



**Who is Where, When, Doing What (4Ws) in  
Humanitarian Mental Health and Psychosocial  
Support in Ethiopia**

## Acknowledgements

This report was prepared by UNICEF Ethiopia, with the support of Federal Ministry of Health, the Ethiopian Public Health Institute, as well as the humanitarian partner members of the CP-GBV Area of Responsibility led by UNICEF, UNFPA and MoWCY, the Health Cluster led by WHO, the IDPs and Early Recovery Task Force led by EPHI, and the Protection and Health and Nutrition Working Groups led by UNHCR.

We would like to express our gratitude to all the partners who contributed to the mapping exercises, from the initial contextualisation of the mapping tool, to the detailed and extensive sharing of data about their work, and finally to the validation of findings and recommendations. Special acknowledgments go to Dr. Dereje Assefa, Mental Health Officer, NCD Case Team, Federal Ministry of Health; Mentwab Geday, Assistant Incident Manager, Ethiopian Public Health Institute; Dr. Benyam Worku, Director, Department of Psychiatry, Addis Ababa University; and Mr. Andy Solomon, Mental Health, Gender and Protection Coordinator, Action Against Hunger; for their enthusiastic support for this initiative, and for contributing to the establishment of the Ethiopia Mental Health and Psychosocial Support Technical Working Group as a safe space for technical coordination, collaboration and exchanges.

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## List of Abbreviations

AAH: Action Against Hunger  
ARRA: Agency for Refugees and Returnees Affairs  
BCSG: Bethany Christian Services Global  
BOWCY: Bureau of Women Children and Youth  
BPRM: Bureau of Population, Refugees and Migrations  
CFS: Child Friendly Space  
CP: Child Protection  
CVT: Centre for Victims of Torture  
ECD: Early Childhood Development  
ECHO: European Commission Humanitarian Aid  
EMHPSS TWG: Ethiopia Mental Health and Psychosocial Support Technical Working Group  
EPHI: Ethiopian Public Health Institute  
ERCS: Ethiopian Red Cross Society  
FMOH: Federal Ministry of Health  
GAC: Global Affairs Canada  
GBV: Gender-Based Violence  
GE: Goal Ethiopia  
HI: Humanity and Inclusion  
HRP: Humanitarian Response Plan  
I1D: Imagine One Day  
IASC: Inter Agency Standing Committee  
IDPs: Internally Displaced Persons  
IM: Information Management  
IMC: International Medical Corps  
INGO: International Non-Governmental Organization  
IOM: International Organization for Migrations  
IRC: International Rescue Committee  
KOICA: Korea International Cooperation Agency  
mhGAP: Mental Health Gap Action Programme  
mhGAP-HIG: Mental Health Gap Action Programme Humanitarian Intervention Guide  
mhGAP-IG: Mental Health Gap Action Programme Intervention Guide  
MoC: Missionaries of Charity  
MHPSS: Mental Health and Psychosocial Support  
MOWCY: Ministry of Women, Children and Youth  
MSF: Médecins Sans Frontières  
MSF-H: Médecins Sans Frontières Holland  
NGO: Non-Governmental Organization  
NRC: Norwegian Refugee Council  
OFDA: Office of Foreign Disaster Assistance  
PFA: Psychological First Aid  
PHC: Primary Health Care  
PHEOC: Public Health Emergency Operations Center

PIE: Plan International Ethiopia  
PLW: Pregnant and Lactating Women  
RADO: Rehabilitation and Development Organization  
SCI: Save the Children International  
SEL: Socio-Emotional Learning  
SGBV: Sexual and Gender-Based Violence  
SIDA: Swedish International Development Cooperation Agency  
SNNPR: Southern Nations, Nationalities and People's Region  
SOPs: Standard Operating Procedures  
STYH: Senay Tegibar Yeaemiro Human Charity Association  
TAAC: Toronto Addis Ababa Collaboration  
TAID: Tigray Association for Intellectual Disabilities  
TSSA: Tebegiso Social Support Association  
UN: United Nations  
UNFPA: United Nations Population Fund  
UNHCR: United Nations High Commissioner for Refugees  
UNICEF: United Nations Children's Fund  
WASH: Water, Sanitation and Hygiene  
WHO: World Health Organisation  
WSS: Women Safe Spaces  
WVE: World Vision Ethiopia

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## Executive Summary

### *Background and rationale*

As part of Core Commitments for Children in Humanitarian Action for Child Protection (UNICEF, 2010), notably Commitment 6 “Psychosocial support is provided to children and their caregivers” and Benchmark 6 “All child protection programmes integrate psychosocial support in their work, in line with the IASC MHPSS guidelines,” the Child Protection Section in the UNICEF Ethiopia Country Office sought to systematically address the psychosocial needs of humanitarian-affected children and caregivers in Ethiopia. Among those affected by the humanitarian situation are Internally Displaced Persons (IDPs), returnees and refugees.

In early 2019, noting the increasing levels of psychosocial distress and mental ill-health among children and adults in affected communities (NDRMC & HCT, 2019a), UNICEF launched a 4Ws MHPSS mapping exercise. This project was designed as a collaborative effort, conducted in consultation and with the support of members of the child protection and gender-based violence (CP-GBV) sub-cluster co-led by UNICEF, UNFPA and the Ministry of Women, Children and Youth (MoWCY); Federal Ministry of Health; Ethiopian Public Health Institute (EPHI), the health cluster led by WHO, the IDPs and Early Recovery Task Force led by EPHI, and the child protection/SGBV working group led by UNHCR.

### *Methodology and mapping tool*

The global 4Ws mapping tool (Who is Where, When, doing What in Mental Health and Psychosocial Support), developed by the Inter-Agency Standing Committee’s Reference Group on MHPSS (IASC, 2013), was used for this exercise. The tool was contextualised to better reflect the characteristics of the IDPs/Returnees and Refugees’ responses in Ethiopia. Detailed guidance was developed to support partners with activity categorisation and data collection (Annex 3). The guidance was meant as an initial contribution towards the harmonisation of MHPSS approaches and to define minimum standards for the country. Data collection took place between mid-March and mid-May 2019. The mapping report was finalised in June 2019. The complete list of contributing partners is reported in Annex 1.

Readers are encouraged to refer to Annex 3 for clarifications regarding the terminology used throughout this report, including activity categorisation and minimum standards required for activities to be included under each of the mapping codes and sub-codes.

### *Key findings – IDP/Returnee context*

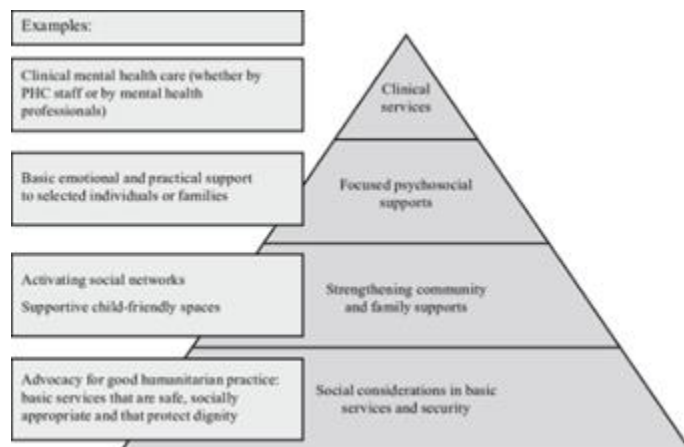
Seventeen partners<sup>1</sup> active in MHPSS in the context of the IDPs/returnees response participated in the mapping exercise including six partners providing MHPSS to host communities and migrant returnees.

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<sup>1</sup> AAH, BOWCYA Oromia, BOWCY SNNPR, BOWCA Somali, EPHI, GE, I1D, IOM, IRC, MoC, MSF, PIE, SCI, STYH, TAID, TSSA, WVE.

Partners' involvement at various levels of the MHPSS intervention pyramid (see figure 1 below) was variable, with **Level 1** activities<sup>2</sup> only reported to be ongoing in a limited number of sites. **Level 2** interventions constituted the bulk of MHPSS efforts as reported by contributing partners; activities appeared to have a clear child focus, with Child Friendly Spaces and awareness-raising programmes on childcare largely driving the response.

**FIGURE 1 – IASC MHPSS INTERVENTION PYRAMID (2007)**



At the higher levels of intervention, basic person-focused support was reported in a minority of the intervention sites, and mainly consisted of basic counseling and emotional support, and provision of Psychological First Aid. Provision of brief, structured psychosocial interventions by non-specialised professionals was negligible, indicating that the task-shifting approach to providing evidence-based mental health care to people experiencing greater difficulties with functioning and coping may still occupy a peripheral role within the strategies of MHPSS

humanitarian partners in Ethiopia. Provision of specialised services appeared largely confined to the care available within the formal health system, with humanitarian interventions limited to very few locations and/or addressing very specific target groups.

For the most part, activities targeted IDPs, returnees and host communities alike, possibly indicating good opportunities for continuity of service provision in the post-emergency/early recovery phase. In qualitative terms, the great majority of the MHPSS activities reported to be under implementation followed an informal format, with only 12 % of the interventions reported to be underpinned by standardised methodologies or contents.

The distribution of activities across intervention sites would suggest limited convergence of MHPSS efforts, with most sites and districts only reached by a small proportion of the full four-tiered range of interventions. Population outreach was not consistently reported by all partners, but findings from the mapping exercise would suggest that, despite the significant efforts made by both governmental and non-governmental partners, a large proportion of the MHPSS needs on the ground remain unmet.

### *Key findings – Refugee context*

Thirteen partners<sup>3</sup> active in MHPSS within the context of the refugee response participated in the mapping exercise. The IDPs/returnees response, in refugee contexts as well as partners' involvement at various

<sup>2</sup> For clarifications regarding activity categorisation and levels of intervention, please see Chapter 2 and Annex 3. Please refer to IASC (2007) and UNICEF (2018) for further details.

<sup>3</sup> AAH, BCSG, CVT, HI, IMC, IRC, MSF-H, NRC, PIE, RADO, SCI, TAAC, UNFPA



levels of the MHPSS intervention pyramid was variable, with **Level 1** activities reportedly having relatively narrow focus and limited geographical spread. **Level 2** interventions constituted the bulk of MHPSS efforts; those activities with a clear child focus – and particularly Child Friendly Spaces, awareness-raising programmes on childcare and structured parenting support – were the ones with the most comprehensive coverage across camps and regions.

At the higher levels of intervention, basic person-focused support was reported in all regions, although with gaps at the level of individual camps. Basic counseling and emotional support, and provision of Psychological First Aid were the most widely reported interventions; while the provision of brief, structured psychosocial interventions was only mentioned to be ongoing in a few locations. Provision of specialised mental health services by humanitarian partners was larger than in the IDPs/returnees context, but still not reaching, in the same comprehensive manner, all regions and camps.

Compared to IDPs/returnees settings, the MHPSS response in refugee settings appeared better structured, with a broader range of activities, better service coverage at the top intervention tiers (Level 3 and 4), and greater convergence of different services within the same localities – constituting a good platform to ensure accessibility of services and continuity of care to this very vulnerable population. However, gaps at the bottom tier (level 1), relatively limited capacity for identification and referral, and small numbers of people accessing person-focused services were also reported, suggesting the need for further strengthening of the MHPSS response, to ensure that service availability translates to better results at all levels of the intervention pyramid.

*Key general recommendations from the mapping report:*

1. Increase the investment in mental and psychosocial health in Ethiopia, across all levels of intervention.
2. Continue to generate evidence of resources, needs and gaps within and beyond the humanitarian context.
3. Strengthen advocacy efforts to ensure access to care and protection for children and adults experiencing mental health difficulties.

*Key recommendations for the strengthening of intervention tiers:*

4. Increase the programmatic focus on Level 1 MHPSS and ensure the mainstreaming of MHPSS considerations in basic services and assistance.
5. Expand the scope and quality of community-based MHPSS work. This may include: exploring community structures and opportunities for incorporating a stronger focus on psychosocial support; mainstreaming socio-emotional learning in child protection and education in emergencies programming; mainstreaming structured parenting skills training and parenting support in humanitarian interventions.
6. Mainstream capacity for basic emotional support and Psychological First Aid among humanitarian partners.

7. Support task-shifting approaches<sup>4</sup> to the provision of person-focused mental and psychosocial health care, in line with the spirit of the National Mental Health Strategy; and, as part of that:
8. Scale up capacity for the provision of structured psychosocial interventions with good evidence of effectiveness in Ethiopia, in both humanitarian settings and within the formal health, education and social welfare systems.

*Key recommendations for the strengthening of the MHPSS continuum of care:*

9. Mainstream capacity for safe identification and referral among humanitarian partners
10. Strengthen programmatic convergence, by identifying a “minimum core package” of MHPSS activities to be systematically rolled out with the widest possible outreach.
11. Strengthen the continuum of care, by developing referral capacity and pathways, linking humanitarian and development interventions and service providers.

*Key recommendations to enhance the quality of the MHPSS response:*

12. Strengthen consistency and quality of service delivery by adopting standardised/validated methodologies, intervention packages and sets of key messages.
13. Map the existing workforce to identify who is present on the ground, which qualifications they hold and how their profile and competencies align with Government-endorsed occupational standards.
14. Mainstream the provision of supportive technical supervision to frontliners<sup>5</sup> – especially at the higher intervention levels, to ensure quality and “do no harm”.
15. Improve age-focused targeting, to mitigate the vulnerabilities and tap into the strengths of the early and teenage years. Strengthen the focus on early childhood development including by mainstreaming ECD/MHPSS and Protection considerations in nutrition and health programming for the early years.
16. Improve gender-based targeting to address the different ways in which adversity affects men and women, boys and girls.
17. Consider revisiting the skill mix in the delivery of MHPSS interventions, to make the best use of the limited pool of mental health professionals.
18. Conduct a technical review of ongoing psychological debriefing interventions and ensure compliance with “do no harm”.

*Limitations*

The mapping exercise faced several limitations which should be considered when looking at its key findings and recommendations. These include, in particular: limited engagement of partners from sectors

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<sup>4</sup> Approach based on delegating low-intensity, person-focused psychosocial interventions, under the supervision of mental health specialists, to health, social welfare, education and other professionals not specialising in mental health.

<sup>5</sup> Personnel with diverse background/qualifications and role, involved in providing services or conducting interventions on the ground, with direct contact with service users/affected populations.

other than protection and health; difficulties in reaching out to national NGOs; changes in the situation on the ground in the time-lapse between data collection and finalization of the report; a few inconsistencies in partners' reporting; limitations in fact-checking of the data reported; and lack of systematic quality assessment of the services included in the report. Unless otherwise stated, the report summarises findings related to activities that partners reported as being "currently under implementation" at the time of data collection, and whose end date beyond May 2019.

## Introduction

Amid profound social transformation and political change, Ethiopia has been pursuing an ambitious developmental agenda covering multiple sectors and domains. At the same time, the country grapples with increasing humanitarian needs derived from conflict-driven internal displacement and returns, as well as by the continued impact of climate change over vulnerable populations, and a protracted refugee presence.

Driven by humanitarian imperatives, provision of Mental Health and Psychosocial Support (MHPSS) services has been expanding in Ethiopia in recent years. Governmental and non-governmental partners

have been scaling up interventions and mobilizing communities to protect and promote psychosocial well-being, and to prevent and treat mental ill-health and disorders in children and adults faced with increasing environmental adversity.

In parallel with these efforts, the Federal Government of Ethiopia has taken a health systems-strengthening approach to developing the mental health system in the country, as reflected in the revised National Mental Health Strategy for 2019-2025 (FMoH, 2019). The strategy is informed by a socio-ecological model of mental health and, as such, it is particularly suitable as a comprehensive reference framework for all stakeholders involved in MHPSS provision in both humanitarian and development settings.

FIGURE 2



SOURCE: WHISE – [HTTPS://WWW.WHISE.ORG.AU](https://www.whise.org.au)

Within this context, better knowledge of “Who is doing What, Where and When” with regard to MHPSS in humanitarian contexts is needed. Such knowledge is essential for coordination and planning purposes, but also, crucially, for the strengthening of the MHPSS continuum of care – to enhance referral mechanisms and to avoid gaps in critical components of psychosocial service provision.

This report summarises the process and findings of a 4Ws MHPSS mapping exercise, conducted by UNICEF in collaboration with government and humanitarian partners over the period January–June 2019. For further details about the mapping methodology, process and tools, please refer to Chapter 2.

# Chapter 1: Contextual Information and MHPSS Background in Ethiopia

## 1.1 Mental Health and Psychosocial Needs

The prevalence of psychosocial distress, common mental health disorders and complex mental illness, is reportedly high in both adults and children in Ethiopia. A 2014 baseline study aimed at determining the broad indicators of population-level psychosocial distress in rural communities (Fekadu et al., 2014) found a high prevalence of symptoms of common mental health disorders, suicidal ideation and suicide attempts and hazardous use of alcohol. Contrary to previous scholarly assumptions and popular wisdom, a large proportion of the population under study (40.8%) reported high exposure to stressors as well as weak social support networks (Fekadu et al., 2014).

These findings were confirmed by a 2017 systematic review and meta-analysis (Getachew et al., 2019), which estimated the prevalence of common mental health disorders to be as high as 21.58% in the general population – and significantly higher in women. A contemporary estimate (Selamu & Singhe, 2017) found mental illness to be one of the most significant contributors to the total Ethiopian burden of disease (11%), with schizophrenia and depression included in the top ten most burdensome conditions, out-ranking HIV/AIDS (Selamu & Singhe, 2017). Prevalence of childhood emotional and behavioral difficulties, as well as neurodevelopmental disorders, has been reported to fall between 12% and 25% (FMoH, 2019).

The recent humanitarian emergency (characterised by high levels of conflict and violence, large-scale displacement, loss of property and livelihoods, and weakening of social and family networks) compounded the pre-existing risk factors, representing a significant threat for the further deterioration of the psychosocial and mental health status of displaced populations, populations returned after displacement, and host communities alike. Most needs assessments, situation analyses and other studies conducted so far to document humanitarian needs in the various regions and areas where displacement has occurred, have highlighted the large prevalence of psychosocial distress in children and adults, as well as a worrying escalation in negative coping mechanisms, including retaliatory violence, substance abuse, suicidal ideation and suicide attempts (NDRMC & HCT, 2019a). The Ethiopian Public Health Institute, in collaboration with the University of Addis Ababa, is planning to conduct an assessment of the magnitude of mental and psychosocial distress and ill-health among IDPs and returnees, which will shed light on the overall burden of mental health difficulties, risk and protective factors, and coping mechanisms at individual, family and community level in the most affected regions of Ethiopia.

## 1.2 Ethiopia Mental Health Service Provision

Against the background described in the paragraph above, Ethiopia's health policy and sectoral plans have long identified mental, neurological and substance use disorders as a key priority for strategic health development. Largely informed by the Global Mental Health Agenda (WHO, 2013), the second National Mental Health Strategy is currently being finalised. It supports the integration of mental health service provision within the primary health care system, largely through the adaptation and scale-up of the World Health Organisation's Mental Health Gap Action Programme (mhGAP; WHO, 2008).

The strategy envisions a tiered approach to mental health promotion, prevention and intervention. This starts from the individual, family and community levels, where informal supports, community-based initiatives and peer support mechanisms are mobilised, and where the health extension workers carry out essential health education, sensitization, and awareness tasks, alongside screening and referrals. At primary health care level, general practitioners and other non-specialised staff collaborate with psychiatric nurses to recognise, diagnose and case manage a range of common mental health conditions. More complex conditions are to be referred to general hospitals, which provide inpatient and outpatient psychiatric and rehabilitative services. Specialised hospitals provide a further level of multidisciplinary care for specific disorders.

Whilst this strategy builds on the progress achieved in the implementation of the 2012–2016 National Mental Health Strategy (FMoH, 2012), its implementation will require significant additional efforts and commitment on the part of all concerned stakeholders. The experience of other countries suggests that the recent humanitarian emergency – and the increased focus on mental and psychosocial health needs of refugees, displaced and host communities alike – may provide opportunities to strengthen the formal health and social welfare systems as well as to reinforce the coordination and collaboration with the non-governmental and humanitarian sector – an effort to which the present 4Ws mapping is hoping to contribute.

### **1.3 The Humanitarian Response Plan and the Ethiopia Country Refugee Response Plan 2019**

The scale and salience of psychosocial and mental health needs in relation to the humanitarian emergency in Ethiopia is reflected in the Humanitarian Response Plan 2019 (NDRMC & HCT, 2019b), which integrates important MHPSS dimensions in its health, education and protection (including child protection and gender-based violence) -clusters' strategies. The plan recognizes that conflict, protracted insecurity, loss of livelihoods and transformation of social and cultural patterns and norms represent significant causes of distress for a large proportion of the population affected. The plan acknowledges the organic and adaptive nature of distress at times of crisis, and the need to articulate the response through complementary preventative/resilience-building initiatives and therapeutic interventions.

The Humanitarian Response Plan (HRP) Strategy, which reflects the consensus around MHPSS programming in emergencies (summarised in the Inter Agency Standing Committee's 2007 Guidelines (IASC, 2007)) is, however, not fully matched by the resource allocation strategy. Out of a population in need estimated at 8.3 million, over half a million are seen to require some level of psychosocial help; however, only 40,000 children and caregivers, and 10,000 women and girls survivors or at risk of Gender-Based Violence, are targeted for psychosocial support interventions. On the other hand, in the health chapter of the HRP, almost four times as many people – over 190,000 individuals – are targeted for MHPSS through health facilities. The plan seems, therefore, to favour clinical MHPSS service provision through health facilities over community-based psychosocial support – a less than optimal approach (IASC, 2007; UNICEF, 2018), which is, however, explained by the much higher level of financial resources and capacity made available to the health-cluster (within which clinical services are supported) as opposed to the protection-cluster and its CP-GBV sub-cluster (whose members conduct the bulk of humanitarian community-based interventions).

The Country Refugee Response Plan 2019 is less explicit than the HRP in recognizing the impact of distress on the psychosocial well-being of refugee children and adults; it does however mention mental health as one of the areas to be strengthened in the context of the health response (Ethiopia Country Refugee Response Plan, 2019).

## 1.4 National Public Mental Health Emergency Response

In consideration of the scale of humanitarian MHPSS needs across Ethiopia, the Federal Ministry of Health (FMOH), and its technical wing, the Ethiopian Public Health Institute (EPHI) established an MHPSS Unit in early 2019 within the Recovery and Resilience Section of the National Public Health Emergency Operations Centre (PHEOC). The role of the MHPSS Unit is to support the operational and technical coordination activities related to the public mental health response in the context of internal displacement and returns. More specifically, the unit is tasked with:

- Planning mental health and psychosocial support services for affected people (IDPs and returnees).
- Conducting surveillance activities and identifying priority mental health needs among affected people.
- Ensuring that standard tools (guidelines, SOPs, reporting formats, etc.) are available for use in carrying out mental health and psychosocial support services.
- Collaborating with stakeholders to put in place MHPSS referral pathways.
- Collaborating with PHEOC's Sexual and Reproductive Section to address gender-based violence and related mental health needs.

In line with this mandate, since the beginning of 2019, the unit has been training health care personnel within the formal health system to integrate mental and psychosocial health dimensions within primary health care service delivery at zonal, district and local level. WHO's Mental Health Gap Action Programme Humanitarian Intervention Guide (mhGAP-HIG; WHO, 2015) has been used for this purpose; the guide includes packages of care for the pharmacological and psychosocial management of some of the most common mental health conditions. In addition, in the early months of 2019, the Ethiopian Public Health Institute (EPHI) deployed emergency medical teams in hotspot areas where the influx of IDPs was largest; the emergency teams included mental health professionals as well as non-specialised health staff trained in mental health care provision in emergencies.

## 1.5 Child Protection and Psychosocial Response

In parallel with the public health response, the Government of Ethiopia and its humanitarian partners have been addressing the psychosocial and protection needs emerging from the humanitarian emergency through the strengthening and scaling up of services provided by the Ministry of Women, Children and Youth (MOWCY) and its regional, zonal and district-level bureaus (BOWCYAs). In partnership with UNICEF, and based on the availability of financial resources, the BOWCYAs have been deploying dedicated human resources in the locations most affected by internal displacement and returns; these staff have the core

responsibility to provide family tracing and reunification (FTR) and other child protection (CP) and gender-based violence (GBV) case management services to displaced children, women and families. This work is linked with UNICEF's efforts to support the development of National Child Protection Case Management Framework for Ethiopia, which has been recently endorsed and for which operational guidance and a workforce training manual is currently being developed.

## 1.6 MHPSS Coordination in Ethiopia

Acknowledging the challenges that fulfilling the vision of the National Mental Health Strategic Plan entails, and aware of the growing psychosocial needs emanating from the humanitarian emergency, the Federal Ministry of Health, and the humanitarian and development agencies active in Ethiopia in the area of MHPSS, have recently taken significant steps to strengthen interagency coordination, collaboration and technical standard-setting, through the establishment, in 2019, of the first Ethiopia Mental Health and Psychosocial Support Technical Working Group. This platform aims to foster closer collaboration and partnership between national, international and government agencies working in mental health and psychosocial support, and to improve the effectiveness and efficiency in meeting MHPSS needs in the various contexts across Ethiopia. The primary goal of the MHPSS Working Group is, therefore, to work collaboratively on technical input in the design and delivery of mental health and psychosocial support interventions across the country.

Specifically, the aims of the MHPSS Technical Working Group are as follows:

1. To provide a forum for sharing of activities and best practices of national and international organizations and governmental institutions.
2. To help ensure adherence to international guidelines in MHPSS programming.
3. To promote the mainstreaming of MHPSS considerations and priorities into other humanitarian clusters and sectors.
4. To support the development and dissemination of key information and advocacy messages on MHPSS to the relevant clusters/sectors and the affected population, as needed.
5. To advocate for and support the development and implementation of referral pathways to ensure quality and continuity of MHPSS care.
6. To support the sharing of data for purposes of joint planning, monitoring and evaluation and advocacy.

Membership of the Technical Working Group is open to government institutions, academic institutions, associations, religious and cultural groups, individuals, donors, NGOs, INGOs and UN agencies who have technical expertise in the field of MHPSS, and for those involved in the delivery of MHPSS services/interventions in Ethiopia. The Mental Health Team of the Ministry of Health serves as Chair of the group, supported by a steering group composed of five partners who will rotate every six months.

The Action Plan for 2019–2020 was endorsed by the group in May 2019; it envisages six areas of technical support contributing to the implementation of the National Strategic Plan, and the fulfillment of participating agencies' humanitarian commitments. The six areas include Coordination, Knowledge Sharing, Capacity Building, Advocacy, Continuity of Care and Staff Well-being.



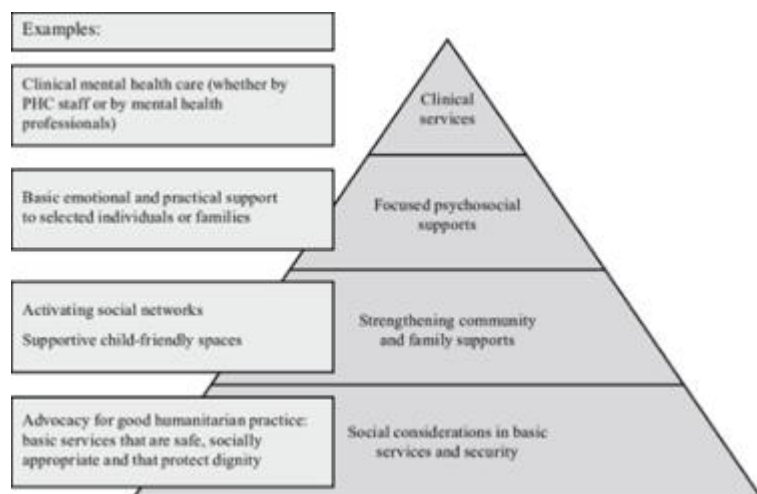
## Chapter 2. The 4Ws MHPSS Mapping Exercise

### 2.1 Background and Aims

As part of its Core Commitments for Children in Humanitarian Action (UNICEF, 2010, pp.26 and 32–35), UNICEF is seeking to systematically address the psychosocial health promotion, prevention and response needs of refugees and IDPs in Ethiopia. In 2019, noting the increasing levels of psychosocial distress and mental ill-health among children and adults in affected communities, UNICEF hired an international consultant to strengthen the psychosocial health response and coordination in the country.

Within this framework, the 4Ws MHPSS mapping exercise was launched in January 2019 by UNICEF as a collaborative exercise conducted in consultation and with the support of the humanitarian partner members of the CP-GBV sub-cluster co-led by UNICEF and UNFPA, with MOWCY, Federal Ministry of Health, Ethiopian Public Health Institute, as well as the Health Cluster led by WHO, the IDPs and Early Recovery Task Force led by EPHI, and the Protection and Health and Nutrition Working Groups led by UNHCR.

FIGURE 3 – IASC INTERVENTION PYRAMID



SOURCE: <https://interagencystandingcommittee.org/mental-health-and-psychosocial-support-emergency-settings-0/documents-public/iasc-guidelines-mental>

As with analogous initiatives conducted in other humanitarian settings, the UNICEF-led MHPSS mapping in Ethiopia aimed to:

(a) Improve coordination and collaboration among stakeholders, and across different segments of the MHPSS response.

(b) Provide an overall picture of the size and nature of the response; identify strengths and gaps to enable coordinated action.

(c) Support the strengthening of referral mechanisms by making information available about who is where, when, doing what.

(d) Provide an opportunity to

review patterns of practice and to draw lessons for future responses.

