

Tool

**MENTAL HEALTH AND
PSYCHOSOCIAL
SUPPORT IN
EMERGENCY
SETTINGS**

**A Common Monitoring
and Evaluation
Framework**

2017

IASC Reference group for Mental Health and
Psychosocial Support in Emergency Settings

Draft for Field Testing

A Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings



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The Inter-Agency Standing Committee was established in 1992 in response to General Assembly resolution 46/182, which called for strengthened coordination of humanitarian assistance. The resolution set up the IASC as the primary mechanism for facilitating inter-agency decision-making in response to complex emergencies and natural disasters. The IASC comprises the heads of a broad range of United Nations, the International Federation of Red Cross and Red Crescent and non-UN humanitarian organisations. For further information on the IASC, please access its website at: www.humanitarianinfo.org/iasc.

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CHAPTER 1

Introduction

- This document provides guidance in the assessment, research, design, implementation and monitoring and evaluation of mental health and psychosocial support (MHPSS) programmes in emergency settings. Although designed specifically for emergency contexts (including protracted crises), the framework may also be applicable for the transition phases from emergency to development (including disaster risk reduction initiatives). The framework assumes familiarity with the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings¹ and an understanding of programming in humanitarian relief and/or development.

Mental health and psychosocial support refers to any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders. Therefore, the common framework described on the following pages is important for any emergency or development personnel who are directly or indirectly engaged in programmes that aim to influence the mental health and psychosocial well-being of others. This may include (but is not limited to) mental health professionals, child protection actors or educators, health providers, nutritionists, faith communities, or programme managers and practitioners engaged in initiatives such as peacebuilding, life skills or vocational learning.

The field of mental health and psychosocial support in humanitarian settings is advancing rapidly, with various MHPSS activities now forming part of standard humanitarian responses. In 2007, the Inter-Agency Standing Committee released the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, which have been widely used to guide MHPSS programmes in many humanitarian contexts. At the same time, rigorous research that evaluates the effectiveness of specific MHPSS activities is increasingly being published.



However, the wide variation of goals, outcomes and indicators for the many MHPSS projects being implemented in different humanitarian settings has led to difficulties in demonstrating their value or impact.² To address this challenge, a common monitoring and evaluation (M&E) framework has been developed to supplement the IASC guidelines.

HOW THE COMMON FRAMEWORK WAS DEVELOPED?

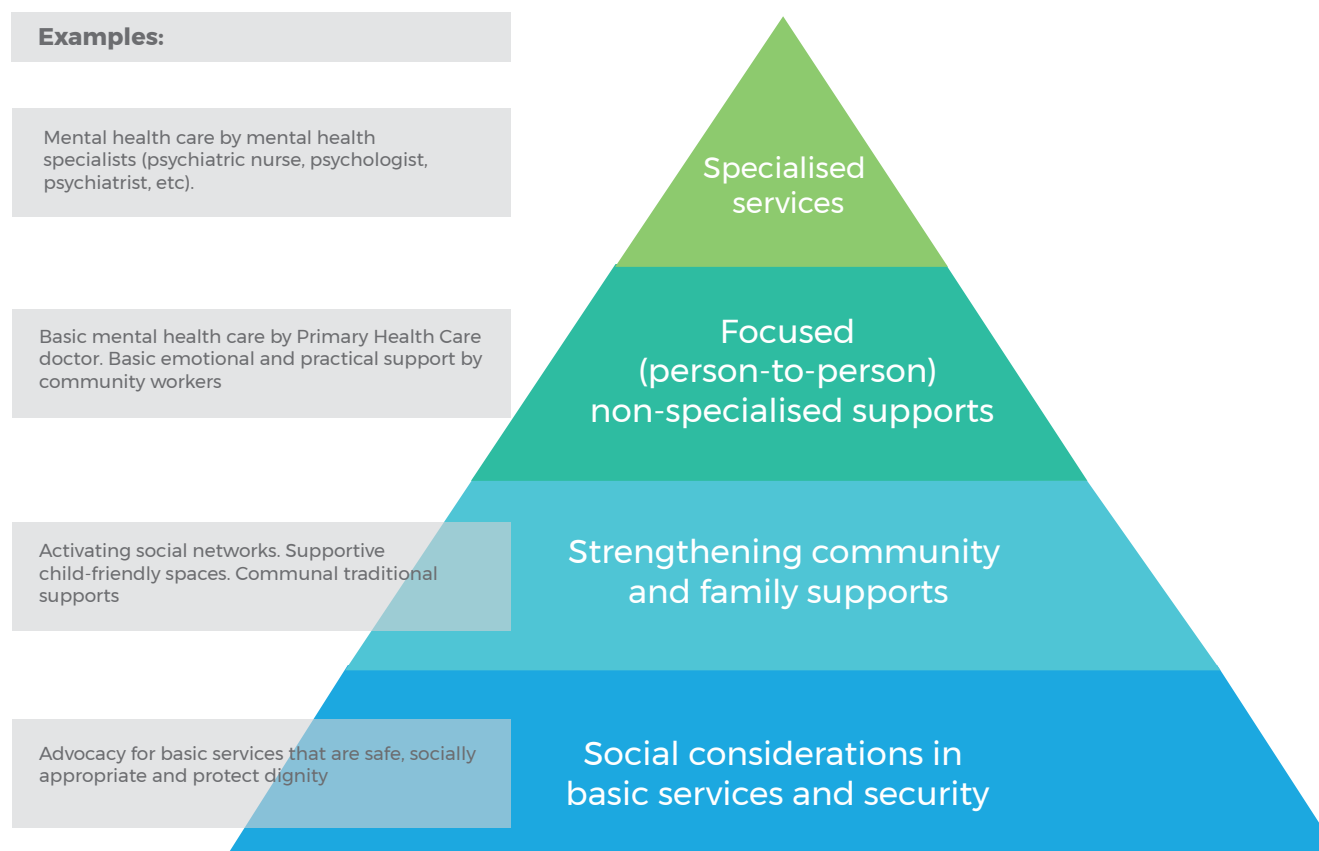
The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings was developed through a process of academic, expert and field reviews. They included: a literature review on frequently measured MHPSS constructs;³ an expert panel and consultation on a draft framework and key terms; field consultations in humanitarian settings in Africa, Asia and the Middle East; an in-depth review of commonly used indicators and measurement tools;⁴ and multiple peer reviews to establish consensus. Annex 1 provides details about the academic reviews undertaken and how these were applied to initial drafts of the framework. The final framework is deemed relevant to the vast majority of MHPSS activities, interventions, projects and programmes that are likely to be implemented in a humanitarian response, as described in the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. The common framework may not cover every possible MHPSS initiative, but it will be relevant to most MHPSS work in emergency settings.

SIX CORE PRINCIPLES

All MHPSS actions undertaken during emergency response must work towards meeting six core principles outlined in the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings:

- 01 **Human rights and equity** for all affected persons ensured, particularly protecting those at heightened risk of human rights violations
- 02 **Participation** of local affected populations in all aspects of humanitarian response
- 03 **Do no harm** in relation to physical, social, emotional, mental and spiritual well-being and being mindful to ensure that actions respond to assessed needs, are committed to evaluation and scrutiny, supporting culturally appropriate responses and acknowledging the assorted power relations between groups participating in emergency responses
- 04 **Building on available resources and capacities** by working with local groups, supporting self-help and strengthening existing resources
- 05 **Integrated support systems** so that MHPSS is not a stand-alone programme operating outside other emergency response measures or systems (including health systems)
- 06 **Multilayered supports**, acknowledging that people are affected by crises in different ways and require different kinds of support. Multilayered supports are ideally implemented concurrently (though all layers will not necessarily be implemented by the same organisation). These are commonly represented by the 'intervention pyramid' shown in Figure 1.

FIGURE 1.
Intervention pyramid for mental health and psychosocial support in emergencies



The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings further describe a series of minimum MHPSS actions for critical work that impacts the mental and psychosocial health of affected groups. The guidelines include 25 action sheets organised into 11 domains of core MHPSS activities and areas of work that require psychosocial considerations. Nearly all of these domains and action sheets are represented in this common framework. The only two areas NOT covered by this framework are the minimum responses for (1) coordination and (2) human resources. These two areas represent actions with indirect rather than direct impacts on emergency-affected populations. However, they are critical for ensuring quality MHPSS.

CHAPTER 2

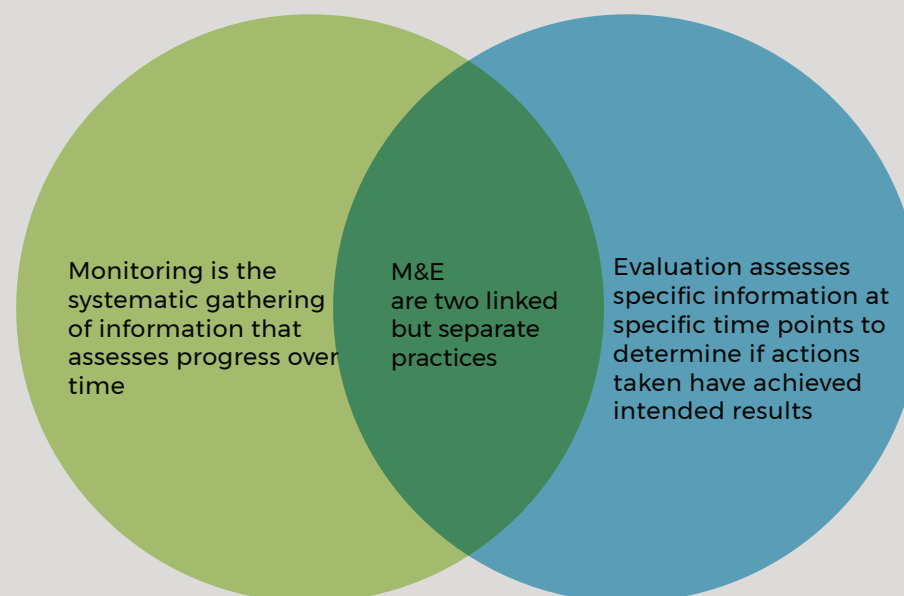
Why is monitoring and evaluation important?

