Frequently asked questions

Why is responding to mental health and psychosocial support (MHPSS) needs important in emergencies?

Humanitarian emergencies cause widespread suffering, affecting people's mental health and psychosocial well-being. Affected populations experience a **range of stressors** that can have both immediate and long-term consequences. These include exposure to violence, separation from or loss of loved ones, poor living conditions, poverty, food insecurity, loss of livelihoods and means of survival, physical injuries and illnesses, and a lack of access to services such as health care, education and social care. Emergencies can also erode protective supports such as family and community networks and can lead to sudden changes in social roles and relationships.

Many people affected by emergencies experience common reactions such as difficulties with sleeping, fatigue, worry, anger and physical aches and pains. For most people, these problems are manageable and improve over time, but for others they impair daily functioning.

Globally, **one in five** (22.1%) people living in areas affected by conflict is estimated to have a **mental health condition**.[1]

Mental health and psychosocial support services are often sparse even before a crisis occurs, and emergencies can disrupt the availability of services and people's access to them. People with **pre-existing mental health conditions** are at risk of relapse or deterioration, often face stigma and discrimination, and need continued access to care and protection.

For **children**, adverse conditions in emergencies can disrupt cognitive, emotional, social and physical development, with enduring consequences for their future.

Effective MHPSS programming provides critical services and supports across the life course to reduce suffering and improve people's mental health and psychosocial well-being. This can lead to improvements in people's abilities to meet their basic needs to survive, recover, and rebuild their lives.

The **integration of MHPSS** into emergency responses **can enhance the impact of programming across sectors** and can contribute to saving lives. MHPSS programmes can also help strengthen health, social, and education systems in the longer term.

How was the MHPSS MSP developed?

The MHPSS MSP has been developed based on desk reviews, consultations, discussions and reviews by key stakeholders in global, regional and frontline positions, including:

a. A review of existing global guidelines, standards and tools (a *list of key documents reviewed* is available in the corresponding section of the MHPSS MSP Web Platform);

b. A review of other key service packages (e.g. *Minimum Initial Service Package for Sexual and Reproductive Health in Crisis Situations*; *Essential Services Package for Women and Girls Subject to Violence*; *Inter-Agency Minimum Standards for Gender Based Violence in Emergencies Programming*);

c. A review of costing tools and lessons learned reviews;

d. Online and in-person expert consultations and peer reviews with actors in global, regional and frontline positions, representing UN agencies, IFRC, INGOs, NGOs/CBOs, mental health service providers, government representatives and funders;

e. A one-year field testing phase which included collection of feedback on the MSP content through surveys and interviews as well as two reviews by the IASC MHPSS Reference Group;

f. Partnerships with implementing agencies in five demonstration countries to gather feedback and field implementation examples.

1 Charlson F. et al. (2019). *New WHO prevalence estimates of mental disorders in conflict settings: a systematic review and meta-analysis*. The Lancet 394, pp. 240-248.

Does the MHPSS MSP replace the IASC 2007 MHPSS guidelines?

- No. The MSP is **based on and consistent with existing guidelines, including the 2007 IASC MHPSS guidelines and other more recent IASC guidelines** (e.g. IASC Common M&E Framework for MHPSS in Emergency Settings, the IASC Handbook of MHPSS Coordination, the IASC Information Note on Disability and Inclusion in Humanitarian Action) and also **includes other global guidance** across different sectors/areas of work such as the Sphere Standards, the Child Protection Minimum Standards, the GBV Minimum Standards, the INEE minimum standards among others.
- The MSP draws on these guidelines to **identify minimum activities** for the MHPSS response across sectors, and outlines key actions plan and implement those activities safely and effectively.
- It also brings together and aligns with more recent resources, such as the key resources that were developed in response to the COVID-19 pandemic.
- The MSP provides a **one-stop resource** on MHPSS across sectors which also links to **up-to-date** relevant guidance that is available for each activity (see sections on "Relevant guidelines, standards and tools" which are listed at the end of each MSP activity). In light of the rapid growth of the field of MHPSS since the publication of the 2007 IASC MHPSS guidelines, with a proliferation of diverse MHPSS activities across sectors, the MSP helps to provide a common language and an overarching framework for MHPSS across sectors/areas of work.

Does the MSP explain in detail how to implement each activity?

- No. The MSP provides a concise checklist outlining what to do to implement each MSP activity safely and effectively. However, **it is not a detailed "how-to" guide** to implementing activities.
- Where available, examples of manuals and curricula which provide detailed guidance on how to implement activities are provided in the **"Relevant guidelines, standards and tools"** section corresponding to each activity.

Does my organization have to implement all the minimum activities?

- ***MSP Sections 1 and 3:*** No single organization is expected to implement the entire MSP. Rather, relevant agencies must work together across sectors to ensure that all MSP activities are implemented. Depending on their mandate and capacities, some agencies will be better placed to implement certain activities than others. For ease of reference, icons are provided alongside each MSP activity to indicate which sectors or areas of responsibility are typically well placed to deliver it.
- ***Section 2:*** This section contains essential activities that are relevant for all organizations implementing any kind of MHPSS activity (e.g. establishing systems for M&E and staff well-being).

Should MSP activities be implemented in any particular order?

- Typically, the first step in any MHPSS response is to establish a coordination group or to connect with an existing coordination group (*see MSP activities 1.1 and 2.1*). In collaboration with this group, MSP activities can be coordinated and prioritized.
- Needs assessments (*see MSP activity 2.1*) are also useful in determining what MHPSS activities are needed and how they can be adjusted to the context and complement existing services and activities (e.g. those provided by government actors).
- The MSP does not prescribe a set order for activities in sections 2 or 3. The prioritization and sequence of activities can be informed by coordination (*see MSP activities 1.1 and 2.1*) and needs assessments (*see MSP activity 2.1*).
- The step-by-step guides for organizations and coordination groups provide a flowchart showing how to use the MSP.