(e) Enhance shared understanding among stakeholders of the MHPSS terminology and of the programmatic principles underlying the categorisation of MHPSS activities across intervention tiers, as illustrated in Figure 3 above, and in line with the Guidelines for Mental Health and Psychosocial Support in Emergency Settings developed by the Inter-Agency Standing Committee in 2007 (IASC, 2007), as well as with UNICEF's Operational Guidelines for Community-based MHPSS in Humanitarian Settings. The latter two documents provided the methodological

underpinning to the mapping exercise, which therefore represents a first step towards the definition of agreed minimum standards for MHPSS interventions in Ethiopia.

## 2.2 The Mapping Tool

The global 4Ws mapping tool developed by the Inter Agency Standing Committee’s reference group on MHPSS (IASC, 2013) was used for this exercise. The tool consists of two parts:

- 1) 4Ws data collection spreadsheet application (Excel), available at [mhps.net/4Ws1](http://mhps.net/4Ws1).
- 2) A manual describing how to collect the data, accessible to partners online.

The 4Ws Data Collection Spreadsheet is a Microsoft Excel file containing three sheets. The first sheet provides introductory information and guidance for participating organizations. The second sheet is to be completed by each organization with the items to be completed listed in Annex 1. The third sheet contains the MHPSS activity codes that participating organizations should use to categorize their activities.

Activity codes are listed in Annex 2. Activities are divided into (a) community-focused activities (activities 1–6 which are targeted at communities or segments thereof), (b) case-focused activities (activities 7–10, which are targeted at identified persons in the affected population), and (c) general activities (activity 11 which includes training, coordination and staff care interventions). Table 1 illustrates the correspondence between the 4Ws Activity Codes and the 2007 IASC Guidelines and intervention pyramid (IASC, 2007):

**TABLE 1 – CORRESPONDENCE OF ACTIVITY CODES AND SUB-CODES WITH IASC GUIDELINES**

<b>Levels of intervention as per IASC Guidelines (2007)</b>	<b>4Ws Mapping Tool</b>
Community-focused (targeted at communities or segments of communities) MHPSS considerations in basic services (Level 1)	Community-focused activities (targeted at communities or segment of the communities) (activities 1–6)
Strengthening community and family support (Level 2)	
Focused non-specialised psychosocial support (Level 3)	Case-focused activities (targeted at individual people) (activities 7–10)
Specialised or clinical services (Level 4)	

## 2.3 The Mapping Process

UNICEF contracted an international consultant to lead the data collection process, and to analyse and report on its findings. A national information management (IM) consultant supported the process throughout. The mapping took place in the period January–June 2019, and underwent the following steps:

*January 2019:* Consultation with governmental and non-governmental agencies in the country, as well as the main coordination platforms, in order to prevent duplication of efforts and to obtain endorsement of, and participation in, the mapping process. As a result of this preliminary step, the Ethiopian Public Health Institute, which had also planned to undertake a similar mapping exercise, agreed to join forces with UNICEF instead. This collaboration constituted an important stepping stone towards the establishment of the Ethiopia MHPSS Technical Working Group.

*February 2019:* Contextualisation of the mapping tool. The Global 4Ws spreadsheet was shared with partners so that they could identify any adaptations that needed to be made to the tool for the context of

Ethiopia. The main activity codes (1 to 11) were kept unchanged, but sub-activities were modified to reflect the interventions currently being implemented in the country. A total of 54 sub-activities were identified. The final list of activity and sub-activity codes is reported in Annex 2. As part of this process, partners discussed whether to include child protection and gender-based violence interventions in the mapping – in line with the way the 4Ws exercise was conducted in other humanitarian settings, notably in Jordan and Lebanon. It was, however, eventually agreed to limit the Ethiopia mapping to MHPSS only, given that other reporting platforms (5Ws) exist for protection including child protection and GBV activities.

Detailed guidance was developed to support partners with identifying the most appropriate activity codes/sub-codes for their interventions. As discussed above, such guidance – reported in Annex 3 – is meant as an initial contribution towards the harmonisation of MHPSS approaches and the definition of minimum standards for Ethiopia. Readers are encouraged to refer to this annex for clarifications regarding the terminology used throughout this report, including activity categorisation and minimum standards required for activities to be included under each of the mapping codes.

*March 2019:* A 4Ws mapping workshop was organised in Addis Ababa with 22 agencies participating. The contextualised mapping tool was presented and the data entry exercise was initiated during the workshop. In total, 18 participating agencies provided feedback, including one agency that reported not having any MHPSS intervention.

*April 2019:* An additional eight agencies who did not attend the workshop were contacted by email, and invited to submit their matrices. In parallel, the Regional MHPSS working group operating in Gambella invited its members to contribute to the exercise, with positive feedback received from eight organizations – some of which had already contributed their inputs at national level. The final list of contributing partners is presented in Annex 1. All information received was reviewed and compiled; UNICEF reached out to those partners whose information was unclear or doubtful to minimize the risk of errors and inconsistencies. All data were processed to produce seven regional service directories, with sub-directories for IDP response, refugee response, and combined responses (Appendix 2).

*May 2019:* In May 2019, a large number of IDPs in Oromia and SNNP region returned to their locations of origin, resulting in dramatic changes in the situation and needs on the ground. In an attempt to capture such changes, and their impact on humanitarian programming, an additional data collection round took place in May 2019 and the regional directories were revised accordingly. However, given the extreme fluidity of the situation, additional changes are expected in the weeks and months subsequent to the release of the mapping report, which has, therefore, to be considered as merely indicative for the regions with most IDPs.

*June 2019:* Findings from the mapping exercise were presented to the Ethiopia MHPSS Technical Working Group, and a draft report was shared with contributing partners for validation.

FIGURE 4 – MAPPING PROCESS TIMELINE

## Mapping Timeline



### 2.4 Qualitative Assessment

In addition to collecting and consolidating 4Ws inputs from partners, UNICEF conducted several field visits to capture the most salient qualitative aspects of the interventions mapped. The key dimensions of availability, accessibility/inclusiveness, acceptability, quality and performance of the services provided were explored through field observation, key informant interviews and focus group discussions. The list of the activities carried out is reported in Annex 4. Given the diversity of the programmes being implemented, it was not possible to utilise standardised quality assessment tools for this part of the exercise. For some specific interventions, however, existing global tools were adopted/adapted to the context of Ethiopia.

### 2.5 Data Analysis

In line with the objectives of the mapping, the quantitative and qualitative data collected from partners were analysed to provide the following:

- An overview of the number and nature of implementing and technical/funding partners active in both IDPs/returnees and refugee contexts, with disaggregation for each one of the seven regions that participated in the mapping exercise;
- An overview of the activities conducted in each region, analysed by MHPSS level of intervention, with identification of key gaps for each tier;
- A rough estimation of the proportion of population reached by MHPSS efforts, which may support the quantification of the response gap; the latter, however does not appear feasible at the time

of compiling this report, given the large population shifts that occurred after data collection, and the related changes in the humanitarian landscape;

- A review of the methodologies and materials reportedly being used by partners, with a view to identifying what proportion of the activities under implementation are being conducted in line with standardised, validated and/or scalable approaches.

In the regions with both IDP and refugee presence and response, a separate analysis was conducted for each humanitarian context. For the analysis above, only information about activities under current implementation was considered and reflected in the charts. However, in the narrative comment, information about pipeline activities is also reflected. Detailed information about pipeline interventions, with and without funding, is included in the service directories.

## 2.6 Limitations of the Mapping Exercise

The mapping exercise faced several limitations which should be considered when looking at its key findings and recommendations.

- 1) Whilst significant efforts were made to reach out to the largest number of humanitarian partners, not all agencies present in Ethiopia and involved in MHPSS responded to the call for inputs; in particular, very few education partners contributed to the exercise – which means that some of the gaps identified in the area of psychosocial support in education may rather be a reflection of the limited involvement of sector partners in the mapping process;
- 2) Since the mapping was rolled out at Federal level, it was more successful in reaching out to international partners than to national ones; this represents an important limitation, as national NGOs represent an important reservoir of technical expertise and play a major role in the intersection between development and humanitarian MHPSS service provision;
- 3) There was a significant time-lapse – two months – between the start of data collection and the finalization of the mapping report. During this period, the situation on the ground changed dramatically – particularly in terms of large-scale returns of IDPs to their localities of origin – which led to adjustments in the humanitarian response that the mapping tried to capture as best as possible – but which were still ongoing at the time of finalising this report;
- 4) Whilst the contextualised mapping tool was well understood by contributing partners, there were instances when individual organizations interpreted the mapping categories in a different way than advised in the guidance. In addition, not all partners were equally comprehensive in their reporting: for example, information about monthly caseload, human resources involved, and target groups were only contributed by a minority of partners.
- 5) Inputs provided by contributing partners were screened for data entry errors and other types of inconsistencies, however, a thorough process of verification was not possible given the geographic and thematic scale of the response. The information was therefore reported and analysed largely as provided.
- 6) Information about activities that had ended before the time of compiling this report (May 2019) was taken out of the Service Directories and the analysis – unless partners explicitly stated that their interventions had been, or were going to be, renewed.

- 7) Information about pipeline activities was included in the Service Directories, but not in the analysis, unless explicitly stated in the narrative and chart captions.

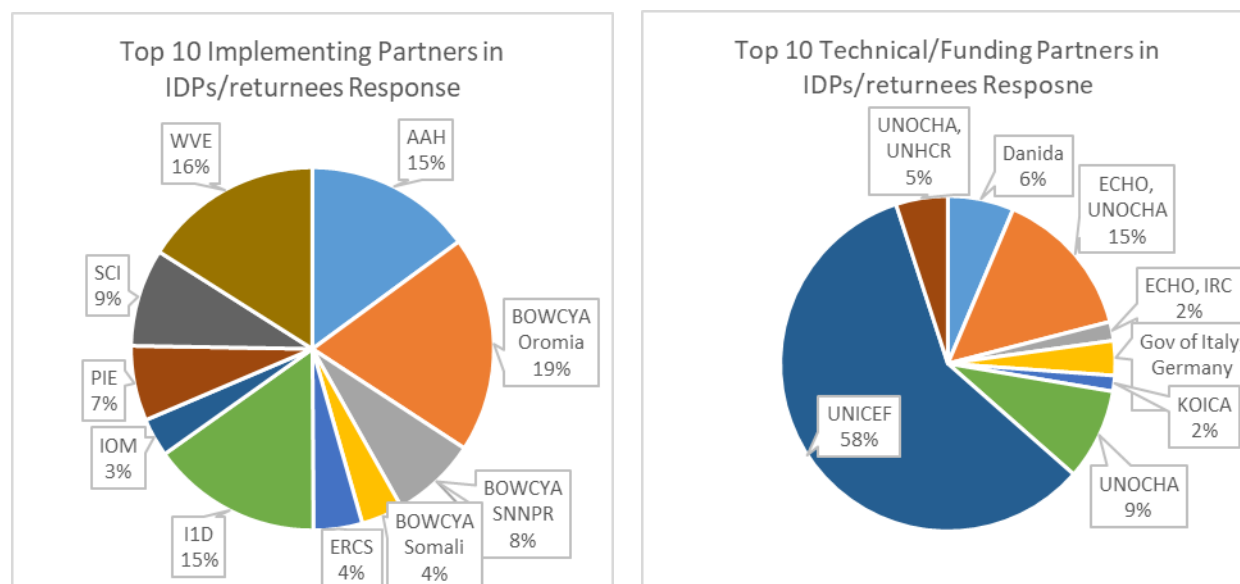
## Chapter 3. Overview of Findings – IDPs Response Context

### 3.1 Partners

Seventeen partners active in MHPSS within the context of the IDP/returnees response, including six partners providing MHPSS to host communities and migrant returnees, participated in the mapping exercise. Governmental partners included the Ethiopian Public Health Institute, as well as the Regional Bureaus of Women, Children and Youth Affairs in Oromia, Southern Nations, Nationalities and People, and Somali Regions. Contributing governmental and non-governmental partners are listed in Annex 1. The combined effort of governmental and non-governmental partners reached, at the time of compiling this report, 131 sites in 42 affected woredas in Amhara, Benishangul Gumuz, Southern Nations, Nationalities and People, Oromia, Somali and Tigray Regional States.

The charts below indicate the 10 implementing partners (Fig. 5) and 10 technical/funding partners<sup>6</sup> (Fig. 6) with the greatest relative weight in terms of the number of MHPSS activities reported to be under implementation in IDPs/returnees and host communities settings at the time of compiling this report.

FIGURE 5 AND 6

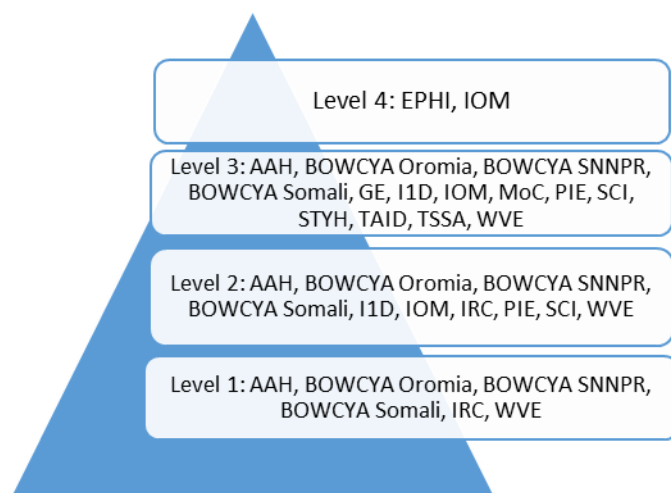


\*Current implementation. Presence/engagement are measured in terms of reported volume of activities, not in terms of funding.

<sup>6</sup> For the purposes of this mapping exercise, implementing partners (IPs) are defined as the organizations who are responsible for direct implementation of humanitarian interventions; whilst technical and funding partners are the organizations providing technical or financial support to the IPs. Presence/engagement are measured in terms of reported volume of activities, not in terms of funding. Also, note that UNICEF-supported activities benefit from the financial support of ECHO and OFDA.

## 3.2 Levels of Intervention and Geographical Coverage

FIGURE 7 – PARTNERS' INVOLVEMENT AT VARIOUS INTERVENTION LEVELS – IDPs AND HOST COMMUNITIES



Partners' engagement at the various levels of intervention – as per IASC MHPSS intervention pyramid – is summarised in Figure 7. Relatively few organizations reported being involved in Level 1 activities – which include mainstreaming of MHPSS considerations in basic services, as well as information dissemination on relief efforts. A larger number of agencies reported providing Level 2 services, including facilitation of community support mechanisms, activation of safe spaces, structured socio-emotional learning (SEL) and life skills learning activities, and psychosocial support in education. Roughly the same group of partners involved in Level 2

activities also mentioned offering basic forms of case-focused support, including Psychological First Aid and basic emotional help. The intervention pyramid is narrow at the top, with only two organizations reporting involvement in broad-range clinical service provision for IDPs and host communities, a few more offering specialised services only to particularly vulnerable groups – including returnee migrants and people with disabilities. For the full list of activity codes and sub-codes at each level of intervention please refer to Annex 2. For clarifications on how activities are categorized and terminology used, please refer to Annex 3.

### *Level 1 – MHPSS Considerations in Basic Services and Assistance*

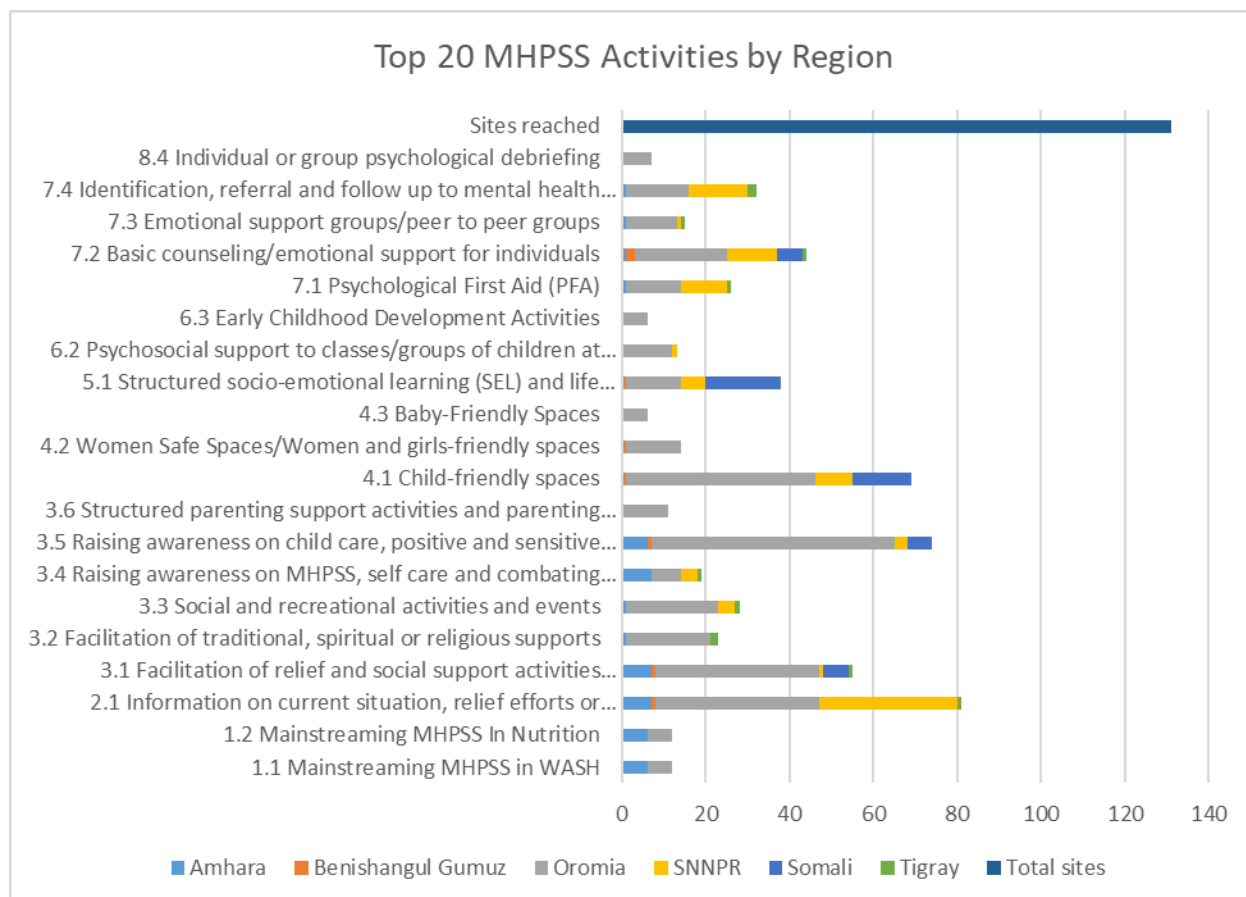
Level 1 activities (activity codes 1 and 2, and related sub-codes), which would ideally reach the greatest number of people, were only reported to be ongoing, at the time of compiling this report, in a limited number of sites in Oromia and Amhara Region. In addition, a large proportion of these activities appeared to be targeting a specific group – pregnant and lactating women and their children under five years of age – which may imply that the needs of other vulnerable groups remain unaddressed. The only Level 1 intervention that appeared to have a wider outreach is information dissemination on relief efforts, which was reported by a relatively large number of partners and seemed to have greater geographical outreach – although still covering less than two-thirds of the total number of sites reached.

### *Level 2 – Strengthening Family and Community Supports*

At the time of compiling this report, Level 2 interventions (activity codes 3, 4, 5 and 6, and related sub-codes) constituted the bulk of MHPSS efforts as reported by contributing partners; activities appeared to have a clear child-focus, with Child Friendly Spaces and awareness-raising programmes on childcare largely driving the response in most regions. On the other hand, early childhood development activities and psychosocial support in education both appeared to have limited outreach – which may partly be a reflection of the limited engagement of education partners in the mapping exercise – but may also indicate a need to strengthen these components of the community-based MHPSS package.



FIGURE 8



Activities targeting adults and communities as a whole, included facilitation of relief and social support mechanisms initiated by the community, social and recreational events, and facilitation of spiritual and religious rituals and activities. These interventions, whilst reported in all regions in different combinations, appeared to be ongoing in only one third or less of all sites covered by the MHPSS humanitarian response.

### Level 3 – Focused Psychosocial Support

At the higher levels of intervention, basic person-focused psychosocial support (activity code 7) was reported in all regions, but again each sub-activity would appear to be covering less than one-third of all sites reached. Basic counselling and emotional support was the most widely reported intervention, and Psychological First Aid the second. Case identification and referral – a key intervention to ensure MHPSS continuity of care – was reported in all regions, but only covered one-third of all targeted sites. Provision of brief, structured psychosocial interventions by non-specialised professionals was only reported by one partner in one affected zone, indicating that the task-shifting approach to providing evidence-based mental health care to people experiencing greater difficulties with functioning and coping may still occupy a peripheral role within the strategies of MHPSS humanitarian partners in Ethiopia.

#### Level 4 – Specialised services

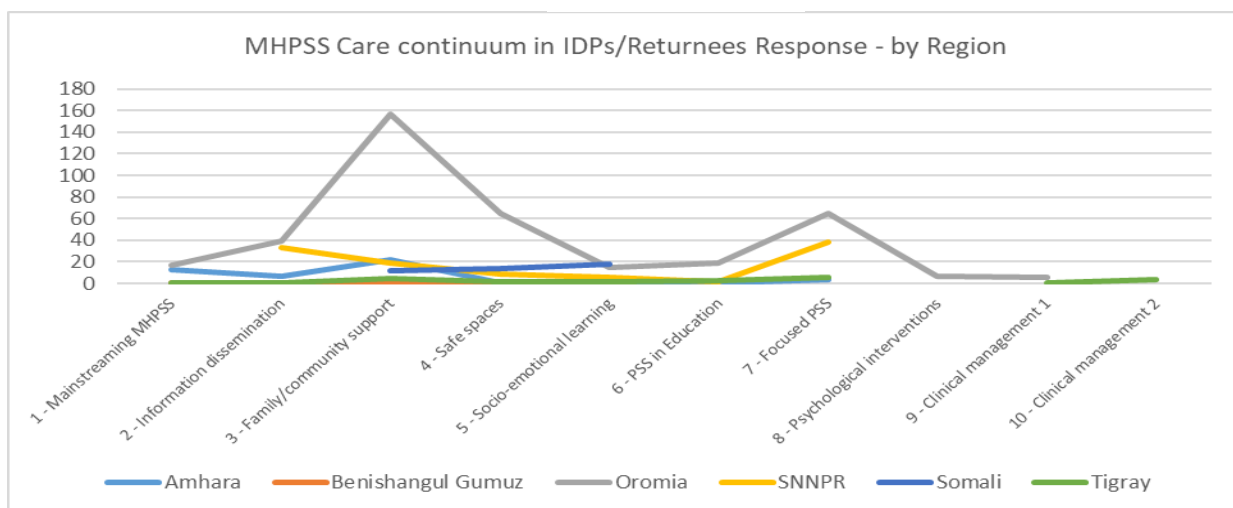
At the time of compiling this report, provision of specialised services appeared largely confined to the care available within the formal health system, with humanitarian interventions confined to very few locations and/or addressing very specific target groups. The Ethiopian Public Health Institute reported deployment of medical teams, including mental health specialists, in some of the most affected districts across the country; in addition, non-specialised health personnel operating in primary health care units were trained in the provision of basic clinical interventions, using WHO’s Mental Health Gap Action Programme Humanitarian Intervention Guide – mhGAP-HIG (WHO, 2015).

Within this limited range of Level 4 activities, some partners reported providing individual and group psychological debriefing<sup>7</sup> – an intervention that is commonly regarded as being potentially harmful (WHO, 2003) – which may suggest the need for closer technical review of the services on offer. Within the humanitarian context, no partner reported providing multidisciplinary care to children experiencing developmental delay, disorders or disabilities – indicating a prominent gap in the care offered to this potentially very vulnerable group of children.

#### Convergence

The distribution of activities across intervention sites and affected districts and zones suggests limited convergence of MHPSS efforts, with most sites and districts only reached by a small proportion of the full four-tiered intervention range. Given that for most IDPs, returnees and host community members, travelling across sites to get access to services may not be a practical option, greater convergence over a core minimum intervention package would appear advisable. The return/reintegration of a majority of the IDPs to their localities of origin, and closer to their homes, still ongoing at the time of compiling this report, may translate in a further scattering of the people in need of assistance, with additional challenges in terms of outreach and continuity of care. The chart below highlights geographical gaps and discontinuities in the care continuum, by region.

FIGURE 9

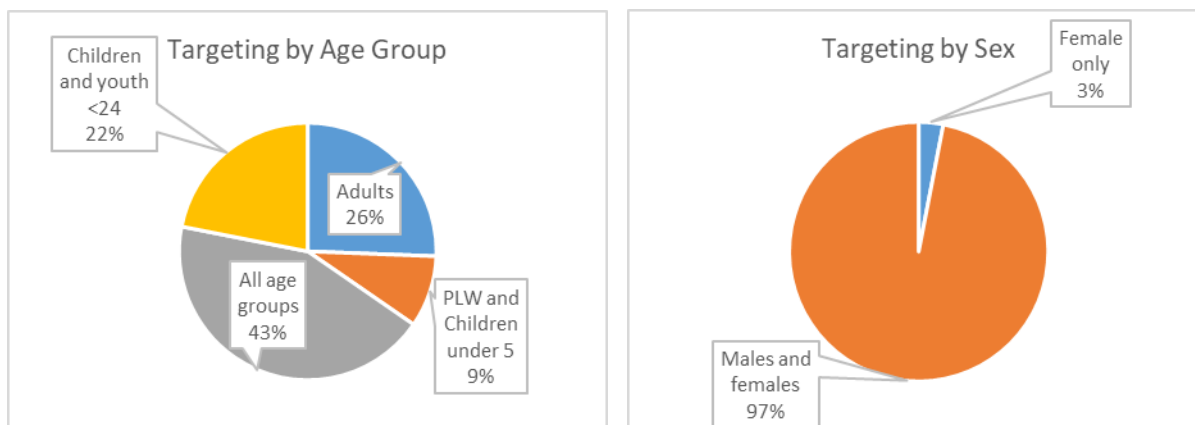


<sup>7</sup> For definitions and activity categorisation, please refer to Annex 3.

### 3.3. Target Groups

At the time of compiling this report, 70% of the MHPSS activities and services offered within the IDPs humanitarian response context were targeting IDPs, returnees and host communities alike – which may suggest that there is scope for cautious optimism regarding the strengthening of the linkages between humanitarian and development intervention frameworks, and in terms of possible continuity of service provision in the post-emergency/early recovery phase as well. 21% of the services were targeting IDPs only; and 9% were interventions designed specifically for the host community. The overwhelming majority of the activities on offer targeted both males and females, with only 3% of the interventions having preferential targeting for women and girls. A little more than 20% of the activities targeted children and youth; a slightly higher proportion targeted adults only; and nearly half of the activities were open to all age groups. 9% of the interventions targeted specifically pregnant and lactating women (PLW) and their children under five years of age, indicating an interesting focus on perinatal mental health that would appear worth strengthening.

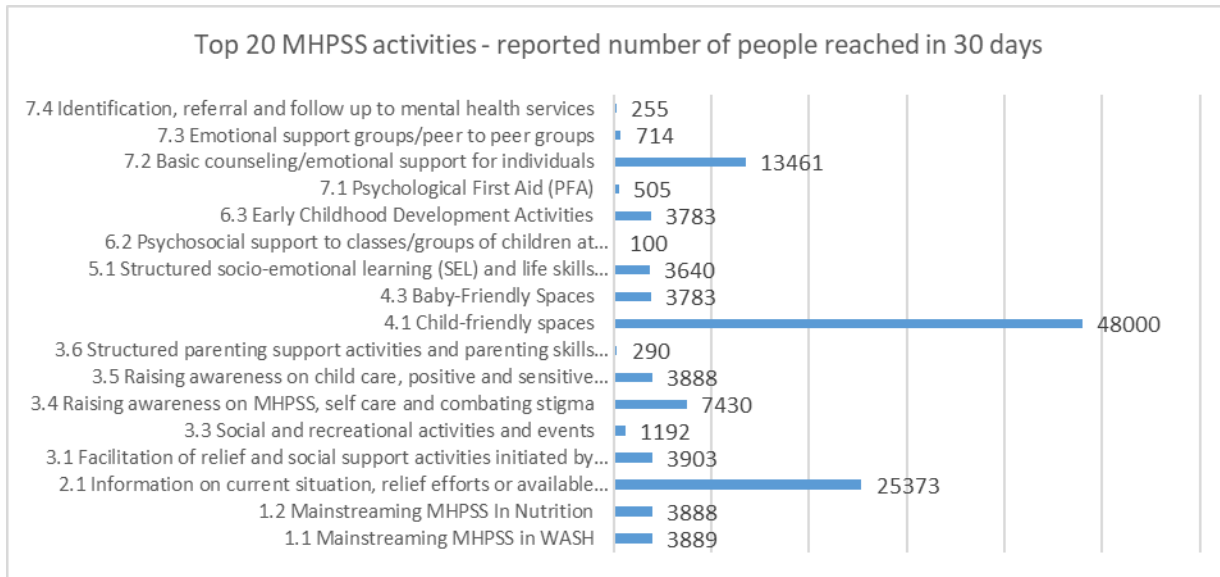
FIGURE 10 AND 11



### 3.4 Population Outreach

As part of the mapping exercise, partners were asked to indicate the number of people reached in the 30 days prior to data collection; unfortunately, results were not reported consistently by all partners and across all levels of intervention and activities – therefore findings should be considered as purely indicative for this dimension.