Monitoring and evaluation is necessary to assess whether or not a programme, project or intervention is achieving its desired results. When done correctly, M&E uses information to demonstrate positive, negative, direct or indirect changes that have occurred and targets reached or not reached, while providing lessons for consideration in future work. Monitoring and evaluation is also necessary for learning, contextualisation, adapting programmes and accountability. It is important that M&E information, in appropriate formats, is shared with the individuals and communities involved in the work and others who may benefit from reviewing the results (such as other organisations, donors and national or regional government authorities). Monitoring and evaluation is part of good humanitarian and programming practice and further contributes to meeting the core principles of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.

For M&E to effectively measure status before, during and after a project, it must be built into the activities of a programme from the very beginning. A M&E framework should be included as part of any good programme design.

FIGURE 2.

The differences and links⁵ between monitoring and evaluation



For our purposes, 'monitoring' refers to the visits, observations and questions we ask while a programme is being implemented to see if it is progressing as expected. One of the key issues, for example, in monitoring MHPSS programmes is to ensure that the programme is doing no harm. Monitoring can help to assess this.

Similarly, 'evaluation', as used here, refers to examining a programme at the beginning, middle (if timing allows), and after it has been completed to see if it achieved the desired results. Obviously, it is important to know what the desired results are in order to evaluate them.

For example, a project aims to reduce symptoms among people with specific mental health problems. The severity of symptoms, along with other indicators in the project (such as the number of personnel involved, risk and protective factors, or number of people in at-risk groups accessing livelihood opportunities) could be **monitored** throughout the life of the project.

Severity of symptoms may also be **evaluated** when people are first seen by service providers (baseline), at points during the project (mid-line) and at the end of the project (end-line or evaluation). Additional measures are also likely at these different data collection stages.

USING MONITORING AND EVALUATION TO ASSESS COST-EFFECTIVENESS

Currently, the field of MHPSS is underfunded. How should limited resources be spent? Decision-makers increasingly seek information on cost-effectiveness as a key consideration when deciding how to invest scarce resources for MHPSS. 'Cost-effectiveness' refers here to comparisons of (a) the financial costs of different programmes with (b) the resulting impacts of the programmes as measured by common indicators of well-being (such as changes in functioning, health or subjective well-being). It thus gives information on value for money. Currently, there is limited evidence and very little comparative work on the cost-effectiveness of any humanitarian action, including of MHPSS programmes in emergency settings. This is an important gap. Agencies are encouraged to work with welfare economists and health economists to start collecting cost-effectiveness data, using the goal-level indicators outlined in the common framework.⁶



CHAPTER 3

Using a shared language

Many organisations have their own M&E approaches, terminology and techniques. The language used to describe components of an M&E framework also varies. Some organisations begin their designs with an overarching 'vision' or 'ultimate goal'. From there, additional terms used may include 'project goal' or 'primary objective', while others may use the term 'project aim'. Similarly, some organisations refer to 'outcomes' as 'objectives', 'outputs', 'deliverables' or 'activities'. 'Indicators' may be called 'targets', 'measures of success', or 'means of verification'. These can then be divided into 'impact indicators', 'outcome indicators' or even 'process indicators'. Adding to the complexity of M&E in the humanitarian sector, organisations and donors also use different project design frameworks (such as various logical frameworks or theories of change) and different 'levels' of detail in their designs. Organisations also differ in what elements of a project they will actually monitor or evaluate.

The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings, described in this publication, is not intended to replace existing or preferred M&E structures or approaches. Rather, the framework is organised in a simple way that will allow individuals and organisations to use the goal and outcomes to complement their own M&E frameworks and project-specific designs. This framework may also be viewed as a supplementary approach towards achieving more global goals, such as those outlined in the Sustainable Development Goals and/or the Mental Health Action Plan 2013-2020.

Practical information about how this common framework can be applied is outlined in Chapter 7.

KEY TERMINOLOGY

For the purposes of this common framework, the meaning of key M&E terms can be understood as follows:⁷

Overall goal: The specific end result desired or expected to occur as a consequence, at least in part, of project outcomes being achieved. Results at the level of a goal are commonly referred to as impacts. A portfolio of multiple programmes may be necessary to achieve an overall goal. Example: Reduced suffering in target area.

Outcomes: The changes that occur as a consequence of a specific project's activities. Results at this level are commonly referred to as project **outcomes**. Example: People with mental health and psychosocial problems use appropriate focused care.

Activities: The actual work implemented. The common framework does not recommend specific activities. However, the activities of each organisation will need to be considered in relation to how they work towards the likely achievement of the outcome and, ultimately, the goal. **Results at the level of an activity are often referred to as outputs.** Example: Social services staff are trained in the correct procedures for mental health and psychosocial support referrals.

Indicators: A unit of measurement that specifies what is to be measured; indicators are intended to answer whether or not the desired impact, outcomes or outputs have been achieved. Indicators may be quantitative (e.g., percentages or numbers of people) or qualitative (e.g., perceptions, quality, type, knowledge, capacity).

> **Impact indicator:** In this framework, impact indicators are aligned with the goal statement and aim to reflect the result (or impact) of actions on a broader social, institutional (or organisational) scale. Example: Improved functioning. There are different methods of measuring impact that involve both quantitative and qualitative indicators. In this framework, impact is recognised as a change at the level of the individual and that of the collective or group.

> **Outcome indicator:** In this framework, outcome indicators are aligned with the outcome statements and aim to reflect the changes for individuals or groups of people that have occurred as a consequence of a particular MHPSS programme or intervention. Example: Number of people who receive clinical management of mental, neurological or substance use disorders through medical services (primary, secondary or tertiary health care).

> **Output indicator:** In this framework, output indicators are aligned with the activity plan and aim to reflect on whether the planned activity was carried out as intended. Given that output indicators are tied to specific activities, they are not covered in this overall framework. Example: Number of social services staff trained in MHPSS referral procedures.

Typically, a project will develop a logical framework or theory of change for one or a few outcomes. However, change may be necessary across multiple projects in order to observe change on impact indicators and achieve the overall goal.

Means of verification (MoV): The tool used to measure the indicator. The common framework does not provide a MoV for each indicator because of the variation in preferences among different organisations on how to measure change. The indicators in this framework can be successfully applied regardless of how change on a specific indicator is assessed (for example, using open-ended interviews or survey forms, or a combination of the two), as long as the tool used is appropriate.

The common framework goal and outcomes use many other terms that could have different meanings for diverse humanitarian or development practitioners, MHPSS professionals or other implementors. For reference and to confirm the meaning of these terms as they relate to this framework, see Chapter 5. However, at the outset, it is important to confirm key terms used in the goal of the common framework, including:

THE COMMON FRAMEWORK'S OVERALL GOAL

Reduced suffering and improved mental health and psychosocial well-being.

Suffering^{8*} A state of undergoing pain, distress or hardship.⁹

Mental health: A state of [psychological] well-being (not merely the absence of mental disorder) in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.¹⁰

Psychosocial well-being: The psychosocial dimension of well-being. Although there is no widely agreed definition, practitioners often use the adjective 'psychosocial' to describe the interaction between social aspects (such as interpersonal relationships and social connections, social resources, social norms, social values, social roles, community life, spiritual and religious life) and psychological aspects (such as emotions, thoughts, behaviours, knowledge and coping strategies) that contribute to overall well-being.

The term 'mental health' is often mistakenly used to merely mean the absence of mental illness. However, the terms 'mental health' and 'psychosocial well-being' overlap. Mental health cannot be attained without psychosocial well-being and vice versa. **The combined term 'mental health and psychosocial well-being'** is often used to reflect the combined goal across diverse agencies and practitioners working on MHPSS.

* Suffering may be individual and/or collective (Kleinman, A., Das, V., and Lock, M.M., Eds., Social Suffering, University of California Press, Berkeley, 1997). Individuals may suffer in unique ways and as a result of a variety of experiences, but this is usually in a wider social (or global) context that informs what suffering is; therefore, individuals may also suffer collectively in the face of certain events and social structures (for example, social, political, economic and humanitarian structures).

CHAPTER 4

The common framework goal and outcomes

Every MHPSS programme, project or activity will require its own unique M&E framework that is appropriate and relevant to its design. However, to build evidence for MHPSS globally and to demonstrate its effectiveness in emergency settings, it will be necessary for diverse MHPSS interventions to measure some common impact and outcome indicators. The goal, outcomes and related indicators in the Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings (see pages 14-15) reflect the need for further shared learning and improved MHPSS programmes in emergency responses.

It is not expected that every MHPSS initiative implemented by every organisation will report against every goal, impact or outcome indicator in the common framework. However, as use of the common framework grows, the field of MHPSS will begin building a shared language and understanding about the most appropriate practices in emergency settings.

THE FRAMEWORK'S OVERALL GOAL

The common framework's goal is: **Reduced suffering and improved mental health and psychosocial well-being.**

The goal comprises two important elements:







- First, the goal to reduce suffering, which is aligned with the agreed Humanitarian Charter's humanitarian imperative "that action should be taken to prevent or alleviate human suffering arising out of disaster or conflict."¹¹
- Second, the goal hones in on MHPSS by asserting that the aim is to improve people's mental health and psychosocial well-being.

The purpose of the common framework is to encourage the use of a select number of outcomes to build the MHPSS evidence base and better inform those working in this area about important goals and impacts. To achieve this, it is recommended that each MHPSS programme or project use:

At least ONE impact indicator from the common framework goal; + At least ONE outcome and corresponding outcome indicator from the common framework.



Whether following core principles in the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, helping to meet peoples' basic needs, or targeting the reduction of symptoms of mental illness, any of these actions will likely improve mental health and psychosocial well-being and/or reduce suffering. Ultimately, the goal suggests that any MHPSS programme ought to aim for improvements in mental health and psychosocial well-being of a population affected by a humanitarian crisis or reduce the ways in which they experience suffering.

