

**MENTAL HEALTH AND  
PSYCHOSOCIAL SUPPORT  
IN EMERGENCY SETTINGS:  
CHECKLIST FOR FIELD USE**

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## CHAPTER 1. INTRODUCTION

### **Background**

#### **Introduction**

One of the priorities in emergencies is to protect and improve people's mental health and psychosocial well-being.

A significant gap has been the absence of a multi-sectoral, inter-agency framework that enables effective coordination, identifies useful practices, flags potentially harmful practices, and clarifies how different approaches to mental health and psychosocial support complement one another.

These Guidelines reflect the insights of practitioners from different geographical regions, disciplines and sectors, and reflect an emerging consensus on good practice among practitioners. The core idea behind them is that, in the early phase of an emergency, social supports are essential to protect and support mental health and psychosocial well-being. In addition, the Guidelines recommend selected psychological and psychiatric interventions for specific problems.

The composite term *mental health and psychosocial support* is used in this document to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder.

#### **Purpose of these guidelines**

The primary purpose of these guidelines is to enable humanitarian actors and communities to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psychosocial well-being in the midst of an emergency.

The focus of the guidelines is on implementing minimum responses, which are essential, high-priority responses that should be implemented as soon as possible in an emergency. Minimum responses are the first things that ought to be done; they are the essential first steps that lay the foundation for the more comprehensive efforts that may be needed (including during the stabilised phase and early reconstruction).

Implementation of the guidelines requires extensive collaboration among various humanitarian actors: no single community or agency is expected to have the capacity to implement all necessary minimum responses in the midst of an emergency.

These guidelines are not intended solely for mental health and psychosocial workers. Numerous action sheets in the guidelines outline social supports relevant to the core humanitarian domains, such as protection, general health, education, water and sanitation, food security and nutrition, shelter, camp management. Mental health and psychosocial workers seldom work in these domains, but are encouraged to use this document to advocate with communities and colleagues from other disciplines to ensure that appropriate action is taken to address the social risk factors that affect mental health and psychosocial well-being. The clinical and specialised forms of psychological or psychiatric supports indicated in the guidelines should only be implemented under the leadership of mental health professionals.

## **How to use this field version**

**Reading the full *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* from cover to cover may not be possible during an emergency. This limitation led to the development of this field version, which may be used as a check-list for programme planning and emergency response. This brief version cannot capture all the important points in the Guidelines. Readers are encouraged to use this field version only in conjunction with the full Guidelines.**

A good way to begin is to scan the table in Chapter 2 below and search for the items of greatest relevance and go directly to the corresponding action sheets that are summarized in Chapter 3. **For more detailed guidance on any particular action, one needs to consult the relevant action sheet in the full *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*** (<http://www.humanitarianinfo.org/iasc/content/products>)

## **Core principles**

### **1. Human rights and equity**

Humanitarian actors should promote the human rights of all affected persons and protect individuals and groups who are at heightened risk of human rights violations. Humanitarian actors should also promote equity and non-discrimination.

### **2. Participation**

Humanitarian action should maximise the participation of local affected populations in the humanitarian response. In most emergency situations, significant numbers of people exhibit sufficient resilience to participate in relief and reconstruction efforts.

### **3. Do no harm**

Work on mental health and psychosocial support has the potential to cause harm because it deals with highly sensitive issues. Humanitarian actors may reduce the risk of harm in various ways, such as:

- Participating in coordination groups to learn from others and to minimise duplication and gaps in response;
- Designing interventions on the basis of sufficient information
- Committing to evaluation, openness to scrutiny and external review;
- Developing cultural sensitivity and competence in the areas in which they intervene/work; and
- Developing an understanding of, and consistently reflecting on, universal human rights, power relations between outsiders and emergency-affected people, and the value of participatory approaches.