FIGURE 12

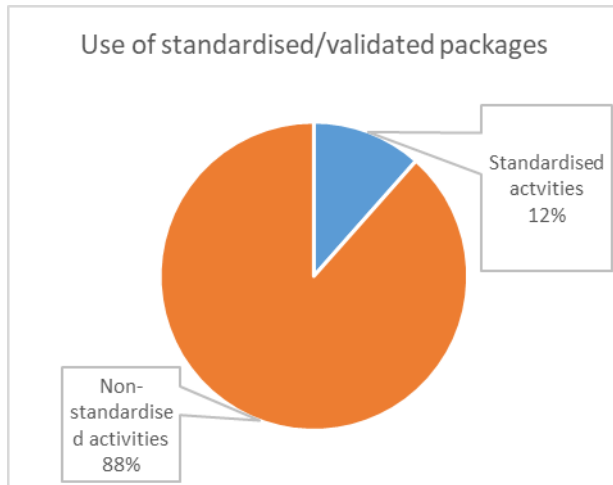


Three activities – information dissemination on relief efforts, Child Friendly Spaces (CFS) and basic counseling/emotional support – would appear to be the ones with the largest outreach, supporting – in the case of the CFSs – almost 50,000 children in a one-month period. Whilst this is a significant result for such a limited timeframe, the recurrent nature of CFS activities may imply that the total outreach over the several months may not be significantly higher than this one-month figure – indicating the likelihood that unmet needs may remain – particularly in those regions where the response was, at the time of compiling this report, significantly undersized.

All other activities, and particularly Level 1, 3, and 4 services, were reportedly offered to small groups. Overall, and across all affected sites, districts and regions, less than 500 adults and children were offered Psychological First Aid; less than 800 people attended emotional support groups – with over 700 of these being in a single site; and less than 300 were identified as being in need of further help, and offered referral services. Even taking into account the possibility of large underreporting, given an estimated population of over 8 million affected people (NDRMC & HCT, 2019a), and an estimated prevalence of mental health difficulties ranging between 4% and 22% (FMoH, 2019; WHO & UNHCR, 2012) these figures would appear extremely small, indicating the persistence of a very significant mental and psychosocial health gap in all the localities affected.

### 3.5 Use of Standardised/Validated Packages

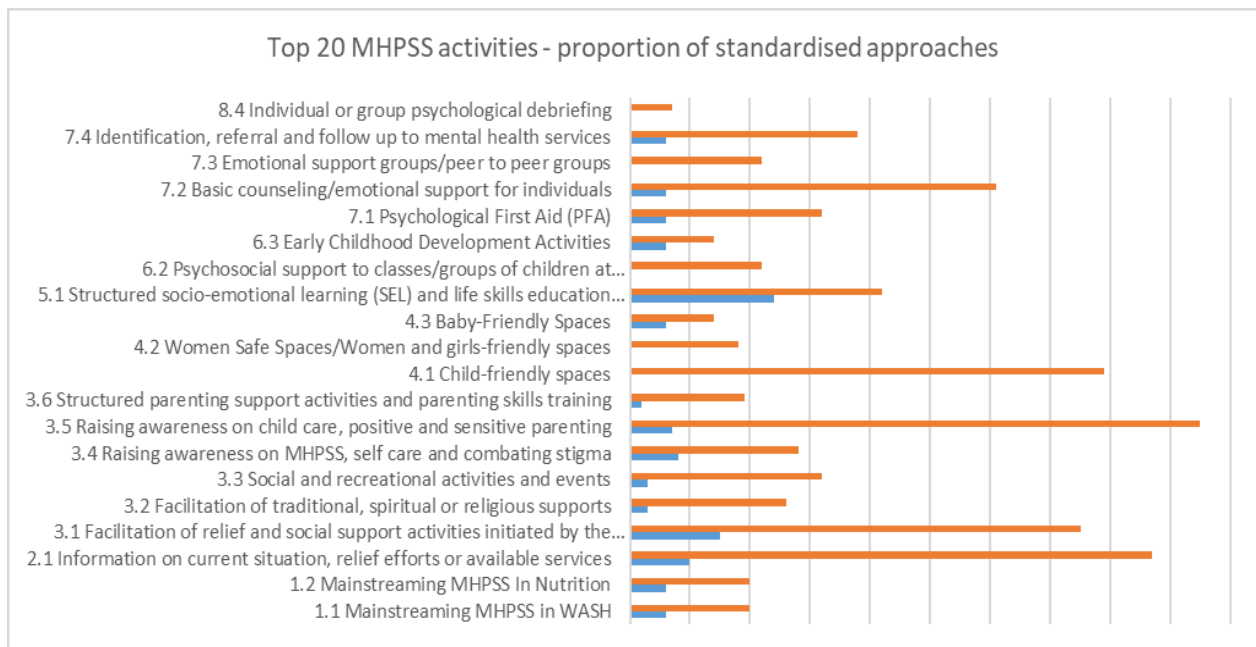
FIGURE 13



Partners were asked to indicate whether the activities reported in the mapping exercise made use of standardised/validated packages, manualised approaches, or formalized sets of key messages (i.e. packages, approaches or key messages that are standardized across interventions sites and providers, that have been tested and found applicable, relevant and effective in the country, and/or that come in the form of a manual, to support standardization and fidelity of implementation, with the due adaptations to local contexts). Overall, at the time of compiling this report, the great majority of the MHPSS activities under implementation appeared to follow an

informal format, with only 12% of the interventions reported to be underpinned by standardised methodologies or contents. This may imply limited replicability and consistency across localities and providers and may represent a challenge in terms of quality assurance, technical sustainability and potential for scale-up. Given that several activity packages, at various levels of intervention, have been either specifically developed, or validated and contextualised for Ethiopia, their wider adoption would appear recommendable.

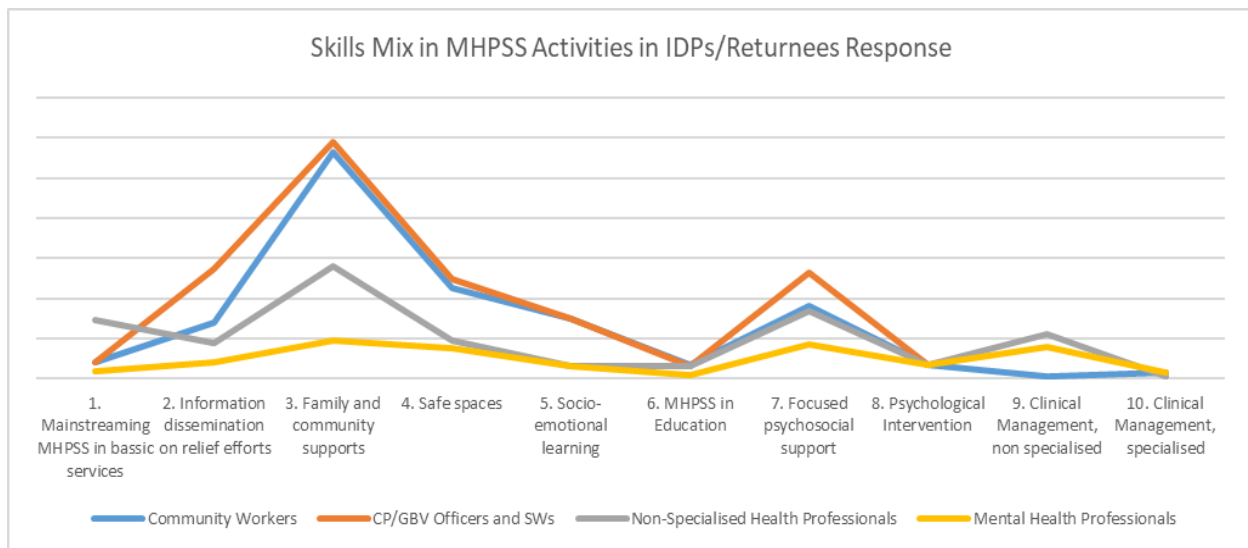
FIGURE 14



### 3.6 Human Resources

As reported by the partners, most of the humanitarian MHPSS activities appeared to be delivered by a mix of specialised and non-specialised protection and health personnel – including CP and GBV officers, qualified social workers and health professionals who collaborate with community workers or “para-social workers” (i.e. humanitarian aid workers who may not have a specific background/qualification in these professions, but may nonetheless work in the field of protection and MHPSS). Interestingly, mental health specialists were reported to be involved at all levels of the intervention pyramid, including in different types of Level 1 and Level 2 activities. It may be argued that, in a country where these specialised human resources are in short supply, their involvement in technical supervision, training, and direct delivery of referral services may perhaps be more strategic than their involvement in community sensitization, recreational events, and similar community-based activities. Also of note, is the absence of social workers at the higher levels of MHPSS service provision, which may suggest the need for a stronger skill mix within clinical settings.

FIGURE 15

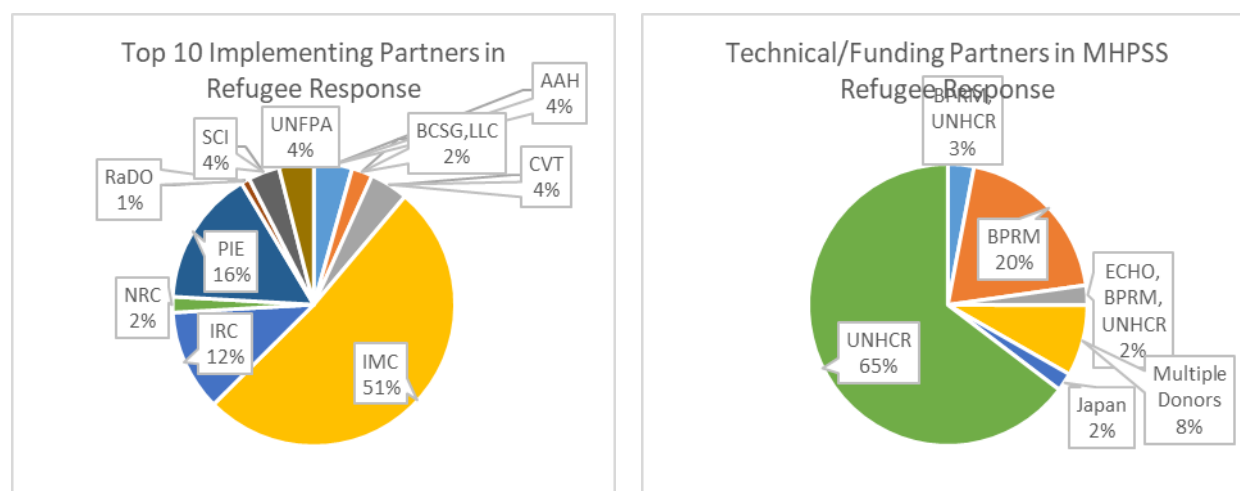


## Chapter 4. Overview of Findings – Refugee Response Context

### 4.1 Partners

Fourteen partners active in MHPSS within the context of the refugee response participated in the mapping exercise. The charts below indicate the 10 implementing partners (Fig. 16) and five technical/funding partners<sup>8</sup> (Fig. 17) with the greatest relative weight in terms of the number of MHPSS activities under implementation in refugee settings at the time of compiling this report.

FIGURE 16 AND 17



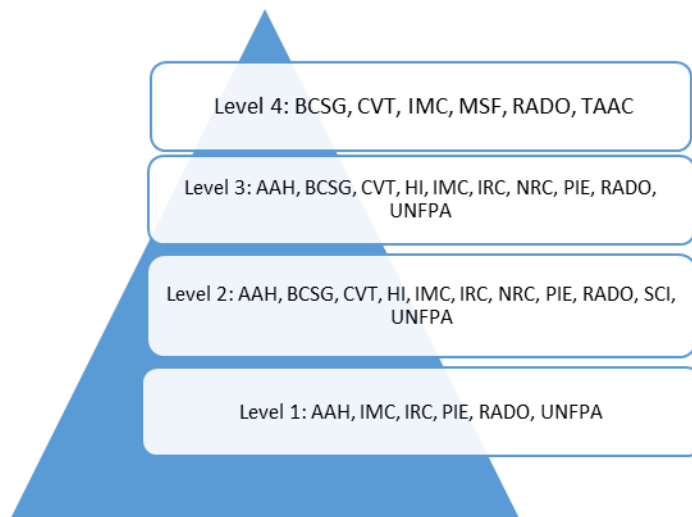
\*Current implementation. Presence/engagement are measured in terms of reported volume of activities, not in terms of funding.

### 4.2 Levels of Intervention and Geographical Coverage

Partners' engagement at the various levels of intervention – as per IASC MHPSS intervention pyramid – is summarised in Figure 18. Six organizations reported being involved in Level 1 activities – which include mainstreaming of MHPSS considerations in basic services, as well as information dissemination on relief efforts. Eleven agencies reported providing Level 2 services, including facilitation of community support mechanisms, activation of safe spaces, structured socio-emotional and life skills learning activities, and psychosocial support in education. Roughly the same group of partners involved in Level 2 activities also mentioned offering various forms of case-focused support. The intervention pyramid is quite well-populated at the top, with six organizations reporting involvement in broad-range clinical service provision for refugee communities – although some of these providers have indicated a focus on specific categories of very vulnerable refugees only.

<sup>8</sup> For the purposes of this mapping exercise, implementing partners (IPs) are defined as the organizations who are responsible for the direct implementation of humanitarian interventions; whilst technical and funding partners are the organizations providing technical or financial support to the IPs. Presence/engagement are measured in terms of reported volume of activities, not in terms of funding.

FIGURE 18



*Level 1 – MHPSS Considerations in Basic Services and Assistance*

Whilst a relatively large pool of partners reported some involvement in Level 1 activities, reported interventions would appear to have a relatively narrow focus and geographical spread. Mainstreaming of MHPSS considerations was only reported in two Regions – Gambella and Somali. In Gambella, activities were limited to two camps, and they appeared to be targeting a specific group – pregnant and lactating women and their children under five years of age – which may imply that the needs of

other vulnerable groups remain unaddressed. The only Level 1 intervention that appeared to have a wider outreach is information dissemination on relief efforts, which was reported in three out of the four regions involved in the refugee response – with the camps in Tigray representing a notable exception.

*Level 2 – Strengthening Family and Community Supports*

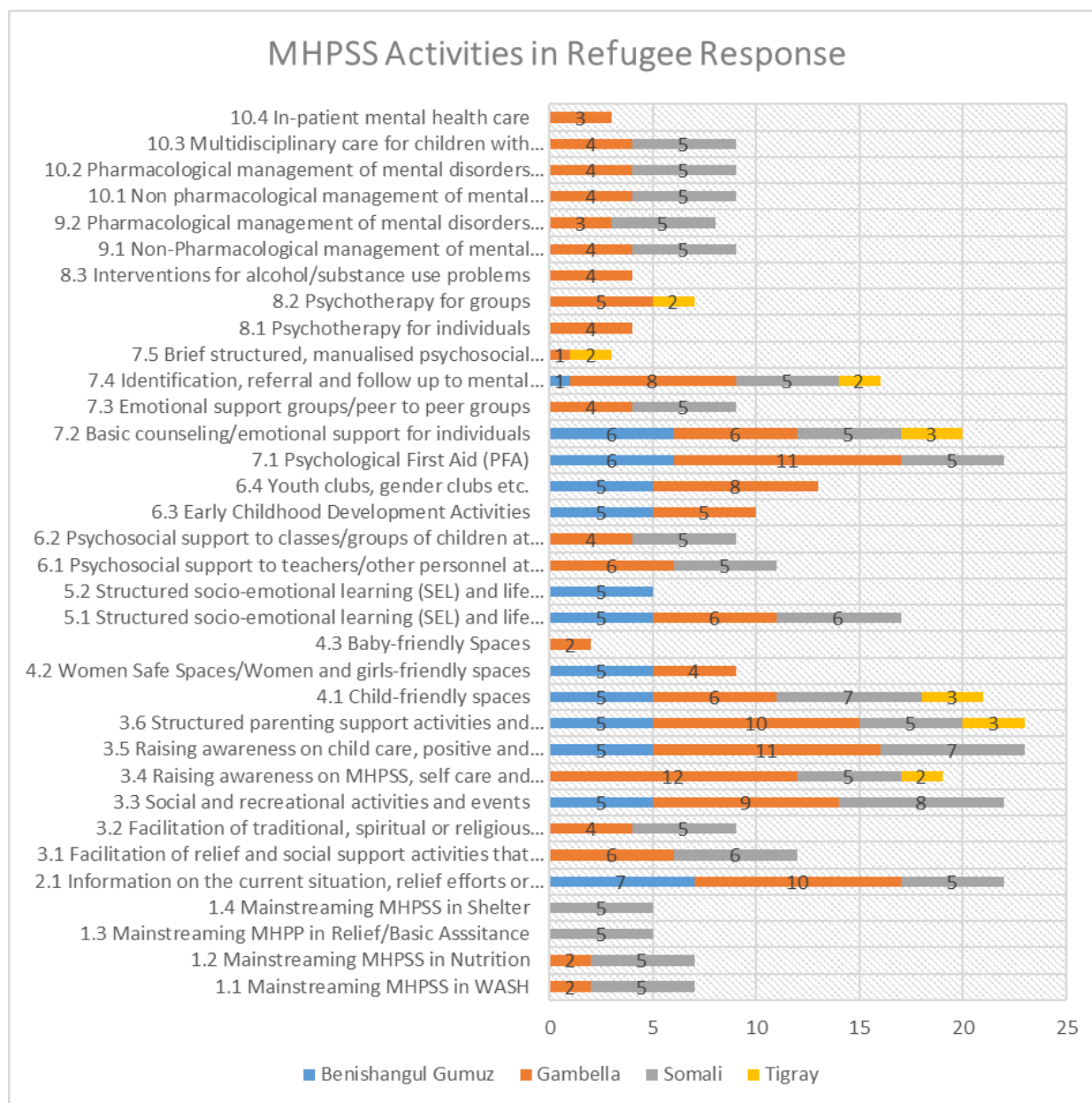
Similar to the IDPs/returnees context, Level 2 interventions (activity codes 3, 4, 5 and 6, and related sub-codes) constituted the bulk of MHPSS efforts reported by contributing partners in refugee settings. Those activities with a clear child-focus – and particularly Child Friendly Spaces, awareness raising on childcare, and structured parenting support – were the ones with more comprehensive coverage across camps and regions; other community-based interventions, and particularly the facilitation of mutual support mechanisms initiated by the community, were equally reported in a large number of locations, with again the camps in Tigray appearing less well-served than the other operations. On the other hand, early childhood development and psychosocial support in education both appeared to have limited outreach – which may partly be a reflection of the limited engagement of education partners in the mapping exercise – but may also indicate a need to strengthen the components of the community-based MHPSS package in refugee settings.

*Level 3 – Focused Psychosocial Support*

At the higher levels of intervention, basic person-focused psychosocial support (activity code 7) was reported in all regions, although with gaps at camp level as highlighted in the regional analysis (Chapter 5). Basic counselling and emotional support and Psychological First Aid were the most widely reported interventions; whilst provision of brief, structured psychosocial interventions by non-specialised professionals was only reported in a few camps across two regions: Benishangul-Gumuz and Gambella – indicating, as mentioned already for the IDPs/returnees response, that the task-shifting approach to providing evidence-based mental health care to people experiencing greater difficulties with functioning and coping may still occupy a peripheral role within the strategies of MHPSS humanitarian partners in Ethiopia.



FIGURE 19



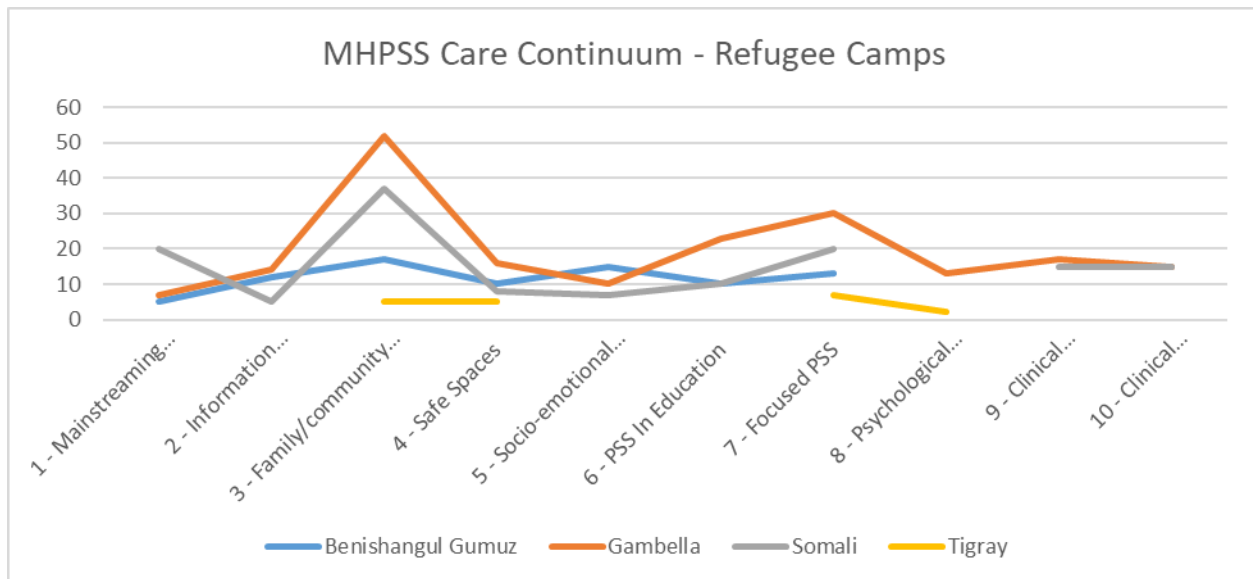
*Level 4 – Specialised services*

At the time of compiling this report, provision of specialised mental health services by humanitarian partners was limited to three regions – Gambella, Somali and Tigray – with additional gaps at the level of specific camps – as further detailed in Chapter 5. Partners appeared to be offering both pharmacological and non-pharmacological interventions, and, in selected camps, specialised services for substance abuse, and multidisciplinary care for children experiencing developmental delay, disorders and disabilities were also reported.

### Convergence and MHPSS care continuum

Compared to IDPs/returnees settings, the MHPSS response in refugee settings appeared better structured, with a broader range of activities, better service coverage at the top intervention tiers, and greater convergence of different services within the same localities – constituting a good platform to ensure accessibility of services and continuity of care to this very vulnerable population. The gaps at the bottom tier, the relatively limited capacity for identification and referral, and the small numbers of people accessing person-focused services would suggest, however, the need for further strengthening of the MHPSS response, to ensure that service availability translates to better results at all levels of the intervention pyramid – as further detailed in paragraphs 4.3 to 4.6. The chart below highlights geographical gaps and discontinuities in the care continuum by region.

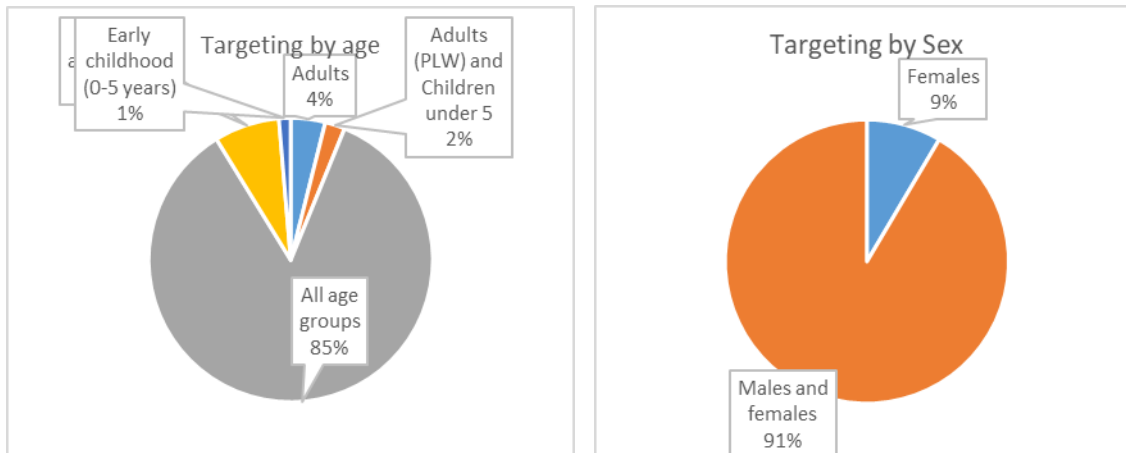
FIGURE 20



### 4.3 Target Groups

At the time of compiling this report, 58% of the MHPSS activities and services offered within the refugee humanitarian response context were targeting host communities as well, which may suggest that there is good potential for the further strengthening of integrated programming across population groups. 39% of the services were targeting refugees only; and 3% were interventions designed for returnee migrants and other groups. The overwhelming majority of the activities on offer targeted both males and females, with only 9% of the interventions having preferential targeting for women and girls. 85% of the activities were open to all age groups, and only less than 10% were specifically designed to reach children and youth. These proportions may indicate a need for greater programmatic focus on MHPSS for children and adolescents.

FIGURE 21 AND 22



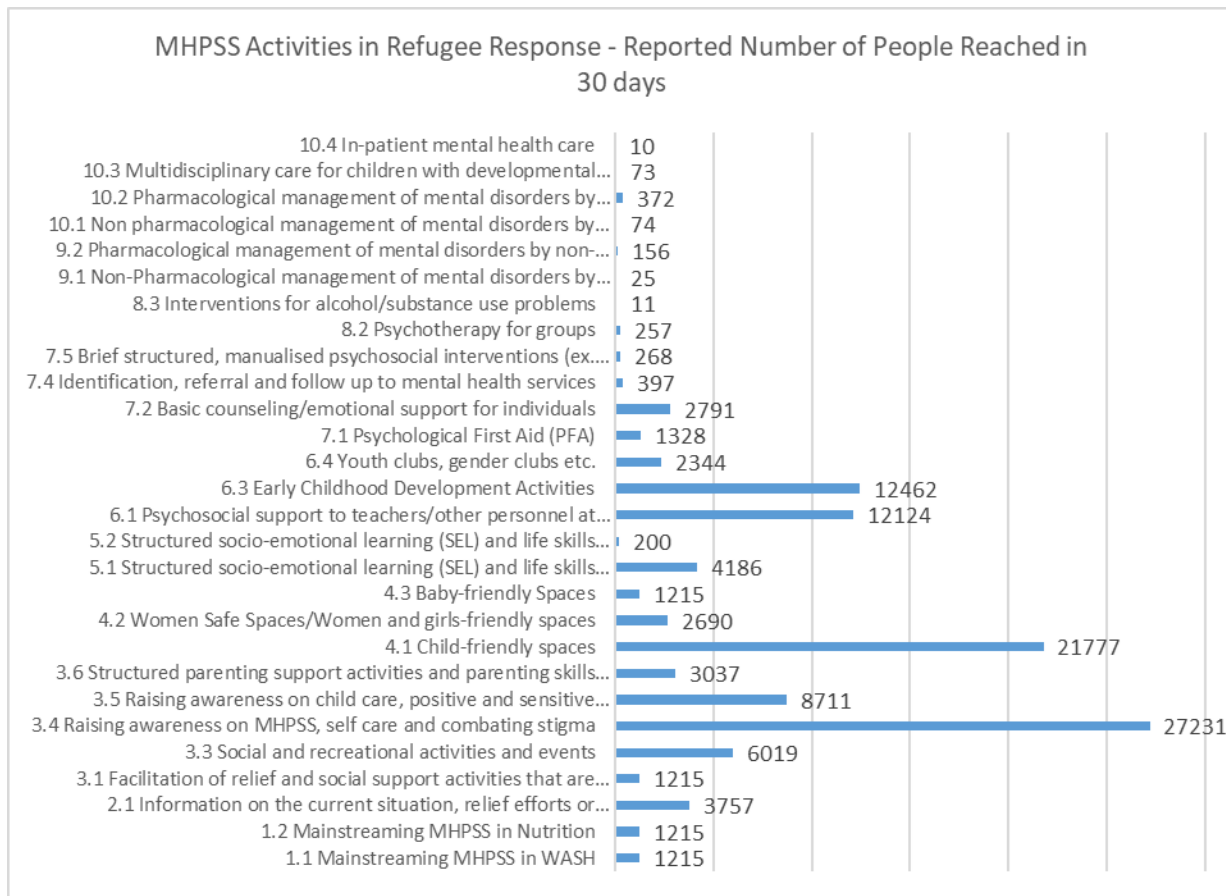
#### 4.4 Population Outreach

As part of the mapping exercise, partners were asked to indicate the number of people reached in the 30 days prior to data collection; unfortunately, results were not reported consistently by all partners and across all levels of intervention and activities – therefore findings should be considered as purely indicative for this dimension.

Three activities – awareness-raising on self-care and mental health; Child Friendly Spaces; and early childhood development interventions – would appear to be the ones with the largest outreach, supporting – in the case of the CFSs – more than 27,000 children in a one-month period. Whilst this is a significant result for such a limited timeframe, the recurrent nature of CFS activities may imply that the total outreach over the medium-term may be not significantly higher than this one-month figure – indicating the likelihood that unmet needs may remain - particularly in those regions where the response was, at the time of compiling this report, significantly undersized. Of note as well is that, whilst the interventions in early childhood development and psychosocial support in education were reported to have limited geographical coverage, their outreach in terms of number of students served was among the highest, possibly indicating that this type of intervention has a higher “return of investment” than other service models – which is line with global evidence on MHPSS.