GOAL INDICATORS

-  **Functioning** (for example, the ability to carry out essential activities for daily living, which will differ according to factors such as culture, gender, age)
-  **Subjective well-being*** (aspects of subjective well-being that could be measured include feeling calm, safe, strong, hopeful, capable, rested, interested, happy, not feeling helpless, depressed, anxious or angry)
-  Extent of prolonged **disabling distress and/or presence of mental, neurological and substance use disorder** (or symptoms thereof).
-  **Ability of people with mental health and psychosocial problems to cope** with problems (for example, through skills in communication, stress management, problem-solving, conflict management or vocational skills)
-  **Social behaviour** (for example, helping others, aggressive behaviour, use of violence, discriminatory actions)
-  **Social connectedness** – referring to the quality and number of connections an individual has (or perceives to have) with other people in their social circles of family, friends and acquaintances. Social connections may also go beyond one's immediate social circle and extend, for example, to other communities.

FRAMEWORK OUTCOMES

The common framework has identified five outcomes that would likely contribute towards realisation of the goal statement. These five outcomes can be further divided across the two levels at which MHPSS programmes are commonly implemented:

-  **Community-focused**, where MHPSS activities centre on social considerations for the provision of safety, human rights, dignity and basic needs; building community and family supports that includes work to nurture the optimal development of children and youth and fostering a social environment to help individuals, families and communities realise their potential. Community-focused MHPSS initiatives usually engage larger groups of children or adults, or link with systems or social or legal structures in community-based approaches.
-  **Person-focused**, where MHPSS activities centre on individuals and families that may require targeted assistance by way of specialised or non-specialised focused support. People may be receiving MHPSS interventions on an individual, family or small-group basis, where implementers working on such person-focused MHPSS initiatives would track service users' individual progress in some way.

The common framework is summarised in Table 1. Table 2 presents the entire framework, including the goal, outcomes and indicators. The following chapters detail how each outcome relates to one or more of the action sheets from the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, provides a rationale for each outcome, and offer specific information about key terms used in those outcome statements and their indicators.

* 'Subjective well-being' refers to all of the various types of evaluations, both positive and negative, that people make of their lives. It includes reflective cognitive evaluations, such as life satisfaction and work satisfaction, interest and engagement, and emotional reactions to life events, such as feelings of joy or sadness (Diener, E., 'Guidelines for National Indicators of Subjective Well-Being and Ill-Being', Journal of Happiness Studies, vol. 7, no. 4, November 2006, pp. 397-404.)¹² Various aspects of subjective well-being may be measured to reflect this goal indicator.

TABLE 1

Summary of the common framework

Goal: Reduced suffering and improved mental health and psychosocial well-being

Outcomes:

Community-focused

1 Emergency responses do not cause harm and are dignified, participatory, community-owned, and socially and culturally acceptable

2 People are safe, protected, and human rights violations are addressed

3 Family, community and social structures promote the well-being and development of all their members

Person-focused

4 Communities and families support people with mental health and psychosocial problems

5 People with mental health and psychosocial problems use appropriate focused care

Underlying core principles: 1. Human rights and equity, 2. Participation, 3. Do no harm, 4. Integrated services and supports, 5. Building on available resources and capacities, 6. Multilayered supports

TABLE 2

The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings*

OVERALL GOAL

Reduced suffering and improved mental health and psychosocial well-being [G]

KEY IMPACT INDICATORS (Gi)

- Gi.1 Functioning (for example, the ability to carry out essential activities for daily living, which will differ according to factors such as culture, gender, age)
- Gi.2 Subjective well-being (aspects of subjective well-being that could be measured include feeling calm, safe, strong, hopeful, capable, rested, interested, happy, not feeling helpless, depressed, anxious or angry)
- Gi.3 Extent of prolonged disabling distress and/or presence of mental, neurological and substance use disorder (or symptoms thereof)
- Gi.4 Ability of people with mental health and psychosocial problems to cope with problems (for example, through skills in communication, stress management, problem-solving, conflict management or vocational skills)
- Gi.5 Social behaviour (for example, helping others, aggressive behaviour, use of violence, discriminatory actions)
- Gi.6 Social connectedness referring to the quality and number of connections an individual has (or perceives to have) with other people in their social circles of family, friends and acquaintances. Social connections may also go beyond one's immediate social circle and extend, for example, to other communities.

Note that some of these six indicators may serve as outcome indicators depending on the logic of the programme (theory of change).

OUTCOMES

(1) Emergency responses do not cause harm and are dignified, participatory, community-owned, and socially and culturally acceptable [O1]

KEY OUTCOME INDICATORS (O)

- O1.1 Percentage of affected people who report that emergency responses (i) fit with local values, (ii) are appropriate and (iii) are provided respectfully
- O1.2 Percentage of affected people who report being actively involved in different phases of emergency response (for example, participation in needs assessment, programme design, implementation, and monitoring and evaluation activities)

- O1.3 Percentage of target communities where local people have been enabled to design, organise and implement emergency responses themselves
- O1.4 Percentage of staff trained and following guidance (for example, the IASC Guidelines) on how to avoid harm
- O1.5 Number of negative events perceived by beneficiaries to be caused by humanitarian and/or MHPSS interventions
- O1.6 Number of affected people who know codes of conduct for humanitarian workers and how to raise concerns about violations
- O1.7 Programmatic changes made after comments were filed through feedback mechanisms
- O1.8 Perceptions of needs addressed (that is, needs perceived as serious problems by affected people themselves, such as perceived problems with shelter, livelihoods)

(2) People are safe, protected, and human rights violations are addressed [O2]

- O2.1 Number of reported human rights violations
- O2.2 Percentage of target communities (that is, villages, neighbourhoods or institutions such as mental hospitals or orphanages) with formal or informal mechanisms that engage in protection, monitoring and reporting of safety risks or at-risk groups (for example, children, women, people with severe mental disorders)
- O2.3 Percentage of target communities where representatives of target groups are included in decision-making processes on their safety
- O2.4 Percentage of target group members who, after training, use new skills and knowledge for prevention of risks and referral
- O2.5 Number of members of at-risk groups (such as children or survivors of sexual violence) who use safe spaces
- O2.6 Percentage of target group members (such as the general population or at-risk groups) who feel safe
- O2.7 Number of protection mechanisms (such as social services or community protection networks) and/or number of people who receive help from formal or informal protection mechanisms
- O2.8 Of people who have reported human rights violations, perceptions about the responses of institutions addressing their case

*Disaggregation by sex and age are encouraged for all relevant indicators. The indicators presented here are not exhaustive. In addition to selecting at least one impact and one outcome indicator, MHPSS practitioners should feel free to create additional indicators that match other elements of the goals and outcomes of their specific projects.

(3) Family, community and social structures promote the well-being and development of all their members [O3]

- O3.1 Number of children reunified with family members or are in other appropriate care arrangements according to their specific needs and best interests
- O3.2 Extent of parenting and child development knowledge and skills among caregivers
- O3.3 Quality of caregiver-child interactions
- O3.4 Level of family connectedness or cohesion
- O3.5 Level of social capital, both cognitive (level of trust and reciprocity within communities) and structural (membership and participation in social networks, civil or community groups)
- O3.6 Percentage of target communities (such as villages or neighbourhoods) where steps have been taken to identify, activate or strengthen local resources that support psychosocial well-being and development
- O3.7 Percentage of target communities where communal rituals for the dead have been organised
- O3.8 Percentage of formal and informal social structures that include specific mental health and psychosocial activities or supports
- O3.9 Number of affected people who use different formal and informal social structures (such as schools or informal education for children of all ages, health care, social services, early child development programmes, women's groups and youth clubs)
- O3.10 Number of people in at-risk groups engaged in livelihood opportunities
- O3.11 Number of children with opportunities to engage in learning developmentally appropriate socio-emotional skills

(4) Communities and families support people with mental health and psychosocial problems [O4]

- O4.1 Number of people with mental health and psychosocial problems who report receiving adequate support from family members
- O4.2 Abilities of caregivers to cope with problems (through, for example, stress management skills, conflict management skills, problem-solving skills, parenting skills, knowledge of where to seek help or information and resources needed to access care)

- O4.3 Level of social capital of individuals with mental health and psychosocial problems (both cognitive and structural)

- O4.4 Perceptions, knowledge, attitudes (including stigma) and behaviours of community members, families and/or service providers towards people with mental health and psychosocial problems

(5) People with mental health and psychosocial problems use appropriate focused care [O5]

- O5.1 Percentages of medical facilities, social services facilities and community programmes who have staff trained to identify mental disorders and to support people with mental health and psychosocial problems
- O5.2 Percentages of medical facilities, social services facilities and community programmes who have staff receiving supervision to identify mental disorders and to support people with mental health and psychosocial problems
- O5.3 Percentages of medical facilities, social services facilities and community programmes that have and apply procedures for referral of people with mental health and psychosocial problems
- O5.4 Number of women, men, girls and boys who receive focused psychosocial and psychological care (such as psychological first aid, linking people with psychosocial problems to resources and services, case management, psychological counselling, psychotherapy or other psychological interventions)
- O5.5 Number of women, men, girls and boys who receive clinical management of mental, neurological or substance use disorders through medical services (primary, secondary or tertiary health care)
- O5.6 Number of people per at-risk group (for example, unaccompanied or separated children, children associated with armed groups, survivors of sexual violence) receiving focused care (such as psychological first aid, linking people with psychosocial problems to resources and services, case management, psychological counselling, psychotherapy or clinical management of mental disorders)
- O5.7 Percentage of available focused MHPSS programmes that offer evidence-based care relevant to the culture, context and age of target group
- O5.8 Level of satisfaction of people with mental health and psychosocial problems and/or their families regarding the care they received.

CHAPTER 5

A description of framework outcomes and indicators

The common framework's outcomes relate to specific aspects and action sheets from the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings; therefore each outcome has a rationale to help explain its intent.