### **4. Building on available resources and capacities**

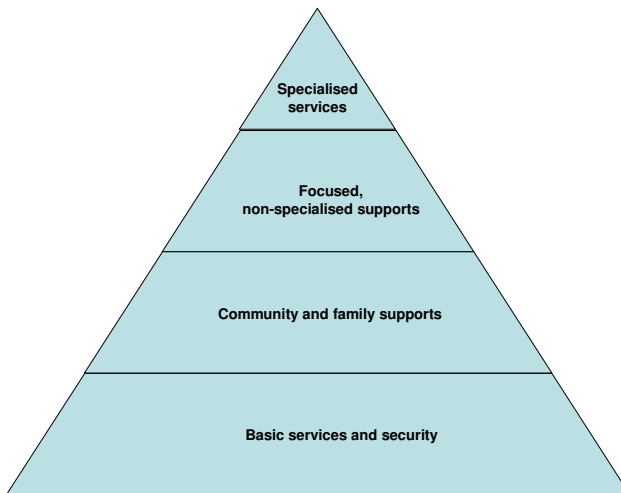
All affected groups have assets or resources that support mental health and psychosocial well-being. A key principle, even in the early stages of an emergency, is building local capacities, supporting self-help and strengthening the resources already present. Externally driven and implemented programmes often lead to inappropriate mental health and psychosocial support and frequently have limited sustainability. Where possible, it is important to build both government and civil society capacities.

## **5. Integrated support systems**

Activities and programming should be integrated as far as possible. The proliferation of stand-alone services, such as those dealing only with rape survivors or only with people with a specific diagnosis, can create a highly fragmented care system.

## **6. Multi-layered supports**

In emergencies, people are affected in different ways and require different kinds of supports. A key to organising mental health and psychosocial support is to develop a layered system of complementary supports that meets the needs of different groups (see Figure 1). All layers of the pyramid are important and should ideally be implemented concurrently.



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

**[design note: please re-attach top layer to pyramid. Also please center pyramid on page.]**

**i. Basic services and security.** The well-being of all people should be protected through the (re)establishment of security, adequate governance and services that address basic physical needs. A mental health and psychosocial response to the need for basic services and security may include: advocating that these services are put in place with responsible actors; documenting their impact on mental health and psychosocial well-being; and influencing humanitarian actors to deliver them in safe, dignified, socio-culturally appropriate ways that promote mental health and psychosocial well-being.

**ii. Community and family supports.** The second layer represents the emergency response for a smaller number of people who are able to maintain their mental health and psychosocial well-being if they receive help in accessing key community and family supports. Useful responses in this layer include family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women's groups and youth clubs.

**iii. Focused, non-specialised supports.** The third layer represents the supports necessary for the still smaller number of people who additionally require more focused individual, family or group interventions by trained and supervised workers (but who may not have had years of training in specialised care). For example, survivors of gender-based violence might need a mixture of emotional and livelihood support from community workers. This layer also includes psychological first aid (PFA) and basic mental health care by primary health care workers.

**iv. Specialised services.** The top layer of the pyramid represents the additional support required for the small percentage of the population whose suffering, despite the supports already mentioned, is intolerable and who may have significant difficulties in basic daily functioning. This assistance should include psychological or psychiatric supports for people with severe mental disorders whenever their needs exceed the capacities of primary/general health services.

Experience from many different emergencies indicates that some actions are advisable, whereas others should typically be avoided. These are identified below as ‘Do’s’ and ‘Don’ts’ respectively.