All other activities, and particularly Level 1, 3, and 4 services, reportedly reached small groups of people. Overall, and across all camps, less than 500 adults and children were offered Psychological First Aid; less than 3,000 people had access to basic emotional support; and less than 400 were identified as being in need of further help and offered referral services. Even taking into account the possibility of large underreporting, these figures would appear extremely small, indicating the persistence of a very significant mental and psychosocial health gap in this population of nearly one million refugees.

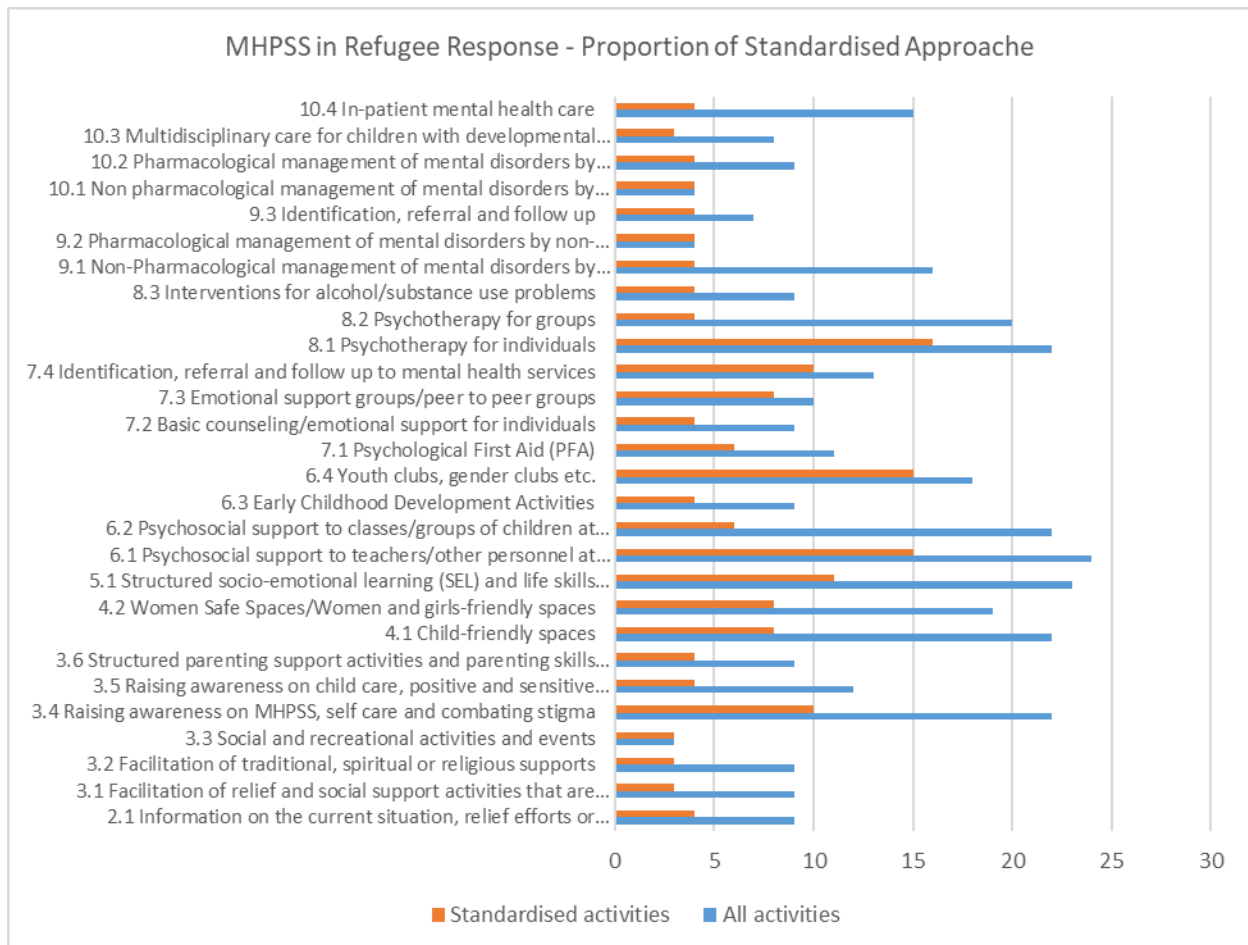
**FIGURE 23**



#### 4.5 Use of Standardised/Validated Packages

Partners were asked to indicate whether the activities reported in the mapping exercise made use of standardised/validated packages, manualised approaches, or formalized sets of key messages. Overall, at the time of compiling this report, the majority of the MHPSS activities under implementation appeared to follow an informal format, with only 20% of the interventions reported to be underpinned by standardised methodologies or contents. This may imply limited replicability and consistency across camps and providers, and may represent a challenge in terms of quality assurance, technical sustainability and potential for scale-up. Given that several activity packages, at various levels of intervention, have been either specifically developed, or validated and contextualized for Ethiopia, their wider adoption would be recommended.

FIGURE 24

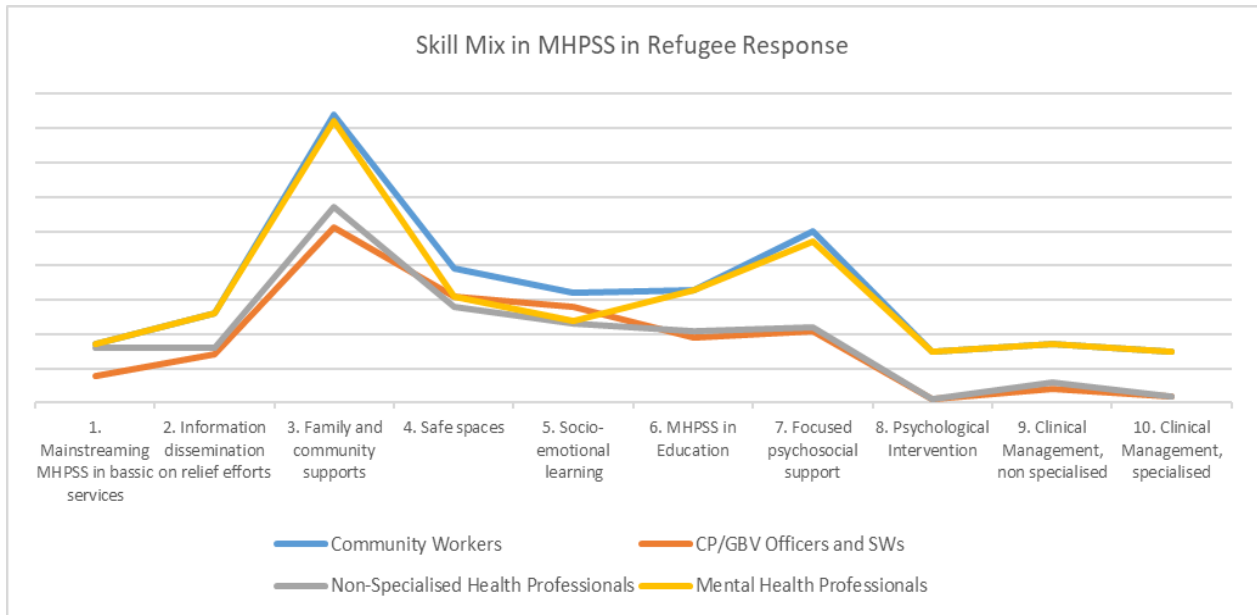


## 4.6 Human Resources

As reported by the partners, most of the humanitarian MHPSS activities appeared to be delivered by a mix of specialised and non-specialised protection and health personnel – including CP and GBV officers, social workers, health professionals – collaborating with “community incentive workers”<sup>9</sup>. Even more than in IDPs/returnee contexts, in refugee settings, mental health specialists were reported to be widely involved at all levels of the intervention pyramid, including in different types of Level 1 and Level 2 activities. It may be argued that, in a country where these specialised human resources are in short supply, their involvement in technical supervision, training, and direct delivery of referral services may perhaps be more strategic than their large involvement in community sensitization, recreational events, and similar community-based activities.

<sup>9</sup> These are community workers who belong to the refugee communities themselves, and who are hired by humanitarian partners to perform community work in child protection, psychosocial support and other sectors.

FIGURE 25

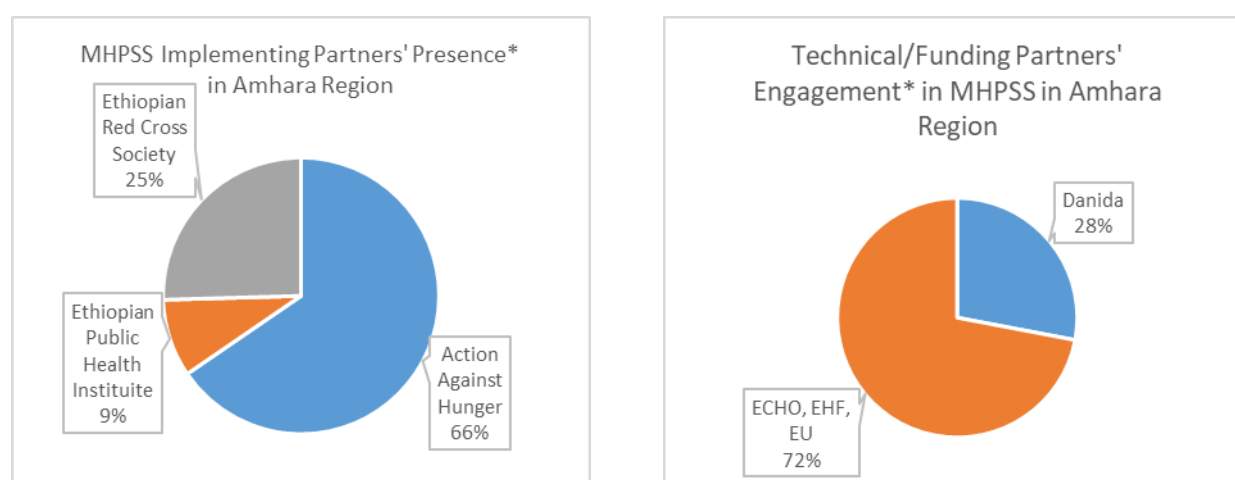


## Chapter 5. Overview of Findings – by Region

### 5.1 Amhara Region

In Amhara Region, only two humanitarian partners – Action Against Hunger and the Ethiopian Red Cross Society – reported an active engagement in the MHPSS response, reaching – at the time of data collection – seven sites across two districts. In addition to these efforts, the Ethiopian Public Health Institute conducted mental health care training of non-specialised personnel operating within the formal health system.

FIGURE 26 AND 27



\*Presence/engagement are measured in terms of volume of activities, not funding.

FIGURE 28 – MHPSS PARTNERS' ENGAGEMENT BY LEVEL OF INTERVENTION – AMHARA REGION

	Level 1		Level 2				Level 3	Level 4		11
	1	2	3	4	5	6	7	8	9/10	
	Mainstream MHPSS	Information Dissemination	Family and Community Support	Safe Spaces	Social and Emotional Learning	Psychosocial Support in Education	Focused Psychosocial Support	Psychological Interventions	Clinical Management of Mental Disorders	
AAH	*	*	*							
ERCS	*	*	*	*	*	*	*			
EPHI									*	*

#### Level 1 – MHPSS Considerations in Basic Services and Assistance

Reported Level 1 activities in Amhara include mainstreaming of MHPSS in WASH, Nutrition and Basic Assistance, using UNICEF's Infant and Young Child Feeding and Child Care Guidelines (UNICEF, 2011) and materials. At the time of data collection, six sites in one district – Sekota – were covered by these activities, with an average outreach of fewer than 100 people per site in the 30 days prior to data collection. In addition, information dissemination activities related to relief efforts reached 206 people in seven sites in Sekota and Debarq. Most of these activities were conducted within health centres by non-specialised

health care staff, and they targeted pregnant and lactating women and their children under five years of age.

#### *Level 2 – Strengthening Family and Community Supports*

Level 2 activities reported by contributing partners include facilitation of community-driven social support initiatives, facilitation of spiritual and religious rituals, social and recreational events and awareness-raising on childcare and MHPSS. These activities make use of standardised packages, including the Community-Based Psychosocial Support, Resilience Programme for Young Men, and Caring for Volunteers Manuals – all by the International Federation of the Red Cross. Activities reached a range of 69 to 186 people in the 30 days prior to data collection. Child Friendly Spaces or Women Safe Spaces were not reported to have been established yet in Amhara at the time of compiling this report.

#### *Level 3 – Focused Psychosocial Support*

Level 3 activities were reported by one partner – ERCS – in one site in Debarq, specifically targeting returnee migrants. Activities included Psychological First Aid, basic counseling, and peer group support, all reportedly delivered in line with the IFRC’s Psychological First Aid/Lay Counseling manual. Between 21 and 28 adults and children were reached in the 30 days prior to data collection.

#### *Level 4 – Clinical MHPSS Services*

Humanitarian partners in Amhara have not reported any Level 4 service. People in need of this level of intervention may be referred to primary and general hospitals across the region, where non-specialised health personnel have been trained to diagnose and manage a range of common mental health conditions. More complex/severe cases can be referred to specialised services within tertiary hospitals. However, in the 30 days prior to data collection, only one person was identified by participating partners as requiring referral to clinical interventions, indicating that detection skills may need to be strengthened. In addition, a number of factors, including distance, cost and cultural aspects, may be affecting the accessibility, affordability and acceptability of the services offered at hospital level. Furthermore, findings from interviews with service providers in other regions, suggest that health care personnel at general hospital level may benefit from additional training to strengthen their ability to deliver recommended evidence-based psychological and psychosocial interventions that may complement, or may be alternative to, the pharmacological treatment of mental health disorders. This is a particularly significant gap in the area of child and adolescent mental health, where pharmacological interventions are often either not recommended at all, or to be considered as a further resort, after other therapeutic options have been unsuccessful.

#### *Summary – Amhara Region*

Overall, at the time of compiling this report, the MHPSS humanitarian response in Amhara appeared to encompass a range of different activities, mostly delivered through standardised and manualised approaches and materials. However, the response appeared significantly undersized both geographically and in terms of people reached in each location, at all levels of intervention, and particularly at community level where the need is expected to be greatest.

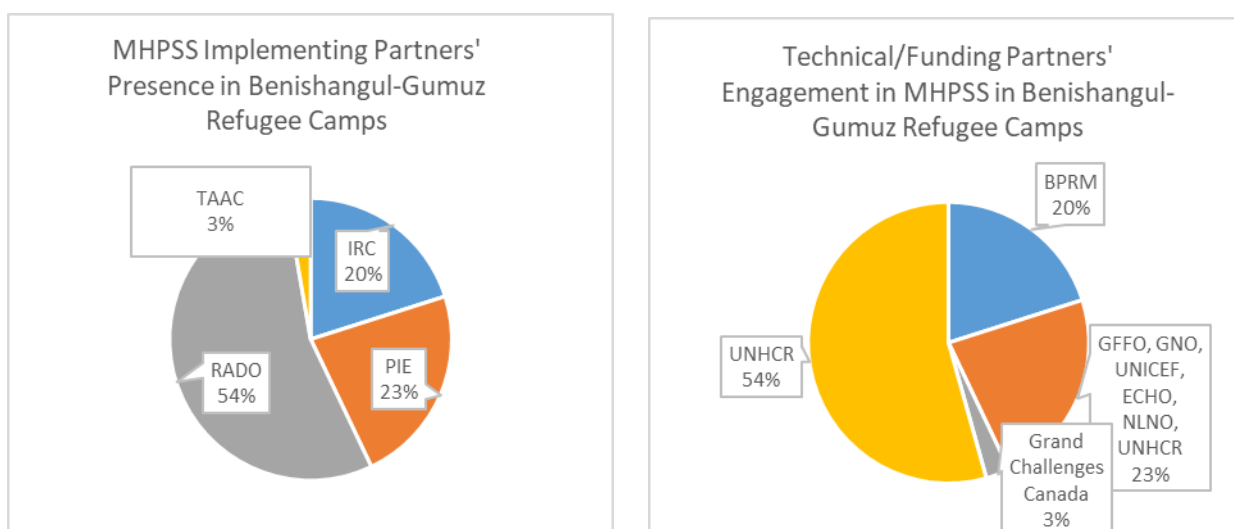
## **5.2 Benishangul-Gumuz Region**



### 5.2.1 Refugee Response

As of August 2018, 62,461 refugees were present in Benishangul-Gumuz (UNHCR, 2018), and located in five camps in the Assosa Zone. The governmental Agency for Refugees and Returnees Affairs (ARRA), is the main provider of facility-based psychosocial and mental health support in the five camps. In line with the UNHCR Accountability Matrix, and complementing ARRA services, three humanitarian partners have reported conducting MHPSS activities in the framework of disability interventions (Rehabilitation and Development Organization), SGBV prevention and response (International Rescue Committee), and disability/special needs interventions (Plan International Ethiopia). In addition, the academic consortium TAAC (Toronto–Addis Ababa Academic Collaboration) reported conducting interpersonal psychotherapy and narrative exposure therapy training of non-specialised health staff, as well as clinical service provision in ARRA’s health facilities.

FIGURE 29

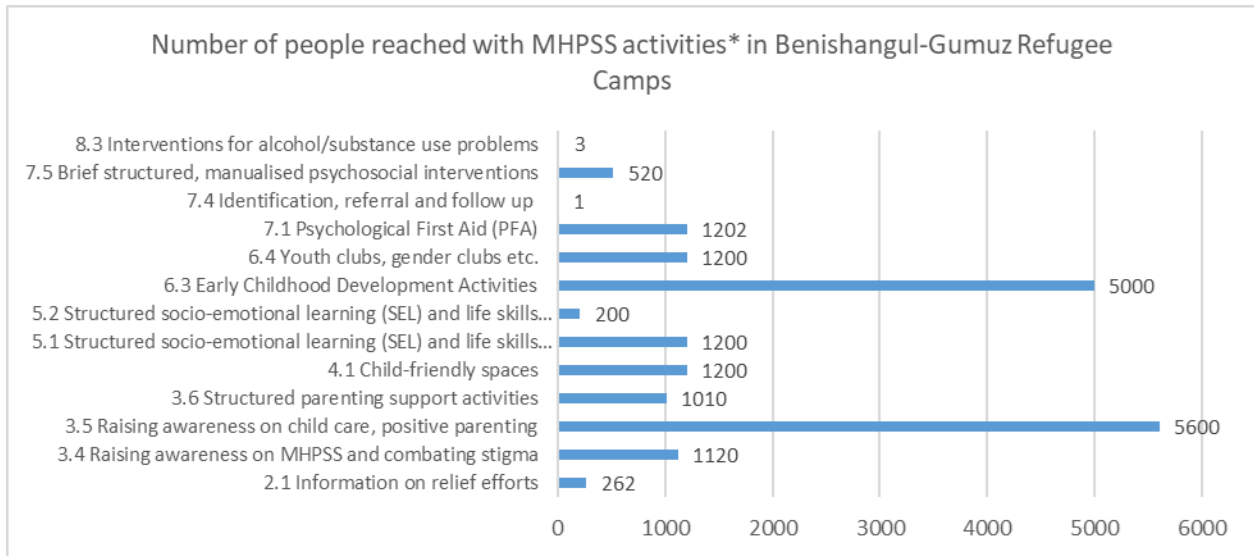


\* Current active presence and pipeline interventions already funded; presence/engagement are measured in terms of volume of activities, not funding

FIGURE 30 – MHPSS PARTNERS’ ENGAGEMENT BY LEVEL OF INTERVENTION – BENISHANGUL GUMUZ, REFUGEE CAMPS

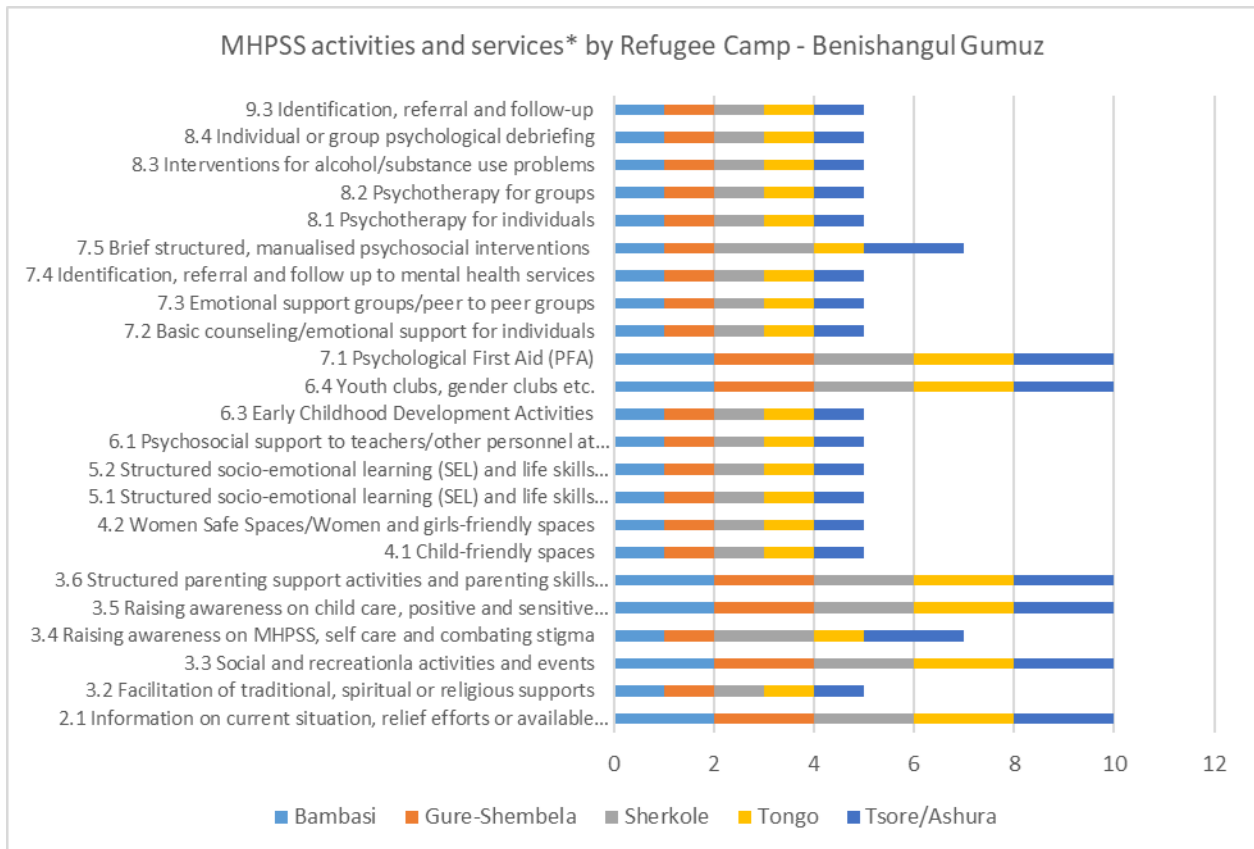
	Level 1		Level 2				Level 3	Levels 3/4		11
	1	2	3	4	5	6	7	8	9/10	
	Mainstreaming MHPSS	Information Dissemination	Family and Community Support	Safe Spaces	Social and Emotional Learning	Psychosocial Support in Education	Focused Psychosocial Support	Psychological Interventions	Clinical Management of Mental Disorders	General Activities
PIE	*	*	*	*	*	*	*			
RADO		*	*	*	*	*	*	*	*	*
IRC		*	*	*	*		*			*
TAAC			*						*	*

**FIGURE 31**



\* Under implementation and in pipeline with funding

**FIGURE 32**



\* Under implementation and in pipeline with funding

### *Level 1 – MHPSS Considerations in Basic Services and Assistance*

Level 1 activities in the five camps appear to be limited to information dissemination on relief efforts, which was reported to be happening in all camps. Mainstreaming efforts, on the other hand, appear to be confined to activities carried out by Plan International within the child protection sector, with no reported outreach to other sectors.

### *Level 2 – Strengthening Family and Community Supports*

A wide spectrum of Level 2 activities – some of which were still in the pipeline at the time of compiling this report, but with funding approved by the donor – was reported by partners in all camps. Broad community-based supports, as well as awareness-raising activities on MHPSS, self-care and combating stigma, were reported at community-level by RADO, and within health facilities by TAAC. As stated by the partners, this work is informed by the Interagency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC, 2007), and it appears to have good outreach, with 1,120 people sensitized in the 30 days prior to data collection.

Unstructured, non-manualised awareness-raising activities on childcare and positive parenting were reported by PIE and RADO; PIE indicated developing child protection-informed key messages to support the delivery of this intervention. Partners appear to have good outreach capacity, with over 6,600 caregivers reached in the 30 days prior to data collection. In the same period, early childhood development interventions were conducted by PIE in ECD centers in all the five camps, making use of a structured ECD curriculum, and reaching out to 5,000 girls and boys under five years of age, in the 30 days prior to data collection.

Both Child Friendly Spaces (CFSs) and Women Safe Spaces (WSSs) were operational in the five camps at the time of compiling this report and run by PIE and IRC respectively. Both types of spaces reportedly operated on a daily basis and were staffed by a mix of child protection officers and community workers; both appear to have been offering a range of structured and unstructured activities, including socio-emotional learning packages (SEL). The CFSs received an average of 240 children per camp in the 30 days prior to data collection; whilst the WSSs had a larger outreach in the same period, with an average of over 1,500 women and girls supported in the three camps for which this information was reported.

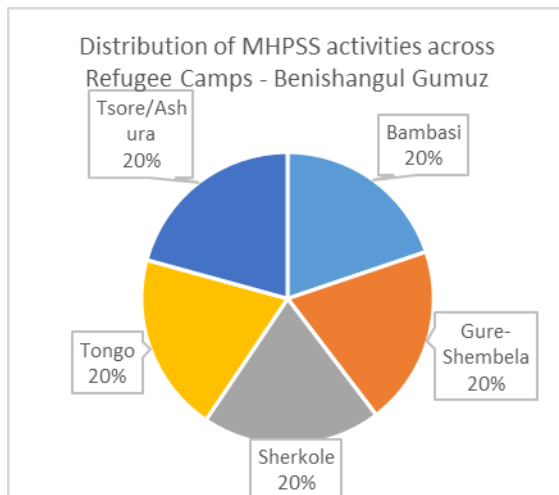
### *Level 3 – Focused Psychosocial Support*

Level 3 interventions were reported in all camps and by all partners. PIE and IRC stated offering Psychological First Aid and basic counseling and emotional support to children, youth and adults; these activities appear to be delivered by non-specialists, i.e. CP officers and community workers. However, PIE reported offering PFA to the same number of children as attending the CFSs – which may indicate that the term PFA is being used to indicate any type of psychosocial support interventions, and not necessarily case-focused ones. RADO reported offering a broader range of Level 3 services, including – in the pipeline at the time of compiling this information – emotional support groups and brief psychological interventions; the latter is planned to be delivered by mental health professionals (psychologists) and will mainly target women and girls at risk and survivors of SGBV.

#### Level 4 – Clinical Services

Across Levels of Intervention 3 and 4, TAAC reported offering Interpersonal Psychotherapy and Narrative Exposure Therapy within ARRA’s health facilities in Sherkole and Tsore camps; these evidence-based interventions, delivered by mental health professionals, appear to have very good outreach, with 260 people per camp supported in the 30 days prior to data collection. In the pipeline, RADO reported the intention to offer individual and group psychotherapy, as well as facilitation of self-help groups for individuals suffering from harmful use of alcohol/substance abuse. These activities are planned to be conducted by mental health professionals with the support of community workers.

FIGURE 33



#### Summary

Overall, the MHPSS response in the refugee camps of Benishangul-Gumuz appears to encompass a broad range of activities, with good outreach and comprehensive coverage across the five camps in the region. At the time of compiling this report, activities were well distributed across all levels of intervention, with the partial exception of Level 1 which remained slightly underrepresented. A number of manuals, guidelines and other materials, mostly produced by the implementing partners themselves, were reported to inform this work, suggesting a good level of standardisation across camps and providers. The presence of mental health professionals and academic

institutions, working collaboratively with non-specialised health staff, non-governmental organizations and communities, appeared to be making an important contribution towards strengthening the MHPSS continuum of care in this refugee setting.

Within this framework, additional attention may need to be paid to improving identification and referral skills of non-specialised and community staff, who only made one referral in the 30 days prior to data collection. Additionally, as in other areas of the country, there would appear to be a need to strengthen the multidisciplinary care of children experiencing neurodevelopmental delays, disorders and disabilities, who continue to represent one of the most under-served groups in the country.

#### 5.2.1 IDP Response

At the time of compiling this report, the overall MHPSS engagement in the context of the IDP response in Benishangul Gumuz appeared to be at the very initial stages, with limited scope and outreach. Only two humanitarian partners reported their presence in the region. With the support of UNICEF, World Vision was to establish Child Friendly Spaces and Women Safe Spaces in Oda District; unstructured parenting support activities, socio-emotional learning for adolescents and basic counseling were planned to be part of the intervention package. Goal Ethiopia, on the other hand, reported to be planning to provide basic emotional support in the frame of a community-based protection intervention in localities to be defined, with the support of OFDA. Significant changes in humanitarian programming in this region may be

expected, as a consequence of the return of a majority of the IDP population previously displaced in other Regions.

### 5.3 Gambella Region

As of August 2018, 401,594 refugees were present in Gambella (UNHCR, 2018), and located in seven camps in the region. The governmental Agency for Refugees and Returnees Affairs (ARRA) is the main provider of facility-based psychosocial and mental health support in six out of the seven camps. Complementing ARRA services, ten humanitarian partners have reported conducting, or having in the pipeline, a full range of MHPSS activities in the camps – with International Medical Corps and the Rehabilitation and Development Organisation covering the largest share of this work.