Also, the outcomes and corresponding outcome indicators use a range of important terms that could have different meanings for different people. These chapters provide details on how the outcomes relate to the guidelines and the ideas behind the key terms used, for both outcomes and indicators.



OUTCOME 1.

Emergency responses do not cause harm and are dignified, participatory, community-owned, and socially and culturally acceptable

Related to outcomes included in IASC guideline action sheets: 3.3, 5.1, 6.1, 6.4, 7.1, 8.1, 9.1, 10.1, 11.1

Rationale: Addressing stressors and preventing harm from inappropriate emergency responses is essential to promote and protect psychosocial well-being, prevent distress and, possibly, to prevent disorders, and to ensure that community ownership and protective safeguarding mechanisms are in place.

KEY TERMS AND DESCRIPTIONS RELATED TO OUTCOME 1:

- **Emergency responses** include all international, domestic and community emergency response activities in any sector (such as nutrition, water and sanitation, health).
- **Not causing harm** is about ensuring that emergency responses do not put people at risk (including physically, mentally, socially, materially, emotionally or legally) or cause any further harm to affected populations, including potential harm by humanitarian personnel, violations of human rights (including violations of privacy and dignity), or the reproduction of harmful power imbalances (new or existing) in decision-making processes.
- **Dignified** refers to the expected outcome of emergency responses that value the concerns of affected people, treat those people with respect as subjects rather than objects, and allow segments of affected communities to guide and inform the emergency response, including individuals or groups that may require special attention.
- **Participatory** refers to the involvement of community members in the emergency response, but further implies that community participation is voluntary, does not add to their burdens, and is sensitive to the capacities and circumstances of the affected population.
- **Community-owned** refers to actions that ensure people – including members of marginalised groups – contribute towards prioritising, planning and implementing the work intended to improve their circumstances. Community ownership is experienced when communities have power to make key decisions related to what aid is delivered and how it is provided. It includes mobilising communities and recognising and/or strengthening the capacities of existing formal and informal community structures.
- **Social and cultural acceptability** describes emergency responses that are sensitive to the norms and values of the affected population and for these to be respected in how emergency response actions are carried out. It describes consideration of diversity of cultural and social values within the affected population, as well as acknowledgement that emergency situations often lead to changes in practices that may be supported by some community members and cause concern to others.*

* Because some local practices cause harm, humanitarian workers should think critically and support local practices only if they fit within international standards of human rights.

OUTCOME 1 INDICATORS:

- O1.1: Percentage of affected people who report that emergency responses (i) fit with local values, (ii) are appropriate and (iii) are provided respectfully
- O1.2: Percentage of affected people who report being actively involved in different phases of emergency response (for example, participation in needs assessment, programme design, implementation, and monitoring and evaluation activities)
- O1.3: Percentage of target communities where local people have been enabled to design, organise and implement emergency responses themselves
- O1.4: Percentage of staff trained and following guidance (for example, the IASC Guidelines) on how to avoid harm
- O1.5: Number of negative events perceived by beneficiaries to be caused by humanitarian and/or MHPSS interventions
- O1.6: Number of affected people who know codes of conduct for humanitarian workers and how to raise concerns about violations
- O1.7: Programmatic changes made after comments were filed through feedback mechanisms
- O1.8: Perceptions of needs addressed (that is, needs perceived as serious problems by affected people themselves, such as perceived problems with shelter, livelihoods)



OUTCOME 2.

People are safe, protected, and human rights violations are addressed

Related to outcomes included in IASC guideline action sheets: 3.1, 3.2, 3.3, 6.2, 6.3, 8.1

Rationale: Feeling safe and being protected can reduce mental health and psychosocial problems, or prevent such issues from arising or becoming worse. Providing opportunities for justice following acts or causes of violations may support affected people's social and psychological recovery, including people impaired by mental illness and living with formal or informal carers.

KEY TERMS AND DESCRIPTIONS RELATED TO OUTCOME 2:

In coordination with existing protection mechanisms, MHPSS actors have a role to play in contributing to the creation of conditions for community members to safely deal with threats and human rights violations.

- **Being safe** may result from: (i) enabling community members to acknowledge, prevent and respond to hazards or threats, (ii) responding to the ways these hazards or threats impact emotional, social and psychological well-being, (iii) supporting individuals affected by rights violations, including those living in formal or informal care situations, to address risks, threats or ongoing harm, (iv) building functional referral systems, accountability measures and networks, (v) undertaking advocacy regarding the ways threats and human rights violations impact people, (vi) assisting communities to access processes for justice, (vii) strengthening community capacity and state capacity (that is, duty bearers) to identify, mitigate and respond to possible risks, (viii) addressing underlying conditions that may result in violence at individual, family, peer/school and community levels.

Supporting individuals who are experiencing distress or illness may also enhance their protection and help them feel safer. Where people experience safety and well-being they are less likely to fall victim to or perpetrate abuses, which may further help reduce the cyclic harm of others.

- **Being protected** relates to ensuring that systems are in place to help prevent or reduce the impacts of threats or human rights violations. This is an outcome that may result from work in relation to rights protection and the building of protective environments. This may require acknowledgement (and action) on matters of justice, reparation or legal rights. It includes understanding the context and approaches that support affected people in addressing the structural factors that influence their well-being and recovery.
- **Addressing human rights violations** refers to aspects of monitoring, reporting, documenting, accompanying or supporting people of all ages to seek justice for human rights violations, where local conditions allow. Many considerations are important when addressing human rights violations, including but not limited to the following:



Local conditions may result in the need to create or strengthen processes to address human rights violations within the frameworks of local laws and customs.

Actions to address violations may be undertaken before (that is, prevention), during or after rights violations are experienced.

Certain groups may be especially at risk of rights violations and harm, often due to vulnerabilities or discrimination that existed before an emergency (such as persons with severe mental illness, children and adults in institutional settings, etc.).

MHPSS actors may work with structures or mechanisms that are responding to issues of safety, protection and justice, or with communities, families and individuals who are seeking to access or engage them.

Technical support may be necessary for documenting human rights violations, including ensuring the safety, protection and ethical management of personal information.

OUTCOME 2 INDICATORS:

- O2.1: Number of reported human rights violations
- O2.2: Percentage of target communities (that is, villages, neighbourhoods or institutions such as mental hospitals or orphanages) with formal or informal mechanisms that engage in protection, monitoring and reporting of safety risks or at-risk groups (for example, children, women, people with severe mental disorders)
- O2.3: Percentage of target communities where representatives of target groups are included in decision-making processes on their safety
- O2.4: Percentage of target group members who, after training, use new skills and knowledge for prevention of risks and referral
- O2.5: Number of members of at-risk groups (such as children or survivors of sexual violence) who use safe spaces
- O2.6: Percentage of target group members (such as the general population or at-risk groups) who feel safe
- O2.7: Number of protection mechanisms (such as social services or community protection networks) and/or number of people who receive help from formal or informal protection mechanisms
- O2.8: Of people who have reported human rights violations, perceptions about the responses of institutions addressing their case

OUTCOME 3

Family, community and social structures promote the well-being and development of all their members

Related to outcomes included in IASC guideline action sheets: 5.2, 5.3, 5.4, 7.1, 8.2.

Rationale: Human development, mental health and psychosocial well-being occur in the context of social relations and connections, which are often disrupted in emergencies. This can negatively impact well-being. The protection, restoration and positive transformation of family and community structures can create a supportive environment to sustain the well-being of its members and foster psychological and social recovery.

KEY TERMS AND DESCRIPTIONS RELATED TO OUTCOME 3:

- **Family, community and social structures** (sometimes viewed as ‘systems’) may be formal or informal. They can provide an environment for social cohesion and building trust so that individuals can be supported in a wider social network. Social, community and family supports enable individuals to continuously learn and adapt to meet development milestones. This is especially true for children and adolescents, but can also apply to adults who may need to adjust to changed life circumstances or to take advantage of new opportunities. Examples of such structures include (but are not limited to) family tracing and reunification systems, formal education structures, religious or spiritual systems, traditional community practices, health structures, institutions or informal structures such as women’s groups, children’s or youth organisations/clubs or advocacy groups.

- **Development**, as it relates to human development, can be described as having two dimensions¹⁴: (1) directly enhancing human abilities, to assure a long and healthy life, knowledge and a decent standard of living, and (2) creating conditions so people can participate in political and community life, work towards environmental sustainability, and experience human security, rights and gender equality. Human development takes place throughout the life cycle. Therefore it relates to any age group, meeting age-appropriate developmental milestones and working towards helping people, individually or collectively, to increase their life choices, opportunities and potential for a reasonable chance of leading productive, creative lives that they value.
- **‘All members’** refers to the fact that these structures should be inclusive of all community members (that is, individuals of any age or gender, education level, health status, disability, family background, religious or ethnic/social group affiliation and so forth).

Women are attending a session on embroidery led by an IOM staff in one of the IDP camps.



Muse Mohammed, ©IOM, 2016, Nigeria

OUTCOME 3 INDICATORS:

- O3.1: Number of children reunified with family members or are in other appropriate care arrangements according to their specific needs and best interests.
- O3.2: Extent of parenting and child development knowledge and skills among caregivers

- O3.3: Quality of caregiver-child interactions
- O3.4: Level of family connectedness or cohesion*
- O3.5: Level of social capital, both cognitive (level of trust and reciprocity within communities) and structural (membership and participation in social networks, civil or community groups)
- O3.6: Percentage of target communities (such as villages or neighbourhoods) where steps have been taken to identify, activate or strengthen local resources that support psychosocial well-being and development
- O3.7: Percentage of target communities where communal rituals for the dead have been organised
- O3.8: Percentage of formal and informal social structures that include specific mental health and psychosocial activities or supports
- O3.9: Number of affected people who use different formal and informal social structures (such as schools or informal education for children of all ages, health care, social services, early child development programmes, women's groups and youth clubs)
- O3.10: Number of people in at-risk groups engaged in livelihood opportunities
- O3.11: Number of children with opportunities to engage in learning developmentally appropriate socio-emotional skills

* While there is no widely agreed understanding of social cohesion, current definitions focus on notions such as sense of belonging, participation, level of attachment to the group and shared (equity in) social and economic outcomes. (Cook, Philip, Marisa O. Ensor and Natasha Blanchet-Cohen, Participatory Action Research on Community Mechanisms Linking Child Protection with Social Cohesion: Interim report, Burundi/Chad, International Institute for Child Rights and Development (IICRD), 2015).

