reports should be, as much as possible, disaggregated by gender and age groups.
- Despite their popularity, surveys that seek to assess the distribution of rates of emergency-induced mental disorders tend to be challenging, resource-intensive and frequently controversial. Such surveys, according to the IASC Guidelines, go beyond minimum responses, which are defined as essential, high-priority responses that should

be implemented as soon as possible in an emergency. For a more detailed discussion on surveys and the difficulties in distinguishing disorder from distress, see page 45 of the IASC Guidelines.

Table 2 below demonstrates the basic aims and principles of an assessment in the MHPSS domain.

Table 2. Summary of key information for assessments

Type of information	Including
Relevant demographic and contextual information^a	<ul style="list-style-type: none"> • Size of (sub)population • Mortality and threats to mortality • Access to basic physical needs (e.g. food, shelter, water and sanitation, health care) and education • Human rights violations and protective frameworks • Social, political, religious and economic structures and dynamics • Changes in livelihood activities and daily community life • Basic ethnographic information on cultural resources, norms, roles and attitudes
Experience of the emergency	<ul style="list-style-type: none"> • Local people's experiences of the emergency (perceptions of events and their importance, perceived causes, expected consequences)
Mental health and psychosocial problems	<ul style="list-style-type: none"> • Signs of psychological and social distress, including behavioural and emotional problems • Signs of impaired daily functioning • Disruption of social solidarity and support mechanisms • Information on people with severe mental disorders
Existing sources of psychosocial well-being and mental health	<ul style="list-style-type: none"> • Ways people help themselves and others (e.g. religious beliefs and practices; seeking support from family/friends) • Ways in which the population may previously have dealt with adversity • Types of social support and sources of community solidarity
Organizational capacities and activities	<ul style="list-style-type: none"> • Structure, locations, staffing and resources for mental health care in the health sector and the impact of the emergency on services • Structure, locations, staffing and resources of psychosocial support programmes in education and social services, and the impact of the emergency on services • Mapping psychosocial skills of community actors (e.g. community workers, religious leaders, counsellors) • Mapping of potential partners and the extent and quality/content of previous MHPSS training • Mapping of emergency MHPSS programmes
Programming needs and opportunities	<ul style="list-style-type: none"> • Recommendations by different stakeholders • Extent to which key actions outlined in IASC Guidelines are implemented • Functionality of referral systems between and within health, social, education, community and religious sectors

^a This information is usually readily available from existing reports.

8

Key tools and resources

Inter-Agency Standing Committee (IASC)

2007 *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. IASC, Geneva.

2008 *Guidelines on Mental Health and Psychosocial Support in Emergency Settings: Checklist for Field Use*. IASC, Geneva.

IASC Global Protection Cluster Working Group and IASC Reference Group for Mental Health and Psychosocial Support

2010 *Mental Health and Psychosocial Supports in Humanitarian Emergencies: What Should Protection Programme Managers Know?* IASC, Geneva.

IASC Reference Group for Mental Health and Psychosocial Support

2010 *Mental Health and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know?* IASC, Geneva.

2012 *IASC Reference Group Mental Health and Psychosocial Support Assessment Guide*, www.mhpss.net/groups.

International Federation of Red Cross and Red Crescent Societies – Reference Centre for Psychosocial Support (IFRC–PSC)

2009a *Community-based Psychosocial Support Training Kit*. IFRC–PSC, Copenhagen. Available from: <http://psp.drk.dk/graphics/2003referencecenter/Doc-man/Documents/docs/Trainers%20book%20LowRes.pdf>.

2009b *Psychosocial Interventions – A Handbook*. IFRC–PSC, Copenhagen. Available from: <http://psp.drk.dk/graphics/2003referencecenter/Doc-man/Documents/docs/Psychosocial%20interventions%20A%20handbook%20LowRes.pdf>.

International Organization for Migration (IOM)

2009 *Psychosocial Needs Assessment in Emergency Displacement Tools*. IOM, Geneva. Available from www.iom.int.

Norwegian Refugee Council (NRC) and The Camp Management Project (CMP)

2008 *Camp Management Toolkit*. NRC and CMP, Oslo.

The Sphere Project

2011 *The Sphere Handbook, Humanitarian Charter and Minimum Standards in Humanitarian Response*. The Sphere Project, Geneva. Available at www.sphereproject.org/resources/download-publications/?search=1&keywords=&language=English&category=22.

United Nations High Commissioner for Refugees and IOM

2010 *Collective Centre Guidelines*. UNHCR and IOM, Geneva.

UNICEF

2011 *Guidelines for Child-Friendly Spaces in Emergencies, Field-testing version*. UNICEF, New York.

United Nations Population Fund (UNFPA) and Save the Children

2009 *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings*. UNFPA and Save the Children, United States.

World Health Organization (WHO)

2010 *mhGAP Intervention Guide for mental, neurological and substance use disorders in non-specialized health settings*, WHO, Geneva

WHO, War Trauma Foundation and World Vision

2011 *Psychological First Aid: Guide for Field Workers*. WHO, Geneva. Available from: http://whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf.

WHO and King's College

2011 *The Humanitarian Emergency Settings Perceived Needs Scale (HESPER): Manual with Scale*. WHO, Geneva. Available from: http://whqlibdoc.who.int/publications/2011/9789241548236_eng.pdf.

This document is for humanitarian actors in the camp coordination and camp management (CCCM) sector, working in countries facing humanitarian emergencies. It applies to CCCM partners, including governmental and non-governmental service providers.

Based on the Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007), this document gives an overview of essential knowledge that CCCM actors should have about mental health and psychosocial support in humanitarian emergencies, and its application in setting up and organizing camps. Managers will need to ensure that CCCM staff are oriented on relevant parts of this document, as applicable.

This document was developed by the IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings with the IASC Global CCCM Cluster.