FIGURE 34 – MHPSS PARTNERS’ ENGAGEMENT BY LEVEL OF INTERVENTION – GAMBELLA, REFUGEE CAMPS

	Level 1		Level 2				Level 3	Levels 3/ 4		11
	1	2	3	4	5	6	7	8	9/10	
	Mainstreaming MHPSS	Information Dissemination	Family and Community Support	Safe Spaces	Social and Emotional Learning	Psychosocial Support in Education	Focused Psychosocial Support	Psychological Interventions	Clinical Management of Mental Disorders	
AAH	*	*	*	*		*	*		*	
BCSG			*			*	*	*	*	
HI			*				*			
IMC		*	*	*	*	*	*	*	*	*
MSF									*	
PIE	*		*	*	*	*	*		*	
RADO		*	*		*	*	*	*		*
SCI			*	*	*					
CVT			*				*			*
UNFPA	*	*	*	*			*			

#### Level 1 – MHPSS Considerations in Basic Services and Assistance

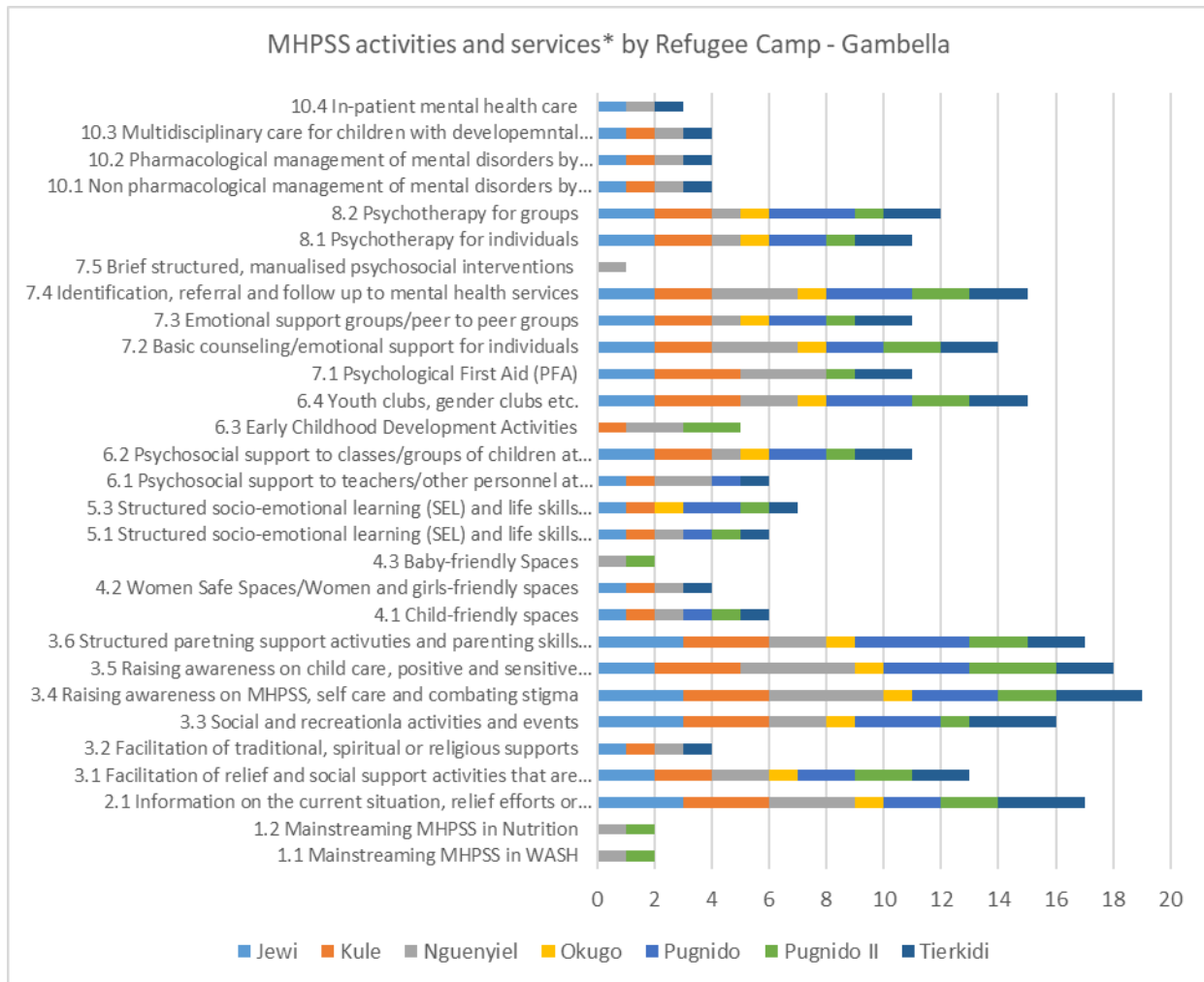
At the time of compiling this report, MHPSS mainstreaming activities only appeared to be conducted by one partner, Action Against Hunger, in Nguenyiell and Pugnido II camps; the sectors reportedly targeted for these mainstreaming efforts were Nutrition, WASH and Basic Assistance, and the target audience was very specific: pregnant and lactating women and children under five years of age. Information dissemination on relief efforts, on the other hand, was reported in all camps – except Okugo – by multiple partners, reaching out to almost 3,500 adults, youth and children in the 30 days prior to data collection.

#### Level 2 – Strengthening Family and Community Supports

Level 2 activities represent the largest proportion of reported MHPSS efforts in Gambella. Nearly all partners stated facilitating mutual support mechanisms initiated by the community, and many organizations mentioned conducting social and recreational events, reaching out to large numbers of adults and children – over 4,700 for both sets of activities in the 30 days prior to data collection. Awareness raising on MHPSS, self-care and against stigma, reportedly reached even larger numbers, with 20,000 people sensitized in the 30 prior to data collection. All camps appeared to be covered – some by more than one partner – with the exception of Okugo camp, where RADO was, however, planning to start

interventions soon after the time when this information was collected, with a focus on disability. No standardised materials or key messages were reported to inform the activities currently ongoing.

FIGURE 35

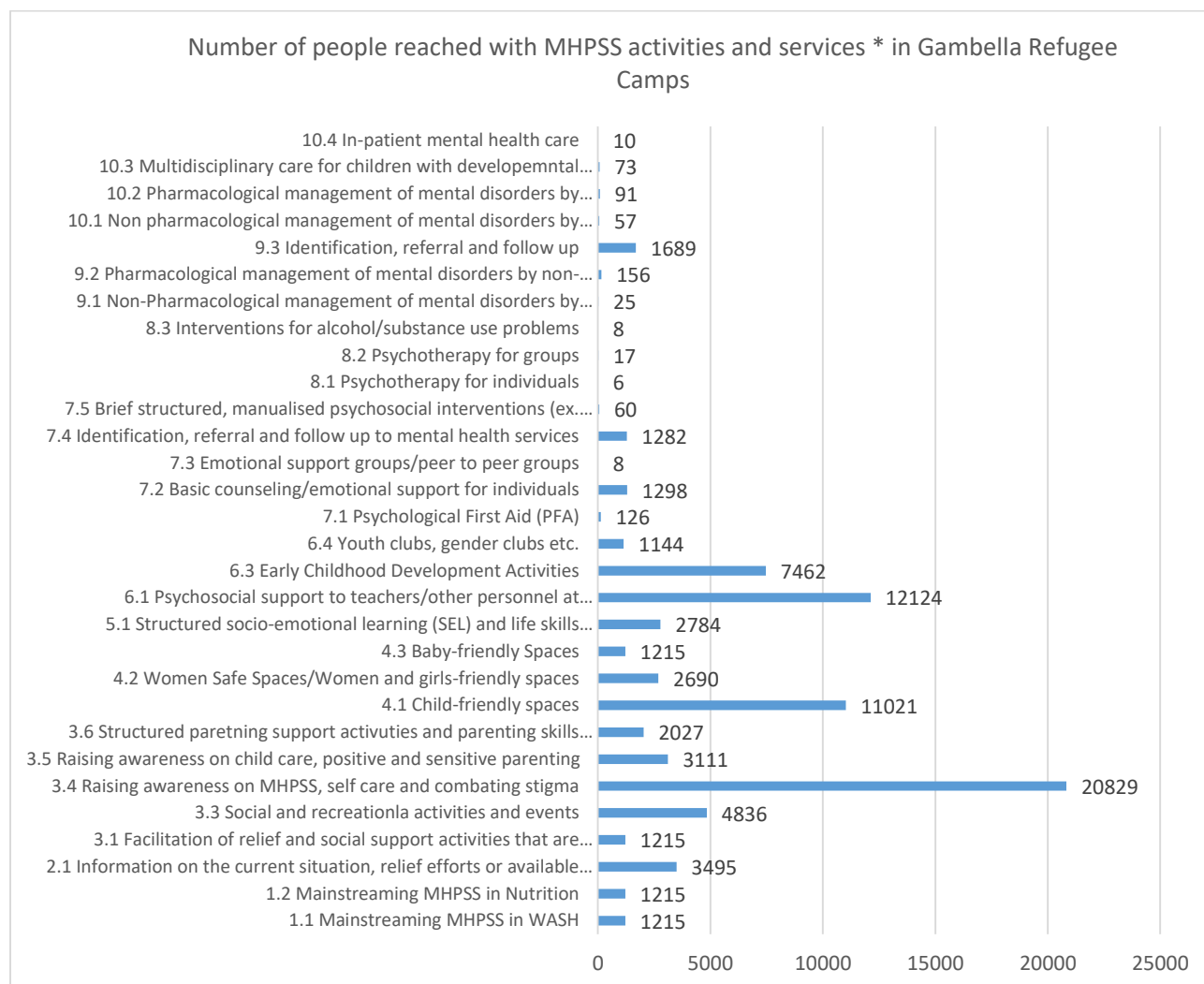


\* Under implementation and in pipeline with funding

Structured and unstructured parenting support activities were reported by seven partners in six camps; in Okugo. These were planned to start soon after the time when data collection occurred. Three organizations stated to be targeting caregivers on a universal basis, and did not report to be making use of any specific curriculum or support package. Four partners however mentioned focusing on particularly vulnerable families, making use of validated and theory-driven approaches: Plan International Ethiopia reported supporting both biological and foster parents with behavioral management skills and positive discipline training; Bethany Christian Service mentioned targeting caregivers of children survivors of abandonment, violence and abuse, through a trauma-informed approach aimed at promoting secure attachment, attunement and bonding; finally, Humanity and Inclusion and RADO reported targeting parents of children with disabilities, supporting them with task-shifting activities aimed at promoting the physical rehabilitation of their children in line with community-based rehabilitation approaches. Overall,

more than 5,500 caregivers were reached with different types of parenting support activities in the 30 days prior to data collection.

**FIGURE 36**



\* Under implementation

Child Friendly Spaces were run by Plan International and Save the Children in three camps respectively. Both partners reported to be targeting boys and girls aged from six to seventeen years; however observational evidence suggests that pre-school and school-aged boys may represent the majority of the children actually reached. Both unstructured and structured activities, including Socio-Emotional Learning (SEL) curriculums, were reported to be part of the CFS intervention package in Gambella; in the 30 prior to data collection, over 11,000 children had access to CFSs, and out of these, over 2,700 – roughly one child in five – reportedly attended SEL sessions. In Okugo camp, no partner reported either operating or planning to establish any CFSs.

Women and Girls Friendly Spaces, or Women Safe Spaces (WSS), are run by UNFPA in partnership with International Medical Corps in Jewi, Nguenyiell, Tierkidi and Kile camps with a fifth location in the pipeline

at the time of data collection, to be located within the host community of Lare. These spaces offer a range of recreational, life-skills building and emotional support activities, complementary to case management services, to women and girls at risk or survivors of gender-based violence. The WSSs catered for an average of 500 women/girls per camp in the 30 days prior to data collection. Baby-Friendly Spaces were also operational in two Gambella camps – Nguenyiell and Pugnido II – reaching in total over 1,200 pregnant and lactating women and infants in 30 days.

Psychosocial support activities in formal and non-formal education settings, including in schools and in Early Childhood Development Centers, were reported to be ongoing in six Gambella camps, and to be in the pipeline for Okugo. A little more than 19,500 children of different ages were reached in the 30 days prior to data collection, with a significant and appropriate focus on the early years (almost 7,500 children reached in 30 days).

### *Level 3 – Focused Psychosocial Support*

Eight partners reported offering Level 3 interventions in six camps, with additional activities in the pipeline for Okugo. Activities include Psychological First Aid, basic counseling, and emotional support groups. The number of people reached by these interventions varies widely from partner to partner, perhaps indicating differences in the way activities are categorized and referred to. For example, Action Against Hunger reported offering basic emotional support to all the 1,215 women and children under five years of age who attended the Baby-friendly Spaces in the 30 days prior to data collection; whilst other partners appear to have a case-focused approach, and accordingly they reported reaching much smaller numbers of adults and children through PFA and counseling. Similarly, Action Against Hunger reported reaching their entire beneficiary group with identification and referral activities; whilst other partners reported making between 5 and 25 referrals per location in the 30 days prior to data collection. All partners reported Level 3 activities to be conducted by a mix of mental health professionals and community workers, supported – in some organizations – by non-specialised health personnel.

### *Level 4 – Clinical Services*

Level 4 services were reported by four partners – BCSG, IMC, MSF and RADO – in six camps, with Okugo in the pipeline for RADO. Services reportedly include a range of evidence-based psychological interventions – including Cognitive Behavioral Therapy, Interpersonal Psychotherapy and Solution-Focused Brief Therapy – as well as pharmacological management of clinical disorders. For the most part, these interventions were offered through health facilities by mental health professionals, with the support of community workers and, in the case of one partner (BCSG), of social workers as well.

Both IMC and MSF reported offering multidisciplinary care to children experiencing neurodevelopmental delays, disorders and disabilities; the camps targeted for these interventions were Jewi, Nguenyiell, Tierkidi and Kule, and the number of children supported in the 30 days prior to data collection was 73.

### *Summary*

Overall, the MHPSS response in the refugee camps of Gambella appeared to encompass, at the time of compiling this report, a very broad range of activities, with good outreach and comprehensive coverage across six of the seven camps in the region. In Okugo camp, there appeared to be significant gaps, which RADO is planning to address through a multifaceted intervention currently in the pipeline and already funded.



FIGURE 37

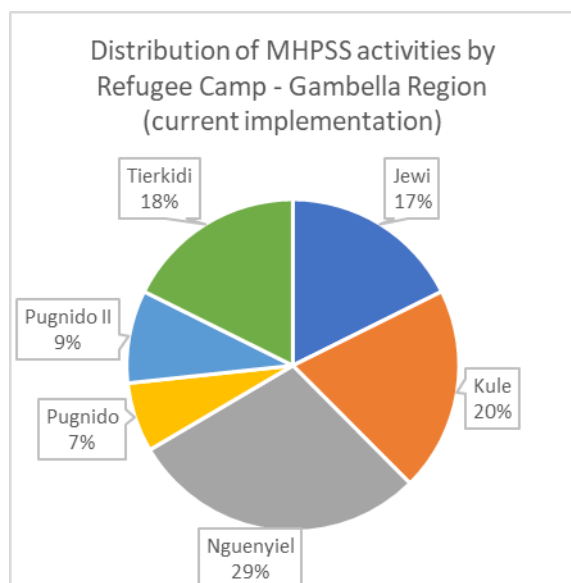
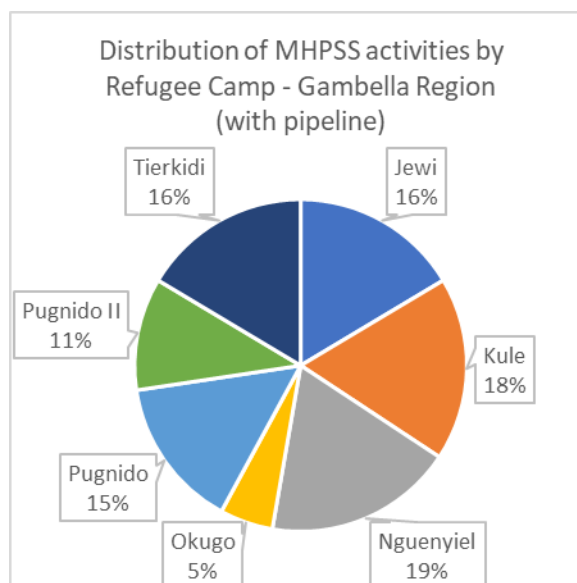


FIGURE 38



Activities appeared well distributed across all levels of intervention, with the partial exception of Level 1 which remained under-represented. Whilst some partners reported following standardised and manualised approaches to service delivery, many activities at all levels of intervention seemed to remain informally designed – which may imply limited consistency in the way the interventions are being delivered across locations and providers. The presence of a number of mental health organizations and professionals, working collaboratively with non-specialised health staff, appeared to be making an important contribution towards strengthening the MHPSS continuum of care in this refugee setting – supported by identification and referral mechanisms at community level that were reported to be functioning reasonably well. Within this picture, the number of people accessing higher levels of mental and psychosocial care remained relatively modest in this highly populated setting, suggesting that the mental health treatment gap may persist even within this quite well-developed and well-structured humanitarian context.

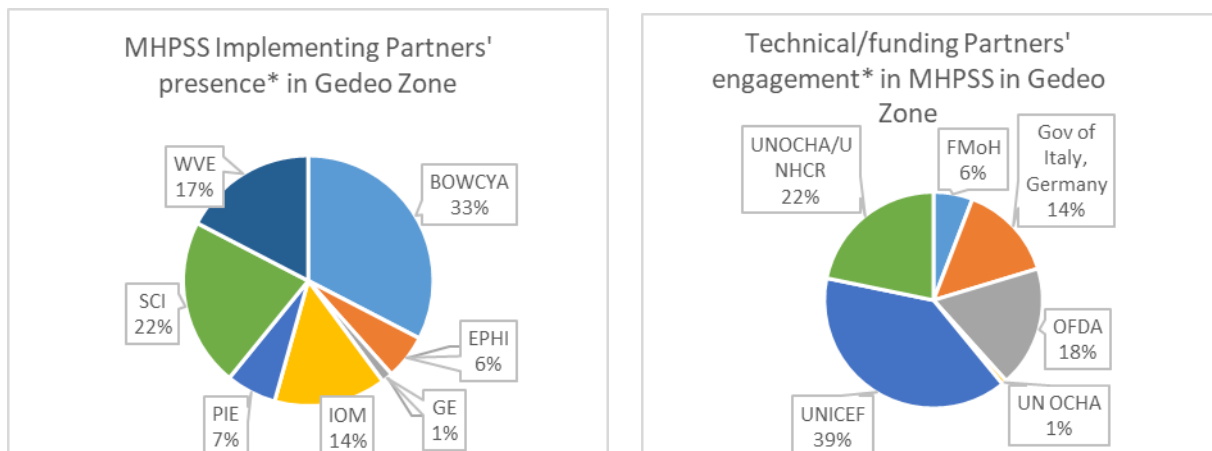
#### 5.4 Gedeo Zone – Southern Nations, Nationalities and People’s Region

The analysis of findings from the 4Ws mapping in Gedeo Zone, SNNP Region presents unique challenges, as during the time between data collection and finalization of the report, dramatic changes occurred at field level, with IDPs population shifts, returns and relocations that have modified, and are likely to further affect in the near future, the humanitarian landscape. Whenever possible, updates as of mid-May 2019 were collected from contributing partners and reflected in both the Service Directory and the mapping report. However, given the extreme fluidity of the situation, both the Directory and the mapping report have to be considered as purely indicative for this zone.

Five humanitarian partners reported either an active presence or pipeline activities in the zone. In addition, the Ethiopian Public Health Institute conducted mental health care training of non-specialised personnel operating within the formal health system; whilst the Bureau of Women, Children and Youth

Affairs has been implementing psychosocial and protection activities in collaboration with the NGOs. At the time of compiling this report, UNICEF was supporting almost 40% of all humanitarian MHPSS interventions. However, several interventions were approaching completion date and, with the significant changes in the situation on the ground, their renewal appeared uncertain.

FIGURE 39 AND 40



\*Current active presence and pipeline interventions already funded; presence/engagement are measured in terms of volume of activities, not funding

FIGURE 41 – PARTNERS' ENGAGEMENT BY LEVEL OF ACTIVITY – GEDEO ZONE

	Level 1		Level 2				Level 3	Levels 4		
	1	2	3	4	5	6	7	8	9/10	11
	Mainstreaming MHPSS	Information Dissemination	Family and Community Support	Safe Spaces	Social and Emotional Learning	Psychosocial Support in Education	Focused Psychosocial Support	Psychological Interventions	Clinical Management of Mental Disorders	General Activities
BOWCYA		*					*			
EPHI									*	*
IOM			*				*	*		*
PIE			*	*		*	*			*
SCI		*	*	*	*		*			
WVI	*	*	*	*	*		*			

**Level 1 – MHPSS Considerations in Basic Services and Assistance**

Information dissemination on relief efforts was the key Level 1 activity reported by partners in Gedeo. At the time of data collection, this intervention was being offered with wide coverage across the most affected sites. Over 18,000 people were reached in the 30 days prior to data collection. No partners active in Gedeo Zone reported conducting, or planning to conduct, any MHPSS mainstreaming in WASH, Nutrition, or other basic services.

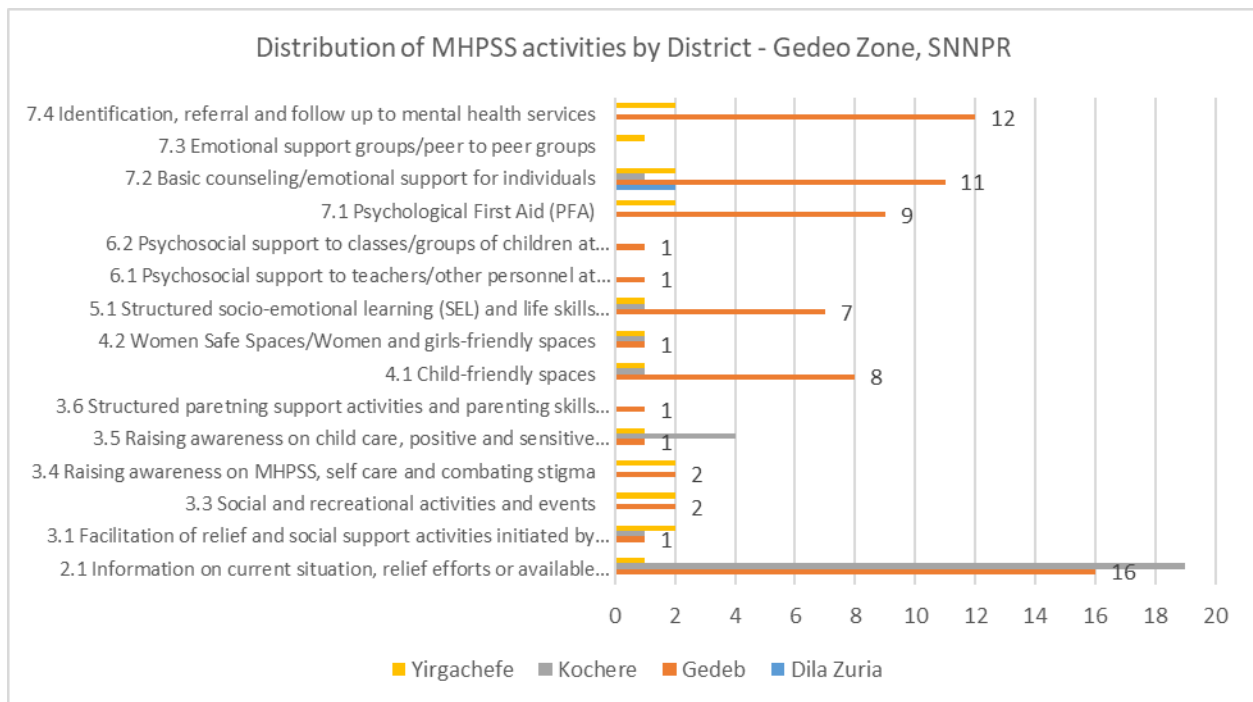
**Level 2 – Strengthening Family and Community Supports**

Level 2 activities reported by partners include facilitation of community-driven social support initiatives, social and recreational events and awareness-raising on childcare and MHPSS. Many of these initiatives were still in the pipeline at the time of compiling this report, and their actualisation appeared uncertain

in the light of the changes on the ground; the activities under implementation reached relatively limited numbers of people (less than 3,500) in the 30 prior to data collection.

Nine Child Friendly Spaces were reported to be operational in Gedeo, with three more in the pipeline. Over 18,000 children aged six to seventeen years had access to the CFSs in the 30 days prior to data collection. Whilst the standard CFS activity package should ideally encompass both structured and unstructured activities, partners operating in Gedeo did not report any structured Socio-Emotional Learning (SEL), life-skills or similar activities to be happening in the spaces; however SEL activities were reportedly taking place within schools in six locations, reaching an average of 190 adolescent girls and boys per location in the 30 days prior to data collection. Parenting support activities with caregivers reportedly had very narrow geographical coverage and did not appear to follow any structured curriculum or standardised package. Three Women and Girls Friendly Spaces were in WVE’s pipeline at the time of data collection.

FIGURE 42



\* Under implementation and pipeline with funding

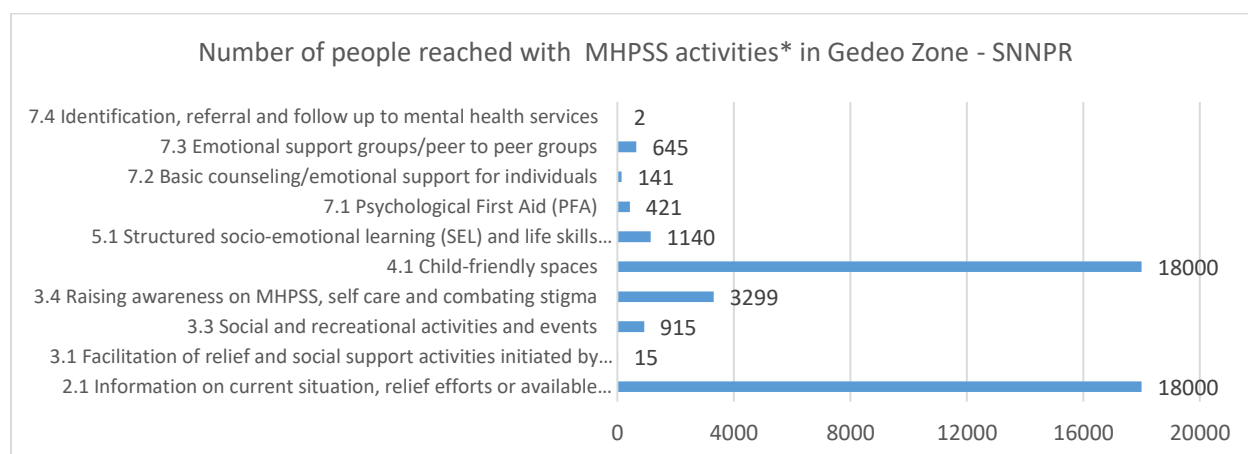
### Level 3 – Focused Psychosocial Support

Most partners reported to be offering some basic Level 3 interventions, including Psychological First Aid and basic counseling. Some partners mentioned delivering these supports through social workers, following standardised PFA packages. Other partners reported relying on community workers, using non-standardised approaches. The number of people reached was modest in both cases (overall, less than 500 in the 30 days prior to data collection).

No partner reported offering brief psychosocial interventions to people experiencing greater difficulties with functioning and coping; however, at the time of compiling this report, IOM had this activity in the

pipeline, and was planning to deliver it through a manualised approach that the organization has been developing for Ethiopia.

FIGURE 43



\* Currently under implementation

#### Level 4 – Clinical Services

Humanitarian partners in Gedeo did not report offering any Level 4 specialised services. People in need of this level of intervention may be referred to primary hospitals in the zone, where non-specialised health personnel have been trained to diagnose and manage a range of common mental health conditions. More complex/severe cases – including post-traumatic presentations in children and adults – may be referred to specialised services within Dilla’s General Hospital. However, in the 30 days prior to data collection, only two people were identified by participating partners as requiring referral to clinical interventions – indicating that detection skills may need to be strengthened. As in other regions/areas, other barriers to access clinical mental health services – related to the availability, affordability and accessibility of the latter – may need to be addressed as well. In addition, children experiencing neurodevelopmental delays, disorders and disabilities may not be able to access the multidisciplinary care often required for this type of difficulties.

#### Summary

At the time of compiling this report, the MHPSS humanitarian response in Gedeo appeared to encompass a good range of different activities, some of which were being delivered using standardised and manualised approaches and materials. The response, whilst larger than in other areas, still appeared undersized both geographically and in terms of number of people reached, with a large proportion of the needs remaining unmet. Population movements and relocations and returns of IDPs are likely to significantly transform the humanitarian landscape in this zone; hence this mapping’s findings may require frequent updates.