OUTCOME 4.

Communities and families support people with mental health and psychosocial problems

Related to outcomes included in IASC guideline action sheets: 5.2, 5.3, 5.4, 6.3, 6.4, 6.5.

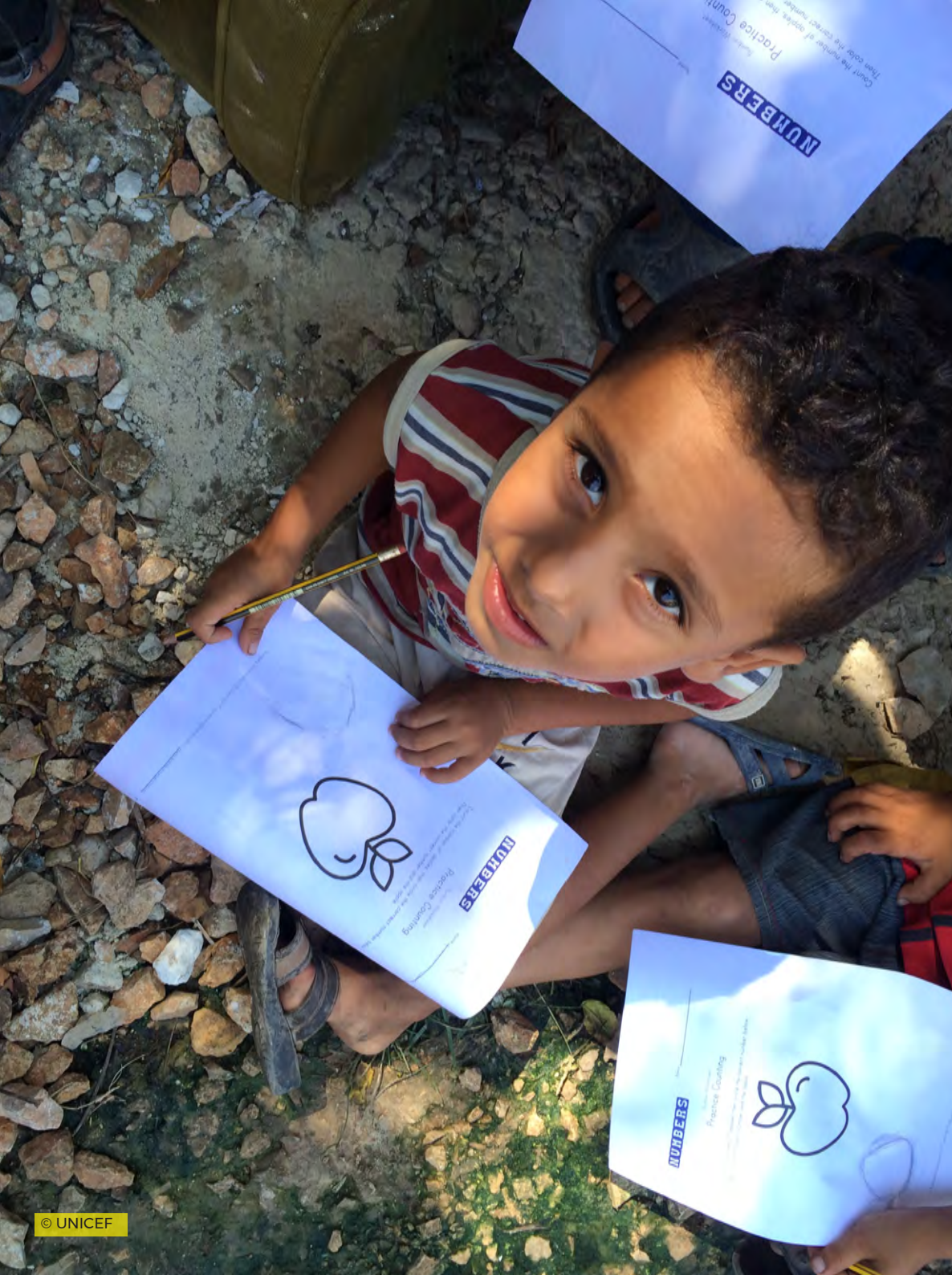
Rationale: Community and family supports can assist individuals or groups with mental health and psychosocial problems. Typically, these are the first support measures that people experiencing mental health and psychosocial problems receive. Families and caregivers are the most important source of protection and well-being for children. Such support may be strengthened, weakened or even become dysfunctional after an emergency. Establishing, restoring or strengthening these supports can ensure that individuals with mental health and psychosocial problems can be cared for in their families and communities, especially in the context of scarce or limited formal services.

KEY TERMS AND DESCRIPTIONS RELATED TO OUTCOME 4:

- **Mental health and psychosocial problems** may include social problems (such as sexual violence or discrimination), psychological distress, mental neurological and substance use disorders, intellectual disability or any combination of these.
- **Community** includes community members, formal and informal institutions (such as schools, health facilities, religious institutions, carer support groups and neighbourhood respite care).

● **Community and family support** occurs when:

- Families help meet the individual needs of people with mental health and psychosocial problems (for example, by responding to psychological distress or assisting them in challenging daily tasks).
- Community members provide support (for example, by organising cultural or healing practices, providing employment and/or encouraging others in their community to respect and include them – for example, by preventing discrimination or actively supporting social inclusion).
- Community institutions facilitate access and inclusion of people with mental health and psychosocial problems (by, for example, including people with severe mental illness in livelihood opportunities or including children with developmental disorders in education).
- Community and family support seeks to reduce suffering by easing the burdens of stress, fear, insecurity and discrimination and helps others to increase their functional contributions to community and family life. Communities and families can be mobilised or strengthened to assist individuals and groups who do not have support networks, such as orphaned children or others requiring special protection.



- It is important to recognise that communities and families themselves may contribute to the creation and maintenance of mental health and psychosocial problems. They may also limit access to opportunities and services for people with mental health and psychosocial problems. Therefore, it may be necessary to complement MHPSS activities that focus on this outcome with additional community-focused interventions to directly support persons in need.

OUTCOME 4 INDICATORS:

- O4.1: Number of people with mental health and psychosocial problems who report receiving adequate support from family members
- O4.2: Abilities of caregivers to cope with problems (through, for example, stress management skills, conflict management skills, problem-solving skills, parenting skills, knowledge of where to seek help or information and resources needed to access care)
- O4.3: Level of social capital of individuals with mental health and psychosocial problems (both cognitive and structural)
- O4.4: Perceptions, knowledge, attitudes (including stigma) and behaviours of community members, families and/or service providers towards people with mental health and psychosocial problems

OUTCOME 5.

People with mental health and psychosocial problems use appropriate focused care

Related to outcomes included in IASC guideline action sheets: 6.1, 6.2, 6.3, 6.4, 8.2.

Rationale: People of any age with identified mental health and psychosocial problems may require focused care beyond those supports that are available from family or community resources. In such cases, access to focused care can help to secure the mental health, well-being and recovery of affected persons.

KEY TERMS AND DESCRIPTIONS RELATED TO OUTCOME 5:

- **Mental health and psychosocial problems** may include social problems (such as sexual violence or discrimination), psychological distress, mental neurological and substance use disorders, intellectual disability or any combination of these.
- **Use of appropriate focused care** indicates that the focused care provided to the individual is accessed, utilised and helpful in one or more ways (for example, by improving functionality, coping, reducing symptoms of mental illness, increasing social supports, reducing social problems and so forth, without severe adverse effects). To enable the most potential benefits from focused care, feasible evidence-based approaches and interventions should be provided to address specific needs. This might also require focused care that is adapted and relevant to meet other special needs, such as children, individuals with developmental problems, gender or people living with other disabilities.

- **Appropriate care** means that people receive individual assistance and treatment specific to their needs, in accordance with international human rights instruments.* It underscores that 'access to appropriate care' is inclusive, available, accessible, acceptable and of good quality. Appropriate access ought to be provided by duty bearers (such as nation states), but may need to be temporarily provided by non-state actors (such as non-governmental organisations) in emergency, recovery and developing contexts.

- **Focused care** may be delivered by specialised professionals (such as qualified psychiatrists, social workers, psychologists, etc.), trained lay counsellors/helpers or by trained service providers who are not necessarily specialised in MHPSS care (such as general nurses /physicians, community health workers and classroom teachers). Focused care could range from community-based to inpatient services and from informal to formal supports.**

* Such as the International Covenant on Economic, Social and Cultural Rights (1966) General Comment No. 14 as well as the Universal Declaration of Human Rights (1948) Article 25, Convention on the Elimination of All Forms of Discrimination against Women (1979) Article 12, Convention on the Rights of the Child (1990) Article 24, and the Convention on the Rights of Persons with Disabilities (2008) Article 25.

** For example: (i) people with social problems may need access to dedicated protection and social services, as well as more generic supportive networks (for example, recreational groups, mothers' groups, etc.) to facilitate rehabilitation and reintegration into community life, (ii) people experiencing grief and acute distress and may need access to basic psychological support, social support from family and community members, and culturally appropriate mourning, (iii) people with mental disorders need access to mental health care and more generic social services/supports from the people, families and communities around them.

An IOM staff member is heading a group counseling session with women at an IDP camp.

Muse Mohammed, ©IOM. Nigeria

OUTCOME 5 INDICATORS:

Some indicators within outcome 5 reflect overlapping services and terms that can be used differently by certain professionals (for example, number of people receiving psychosocial care, psychological interventions and clinical management). However, these have been separated in the indicators to enable implementers to utilise the approach best suited to their interventions.