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

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

## CHAPTER 2. MATRIX OF MINIMUM RESPONSES IN MIDST OF EMERGENCIES

| Area   | A. Common functions   |
|--|---|
| 1 Coordination   | 1.1 Establish coordination of intersectoral mental health and psychosocial support (page 9)   |
| 2 Assessment, monitoring and evaluation                | 2.1 Conduct assessments of mental health and psychosocial issues (page 9)<br>2.2 Initiate participatory systems for monitoring and evaluation (page 9)  |
| 3 Protection and human rights standards                | 3.1 Apply a human rights framework through mental health and psychosocial support (page 10)<br>3.2 Identify, monitor, prevent and respond to protection threats and failures through social protection (page 10)<br>3.3 Identify, monitor, prevent and respond to protection threats and abuses through legal protection (page 10)  |
| 4 Human resources                                      | 4.1 Identify and recruit staff and engage volunteers who understand local culture (page 11)<br>4.2 Enforce staff codes of conduct and ethical guidelines (page 11)<br>4.3 Organise orientation and training of aid workers in mental health and psychosocial support (page 12)<br>4.4 Prevent and manage problems in mental health and psychosocial well-being among staff and volunteers (page 12)   |
| <b>B. Core mental health and psychosocial supports</b> |   |
| 5 Community mobilisation and support                   | 5.1 Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors (page 13)<br>5.2 Facilitate community self-help and social support (page 13)<br>5.3 Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices (page 13)   |
| 6 Health services                                      | 5.4 Prevent separation and facilitate support for young children (0–8 years) and their care-givers (page 14)<br>6.1 Include specific psychological and social considerations in provision of general health care (page 14)<br>6.2 Provide access to care for people with severe mental disorders (page 14)<br>6.3 Protect and care for people with severe mental disorders and other mental and neurological disabilities living in institutions (page 15)<br>6.4 Learn about and, where appropriate, collaborate with local, indigenous and traditional health systems (page 15)<br>6.5 Minimise harm related to alcohol and other substance use (page 15) |
| 7 Education  | 7.1 Strengthen access to safe and supportive education (page 16)  |
| 8 Dissemination of information                         | 8.1 Provide information to the affected population on the emergency, relief efforts and their legal rights (page 16)<br>8.2 Provide access to information about positive coping methods (page 16)   |
| <b>C. Social considerations in sectors</b>             |   |
| 9 Food security and nutrition                          | 9.1 Include specific social and psychological considerations (safe aid for all in dignity, considering cultural practices and household roles) in the provision of food and nutritional support (page 17)   |
| 10 Shelter and site planning                           | 10.1 Include specific social considerations (safe, dignified, culturally and socially appropriate assistance) in site planning and shelter provision, in a coordinated manner (page 17)   |
| 11 Water and sanitation                                | 11.1 Include specific social considerations (safe and culturally appropriate access for all in dignity) in the provision of water and sanitation (page 18)  |

**The full guidelines include 25 action sheets that explain how to implement each of the above minimum responses (See Chapter 3).**

## **CHAPTER 3. Summary of Action Sheets: Checklists for Minimum Response**

Each of the checklists below summarise key actions of a minimum response. The checklists correspond to the 25 action sheets of the full version of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, which provide more detailed information and instruction.

### **1. Coordination**

#### **1.1 Establish coordination of intersectoral mental health and psychosocial support**

- Activate or establish mechanisms for intersectoral MHPSS coordination (e.g., establish a MHPSS coordination group).
- Coordinate programme planning and implementation, including development of a MHPSS strategic plan.
- Adapt/develop and disseminate guidelines and coordinate advocacy on MHPSS.
- Coordinate fundraising and advocacy for resources.

**For a detailed explanation, see pages 33-37 of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.**

### **2. Assessment, monitoring and evaluation**

#### **2.1 Conduct assessments of mental health and psychosocial issues**

- Ensure that assessments are coordinated.
- Collect and analyse key information relevant to mental health and psychosocial support.
- Conduct assessments in an ethical, rigorous and appropriately participatory manner.
- Collate, disseminate and use assessment results with the community and humanitarian actor, ensuring confidentiality and respecting the Do No Harm principle, including protection risks.

**For a detailed explanation, see pages 38-45 of the IASC Guidelines.**

#### **2.2 Initiate participatory systems for monitoring and evaluation**

- Define a set of indicators for monitoring, according to defined objectives and activities.
- Apply monitoring and evaluation methods in an ethical and appropriately participatory manner.
- Use monitoring for reflection, learning and positive change.

**For a detailed explanation, see pages 46-49 of the IASC Guidelines.**

### **3. Protection and human rights standards**

#### **3.1 Apply a human rights framework through mental health and psychosocial support**

- Advocate for compliance with international human rights standards in all forms of mental health and psychosocial support in emergencies.
- Implement mental health and psychosocial supports in a way that that promotes and protects human rights
- Include a focus on human rights and protection in the training of all relevant humanitarian and human rights actors.
- Establish – within the context of humanitarian and pre-existing services – mechanisms for the monitoring and reporting of abuse and exploitation by humanitarian agencies.
- Advocate and provide advice to states on bringing relevant national legislation, policies, programmes and practices into line with international law and standards

**For a detailed explanation, see pages 50-55 of the IASC Guidelines.**

#### **3.2 Identify, monitor, prevent and respond to protection threats and failures through social protection**

- Learn from protection experts or their specialised protection assessments whether, when and how to collect information on protection threats.
- Conduct a multi-sectoral, participatory assessment of protection threats and capacities.
- Activate or establish social protection mechanisms, building local protection capacities where needed.
- Respond to protection threats by taking appropriate, community-guided action.
- Monitor on an ongoing basis protection threats in venues such as schools and marketplaces, sharing information with relevant agencies and protection stakeholders.
- Prevent protection threats through a combination of programming and advocacy.