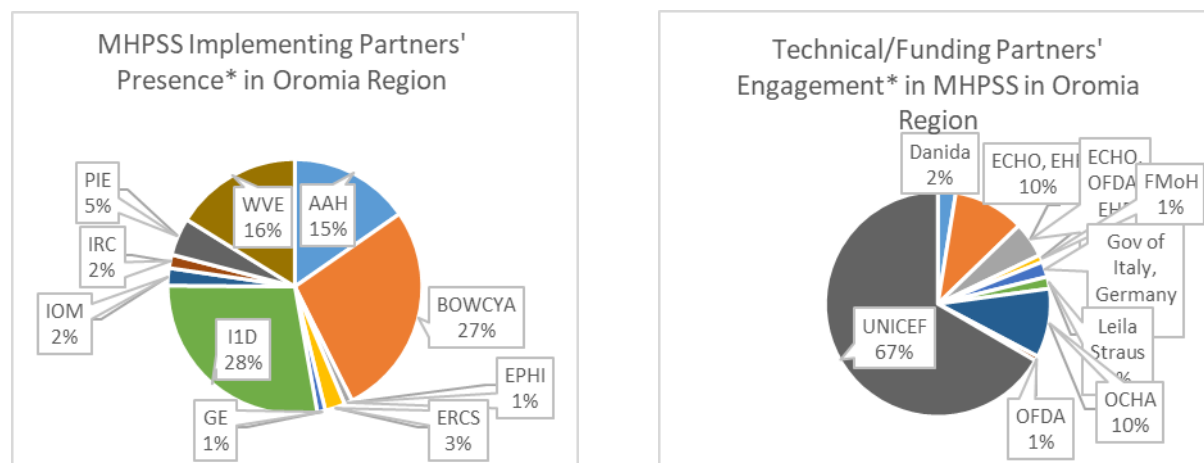
## 5.5 Oromia Region

As in Gedeo Zone, the analysis of findings from the 4Ws mapping in Oromia Region presents significant challenges, as during the time between data collection and finalization of the report, dramatic changes

occurred at field level, with IDPs population shifts, returns and relocations that have modified, and are likely to further affect the humanitarian landscape in the near future. Whenever possible, updates as of mid-May 2019 were collected from contributing partners and reflected in both the Service Directory and the mapping report. However, given the extreme fluidity of the situation, both the Directory and the mapping report have to be considered as purely indicative for this region. For the same reasons, unlike in other regions, only activities currently under implementation were considered for analysis, as pipeline funding may be affected by situational changes.

At the time of compiling this report, seven humanitarian partners were reportedly present in Oromia Region, and covering a relatively broad spectrum of MHPSS activities. In addition, the Ethiopian Public Health Institute conducted mental health care training of non-specialised personnel operating within the formal health system; whilst the Bureau of Women, Children and Youth Affairs has been implementing emergency psychosocial and protection activities in line with their mandate and complementing the community mobilization and case management work that is regularly carried out at woreda level. At the time of compiling this report, the combined effort of these governmental and non-governmental actors covered the 31 most affected districts within nine zones across the region.

FIGURE 44 AND 45

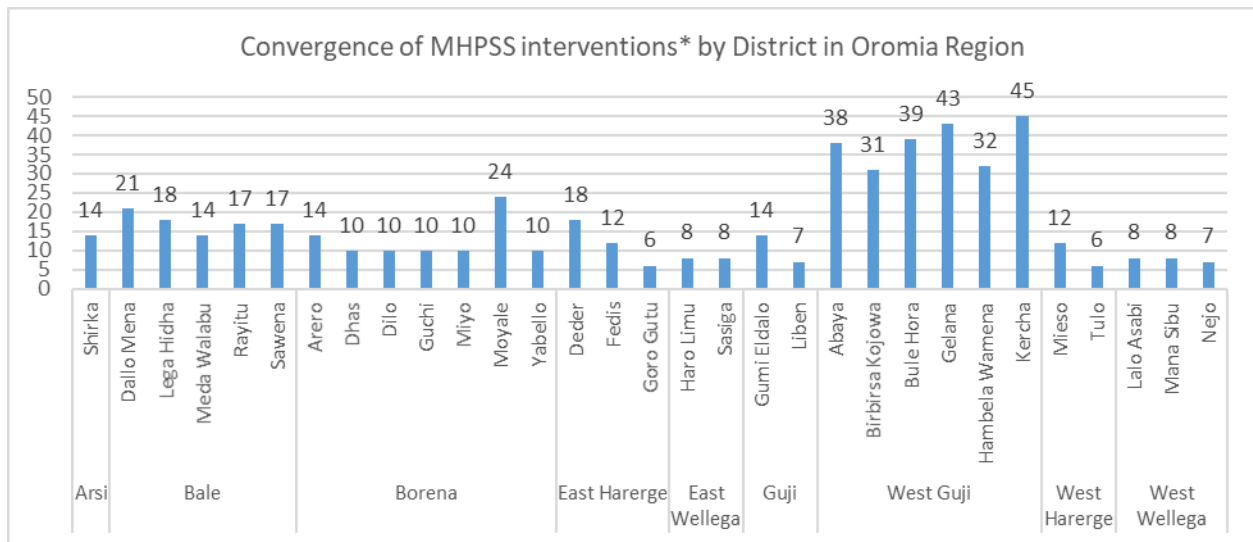


\* Current active presence; presence/engagement are measured in terms of volume of activities, not funding

FIGURE 46 – PARTNERS' ENGAGEMENT BY LEVEL OF ACTIVITY – OROMIA REGION

	Level 1		Level 2				Level 3	Level 4		11
	1	2	3	4	5	6	7	8	9/10	
	Mainstream MHPSS	Information Dissemination	Family and Community Support	Safe Spaces	Social and Emotional Learning	Psychosocial Support in Education	Focused Psychosocial Support	Psychological Interventions	Clinical Management of Mental Disorders	General Activities
AAH	*	*	*	*		*	*			
BOWCYA		*	*	*						*
EPHI									*	
ERCS	*	*	*	*	*	*	*			
GE							*			
I1D			*	*		*	*			*
IOM							*			
PIE			*	*			*	*		
WVE	*	*	*	*	*		*			

FIGURE 47



\* Under implementation

### Level 1 – MHPSS Considerations in Basic Services and Assistance

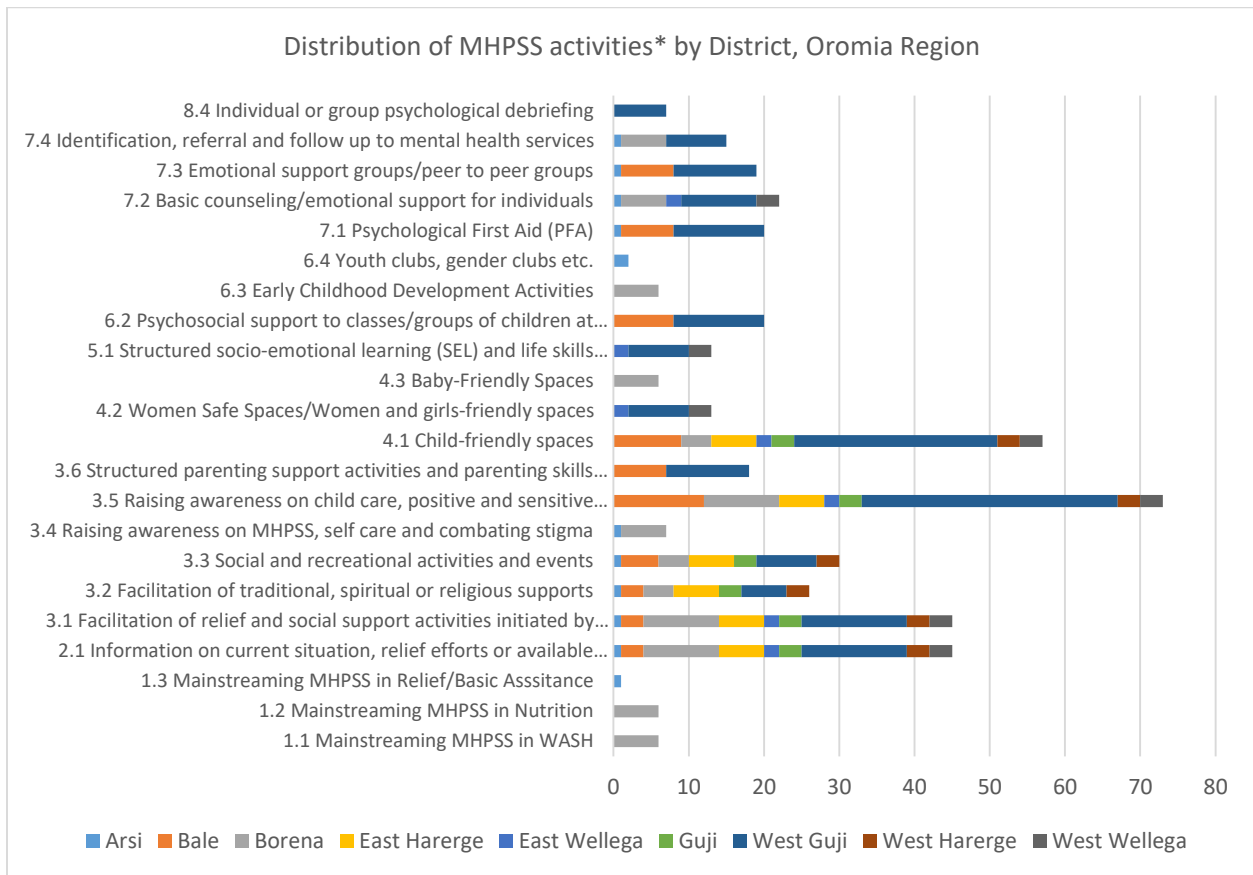
Three humanitarian partners – Action Against Hunger, the Ethiopian Red Cross Society and World Vision Ethiopia – reported conducting MHPSS mainstreaming activities in basic services and assistance; these interventions had limited geographical outreach, covering the Borena, Arsi and Wellegas zones only. No comprehensive information is available about how many sites per district were covered, nor how many people were reached within a 30-day period. Information dissemination, on the other hand, was reported to be a key component of BOWCYA’s interventions, with wide coverage both geographically and in terms of target groups.

### Level 2 – Strengthening Family and Community Supports

Level 2 activities were reported by six partners in 11 zones, with the greatest concentration and largest range of interventions reported in six affected districts in West Guji Zone. Activities include facilitation of community-driven social support initiatives, social and recreational events and awareness-raising on child care and child protection. Mental health awareness and self-care guidance were only reported by AAH and ERCS in Borena and Arsi respectively; there would appear to be a significant gap in terms of this crucial intervention in the other zones. Similarly, whilst unstructured parenting support activities were reported in all zones, only one partner – Imagine One Day – mentioned offering structured parenting curriculums in 10 Districts in Bale and West Guji.

57 Child Friendly Spaces were reported to be operational across the region at the time of data collection, with almost half of these concentrated in West Guji; in many instances, these CFSs were operated within schools or churches, and would not always offer the full package of both structured and unstructured activities that corresponds to the global CFSs standard. For example, manualised socio-emotional learning activities were only reported by Imagine One Day in West Guji, and by World Vision Ethiopia in East and West Wellegas; in both cases, at the time of reporting the continuation of these activities appeared predicated upon the evolving of the humanitarian situation on the ground.

FIGURE 48



\* Under implementation

Early childhood development activities were reported by one partner only, AAH, in Borena – representing another significant gap in the other zones. Psychosocial support activities in schools and learning places were only reported by I1D in Bale and West Guji.

### Level 3 – Focused Psychosocial Support

Most partners in Oromia reported offering some type of focused psychosocial support, with good geographical spread across the different affected zones. The East and West Hararghe and Guji zones represent an important exception, as no partner indicated their involvement with this level of intervention in such localities.

Reported activities appear to be largely limited to the provision of Psychological First Aid, basic counseling and emotional support, with no partner offering structured, manualised psychosocial interventions to children and adults experiencing greater difficulties in functioning and coping. Of additional concern, is the reported provision of individual and group debriefing – an intervention that is widely regarded to be potentially harmful – in West Guji. A technical review of this service may be advisable.

### Level 4 – Clinical Services

Humanitarian partners in Oromia region did not report offering any Level 4 specialised services. People in need of this level of intervention may be referred to primary hospitals, where non-specialised health personnel were trained by EPHI to diagnose and manage a range of common mental health conditions. More complex/severe cases – including post-traumatic presentations in children and adults – may be referred to the specialised mental health personnel stationed in general hospitals or referral hospitals. However, only three partners – AAH, ERCS and I1D – reported conducting identification and referral activities, indicating a need to invest more in building relevant skills in other partners’ teams; as in other regions/areas, other barriers to accessing clinical mental health services – related to the availability, affordability and acceptability of services – may need to be addressed as well. In addition, children experiencing neurodevelopmental delays, disorders and disabilities may not be able to access the multidisciplinary care often required for these types of difficulties.

### *Summary*

At the time of compiling this report, the MHPSS humanitarian response in Oromia Region appeared to include a good range of community-based interventions, mostly delivered through non-standardised approaches and packages. This level of intervention, if maintained in scope and size in the future to address the needs of returnee population, would benefit from greater alignment to minimum quality standards, as relevant and feasible in the humanitarian context in Ethiopia. Significant gaps in the area of Early Childhood Development, parenting support, and psychosocial support in education would need to be addressed to reach a more comprehensive scope of Level 2 activities.

Additionally, the response appeared significantly undersized at the other levels of intervention, and particularly in terms of case-focused and specialised support to children and adults experiencing more complex difficulties. It would appear advisable for partners to invest in strengthening capacity for safe case identification and referral, and possibly for specialised mental health organizations to expand their operations in the region. The development of referral pathways appears an urgent priority for the strengthening of the MHPSS continuum of care across both humanitarian and development settings.

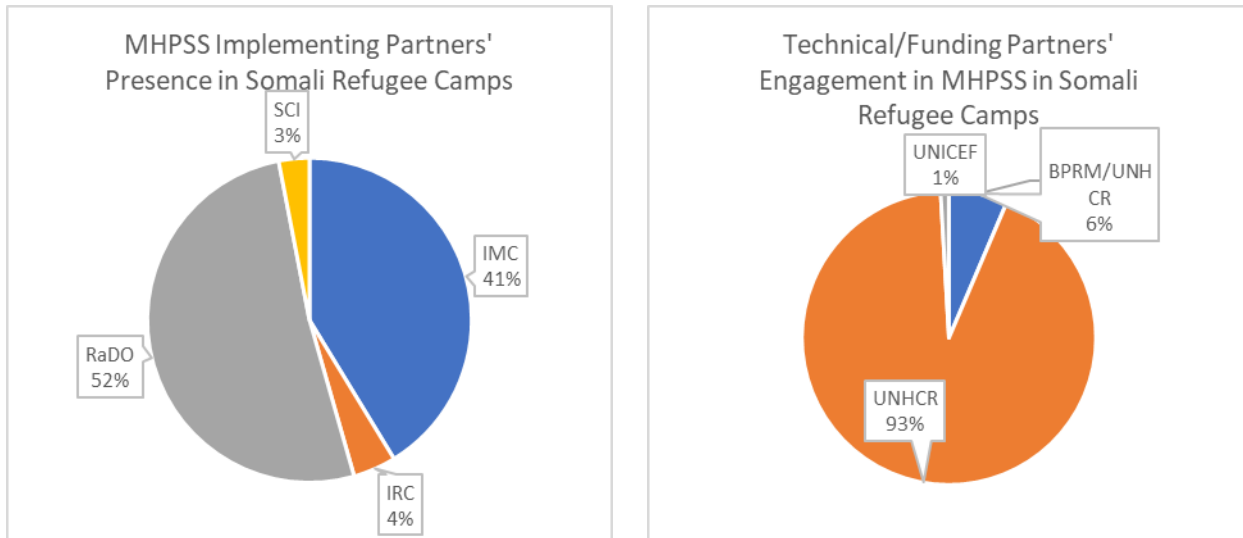
## **5.6 Somali Region**

### *5.6.1 Refugee Response*

As of August 2018, 256,200 refugees were present in the eight camps established in Somali Region (UNHCR, 2018). The governmental Agency for Refugees and Returnees Affairs (ARRA), is the main provider of facility-based psychosocial and mental health support in the camps. Complementing ARRA services, four humanitarian partners reported conducting, or planning to conduct, a range of community and facility-based MHPSS activities.



FIGURE 49 AND 50



\* Current active presence and pipeline interventions already funded; presence/engagement are measured in terms of volume of activities, not funding

FIGURE 51 – MHPSS PARTNERS' ENGAGEMENT BY LEVEL OF INTERVENTION – SOMALI REGION, REFUGEE CAMPS

	Level 1		Level 2				Level 3	Levels 3/4		11 General Activities
	1	2	3	4	5	6	7	8	9/10	
	Mainstreaming MHPSS	Information Dissemination	Family and Community Support	Safe Spaces	Social and Emotional Learning	Psychosocial Support in Education	Focused Psychosocial Support	Psychological Interventions	Clinical Management of Mental Disorders	
IMC	*	*	*			*	*		*	*
IRC			*	*	*					
RADO		*	*	*	*	*	*	*		*
SCI				*	*					

**Level 1 – MHPSS Considerations in Basic Services and Assistance**

MHPSS mainstreaming activities were reported by one partner, International Medical Corps, in the five camps in Liben/Dolo Ado; the sectors targeted for these mainstreaming efforts are Nutrition, WASH, Shelter and Basic Assistance. Information dissemination on relief efforts was reported by IMC, and is in the pipeline for Rehabilitation and Development Organisation. Information regarding the number of people reached by these activities is not available. Partners did not report any Level 1 activity, besides information dissemination, in the three camps in Fafan Zone.

**Level 2 – Strengthening Family and Community Supports**

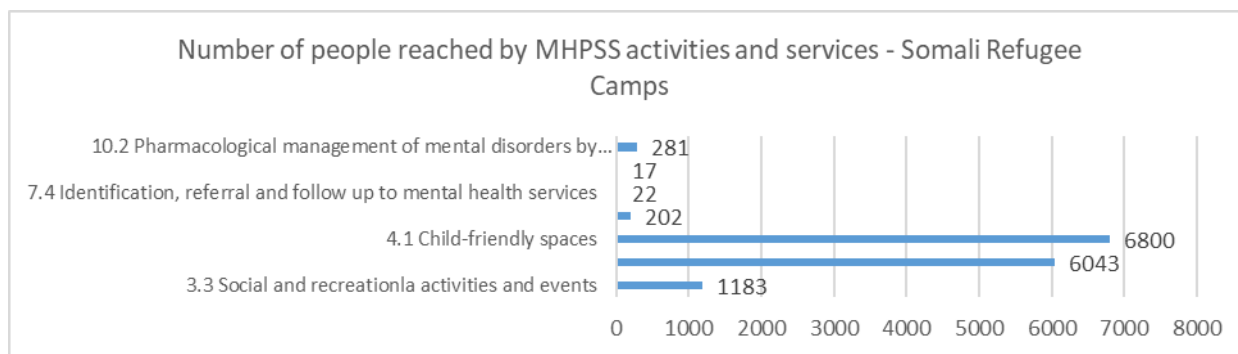
All partners reported conducting a range of Level 2 MHPSS activities, covering all camps in the region. Facilitation of community-led mutual support initiatives, social and recreational events, and awareness-raising on MHPSS and self-care were reported by IRC and IMC and, at the time of compiling this report, were in the pipeline for RADO; similarly, awareness-raising on childcare and structured parenting support appear to be run by all partners, although only IRC mentioned utilizing a validated package to support programme delivery.

At the time of compiling this report, Child Friendly Spaces were being operated by IRC and Save the Children in Fafan and Liben camps respectively, reaching out to 6,800 children in total in the 30 days prior to data collection. Given the large refugee population in the region, there appeared to be a need for additional safe spaces, which were indeed in the pipeline for RADO in all camps and were planned to target children with special needs. The activity package in the existing CFSs appeared to include both structured and unstructured activities, with all partners reporting the utilization of standardised Socio-Emotional Learning curriculums delivered by CP officers and social workers.

Women Safe Spaces were not reported by any of the contributing partners for the Somali refugee camps, however this activity as well was in RADO’s pipeline and was planned to cover all the camps in the region.

Psychosocial support in education was reported by IMC in the five camps in Fafan Zone. Additional interventions were planned by RADO, covering all the eight camps in the region, with a focus on Disability and Inclusion. Partners did not report any interventions in Early Childhood Development, which – given the criticality of the early years for long term emotional and psychosocial well-being – would appear to remain a significant gap.

**FIGURE 52**



\* Under implementation

### *Level 3 – Focused Psychosocial Support*

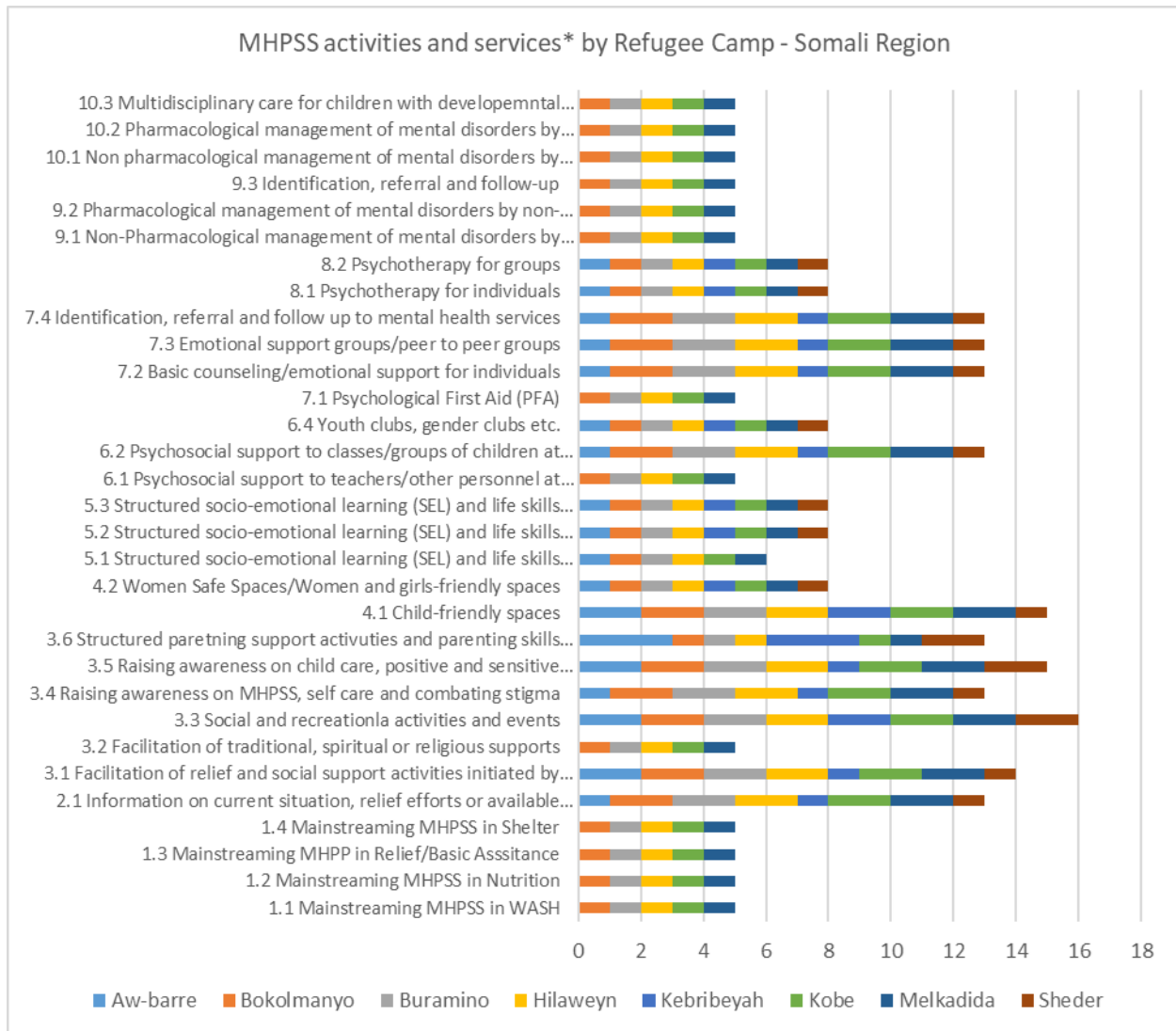
Focused psychosocial support, in the form of Psychological First Aid, basic counseling, and emotional support groups, was reported by IMC in the five camps in Fafan Zone. At the time of compiling this report, RADO was planning to extend this type of intervention to all the eight camps in the region, with a specific focus on Disability. The other partners involved in community-based psychosocial work did not report any case-focused interventions.

### *Level 4 – Clinical Services*

The partners offering focused psychosocial support also reported being involved in clinical mental health service delivery, which, in the case of IMC, is mainly provided within health care facilities and complementary to ARRA’s primary health care services. Partners provided very limited details regarding the type of clinical interventions provided, the number of people reached, and the profile of the professionals delivering these interventions; overall, the number of people receiving pharmacological treatment (281 in the 30 days prior to data collection) would appear to be much larger than the ones

receiving psychological interventions (17 reported for the same period), suggesting a possible need to strengthen the latter.

FIGURE 53



\* Under implementation and in pipeline with funding

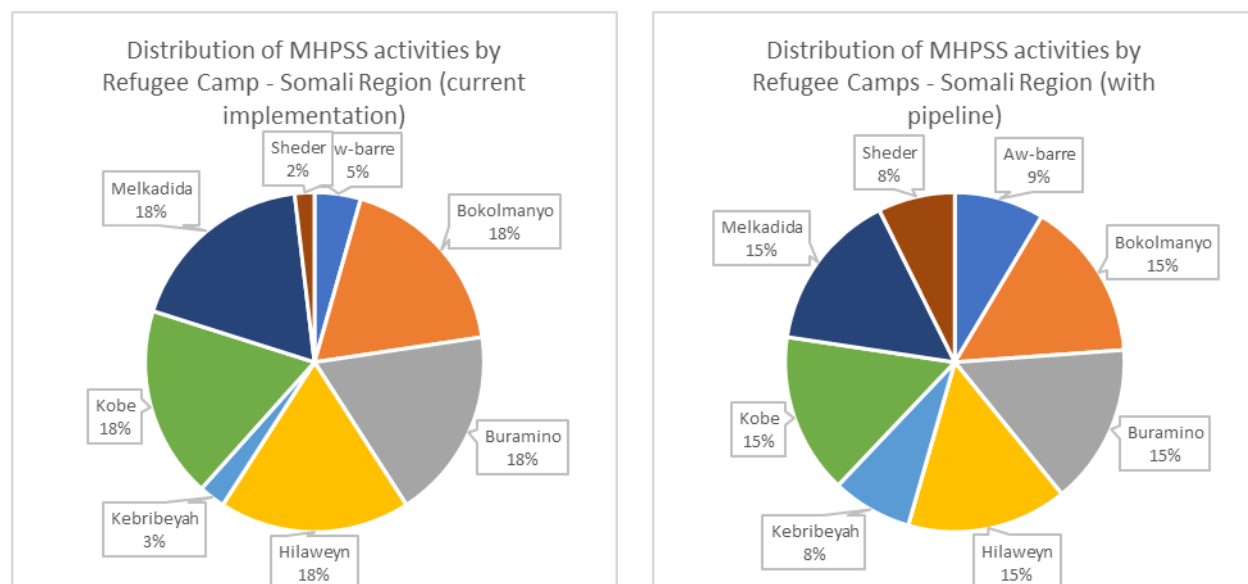
### Summary

Overall, at the time of compiling this report the MHPSS response in the refugee camps in Somali Region appeared less comprehensive than in other refugee operations in Ethiopia, particularly at the higher levels of mental and psychosocial care. Focused and specialised supports appeared to have limited coverage, with significant gaps reported in the three camps in Fafan Zone. The multifaceted initiative in RADO's pipeline may partly address the existing gaps – although the prevalent focus of this organization on Disability may imply that other priority issues within this very vulnerable refugee population may receive less attention. More than in other regions, in Somali there would appear to be a separation between the

partners engaged in community-based psychosocial support, and the ones involved in case-focused service provision, with limited continuity across the spectrum of MHPS care.

At community level, several partners were present with multiple activities, and with good geographical spread across the different camps; however, given the large number of adults and children in need, there may be scope for a scale-up of this level of intervention. Specific gaps would seem to exist in the area of Early Childhood Development, and in relation to Women’s Safe Spaces. The use of standardised packages and validated approaches in a majority of these psychosocial health promotion and prevention initiatives is a strength in this region to be further encouraged.

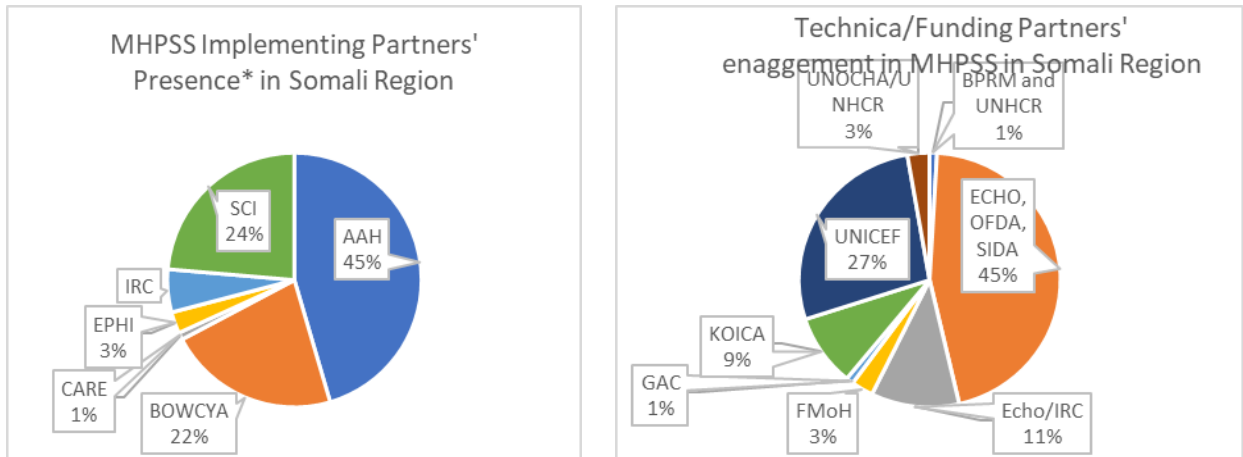
**FIGURE 54 AND 55**



### 3.6 IDPs response

Four humanitarian partners – Action Against Hunger, Care Ethiopia, International Rescue Committee and Save the Children – reported either an active presence or pipeline activities in the context of the IDP response in Somali Region. In addition, the Ethiopian Public Health Institute conducted mental health care training of non-specialised personnel operating within the formal health system; whilst the Bureau of Women, Children and Youth Affairs has been implementing emergency psychosocial and protection activities in line with their mandate and complementing the community mobilization and case management work that is regularly carried out at woreda level. The combined effort of these governmental and non-governmental actors covered, at the time of compiling this report, 11 most affected districts (with many districts reached by multiple partners). UNICEF supported 27% of these interventions.