- O5.1: Percentages of medical facilities, social services facilities and community programmes who have staff trained to identify mental disorders and to support people with mental health and psychosocial problems
- O5.2: Percentages of medical facilities, social services facilities and community programmes who have staff receiving supervision to identify mental disorders and to support people with mental health and psychosocial problems
- O5.3: Percentages of medical facilities, social services facilities and community programmes that have and apply procedures for referral of people with mental health and psychosocial problems
- O5.4: Number of women, men, girls and boys who receive focused psychosocial and psychological care (such as psychological first aid, linking people with psychosocial problems to resources and services, case management, psychological counselling, psychotherapy or other psychological interventions)
- O5.5: Number of women, men, girls and boys who receive clinical management of mental, neurological or substance use disorders through medical services (primary, secondary or tertiary health care)
- O5.6: Number of people per at-risk group (for example, unaccompanied or separated children, children associated with armed groups, survivors of sexual violence) receiving focused care (such as psychological first aid, linking people with psychosocial problems to resources and services, case management, psychological counselling, psychotherapy or clinical management of mental disorders)
- O5.7: Percentage of available focused MHPSS programmes that offer evidence-based care relevant to the culture, context and age of target group
- O5.8: Level of satisfaction of people with mental health and psychosocial problems and/or their families regarding the care they received

CHAPTER 6

Measuring indicators using means of verification

When using the Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings, the first step is to identify an overarching goal, impact indicators to measure progress towards that goal, desired outcomes and associated outcome indicators. The next step is to ascertain how to measure impact and/or outcome indicators. The means of verification (MoV) identifies tools (such as surveys, questionnaires, focus group discussions and project reports) that explain how the indicators will be measured. Means of verification may be specific tools or simply information that is necessary to collect in order to report against the given indicator(s). The indicators may be quantitative and/or qualitative. It is possible that some indicators may require more than one MoV, depending on what is being measured and how.

ENSURING THAT VERIFICATION TOOLS ARE APPROPRIATE

Currently, MoV tools that could be implemented to measure the indicators suggested in this common framework are highly variable in their cross-cultural appropriateness and psychometric properties (markers of validity and reliability). Some tools have been well-researched and validated across multiple cultures and contexts*. However, other tools need to be adapted and piloted across different cultures and contexts to ensure that they are globally acceptable. In addition, many tools have copyright and other restrictions on how they may be adapted and used; in this case, relevant permissions should be sought from copyright holders if individual organisations wish to use or adapt such measures.

For these reasons, the common framework, for now, does not make specific recommendations for MoV tools to be used for the indicators included in this publication. However, when deciding on MoV, the following are important considerations:

- Is the MoV tool age-appropriate, gender sensitive and relevant to the audience?
- Does the tool specifically measure the indicator of interest?
- What is the validity and reliability of the tool in the given context or in similar social and cultural contexts (taking into account the fact that language adaptations may alter the validity and/or reliability of the tool)? If such factors are not known, determine if the project may need to undertake such validation work as part of M&E measurement and practice.
- Are there any copyright and/or permission requirements from the owners of the tools?
- Does the tool provide information that is quantitative or qualitative in nature, or both?
- Does using the tool require participation on the part of project beneficiaries, particularly children, which may enhance the value of the M&E process for participants?

* Such as the World Health Organization's Disability Assessment Schedule – known as WHO-DAS – which is used to measure one's ability to function, or the Patient Health Questionnaire-9, which is used to measure depression.

- Does using the tool require the time, effort and participation of project participants? For example, is it necessary to undertake a survey or focus group discussion if the information is readily available from secondary sources, such as project documentation? Furthermore, will using the tool create an unnecessary burden on those participants? (Keep in mind that participants may not wish to spend a lot of time answering surveys or questionnaires or making themselves available for interviews.)

- How will the results gathered from the MoV tools be reported, documented and disseminated in ways that all participants will understand? In other words, how can you ensure that any quantitative data analyses are communicated in lay terms back to the communities involved?

WHY DISAGGREGATE DATA?

When collecting information to measure results against a goal and/or outcome, it is important that data are inclusive of particular groups that have special needs or that are likely respond to interventions differently. Therefore, any indicators being measured must collect data that are disaggregated, including but not limited to gender and different age ranges, including age ranges for children and adults. Depending on the context or the programme being implemented, it may also be necessary to disaggregate data by ethnicity, identity status (for example, refugee versus host), disability, education, etc.



CHAPTER 7

Practical tips for using the common framework

Each MHPSS programme is unique. What and how programmes are implemented will depend on the context, assessed needs, the experience and capacity of the implementing organisation or partners, and local resources, as well as capacity, timing, budget and other considerations. It is NOT expected that an MHPSS programme will use every outcome or indicator from this common framework. Nonetheless, it is hoped that the majority of MHPSS programmes in emergency settings or M&E designs will include **at least ONE goal impact indicator from the common framework and at least ONE outcome indicator from the common framework.**



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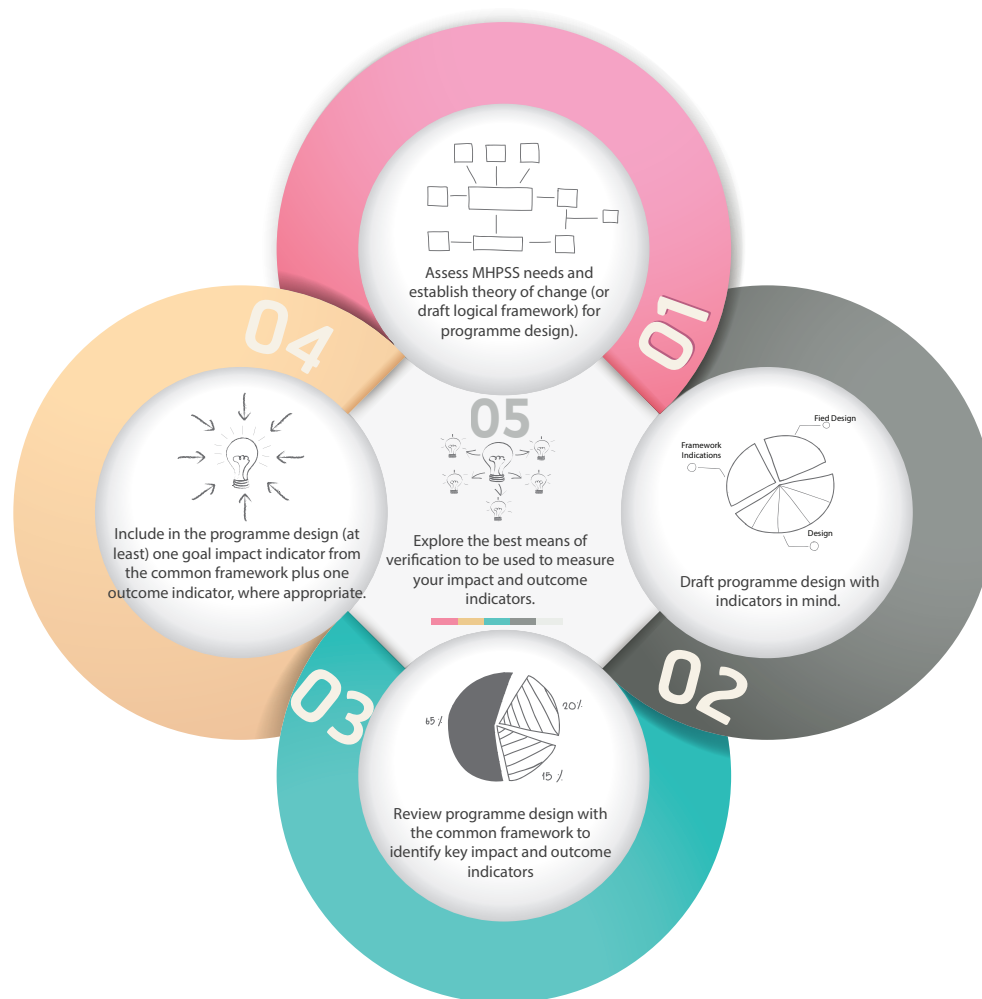
A FIVE-STEP PROCESS

In line with emergency coordination efforts (e.g., emergency response MHPSS working groups) the following process can be initiated to include indicators from this common M&E framework (see Figure 3):

- 1 Assessments of MHPSS proceed as usual. The beginning of a MHPSS programme design is initiated to meet assessed needs.
- 2 Each organisation considers its own programme outcomes and outputs as they relate to the programme design. Each organisation considers how its project will contribute to the goal in the common framework.
- 3 During the design phase, practitioners/implementors are encouraged to review the common framework to see how it aligns with their own proposed intervention(s).
- 4 Programmes take (at least) one goal impact indicator and at least one outcome indicator from the common framework. Programmes will also include output indicators unique to the programme design.
- 5 Explore possible means of verification to be used to measure your impact and outcome indicators, which may be measures previously used by your own or other organisations.

FIGURE 3.

Flow chart outlining how individual MHPSS programme designs and M&E plans can include aspects of the common framework



The basic idea behind the common framework is that it can be used in a way that best ‘fits’ within the intended goal, outcomes and outputs of various MHPSS programmes. The framework has been designed to be broad enough to be relevant to the majority of MHPSS initiatives known to be implemented in emergency settings. However, this may also mean that certain indicators or outcomes in the common framework could relate to a range of activities or programmes. For example: An intervention that encourages families to better care for household members living with mental disorders might relate to outcome 2 (People are safe, protected and human rights violations are addressed), since the goal of the project is to keep people living with mental disorders safe and to ensure that their rights to protection and treatment are realised. However, the same project might also relate to outcome 4 (Communities and families support people with mental health and psychosocial problems), since project activities may relate to empowering families with the knowledge and resources needed to better support family members who have mental disorders.

Ultimately, the practitioner designing the programme is empowered to match up the most suitable outcomes with the accompanying indicator(s) from the common framework. Direction may come from a practitioner’s own MHPSS programme design, programme activities, the description of the outcomes provided in this publication or the action sheets from the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.