Must MSP activities be implemented within a set timeframe?

- Activities should be implemented as soon as possible after the onset of an emergency (if they are not already available in the affected community).
- MSP activities can typically be initiated and implemented within a 12-month timeframe, but most activities will need to continue well beyond that.
- The additional actions under each activity should be reviewed in each context to determine their level of priority and feasibility, based on local needs and available resources.

Is the MSP suitable for all kinds of emergencies?

- Yes. The MSP is designed for all types of humanitarian emergencies, including:
  - sudden-onset natural disasters such as earthquakes and hurricanes;
  - protracted crises such long-term conflicts;
  - public health emergencies e.g. infectious disease outbreaks.
- The MSP was developed to support humanitarian emergencies that require a coordinated international response (e.g. where the humanitarian cluster system has been activated, or in a large refugee crisis). Nonetheless, the MSP can also be adapted and to inform the response in smaller emergencies that do not involve international actors.

Is the MSP prescriptive?

- The MSP identifies activities that should, in principle, be available and accessible to people in all emergencies. However, it does not prescribe which specific programme materials (e.g. training manuals) should be used to implement each activity.
- The MSP points users towards a range of guidelines, standards and tools, and provides recommendations on training topics for staff implementing particular activities.
- However, the specific programme content will vary according to the needs in each specific emergency context, and materials must be developed or adapted using participatory methods to improve their appropriateness and relevance to the needs of the affected population (*see key consideration on Contextualization*).

Is the MSP only for international organizations?

- No. The MHPSS MSP is a resource for all humanitarian actors who plan, support, coordinate, implement and/or evaluate humanitarian activities. This includes government agencies, MHPSS Technical Working Groups (TWGs), national and international non-governmental organizations (NGOs), civil society and advocacy groups, Red Cross and Red Crescent networks, UN agencies, coordinators of sectors/clusters/AoRs and donors.

Where does psychological first aid (PFA) fit within the MSP?

- The MSP uses the broader term “basic psychosocial support” to cover a range of similar orientation packages, including PFA and other packages such as the Basic Psychosocial Skills for COVID-19 Responders package and the WHO LIVES approach for providers working with survivors of GBV. These packages all cover basic psychosocial support skills and are described in *MSP activity 3.2*.
- *Activity 3.2* also outlines relevant considerations for health care settings and different protection services, and a list of additional potentially relevant training topics for frontline workers and community leaders.

Is the MSP only for short-term emergency programming?

- No. While the MSP focuses on emergency response programming, it incorporates planning for longer-term recovery.
- Emergency response activities will be more effective and sustainable if they are grounded in building or rebuilding local systems of care (including both government systems and civil society).
- Many activities and actions in the MSP are also relevant and can be adapted for longer-term programming. Each MSP activity is accompanied by a list of ‘’additional actions for consideration’’, many of which are focused on longer-term capacity building and planning.

Does the MSP consider remote programme implementation, for example, in public health emergencies?

- Remote programme implementation is sometimes required where there is a risk of spreading infectious diseases, where security risks make travel or in-person programming too dangerous, and where remote services facilitate access to populations that may otherwise be difficult to reach.
- The *key consideration on implementing MHPSS activities remotely* provides information and a list of relevant guidelines on remote MHPSS programme implementation
- The MSP also includes dedicated *guidance for its use in the public health emergency (PHE) response to infectious disease outbreaks*, which outlines:
  - MSP activities and actions specific to the public health emergency response to infectious disease outbreaks;
  - Guidance for adapting MSP activities during infectious disease outbreaks;
  - Relevant guidelines, standards and tools to support the implementation of the MSP in the context of infectious disease outbreaks.

Does the MSP consider age, gender, disability and groups with specific needs?

- Yes. Experts in age, gender, and diversity mainstreaming provided input throughout the development process.
- The overall structure of the MSP does not single out specific subgroups, as the same core MHPSS activities should be provided for all groups. However, specific considerations and adaptations may be required to meet the needs of some individuals and groups. Many of these are described in key considerations throughout the MSP, and additional information about existing guidance is also provided in *Resources on MHPSS for at-risk groups*.

How can the MSP support coordination between actors across different sectors?

- In defining a common set of minimum activities, the MSP provides a shared language and framework to help diverse actors communicate and collaborate on MHPSS.
- The MSP highlights which sectors/areas of work are typically well-placed to deliver and contribute to each activity. This can help to clarify the complementary roles of actors with expertise in different areas.
- *Activity 1.1* lists actions to facilitate inter-agency coordination among relevant actors, including both national actors (e.g. community-based organizations, government) and international actors (e.g. INGOs, UN agencies).
- The *step-by-step guide for coordination groups* shows how groups such as MHPSS Technical Working Groups can use the MSP.
- *Activity 2.1* outlines how individual agencies can help to ensure that their work is well coordinated with other actors, and that programme design incorporates and builds on the strengths of affected community members.

Who can I contact if I have more questions about the MSP?

- For questions about the MSP project and website, you can contact the leads of the MSP project: Inka Weissbecker (*weissbeckeri@who.int*) and Caoimhe Nic a Bháird (*cnic@unicef.org*).
- For guidance on implementing MHPSS programme activities and up-to-date contact information for MHPSS TWGs, you can contact the IASC MHPSS RG Co-chairs (*mhpss.refgroup@gmail.com*).

See MHPSS MSP: *https://mhpssmsp.org*