FIGURE 56 AND 57

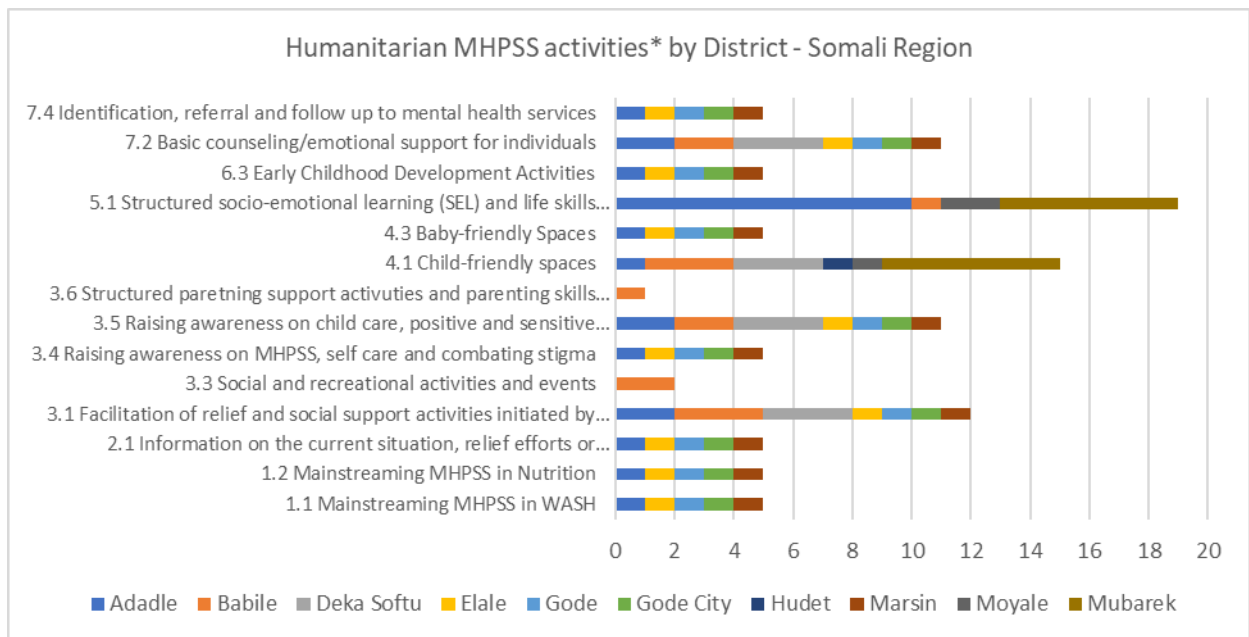


\*Current active presence and pipeline interventions already funded; presence/engagement are measured in terms of volume of activities, not funding

FIGURE 58 – PARTNERS' ENGAGEMENT BY LEVEL OF ACTIVITY – SOMALI REGION

	Level 1		Level 2				Level 3	Levels 3/4		11
	1	2	3	4	5	6	7	8	9/10	
	Mainstreaming MHPSS	Information Dissemination	Family and Community Support	Safe Spaces	Social and Emotional Learning	Psychosocial Support in Education	Focused Psychosocial Support	Psychological Interventions	Clinical Management of Mental Disorders	General Activities
AAH	*	*	*	*		*	*			
BOWCYA			*	*			*			
EPHI									*	
IRC			*	*	*					
SCI				*	*					

FIGURE 59



\*Currently under implementation

### *Level 1 – MHPSS Considerations in Basic Services and Assistance*

Level 1 activities in Somali IDPs sites were reported by one partner, Action Against Hunger, in five districts. No information was made available by the partner about how many sites per district were covered, nor how many people were being reached. Activities focused on mainstreaming MHPSS in WASH and Nutrition, as well as information dissemination on relief efforts. Since AAH targets a specific group – pregnant and lactating women and their children under five – it is reasonable to presume that the needs of other vulnerable categories of IDPs may still be insufficiently addressed.

### *Level 2 – Strengthening Family and Community Supports*

Level 2 activities were reported by four partners, covering 11 districts, with the greatest concentration and largest range of interventions reported in Adadle and Babile. Activities include facilitation of community-driven social support initiatives, social and recreational events, and awareness-raising on childcare, child protection and MHPSS. Structured parenting support activities were reported in one district only (Babile) and would appear to be an area of possible expansion and focus for future interventions.

Fifteen Child Friendly Spaces were reported to be operational in six districts, with more spaces in the pipeline for two partners. Over 30,000 children aged 6 to 17 years had access to the existing CFSs in the 30 days prior to data collection. The standard CFS activity package in the CFSs appeared to include both structured and unstructured activities, with socio-emotional learning and life skills activities reported in 7 CFSs and 12 schools across 19 sites.

### *Level 3 – Focused Psychosocial Support*

The higher levels of psychosocial care appeared to be a significant gap in Somali Region. Only two partners mentioned offering case-focused support to adults and children in distress: Action Against Hunger – which, as mentioned above, only focuses on a very specific target group – and BOWCYA, who reported providing basic emotional support and counseling in the context of child protection and GBV prevention and response activities. Partners did not mention utilising any standardised case-focused methodologies; however, BOWCYA staff were trained to deliver WHO’s Psychological First Aid model. No partner reported offering brief psychosocial interventions to people experiencing greater difficulties with functioning and coping.

### *Level 4 – Clinical Services*

Humanitarian partners in Somali Region did not report offering any Level 4 specialised services. People in need of this level of intervention may be referred to primary hospitals across the region, where non-specialised health personnel were trained by EPHI to diagnose and manage a range of common mental health conditions. More complex/severe cases – including post-traumatic presentations in children and adults – may be referred to general hospitals at zonal level, or to specialised services within Jigjiga’s referral hospital. However only Action Against Hunger reported conducting identification and referral activities, indicating a need to invest more in building relevant skills of staff of other partners; as in other regions, additional barriers to accessing clinical mental health services – related to the availability, affordability and acceptability of the latter – may need to be addressed as well. In addition, children experiencing neurodevelopmental delays, disorders and disabilities may not be able to access the multidisciplinary care often required for this type of difficulties.

### *Summary*

Overall, at the time of compiling this report the MHPSS humanitarian response in Somali region appeared to include a range of community-based interventions, delivered through a sound mix of standardised and non-standardised approaches. The response, whilst better structured than in other affected regions, still appeared undersized in terms of geographical outreach and number of people assisted, with a large proportion of the needs remaining unmet. Planned interventions by IRC and CARE – still in the pipeline at the time of compiling this report – may contribute to addressing this gap; however additional efforts may be required to ensure that the response reaches the most vulnerable within the affected communities, particularly those residing in remote locations. Of particular concern is the reported extreme paucity of referral options for children and adults in need of case-focused and specialised care, as well as the apparently limited capacity for case identification and referral; both would appear to be urgent priorities for future planning and intervention.

## **5.7 Tigray Region**

### *5.7.1 Refugee Response*

As of August 2018, 43,740 refugees were present in Tigray Region – Shire (UNHCR, 2018). The governmental Agency for Refugees and Returnees Affairs (ARRA) is the main provider of facility-based Psychosocial and Mental Health Support in the camps. Complementing ARRA services, three humanitarian partners – the Center for Victims of Torture, the Norwegian Refugee Council and the Rehabilitation and Development Organisation – reported conducting, or planning to conduct, a range of community and facility-based MHPSS activities. A fourth partner, Médecins Sans Frontières Holland, reportedly provides similar services in Shimelba and Hitsats Refugee Camps – however the organization has not shared inputs into the mapping exercise, therefore detailed information about their work was not available at the time of compiling this report.

#### *Level 1 – MHPSS Considerations in Basic Services and Assistance*

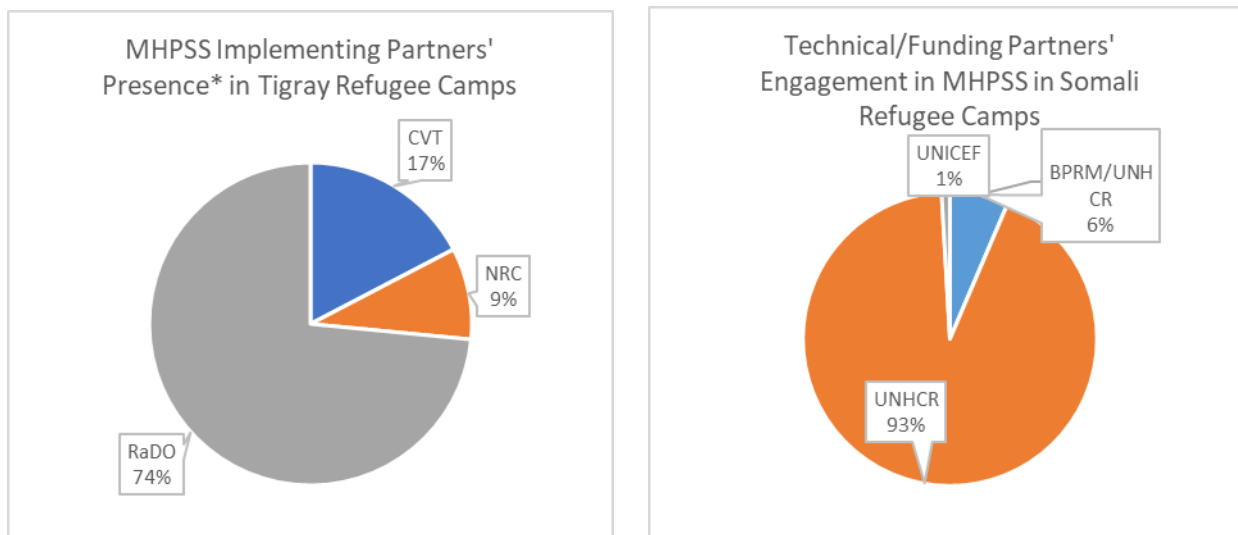
Partners did not report any ongoing Level 1 activity at the time of compiling this report. However, MHPSS mainstreaming activities in Nutrition were reported to be in RADO's pipeline for Mai-Aini camp, and information dissemination was being planned by the same organization for the other three camps. As in most other regions, additional investments in MHPSS mainstreaming would appear advisable in Shire, given the vulnerability of the population affected and the generally limited attention that non-MHPSS humanitarian actors pay to addressing psychosocial needs of the people they aim to assist.

#### *Level 2 – Strengthening Family and Community Supports*

Level 2 activities are equally limited in Shire. Awareness-raising on MHPSS and self-care were reported by CVT in Mai-Aini and Adi Harush; in the same camps, and in Hitsats, NRC reported conducting structured parenting support activities. Additional activities, including facilitation of community-led mutual support initiatives, social and recreational events, and awareness-raising on childcare were reported to be in the pipeline for the four camps by RADO.

Child Friendly Spaces were being operated, at the time of compiling this report, by NRC in three camps, reaching out to 2,576 children in total in the 30 days prior to data collection. No CFS was reported to be functioning, or to be in the pipeline, for Shimelba. Partners did not report running any Women Safe Spaces, however the organization with primary accountability on SGBV prevention and response in Shire, IRC, did not share inputs for the Tigray Region, therefore no details are available about this component of their work.

FIGURE 60 AND 61



\* Current active presence and pipeline interventions already funded; presence/engagement are measured in terms of volume of activities, not funding

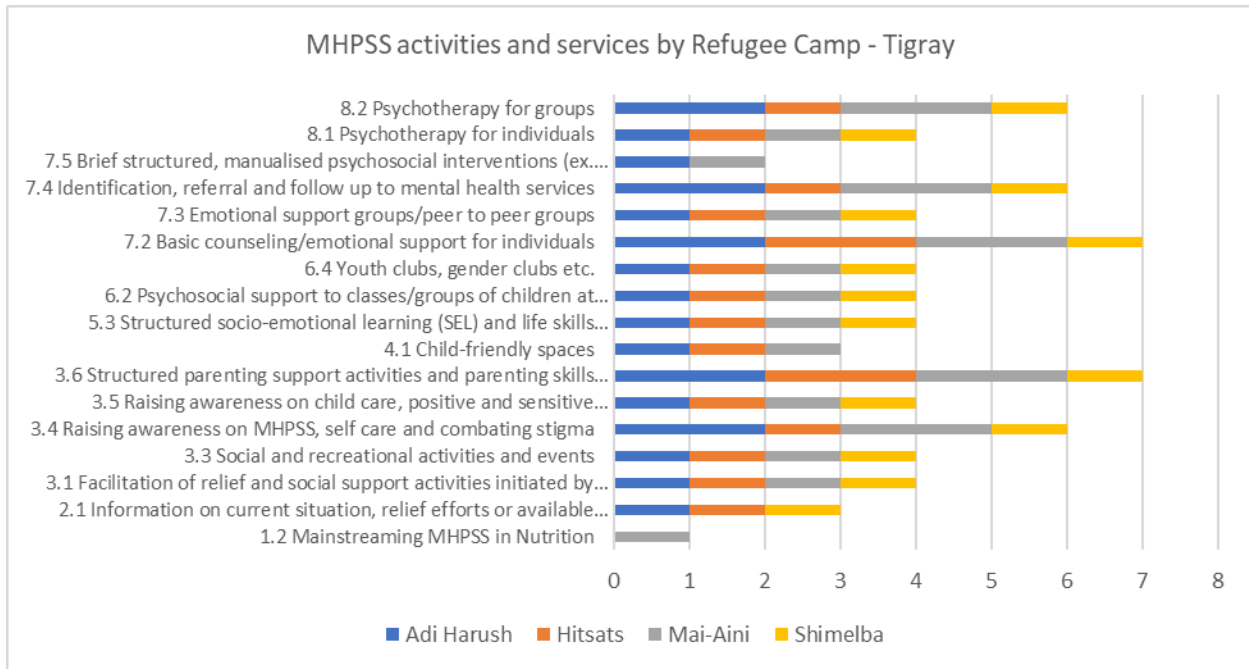
FIGURE 62 – MHPSS PARTNERS' ENGAGEMENT BY LEVEL OF INTERVENTION – TIGRAY REGION, REFUGEE CAMPS

	Level 1		Level 2				Level 3	Levels 3/4		11
	1	2	3	4	5	6	7	8	9/10	
	Mainstreaming MHPSS	Information Dissemination	Family and Community Support	Safe Spaces	Social and Emotional Learning	Psychosocial Support in Education	Focused Psychosocial Support	Psychological Interventions	Clinical Management of Mental Disorders	General Activities
NRC			*	*			*			
RADO		*	*		*	*	*	*		*
CVT			*	*			*			

At the time of data collection, psychosocial support in education was being planned by RADO in the four camps. This includes socio-emotional learning and life skills building activities, psychosocial support to teachers and students, and mobilisation of youth and gender clubs, with a focus on Disability and Inclusion. Partners did not report any interventions in Early Childhood Development, which – given the criticality of the early years for long term emotional and psychosocial well-being – would appear to remain a significant gap.



FIGURE 63

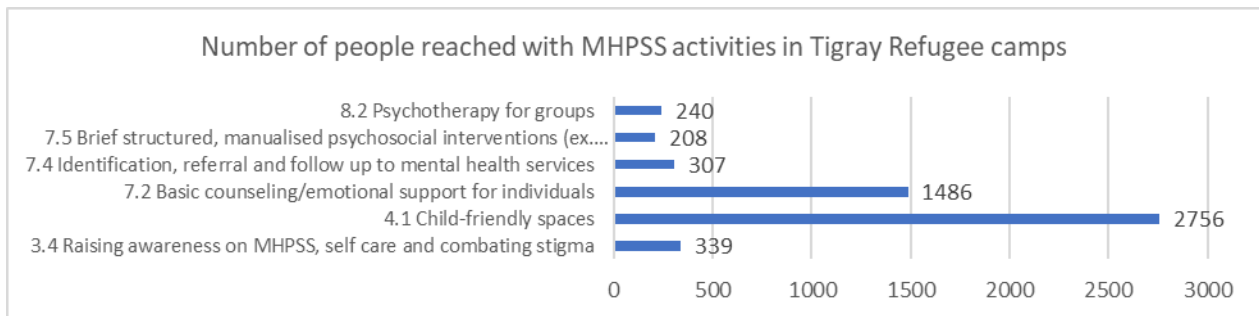


\* Under implementation and in pipeline with funding

**Level 3 – Focused Psychosocial Support**

Compared to community-based interventions, Level 3 and 4 activities appeared better structured in Shire. Focused psychosocial support, in the form of basic counseling and emotional support groups, was reported by NRC in Mai-Aini, Adi Harush and Histats, with a good outreach – 1,486 adults and children assisted in the 30 days prior to data collection. In addition, in the first two camps, CVT reported providing psychoeducation and case identification and referral, with 208 and 307 people reached in 30 days, respectively. RADO on the other hand, was planning to extend similar interventions to all the camps in the region, with a specific focus on Disability. None of the partners indicated using standardised or manualised methodologies for these activities.

FIGURE 64



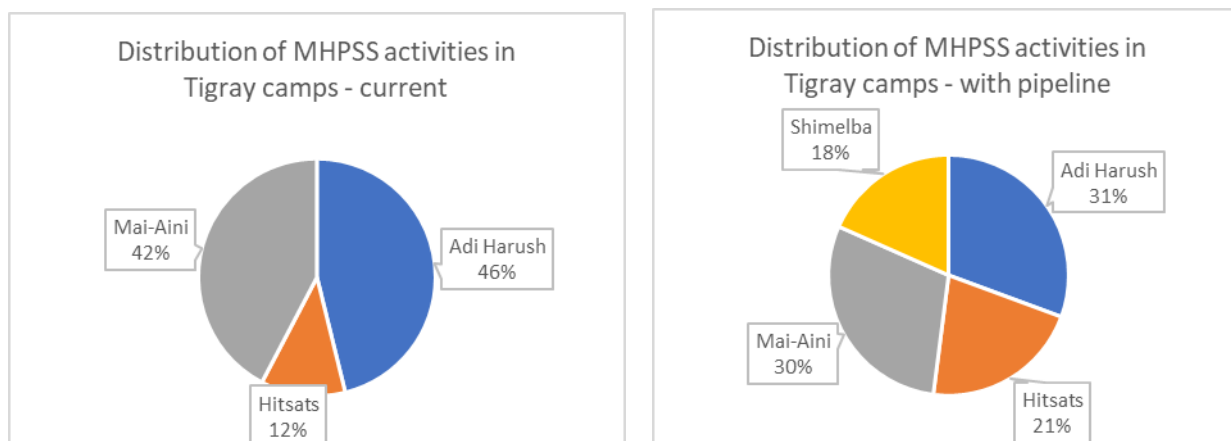
\* Under implementation

**Level 4 – Clinical Services**

Psychotherapy services for trauma survivors were being offered, at the time of compiling this report, by CVT in Mai-Aini and Adi Harush, following the organization’s internationally validated Group Trauma

Counseling approach. 240 adults and children were reached through this intervention in the 30 days prior to data collection. In addition, RADO reported plans to extend individual and group psychotherapy to all Shire camps. Contributing partners did not report any current or pipeline initiatives related to the clinical management of mental disorders within health facilities – which, as mentioned above, would appear to fall within MSF-H’s area of responsibility in Shimelba and Hitsats, and ARRA’s in Mai-Aini and Adi Harush.

FIGURE 65 AND 66



### Summary

Overall, at the time of compiling this report, the MHPSS response in the refugee camps in Tigray Region appeared less comprehensive than in other refugee operations in Ethiopia, particularly at the level of community-based interventions. The relative shortage of mental and psychosocial health promotion and prevention activities would appear to represent a concerning gap, given the role that such initiatives may play in boosting the resilience of very vulnerable individuals and communities – and particularly of children and young people. Further investments in Level 1 and 2 interventions, and additional attention paid to the use of validated approaches at these levels of intervention, may be advisable in this region.

In addition, case-focused psychosocial and mental health care services, whilst reportedly having good outreach, appeared unequally distributed across the four camps, covering – as per the information available for this report – only the two camps of Mai-Aini and Adi Harush. The multifaceted intervention planned by RADO appeared designed to cover some of these gaps, both geographically and in terms of service range; however, the organization’s main focus on Disability may imply that other important priorities within the MHPSS spectrum of intervention may receive comparatively less attention. The presence of organizations specialising in mental health – particularly CVT – represents an important asset for this region, with perhaps untapped potential that could be further explored.

### 3.3.7.2 Other MHPSS services not directed to refugees

In addition to the services reported above, five partners working with specific vulnerable groups in Tigray, provided additional inputs into the mapping exercise. ERCS reported providing Level 1, 2 and 3 activities to children and adult returnees from Gulf Countries; activities were reported to take place in Endabaguna town. In addition, four local organizations – Tebegiso Social Support Association (TSSA), Senay Tegibar Yeaemiro Human Charity Association (STYH), Tigray Association for Intellectual Disabilities (TAID) and

Missionaries of Charity (MoC) – reported providing Level 3 and 4 services to children and adults with intellectual disabilities, and parenting support to their caregivers. TSSA and STYH’s activities were reported to be taking place in Mekelle Ayder Referral Hospital, with outreach interventions in the suburbs of the city; TAID and MoC’s activities were indicated for Mekelle, Adigrat and Axum. The latter two organizations also stated providing livelihoods support to families of children with specific needs.

## Chapter 6 – Summary of Key Recommendations

### General recommendations

#### *1. Increase investment in mental and psychosocial health in Ethiopia.*

The most significant finding from the mapping exercise is the persistence of a large gap between the estimated needs on the ground and the financial, technical and human resources available to address these. Within the context of the IDPs/returnees response, mental and psychosocial health interventions appeared to have very limited range and coverage in some regions (Benishangul Gumuz, Oromia, Somali) and to be almost non-existent in others (Amhara, Tigray). Within the refugee response, whilst a larger range of better-structured services and activities appeared to be in place, gaps seemed to remain both in terms of geographical coverage, and in terms of scope of service provision – particularly at the higher levels of intervention. There appeared to be a pressing need for much larger investments in the entire MHPSS care continuum, from basic community-driven interventions up to the level of specialised services, to mitigate the impact that structural and contingent adversities might otherwise have on generations of Ethiopians and refugees.

### Recommendations focused on strengthening the different tiers of interventions

#### *2. Mitigate mental and psychosocial health risk factors, by increasing the programmatic focus on Level 1 MHPSS.*

The mapping highlighted a significant gap in Level 1 interventions – that is, interventions aimed at mainstreaming MHPSS considerations and priorities in the design and delivery of basic services and assistance, and in the establishment of safety and security for the people affected by the humanitarian emergency. The programmatic consensus (IASC, 2007) recommends Level 1 interventions to have the widest scope and outreach – something that the mapping did not reflect as being in place in either the IDPs/returnee or the refugee context in Ethiopia. It would appear, therefore, desirable for the MHPSS TWG and its members to strengthen this tier, and possibly to develop contextualised minimum standards, guidelines and sets of key messages for easy use by non-specialised partners (i.e. humanitarian partners non-specialized in MHPSS, and who provide basic services and assistance). Among the specific areas to be strengthened, the mainstreaming of MHPSS key messages around early childhood development – including physical and emotional safety, nurturing caregiving and stimulation – in maternal, neonatal and child health and nutrition programming.

#### *3. Expand scope and strengthen quality of community-based MHPSS work across humanitarian settings.*

Findings from the mapping suggest that whilst Level 2 interventions – strengthening of family and community supports – constituted the bulk of MHPSS efforts in both IDPs and refugees settings, scope for qualitative improvements would appear to exist in both contexts.

Child Friendly Spaces appeared to drive the MHPSS response in the country; findings from the mapping exercise suggest that the structure and scope of the CFSs varied widely from partner to partner, and according to location and response setting. It is recommended that partners agree on a contextualised set of minimum standards, aligned to global standards, that can inform the planning and delivery of CFS activities across the board.

Socio-emotional learning activities – which have a solid evidence base as effective resilience-building interventions in low-resource and post-conflict settings (Petersen *et al.*, 2016) – appeared to be mainstreamed in the refugee context, but relatively underdeveloped in IDPs/returnees settings, and should be comprehensively included in intervention packages within and beyond the child protection and education sectors. The same would appear to be true for structured parenting support activities – an equally well-researched intervention (Petersen *et al.*, 2016) – which seemed to be only occasionally included within IDPs/returnees response packages.

*4. Mainstream capacity for basic emotional support and Psychological First Aid among humanitarian partners.*

The mapping highlighted important gaps in the provision of person-focused services (Level 3 and 4 MHPSS), particularly within the IDPs/returnees response context. Whilst this is understandable in the light of the structural challenges that affect mental and psychosocial care in the country – and whilst widespread stigma continues to affect both the demand and supply sides of mental health service provision – the widely reported prevalence of high levels of distress, mental health difficulties, and suicidality among adults, youth and children represent a compelling call for action for institutional, humanitarian and development partners.

An important first step in the direction of more comprehensive person-focused care would be the strengthening of basic emotional support capacity and Psychological First Aid among frontliners, as a key gap-stopping and “do no harm” measure, whilst more elaborate interventions are being set up. Such capacity appeared to be already quite well developed within the refugee context, and in some locations interested by IDPs/returnees presence; but significant gaps appeared to exist in the latter context, which MHPSS partners are recommended to address as a matter of priority. Further steps may include strengthening capacity for psychosocial assessment, case formulation and case planning, which partners appeared to be already conducting in the context of child protection and GBV case management, particularly within the refugee context, and that may need further reinforcement, particularly within the IDPs/returnees context.

- 5. Support task-shifting approaches to the provision of person-focused mental and psychosocial health care, and as part of that,*
- 6. Scale-up capacity for the provision of structured psychosocial interventions with good evidence of effectiveness in Ethiopia, both in humanitarian settings and within the formal health system.*

Partners engaged in person-focused work may wish to consider adopting task-shifting approaches to expand the provision of validated low-intensity interventions that have good evidence of effectiveness for emotional distress and interpersonal difficulties in low-resource, post-conflict settings. Technical capacity

exists in the country to provide some of these interventions: examples would include manualised interventions such as the Problem Management + package, Solution-Focused Brief Therapy and Interpersonal Psychotherapy protocols, and others. Findings from the mapping suggest that these services were, at the time of compiling this report, offered in a limited number of locations within the refugee context. It would appear recommendable to look at sustainable models through which these initiatives could be scaled up to reach larger numbers of people; task-shifting would involve training non-specialised health, social welfare and community workers to provide these interventions under technical supervision. This approach would be in line with the National Mental Health Strategy, which also prioritises task-shifting and stepped-care approaches as main tools for reducing gaps in mental and psychosocial health care in the country.

*7. Support access to care for children and adults in need of specialised interventions.*

Referral options at the highest level of care appeared to be quite limited in the humanitarian context; in particular, access to multidisciplinary care for children experiencing developmental disorders or disabilities would appear to be one of the most significant systemic gaps in the country. Whilst this type of intervention may be considered beyond the scope and remit of humanitarian partners, a quick review of prevalence data (FMoH, 2019) may serve as a reminder of the importance of this theme, and as a call for contributions to fill this service gap for hundreds of thousand Ethiopian and refugee children.

### Recommendations focused on strengthening the MHPSS continuum of care

*8. Mainstream capacity for safe identification and referral among humanitarian partners.*

The mapping highlighted what would appear to be a rather modest capacity for identification and referral of mental and psychosocial health needs in both IDPs/returnees and – to a slightly lesser extent – in refugee contexts. The MHPSS TWG and its members may want to develop a capacity training package for non-specialised humanitarian actors, whilst working collaboratively with the Federal Ministry of Health and MHPSS service providers within the formal health system to develop viable referral pathways, mechanism and tools.

*9. Strengthen convergence, by identifying a “minimum core package” of humanitarian MHPSS activities, in line with IASC recommendations (2007), that can be implemented with the widest outreach.*

Recognizing that access to services and interventions that are geographically distant may be challenging for most people, it would appear advisable to strengthen geographic convergence, by identifying a minimum core package of interventions that MHPSS partners would implement with the widest possible outreach. In line with IASC recommendations, such minimum package would include, for the most part, Level 1 and 2 activities, with a strong component of safe identification and referral to ensure good access to further help for those individuals for whom community-based support is not sufficient. The EMHPSS TWG may represent an ideal platform to develop such minimum package, in coordination with the CP/GBV AoR.