To further assist organisations in using the common framework, Annexes 2 through 5 provide possible case scenarios for four commonly used MHPSS interventions in emergency settings. The scenarios help demonstrate how these types of interventions and typical MHPSS programme designs may be linked back to and integrated with the common framework. Although the case scenarios are abbreviated versions of programmes, they will hopefully provide further guidance to MHPSS programme designers and M&E planners seeking to incorporate at least one goal indicator and at least one outcome indicator from the common framework.

CHAPTER 8

Ethical considerations in monitoring and evaluation

Ethical principles help in determining what may be helpful or harmful. Applying ethical principles to all aspects of M&E is important in avoiding potentially risky or bad practices and keeping people involved safe. Research – often described as the systematic collection and analysis of data – encompasses many aspects of M&E work. Whether termed as research or M&E, both approaches involve the collection and analysis of data, and will likely include direct or indirect engagement with individuals throughout the process. Therefore, M&E must always involve the examination of specific ethical considerations to ensure that related activities do no harm to the people involved.

In this regard, the IASC Reference Group for Mental Health and Psychosocial Support has published *Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergencies*. These recommendations cover six important areas of research: (1) purpose and benefits, (2) analysis of ethical issues, (3) participation, (4) safety, (5) neutrality and (6) design. Within these six areas are sub-components (see Figure 4) that form a framework for undertaking data collection in emergency settings. All of these areas should be informed by ethical considerations, in accordance with IASC recommendations.

FIGURE 4.

Six key areas covered in the *Recommendations for Conducting Ethical Mental Health and Psychosocial Research in Emergencies*¹⁵



CHAPTER 9

Sharing results and lessons learned

It has been recognised that the lack of a common M&E framework for MHPSS work in emergency settings has led to huge variations in the goals, outcomes and indicators that organisations use to measure the effectiveness of their work. Consequently, this has led to difficulties in demonstrating the value or impact of MHPSS programmes in emergency settings. However, even if organisations use this common M&E framework, it is critical that results are shared and widely disseminated so that others can benefit from lessons learned. Over time, the resulting data can be used to build a body of evidence to advocate for MHPSS resources. Therefore, when using this common framework, organisations are encouraged to share their findings, results, challenges and lessons, irrespective of whether the impact has been positive. It is just as critical to learn about what has not worked, so as to avoid repeating the same mistakes.

Any MHPSS programme should include M&E reporting, in some format, as part of responsible and ethical programming practice. There are many formal and informal ways that results can be documented, including standard organisational or donor reporting templates, project notes, published reports, one-page fact sheets or (open access) peer-reviewed journal articles. Depending on how results are documented, there are also many formal and informal ways findings can be shared. For example, results can be posted on the www.MHPSS.net website, shared with others in the sector through MHPSS meetings, country-level coordination groups or conferences, or published as reports or articles.

The ultimate aim is to ensure that most, if not all, organisations implementing MHPSS activities in emergency settings are measuring some shared constructs, which can eventually form part of the literature reviews that move the collective state of knowledge of the field forward.

CONCLUSION

Work in the area of MHPSS in emergency settings is expanding. The IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings are widely used to direct that work. Efforts to ascertain the best possible impacts of MHPSS approaches have also grown, but global actors in the field of MHPSS have lacked a common M&E framework in which to report on their work in a unified way. Through academic, expert and field consultations – underpinned by the six core principles of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings – the common M&E framework described in this publication offers a goal statement, five outcomes, plus a selection of indicators. The framework is intended to assist organisations in using at least one (or a few) of these measures, in an ethical way, as part of their efforts to enhance mental and psychosocial well-being.



WE WANT YOUR FEEDBACK

The Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings is the first product of its kind, aiming to establish guidance for M&E approaches as they relate to the goals of the *ASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. After further field use and testing, it is anticipated that valuable new lessons will emerge. Receiving feedback on how this publication has been helpful, or suggestions of ways that it could be improved, will greatly benefit any future revisions. Please forward your feedback to the IASC Reference Group for MHPSS at:

[<mhpss.refgroup@gmail.com>](mailto:mhpss.refgroup@gmail.com).

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Annex 1

Academic reviews to support development of the common framework

INTRODUCTION

Johns Hopkins University performed two reviews to help guide the development of the Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings. First, it reviewed logical frameworks (logframes) and 'theory of change' documents. Second, it reviewed the academic literature to identify the most commonly applied strategies used to monitor and evaluate MHPSS interventions in humanitarian settings in low-and middle-income countries. Findings from the first phase of the review process revealed significant and confusing overlaps in project goals and outcomes, as well as confusion around the definitions of goals and purposes of MHPSS programmes and research. Furthermore, while most reports of MHPSS implementation projects focused on wider MHPSS constructs (such as descriptions of general psychosocial support, information provision and strengthening community and family supports), the review found that research continues to focus mainly on individual clinical interventions and training to achieve those goals. Findings from the first phase of the review confirmed that a common M&E framework for MHPSS, based on the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, would be very beneficial for improving the ability of the MHPSS implementers to align their work plans to a common goal and range of outcomes. The second phase of the review focused on identifying potential indicators for the framework.

METHODS

Logframes and theory of change documents were collected from member organisations of the IASC Reference Group on Mental Health and Psychosocial Support, and included multiple disciplines in which MHPSS work is implemented.

All logframes, theory of change documents, geographic locations, agencies, individuals, donors and budget details were anonymised prior to data being extracted from the documents. Embase, PILOTS, PsycInfo, PubMed/MEDLINE and WHO regional databases were searched for peer-reviewed studies. The academic literature search was restricted to peer-reviewed articles describing M&E for MHPSS in humanitarian settings in low-and middle-income countries. Inductive and deductive strategies were used for analysis. Mental health and psychosocial support constructs were grouped from the 'ground up', using the inductive strategy for thematic content analysis. The deductive strategy was used to first map data and then group themes according to the goal and outcomes drafted by the IASC Reference Group on Mental Health and Psychosocial Support. Systematic differences in mapping and gaps in the current version of the framework were identified, based on the inductive development of themes.

RESULTS

Based on deductive analysis, the distribution of mapping the information extracted from the logframes and articles onto the draft common framework goal, outcomes and indicators is described in Figures 5 and 6, respectively. Across the logframes and peer-reviewed articles, there were **six distinct themes** identified using the inductive analysis at the goal and outcome levels:

1. Increasing resilience, promoting social well-being, and preventing mental health and psychosocial problems. The overarching idea behind this theme is that programmes strive to support or enhance individual resilience and well-being.
2. The goal of reducing mental illness and psychosocial symptoms and associated function impairment through care.
3. Building capacity to identify, intervene in and monitor MHPSS problems. While this theme may be implicit within the overall goal drafted for the framework, it was not directly reflected in the outcomes, reflecting a potential gap in the draft (since many logframes and articles mentioned this explicitly as a goal).
4. The goal of promoting optimal human development within existing social systems. This theme differed from the second theme in that programmes specifically strived to support or enhance community level structures and systems that would, in turn, promote individual healthy development and enhanced quality of life, including physical health and social and economic development.
5. Macro-level goals that sought to build peace among groups after conflict and to address structural problems within societies.
6. Goals pertaining to the protection of vulnerable groups, such as women, children, the elderly and people with disabilities.

CONCLUSIONS

Overall, the reviews indicated that the draft common framework could be generally applied to existing programmes and peer-reviewed literature, but clearly defining goals and outcomes would be essential to such application. The reviews also found that even though psychometrically sound means of verification are published in peer-reviewed literature, these were not commonly applied to logframes or theories of change used in programming.

FIGURE 5.

The common M&E framework outcome mapping frequencies for logframes

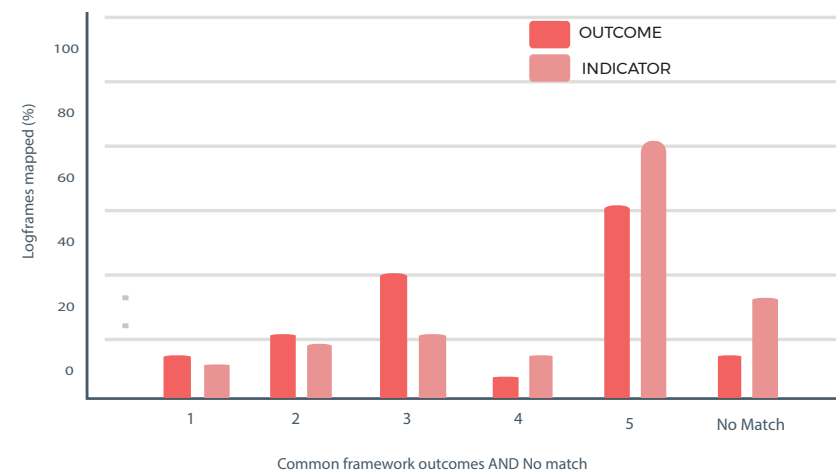
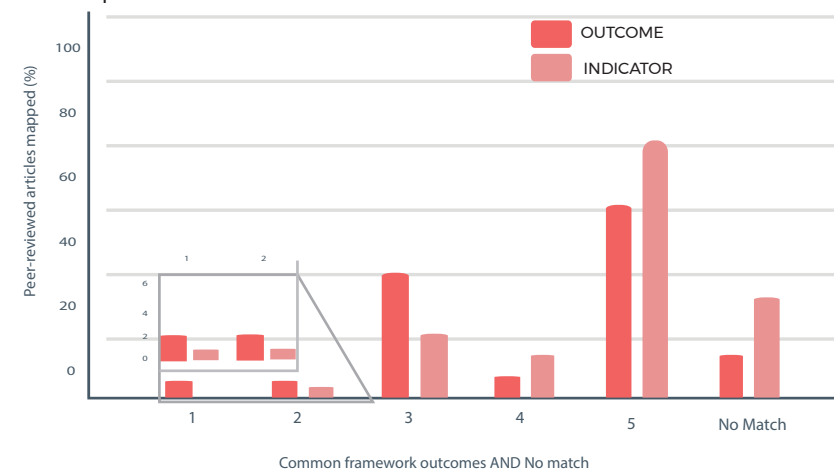


FIGURE 6.

The common M&E framework outcome mapping frequencies for peer-reviewed articles and book chapters



Notes on Annexes 2, 3 4 and 5

The following Annexes provide sample logframes for different types of MHPSS responses in emergencies. The logframes are not comprehensive or technical examples of MHPSS programmes. Nor are they intended to be instructive or illustrative about how MHPSS programmes should be designed. However, they are intended to provide an abbreviated example of how aspects of the common M&E framework might be embedded into a wider, organisation-specific programme design.

The background and programme descriptions focus on common scenarios in emergency settings and the types of goals, outcomes and outputs such programmes target. Based on the context, the assessed needs and priorities of the organisation, a programme design is prepared, and include the following:

- For programme goals, at least one goal impact indicator (Gi) has been selected from the common framework and included as a measure.
- For programme outcomes, at least one outcome plus one or more outcome indicators (O) have been selected from the common framework and included as a measure.
- Sample outputs show the types of activities that may lead to the achievement of the outcomes and, ultimately, the goal.

It is important to observe that goal and outcome statements, even indicators, are not always worded exactly as they are in the common framework. Rather, key words from the common framework have been used to strengthen the relevance of the goal, outcome or indicator to the organisation-specific programme. However, the meaning of what is being targeted and measured remains the same. This demonstrates the flexibility of the common framework for individual organisations and their unique programmes. Furthermore, it is important to note that the common framework does not cover all goals, outcomes and indicators.

To help understand where goals, outcomes and indicators in these abbreviated logframes link back to the common framework, specific reference numbers have been added to guide the reader.

Annex 2

Sample framework for providing emergency supplies in response to an earthquake

Background and programme description: An earthquake has struck the capital city leaving hundreds of thousands of people without homes or access to basic services. Your organisation has mounted an emergency response to help families meet their immediate needs, including temporary shelter and the distribution of family kits for non-food items. You are asked to integrate psychosocial aspects into the initial relief work, ensuring that the core principles of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* are followed and people receive aid in a dignified and safe way.

Sample (abbreviated) logframe:

	Indicators	Means of verification
Programme goal: Earthquake affected families feel safe, have access to emergency supplies and feel ready to cope with emergency recovery	Percentage of affected people who have necessary shelter and non-food items Percentage of women, men, girls and boys who report feeling safe, calm and able to cope with problems [Ci.2]	Project documentation Rapid post-distribution evaluation Key informant interviews
Outcome A: Equipment for basic needs is distributed to 5,000 families	5,000 tents used by families in need 5,000 family non-food item kits used by families in need	Distribution records
Output A.1: Distribution of 5,000 four-person tents		
Output A.2: Distribution of 5,000 family non-food item kits		
Outcome B: Emergency responses do not cause harm and are dignified, participatory, community-owned, and socially and culturally acceptable [O1]	Percentage of staff trained and following guidance from the IASC Guidelines on MHPSS in Emergency Settings [O1.4] Number of affected people who know codes of conduct for humanitarian workers and how to raise concerns about violations [O1.6] Percentage of affected people who report that emergency responses (i) fit with local values, (ii) are appropriate and (iii) are provided respectfully [O1.1]	Project training records Distribution records Rapid post-distribution evaluation Key informant interviews
Output B.1: Emergency response staff are briefed on <i>IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings</i> , using action sheets relevant to their sectors		
Output B.2: Women, men, girls and boys are consulted to identify critical items to be included in non-food item kits		
Output B.3: Flyers (including organisational information, list of beneficiary rights and a complaints mechanism description) are designed, printed and included in distribution kits		

Annex 3

Sample framework for a programme to protect and support women affected by or at risk of sexual violence

Background and programme description: A conflict has been raging for years and women widely report sexual violence, past and present. This has led women to feel unsafe and unable to move about the community. In addition, many women are experiencing depressive symptoms to the extent that they do not feel able to engage in their daily activities. In collaboration with a local welfare services agency, your organisation establishes a programme to respond to the needs of women affected by or at risk of sexual violence in the Zal community.

Sample (abbreviated) logframe:

Programme goal: Reduced suffering and improved mental health and psychosocial well-being [G] among women in the Zal community

Indicators

Percentage of Zal women who feel safe in their community [O2.6]
Percentage of Zal women using mental health and psychosocial support services with improved daily functioning [Gi.1]
Number of reported incidences of sexual violence in Zal

Means of verification

WHO Disability Assessment Schedule
Community survey of women with regard to subjective well-being and safety
Documentation from local authorities

Outcome A: Women are safe, protected [O2] and able to move about their community

Percentage of women who, after training, use new skills and knowledge for prevention of risks and referral [O2.4]
Percentage of Zal women who feel safe in their community [O2.6]

Project training records
Community survey of women with regard to subjective well-being and safety

Output A.1: Risk mitigation interventions are implemented: better-located latrines with adequate lighting, fuel-efficient stoves and the formation of groups for safe movement

Output A.2: Community groups learn and implement 'smartphone safety' approaches to promote safe routes for women moving within their communities

Output A.3: Posters are designed to promote services available for women who may be experiencing depression

Outcome B: Community welfare officers provide interpersonal therapy for women with depression [O5]

Number of Zal women receiving interpersonal therapy [O5.4]
Percentage of Zal women receiving interpersonal therapy who report increased functioning and reduced symptoms of depression [Gi.1; Gi.3]
Lay helpers providing interpersonal therapy interventions report satisfaction with supervision support

Client records
WHO Disability Assessment Schedule
Weekly data on depression collected at the beginning of interpersonal therapy sessions
Focus group discussions with lay helpers

Output B.1: Thirty interpersonal therapy lay helpers across 10 community welfare service offices are trained

Output B.2: Lay helpers provide interpersonal therapy

Output B.3: Interpersonal therapy lay helpers participate in weekly group supervision

Annex 4

Sample framework for a children's informal education programme

Background and programme description: Families have been displaced by war for more than three years and are living in a refugee camp. Children are not permitted to attend school in their host community. Your organisation coordinates an informal education programme with the refugee children to promote ongoing learning, psychosocial support and life skills activities.

Sample (abbreviated) logframe:

Programme goal: Improved psychosocial well-being [G] of children living in the refugee camp

Indicators

Improved feelings of social connectedness among children [Gi.6]
Improved subjective well-being among children [Gi.2]
Children's literacy and numeracy skills improve by at least two levels through the course of the programme

Means of verification

Children's social connectedness measure
Tracking of child-led indicators
Education records

Outcome A: Children participating in the programme improve literacy, numeracy and problem-solving skills [O3]

Increased literacy skills
Increased numeracy skills
Ability of children to cope with psychosocial problems [Gi.4]

Education records
Children's qualitative evaluation

Output A.1: Teachers deliver the literacy and numeracy education modules

Output A.2: Participatory life skills modules are implemented with children

Output A.3: Teachers are trained to provide a teaching environment that promotes social interaction and psychosocial support for children

Outcome B: Children with specific protection and mental health needs are referred for specialised care

Increased teacher knowledge of procedures for referral of children with specific protection and mental health needs
Number of children referred to specialised services [O5.6]

Education records

Output B.1: Referral networks, pathways and processes are mapped and documented

Output B.2: Teachers are trained in codes of conduct and to identify and manage referral of children where needed

Annex 5

Sample framework for a health programme to treat people with mental disorders in primary health clinics

Background and programme description: In an effort to reduce the mental healthcare gap, your organisation has partnered with the Ministry of Health to provide training and support to primary health-care nurses to identify, manage and treat women, men, girls and boys with mental disorders. An important component of this work is community education about community-based care needs of people living with mental disorders.

Sample (abbreviated) logframe:

	Indicators	Means of verification
Programme goal: People living with mental disorders experience improved mental health and psychosocial well-being[G]	Number of individuals with mental disorders reporting a reduction in symptoms [Gi.3] Number of individuals with mental disorders reporting an improvement in functioning [Gi.1]	Health-care facility records Patient records with relevant questionnaires
Outcome A: Nurses at primary health-care facilities identify, manage and support individuals living with mental disorders	Percentage of medical facilities who have staff trained to identify mental disorders and to support people with mental health and psychosocial problems [O5.1] Number of women, men, girls and boys who receive clinical management of mental, neurological or substance use disorders through primary healthcare services [O5.5] Increased availability and restocking of essential medicines for mental disorders	Ministry of Health records Health-care facility records Patient records
Output A.1: Nurses from primary health-care facilities receive training and supervision in the WHO Mental Health GAP Action Programme (mhGAP) Intervention Guidelines		
Output A.2: Provision of psychotropic medications is supported		
Outcome B: Communities and families support people with mental health and psychosocial problems [O4]	Perceptions, knowledge, attitudes and behaviours of community members towards people with mental health and psychosocial problems [O4.4] Level of social capital of individuals with mental health and psychosocial problems [O4.3]	Community survey at baseline and follow-up Key informant interviews and social capital assessment of individuals receiving treatment for mental disorders
Output B.1: Implementation of community educational campaign about mental health		
Output B.2: Engagement with local organisations to encourage the inclusion of individuals living with mental disorders to engage in community livelihoods opportunities		



Goal: Reduced suffering and improved mental health and psychosocial well-being

Outcomes:

Community-focused

- 1 Emergency responses do not cause harm and are dignified, participatory, community-owned, and socially and culturally acceptable
- 2 People are safe, protected, and human rights violations are addressed
- 3 Family, community and social structures promote the well-being and development of all their members

Person-focused

- 4 Communities and families support people with mental health and psychosocial problems
- 5 People with mental health and psychosocial problems use appropriate focused care

Underlying core principles: 1. Human rights and equity, 2. Participation, 3. Do no harm, 4. Integrated services and supports, 5. Building on available resources and capacities, 6. Multilayered supports