*10. Strengthen referral pathways and the continuum of care*

Findings from the mapping exercise highlight what appear to be significant inconsistencies and gaps in the humanitarian MHPSS care continuum in all regions. It is advisable to plan interventions aimed at filling the most prominent service gaps, whilst in parallel strengthening the integration of MHPSS care across levels of interventions. In particular, the establishment of reciprocal referral pathways and mechanisms for integrated care planning across the community-based and person-focused levels of MHPSS intervention might make a significant contribution to better psychosocial health for individuals and communities in Ethiopia. A possible model for this may be provided by the Programme for Improving Mental Health (PRIME) project<sup>10</sup>, a consortium of academic institutions and ministries of health in five countries, including Ethiopia; through this project, Mental Health Care Plans have been established in two districts, bringing together community and health systems knowledge, resources and networks at local level. This experience is currently under evaluation (De Silva *et al.*, 2016) and may provide an interesting blueprint for further participatory and community-based planning of mental and psychosocial health promotion, prevention and intervention in the country.

*11. Consider revisiting the skill mix in the delivery of MHPSS interventions.*

As reported by the partners, most of the humanitarian MHPSS activities appeared to be delivered by a mix of specialised and non-specialised protection and health personnel – including CP and GBV officers, social workers, health professionals – collaborating with community workers. Mental health specialists were reported to be involved at all levels of the intervention pyramid, including in different types of Level 1 and Level 2 activities. It may be argued that, in a country where these specialised human resources are in short supply, their involvement in technical supervision, training, and direct delivery of referral services may be more strategic than their large involvement in community sensitization, recreational events, and similar community-based activities. Also of note, is the absence of social workers at the higher levels of MHPSS service provision, which may suggest the need for a stronger skill mix within clinical settings.

### Recommendations focused on strengthening quality of service delivery

*12. Strengthen consistency and quality service delivery by adopting standardised/validated packages and approaches.*

As reported by contributing partners, the large majority of the activities and services delivered in both IDPs/returnees and refugee settings appeared not to follow any standardised/validated approach, curriculum or set of key messages. This may imply limited replicability and consistency across localities and providers, and may represent a challenge in terms of quality assurance, technical sustainability and potential for scale-up. Given that several activity packages, at various levels of intervention, have been either specifically developed, or validated and contextualised, for Ethiopia, their wider adoption would appear advisable.

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<sup>10</sup> <http://www.prime.uct.ac.za/prime-ethiopia>

*13. Mainstream the provision of supportive technical supervision to frontliners, to ensure quality and “do no harm”.*

It is advised that efforts to expand the scope and depth of MHPSS service provision go hand in hand with the setting up or strengthening of technical supervision systems. Inconsistencies in partners’ reporting do not allow for any conclusions to be drawn regarding how well-established these are across levels of intervention. Observational evidence would suggest that this may be an aspect to further consolidate; as far as possible, partners should ensure that provision of psychosocial care, at any level, is supported and complemented by viable and effective safety and quality assurance mechanisms.

*14. Improve age-focused targeting, to mitigate vulnerabilities and increase “return-of-investment” in MHPSS.*

Findings from the mapping suggest that most activities in refugee settings were designed to reach “all age groups”. In the IDPs/returnees context, on the other hand, a more explicit focus on targeting children and youth was reported, but without great differentiation according to age bracket. In the light of the specific strengths and vulnerabilities that very young children on the one hand, and adolescents on the other, are more likely to display in contexts of adversity, it is recommended to strengthen programmatic efforts explicitly designed to meet the needs of these two groups – whilst continuing to focus on school-age children as well.

*15. Improve gender-based targeting, to address the different ways in which adversity affects men and women, boys and girls.*

As reported by contributing partners, most activities and services are designed to reach both “males and females”, with limited deliberate targeting of girls/women or boys/men. Whilst it may be that more gender-specific activities are actually in place than the partners reported, it is recommended to ensure that, besides universal interventions aimed at the community, at students, or at children as a whole, more initiatives are also set up to respond to the specific needs of males and females.

*16. Conduct a technical review of ongoing psychological debriefing interventions, and ensure compliance with “do no harm”.*

Findings from the mapping exercise suggest that psychological debriefing interventions may be ongoing in certain locations; observational evidence would suggest that a large number of humanitarian aid workers believes that prompting people, in the immediate aftermath of a highly distressing event, to revisit the minute details of their factual and emotional experience, may help survivors overcome their feelings of distress. However, research evidence – summarised in a WHO recommendation (2003) – points to the fact that such interventions may not be effective and may, in fact, be potentially hindering the healing process. It would be useful to review the existing interventions in the light of this recommendation – noting that the latter may undergo further review and update in the future.



## Recommendations focused on strengthening the MHPSS sector

### *17. Strengthen advocacy efforts and ensure access to care and protection for children and adults experiencing mental health difficulties.*

The findings of this mapping suggest that there is a need for continued advocacy efforts to ensure access to good quality mental and psychosocial health promotion, prevention and intervention in both humanitarian and development settings in Ethiopia. Parallel efforts should be made to advocate for the rights and protection of children and adults who experience mental health difficulties, and who would appear to be – in Ethiopia much like many other contexts across the world – particularly vulnerable to violations and maltreatment. The strengthening of systems of support should go hand in hand with wide-scale efforts to remove the stigma attached to mental health, which appear to be still widely present among the affected communities as well as the humanitarian actors in charge of assisting them. The demystification of mental health care and mental health difficulties appear an urgent preliminary step towards removing some of the obstacles that hinder the effective prevention and mitigation of psychosocial distress across humanitarian and development contexts.

### *18. Continue to generate evidence of resources, needs and gaps within and beyond the humanitarian context.*

This mapping provides a relatively comprehensive overview of humanitarian MHPSS services available in Ethiopia at the time of the data collection (for its limitation, please see Chapter 7). Given the fluidity of the situation on the ground, and the evolving humanitarian landscape, ideally this exercise – or a “lighter” version of it – should be repeated and updated on a yearly basis. It would also be important for this to be accompanied by a comprehensive mental health needs assessment, aimed at estimating quantitative and qualitative dimensions of mental distress and ill-health among affected populations and host communities. At the time of compiling this report, the latter was being planned by the Ethiopian Public Health Institute, in collaboration with the University of Addis Ababa. Finally, since the 4Ws mapping was mainly focused on humanitarian MHPSS interventions, a parallel assessment of the formal Mental Health System – complemented by qualitative analyses of service users’ perspectives, experiences, and understanding of mental well-being and ill health – would be helpful to generate a full picture of existing resources, needs and gaps in the country.

## References

- De Silva *et al.* (2016). Evaluation of District Mental Healthcare Plans: the PRIME Consortium Methodology. *British Journal of Psychiatry*, 208 (Suppl 56): s63–s70.
- Fekadu, A., et al. (2014). Development of a scalable mental healthcare plan for a rural district in Ethiopia. *British Journal of Psychiatry Supplement*
- FMoH (2012). *National Mental Health Strategy 2012/13–2015/16*
- FMoH (2019). *National Mental Health Strategy 2019–2015 (2011–2017 EFY)*. Unpublished document.
- Getachew *et al.* (2019). Prevalence of common mental illnesses in Ethiopia: A systematic review and meta-analysis. *Neurology, Psychiatry and Brain Research*, 30: 74–85
- IASC (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. <http://www.humanitarianinfo.org/iasc>
- IASC (2013). Who is doing What, Where in Mental Health and Psychosocial Support. Manual with Activity Codes. [https://www.who.int/mental\\_health/publications/iasc\\_4ws/en/](https://www.who.int/mental_health/publications/iasc_4ws/en/)
- NDRMC & HCT (2019a). Ethiopia Humanitarian Needs Overview, 2019. <https://www.humanitarianresponse.info/en/operations/ethiopia>
- NDRMC & HCT (2019b). Ethiopia Humanitarian Response Plan, 2019. <https://www.humanitarianresponse.info/en/operations/ethiopia>
- Petersen, I; Evans-Lacko, S; Semrau, M; Barry, M. M. Chisholm, D.; Gronholm, P.; Egbe, C. O.; Thornicroft, G. (2016). Promotion, prevention and protection: interventions at the population- and community-levels for mental, neurological and substance use disorders in low- and middle-income countries. *International Journal of Mental Health Systems*, 10
- Selamu & Singhe (2017). Mental Illness: Global African and Ethiopian Perspectives. *Psychology and Psychiatry*, 3.4: 107–110
- UNICEF (2010). Core Commitments for Children in Humanitarian Action. [https://www.unicef.org/publications/index\\_21835.html](https://www.unicef.org/publications/index_21835.html)
- UNICEF (2011). Community-based Infant and Young Child Feeding. [https://www.unicef.org/nutrition/index\\_58362.html](https://www.unicef.org/nutrition/index_58362.html)
- UNICEF (2018). Community-based Mental Health and Psychosocial Support in Humanitarian Settings: three-tiered support for children and families. <https://www.unicef.org/media/52171/file>

WHO (2003). Single-session Psychological Debriefing: Not Recommended. Geneva, World Health Organization

WHO (2008). *Mental Health Gap Action Programme. Scaling up care for mental, neurological, and substance use disorders*. [https://www.who.int/mental\\_health/evidence/mhGAP/en/](https://www.who.int/mental_health/evidence/mhGAP/en/)

WHO (2013). Comprehensive Mental Health Action Plan 2013–2020. [https://www.who.int/mental\\_health/action\\_plan\\_2013/en/](https://www.who.int/mental_health/action_plan_2013/en/)

WHO (2015). *mhGAP Humanitarian Intervention Guide (mhGAP-HIG). Clinical management of mental, neurological and substance use conditions in humanitarian emergencies*. [https://www.who.int/mental\\_health/publications/mhgap\\_hig/en/](https://www.who.int/mental_health/publications/mhgap_hig/en/)

WHO (2016). *mhGAP Intervention Guide, v.2.0. For mental, neurological and substance use disorders in non specialised health settings*. [https://www.who.int/mental\\_health/mhgap/mhGAP\\_intervention\\_guide\\_02/en/](https://www.who.int/mental_health/mhgap/mhGAP_intervention_guide_02/en/)

WHO & UNHCR (2012). Assessing mental health and psychosocial needs and resources. Toolkit for humanitarian settings. <https://cms.emergency.unhcr.org/documents/11982/49286/WHO+and+UNHCR%2C+Assessing+mental+health+and+psychosocial+needs+and+resources/0ab28c11-fc35-4996-8ea4-0575e88ee299>

## Annex 1. List of Contributing Partners

Action Against Hunger; Addis Ababa University; Bethany Christian Services Global; Bureau of Women, Children and Youth, Oromia Regional State; Bureau of Women, Children and Youth, Southern Nations, Nationalities and People's Regional State; Bureau of Women, Children and Youth, Somali Regional State; Centre for Victims of Torture; Ethiopian Public Health Institute; Ethiopian Red Cross Society; Goal Ethiopia; Humanity and Inclusion; Imagine One Day; International Medical Corps; International Organization for Migration; International Rescue Committee; Missionaries of Charity; Médecins Sans Frontières Holland; Médecins Sans Frontières Spain; Norwegian Refugee Council; Plan International Ethiopia; Rehabilitation and Development Organization; Save the Children International; Senay Tegibar Yeaemiro Human Charity Association; Toronto Addis Ababa Collaboration; Tigray Association for Intellectual Disabilities; Tebegiso Social Support Association; United Nations Population Fund; United Nations High Commissioner for Refugees; United Nations Children's Fund; World Health Organisation; World Vision Ethiopia.

## Annex 2. Activity Codes and Sub-codes

Please use the following Activity and corresponding Sub-Activity Codes			
Activity Code	Activity / Intervention	Sub-Activity Code	Sub-Activities (examples or details of activities)
1	Mainstreaming psychosocial support considerations in the provision of basic assistance and services (training, advocacy etc.)	1.1	Mainstreaming MHPSS in WASH
		1.2	Mainstreaming MHPSS in Nutrition
		1.3	Mainstreaming MHPSS in Relief/Basic Assistance
		1.4	Mainstreaming MHPSS in Shelter
		1.5	Other (describe in column)
2	Information dissemination to the community at large	2.1	Information on the current situation, relief efforts or available services
		2.2	Other (describe in column)
3	Strengthening of community and family support	3.1	Facilitation of relief and social support activities that are initiated by the community; activation or re-activation of community solidarity networks
		3.2	Facilitation of conditions for indigenous traditional, spiritual or religious supports, including communal healing practices
		3.3	Social and recreational activities and events
		3.4	Raising awareness on MHPSS, self care and combating stigma
		3.5	Raising awareness on child care, positive and sensitive parenting
		3.6	Structured parenting support activities and parenting skills training
		3.70	Other (describe in column)
4	Safe spaces	4.1	Child-friendly spaces
		4.2	Women Safe Spaces/Women and girls-friendly spaces
		4.3	Baby-friendly Spaces
		4.4	Other (describe in column)
5	Structured socio-emotional learning (SEL) and life skills education	5.1	Structured socio-emotional learning (SEL) and life skills education in Child-Friendly Spaces
		5.2	Structured socio-emotional learning (SEL) and life skills education in Women and Girls friendly spaces
		5.3	Structured socio-emotional learning (SEL) and life skills education in schools
		5.4	Other structured socio-emotional learning not covered above
6	Psychosocial support in education	6.1	Psychosocial support to teachers/other personnel at schools/learning places
		6.2	Psychosocial support to classes/groups of children at schools/learning places
		6.3	Early Childhood Development Activities
		6.4	Youth clubs, gender clubs etc.
		6.5	Other (describe in column G)
7	(Person-focused) psychosocial work	7.1	Psychological first aid (PFA)
		7.2	Basic counseling/emotional support for individuals
		7.3	Emotional support groups/peer to peer groups
		7.4	Identification, referral and follow up to mental health services
		7.5	Brief structured, manualised psychosocial interventions (ex. Solution-Focused Brief Therapy, Problem Management +, etc.) (specify type in column )
		7.6	Other (describe in column)

8	Psychological intervention	8.1	Psychotherapy for individuals (specify type in column )
		8.2	Psychotherapy for groups (specify type in column)
		8.3	Interventions for alcohol/substance use problems (specify type in column)
		8.4	Individual or group psychological debriefing
		8.5	Other (describe in column )
9	Clinical management of mental disorders by non specialized health care providers in health settings (e.g. PHC, health extension workers)	9.1	Non-pharmacological management of mental disorders by non-specialised providers
		9.2	Pharmacological management of mental disorders by non-specialised providers
		9.3	Identification, referral and follow up
		9.4	Other (describe in column)
10	Clinical management of mental disorders by specialized mental health care providers in health settings (e.g. psychiatrists, psychiatric nurses and psychologists working at PHC/ general health facilities/	10.1	Non-pharmacological management of mental disorders by specialised providers
		10.2	Pharmacological management of mental disorders by specialised providers
		10.3	Multidisciplinary care management for children with developmental delay, disorders and disabilities
		10.4	In-patient mental health care
		10.5	Other (describe in column)
11	General activities to support MHPSS programming	11.1	Situation analyses/assessment
		11.2	Monitoring/evaluation
		11.3	Training / orienting (specify topic in column of the data entry sheet)
		11.4	Technical or clinical supervision
		11.5	Psychosocial support for staff/volunteers /Staff care
		11.6	Research
		11.7	Other (describe in column)

## Annex 3. Guidance for Partners – Description of Activity Codes and Sub-codes

Activity Code	Activity / Intervention	Sub-Activity Code	Sub-Activities (examples or details of activities)	Guidance
1	Mainstreaming psychosocial support considerations in the provision of basic assistance and services (training, advocacy etc.)	1.1	Mainstreaming MHPSS in WASH	<p>Description/aims: Activities that aim at ensuring that basic MHPSS considerations are mainstreamed in other sectors. This may include: ensuring respect and dignity of affected populations; ensuring that services are provided in a way that is consistent with affected people's cultural and religious norms; ensuring that aid workers are able to provide basic emotional support and stabilisation to people in acute distress, according to PFA principles; and similar activities)</p> <p>Mode of delivery: Advocacy, Coordination, Training, Technical support and similar modalities.</p> <p>Target group: Humanitarian agencies; humanitarian aid workers.</p>
		1.2	Mainstreaming MHPSS in Nutrition	
		1.3	Mainstreaming MHPSS in Relief/Basic Assistance	
		1.4	Mainstreaming MHPSS in Shelter	
2	Information dissemination to the community at large	2.1	Information on the current situation, relief efforts or available services	<p>Description/aim: Activities that aim to provide affected people/communities with information about available services and assistance, planned aid distributions, and other relief efforts.</p> <p>Mode of delivery: Information sessions, Dissemination of information materials, Dissemination of service directories and similar modalities.</p> <p>Target group: Entire community (affected people/host community) or vulnerable groups</p>
3	Strengthening of community and family support	3.1	Facilitation of relief and social support activities that are initiated by the community; activation or re-activation of community solidarity networks	<p>Description/aims: Support to initiatives initiated by the affected people and/or the host communities, which aim at providing material/practical assistance, social support or other kind of help to people in need (ex. Community Care Coalitions' support to vulnerable groups and individuals)</p> <p>Mode of delivery: A range of modalities including provision of technical and/or financial support, coordination, and other.</p> <p>Target groups: Community leaders; community-based organisations; Community Care Coalitions; and similar groups/networks.</p>
		3.2	Facilitation of conditions for indigenous traditional, spiritual or religious supports, including communal healing practices	<p>Description/aims: Support to the restoration of community rituals, routines and traditional practices, including those related to mournin/burial functions, and other religious practices.</p> <p>Mode of delivery: A range of modalities including facilitation, coordination, advocacy and others.</p> <p>Target groups: entire community (affected people/host community); community leaders; religious leaders; community formal and informal groups.</p>
		3.3	Social and recreational activities and events	<p>Description/aims: Activities that aim to provide opportunities for recreation and socialisation</p> <p>Mode of delivery: Community events, festivals, celebrations; Activity days; Recreational activities included in regular programming in Child-Friendly Spaces and Women and Girls Safe Spaces</p> <p>Frequency: One off or periodical; can be part of CFSs/WSSs' regular schedule</p> <p>Target groups: Entire community (affected people/host community); children; youth; women</p>
		3.4	Raising awareness on MHPSS, self care and combating stigma	<p>Description/aim: Activities that aim to provide affected communities with information about the impact of stressors/crises on mental and psychosocial health and well-being; about self-help; about common manifestations of distress/what to do/when to seek help; about common clinical diagnoses in mental health.Awareness/advocacy activities on human rights of people suffering from mental health disorders.</p> <p>Mode of delivery: Awareness sessions, Community sessions, Campaigns and events, Dissemination of information, education and communication materials and similar activities.</p> <p>Target group: Entire community (affected people/host community); community leaders; community-based child protection networks; caregivers; teachers; children and youth.</p>
		3.5	Raising awareness on child care, positive and sensitive parenting	<p>Description/aims: Activities that aim at raising caregivers' awareness and at providing information around a range of child care and child development topics.</p> <p>Mode of delivery: - Awareness sessions - Information sessions - Dissemination of information, education and communication materials And similar activities</p> <p>Frequency: activities can be delivered as one-offs or according to a schedule.</p> <p>Target groups: Caregivers (parents, foster parents etc.)</p>
		3.6	Structured parenting support activities and parenting skills training	<p>Description/aims: Activities that aim at strengthening parents' ability to provide positive, sensitive and nurturing care to their children. Activities that support parents with understanding the effects of distress on children's behavior and development. Activities that support parents with understanding the importance of early childhood development and early learning for child development and well-being.</p> <p>Mode of delivery: Activities are delivered through manualised, structured packages of sessions, with predefined but flexible session plans.</p> <p>Frequency: Activities are delivered at regular intervals (monthly, bi-monthly, weekly or bi-weekly). It is expected that the same group of caregivers will attend the entire series of sessions.</p>

4	Safe spaces	4.1	Child-friendly spaces	<p>Description/aims: CFSs aim at providing children and adolescents with a safe space where they can meet peers, socialise, build trusting relations with one another and with adult CFS staff, and have access to a range of opportunities to play, learn, and enhance their social, emotional and life skills.</p> <p>Mode of delivery: CFSs are expected to offer a broad range of activities, including structured and unstructured ones, differentiated to meet the diverse needs of boys and girls belonging to different age groups - as well as the specific needs of children and youth experiencing developmental difficulties and/or disabilities. Range of activities will typically include:</p> <ul style="list-style-type: none"> <li>- creative activities (painting, drawing, clay, collage etc.);</li> <li>- imaginative and expressive activities (role play, acting performances, theatre and forum theatre, dance, singing, music, etc.);</li> <li>- communicative activities (storytelling, reading, conversation time, discussion groups, etc.);</li> <li>- sports activities (team sports; martial arts; yoga etc.);</li> <li>- social-emotional learning and life skills building activities.</li> </ul> <p>Frequency: CFSs are expected to be accessible on daily basis for several hours a day. Children and youth (and caregivers) are expected to attend regularly and/or frequently. Activities are expected to run according to a regular schedule, however children should be able to access on drop-in basis.</p> <p>Target groups: Children of all ages; youth; caregivers.</p>
		4.2	Women Safe Spaces/Women and girls-friendly spaces	<p>Description/aims: WSS aim at providing women and girls with a safe space where they can meet peers, socialise, build trusting relationships with one another and with WSS staff, and have access to emotional support, learning and life-skills building opportunities.</p> <p>Mode of delivery: WSSs are expected to provide a broad range of activities, including structured and unstructured ones, differentiated to meet the diverse needs of women and girls of different ages and different specific needs.</p> <p>Frequency: WSS are expected to be accessible on daily basis for several hours a day. Activities are expected to run according to a regular schedule, however women and girls should be able to access on drop-in basis.</p> <p>Target groups: Women and girls.</p>
		4.3	Baby-Friendly Spaces	<p>Description/aims: Activities that aim at supporting mother-child bonding, secure attachment in children, positive and nurturing parenting and child care</p> <p>Mode of delivery: Activities are often linked to maternal and child health and nutrition programmes/services</p> <p>Target groups: Pregnant and lactating mothers, newborns, infants and toddlers</p>
5	Structured socio-emotional learning (SEL) and life skills education	5.1	Structured socio-emotional learning (SEL) and life skills education in Child-Friendly Spaces	<p>Description/aims: Activities that aim at enhancing children and young people's resilience by building social and relational skills; by strengthening children's capacity to identify, understand and manage emotions; and by enhancing decision-making, problem solving and related abilities.</p>
		5.2	Structured socio-emotional learning (SEL) and life skills education in Women and Girls friendly spaces	<p>Mode of delivery: Activities are delivered through manualised, structured packages of sessions, with predefined session plans. Activities are delivered in CFSs, WSSs, schools or in other similar settings.</p>
		5.3	Structured socio-emotional learning (SEL) and life skills education in schools	<p>Frequency: Activities are conducted at regular intervals (monthly, bi-monthly, weekly or bi-weekly). It is expected that the same group of children and youth will attend the entire series of sessions.</p> <p>Target groups: children; youth; school students; women.</p>
6	Psychosocial support in education	6.1	Psychosocial support to teachers/other personnel at schools/learning places	<p>Description/aims: Activities that aim at strengthening teachers' ability to understand the impact of distress on children's cognitive, emotional and behavioral development; to mitigate such impact through appropriate educational and psychosocial techniques; to identify and appropriately respond to manifestations of distress in children, including through referrals when indicated and feasible.</p> <p>Mode of delivery: Awareness sessions; Training programmes; Mentoring and coaching; Supportive supervision</p>
		6.2	Psychosocial support to classes/groups of children at schools/learning places	<p>Description/aims: Activities that aim at identifying and appropriately respond to manifestations of distress in students including through appropriate classroom management techniques, school counseling, and referrals when indicated and feasible.</p>
		6.3	Early Childhood Development Activities	<p>Description/aims: Activities that aim at stimulating young children's (aged 0 to 8) cognitive, emotional, social and physical development through structured and unstructured play, socialisation, learning and creative activities. Activities that aim at strengthening mother-child bonding.</p> <p>Mode of delivery: Play sessions; Creative (drawing, painting, clay etc.), expressive (role play, singing, dancing, music etc.), communicative (storytelling, etc.) and sports activities; Mothers-and-babies or mothers-and-toddlers activities</p>
7	(Person-focused) psychosocial work	7.1	Psychological first aid (PFA)	<p>Description/aims: Activities that aim at providing basic comfort and emotional stabilisation to individuals (children and adults) in distress; to help them identify and prioritise their own needs; to connect people in distress to sources of practical and social support; and to identify people in need of additional psychosocial/psychological/mental health support, including urgent referrals.</p> <p>Mode of delivery: Semi-structured, mostly one-to-one support delivered by non specialised staff who have received relevant training and supervision. PFA is provided according to a recognised PFA package (WHO, Johns Hopkins, SCI and others)</p> <p>Target group: Individuals (children and adults) manifesting acute distress.</p>
		7.2	Basic counseling/emotional support for individuals	<p>Description/aims: Activities that aim at providing basic emotional/listening support to individuals in distress.</p> <p>Mode of delivery: one to one or group interventions delivered by non specialised staff who have received relevant training and supervision.</p>
		7.3	Emotional support groups/peer to peer groups	<p>Description/aims: Activities that aim at facilitating mutual support - including emotional, social and practical - among affected people who share a similar condition and/or similar needs.</p> <p>Mode of delivery: Emotional support groups are facilitated by a trained professional (social worker or psychosocial support officer or psychologist). Peer support groups can be facilitated by a professional or be self-organised by the group members. Support group sessions are normally structured.</p> <p>Frequency: Activities are typically delivered at regular intervals (monthly, bi-monthly, weekly or bi-weekly). Regular attendance by the same group of people is expected.</p> <p>Target groups: Women; adolescent girls; adolescent boys; caregivers; people with disabilities; other groups are also possible.</p>
		7.4	Identification, referral and follow up to mental health services	<p>Description/aim: Identification, referral and follow up of individuals experiencing mental health difficulties to mental health services provided in specialised or non-specialised health settings</p>
		7.5	Brief structured, manualised psychosocial interventions (ex. Solution-Focused Brief Therapy, Problem Management +, etc.) (specify type in column )	<p>Description/aims: Interventions that aim at addressing distress and mental health difficulties in children and adults, that are not solved through community-based mechanisms and activities.</p> <p>Mode of delivery: one to one or group interventions delivered by a trained professional (psychologist, other mental health professional or social worker) with supervision. Interventions are manualised and delivered in a limited number of sessions (normally ranging from 5 to 7)</p>



8	Psychological intervention	8.1	Psychotherapy for individuals (specify type in column )	Description/aims: Interventions that aim at addressing distress and mental health difficulties in children and adults that are not solved through community-based mechanisms.
		8.2	Psychotherapy for groups (specify type in column)	Mode of delivery: one to one or group interventions delivered by a trained professional (psychotherapist) according to a recognised modality: - Cognitive Behavioral Therapy/ Trauma-Focused CBT - Interpersonal Psychotherapy - Psychodynamic Psychotherapy - Systemic Psychotherapy and other modalities/sub-modalities.
		8.3	Interventions for alcohol/substance use problems (specify type in column)	
		8.4	Individual or group psychological debriefing	Description/aims: Interventions that aim at encouraging people who have undergone distressing experiences to provide detailed accounts of such experiences as a way to release/resolve strong emotions.
9	Clinical management of mental disorders by non specialized health care providers in health settings (e.g. PHC, health extension workers)	9.1	Non-pharmacological management of mental disorders by non-specialised providers	Description/aims: Clinical management of mental health disorders in a health setting by health professionals who are not specialised in mental health (General Practitioners, Health Officers, Nurses, Midwives)
		9.2	Pharmacological management of mental disorders by non-specialised providers	Mode of delivery: According to an accredited package (ex. mhGAP; mhGAP-HIG) and national protocols
		9.3	Identification, referral and follow up	Description/aim: Identification, referral and follow up of individuals experiencing mental health difficulties to mental health services provided in specialised or non-specialised health settings
10	Clinical management of mental disorders by specialized mental health care providers in health settings (e.g. psychiatrists, psychiatric nurses and psychologists working at PHC/ general health facilities/ mental health facilities)	10.1	Non-pharmacological management of mental disorders by specialised providers	Description/aims: Clinical management of mental health disorders in a health setting by health professionals who are specialised in mental health (Psychiatrists, Clinical Psychologists, Psychiatric Nurses)
		10.2	Pharmacological management of mental disorders by specialised providers	Mode of delivery: According to national protocols
		10.3	Multidisciplinary care management for children with developmental delay, disorders and disabilities	Description/aims: Multidisciplinary care management for children with developmental delay, disorders, disabilities. Including psychiatric/psychological intervention, physical, occupational and speech therapy, social and educational support as required.
		10.4	In-patient mental health care	Description/aims: In-patient (hospitalised) treatment of diagnosed psychiatric disorders Mode of delivery: According to national protocols

## Annex 4. List of Field Visits

1. Plan International Ethiopia, Pamdong Reception Center, Gambella – 30.01.2019
2. Plan International, Nguenyell Camp, Gambella – 01.02.2019
3. Community Care Coalition, Itang, Gambella – 02.02.2019
4. International Medical Corps, Gambella – 02.02.2019
5. Plan International, Gedeb, SNNP Region – 10.02.2019
6. Gedeb Primary Hospital, SNNP Region – 11.02.2019
7. Plan International, Dilla, SNNP Region – 12.02.2019
8. Imagine One Day, Gelana, Oromia – 10.03.2019
9. Imagine One Day, Kercha, Oromia – 21.03.2019
10. Imagine One Day, Bule Hora, Oromia – 20.03.2019
11. Bule Hora General Hospital, Oromia – 20.03.2019
12. Jijjiga General Hospital and One Stop Center, Somali – 16.05.2019