**For a detailed explanation, see pages 56-63 of the IASC Guidelines.**

#### **3.3 Identify, monitor, prevent and respond to protection threats and abuses through legal protection**

- Identify the main protection threats and the status of existing protection mechanisms, especially for people at particular risk.
- Increase affected people's awareness of their legal rights and their ability to assert these rights in the safest possible way, using culturally appropriate communication methods.
- Support mechanisms for monitoring, reporting and responding to violations of legal standards.
- Advocate for compliance with international law and standards, and with national and customary laws consistent with international standards.
- Implement legal protection in a manner that promotes psychosocial well-being, dignity and respect.

- Provide psychosocial support and legal protection services in a complementary fashion.

**For a detailed explanation, see pages 64-70 of the IASC Guidelines.**

#### **4. Human resources**

##### **4.1 Identify and recruit staff and engage volunteers who understand local culture**

- Designate knowledgeable and accountable personnel to undertake recruitment.
- Apply recruitment and selection principles.
- Balance gender in the recruitment process and include representatives of key cultural and ethnic groups.
- Establish terms and conditions for volunteer work.
- Check references and professional qualifications when recruiting national and international staff, including short-term consultants, translators, interns and volunteers.
- Aim to hire staff who have knowledge of, and insight into, the local culture and appropriate modes of behaviour.
- Carefully evaluate offers of help from individual (non-affiliated) foreign mental health professionals.

**For a detailed explanation, see pages 71-75 of the IASC Guidelines.**

##### **4.2 Enforce staff codes of conduct and ethical guidelines**

- Establish within each organisation a code of conduct that embodies widely accepted standards of conduct for humanitarian workers.
- Inform and regularly remind all humanitarian workers, both current and newly recruited workers, about the agreed minimum required standards of behaviour, based on explicit codes of conduct and ethical guidelines.
- Establish an agreed inter-agency mechanism (e.g. Focal Point Network proposed by the United Nations Secretary-General) that builds consistency, coordination and best practices to implement of codes of conduct and ethical guidelines.
- Establish accessible, safe, confidential and trusted complaints mechanisms.
- Inform communities about the standards and ethical guidelines, and of how and to whom they can raise concerns confidentially.
- Ensure that all staff understand that they must report all concerns as soon as they are raised.
- Use investigation protocols that comply with an agreed standard, such as the IASC Model Complaints and Investigations Procedures.
- Take appropriate disciplinary action against staff for confirmed violations of the code of conduct or ethical guidelines.
- Establish an agreed response in cases in which the alleged behaviour constitutes a criminal act in either the host country or the home country of the alleged perpetrator.
- Maintain written records of workers who have been found to have violated codes of conduct, to increase the effectiveness of subsequent referral/recruitment checks.

**For a detailed explanation, see pages 76-80 of the IASC Guidelines.**

**4.3 Organise orientation and training of aid workers in mental health and psychosocial support**

- Prepare a strategic, comprehensive, timely and realistic plan for training.
- Select competent, motivated trainers.
- Utilise learning methodologies that facilitate the immediate and practical application of learning.
- Match trainees' learning needs with appropriate modes of learning through brief orientation seminars or training seminars.
- Prepare orientation and training seminar content directly related to the expected emergency response.
- Consider Training of Trainers (ToT) programmes to prepare trainers to train others.
- After any training, establish a follow-up system for monitoring, support, feedback and supervision of all trainees, as appropriate to the situation.
- Document and evaluate orientation and training to identify lessons learned, to be shared with partners and to enhance future responses.

**For a detailed explanation, see pages 81-86 of the IASC Guidelines.**

**4.4 Prevent and manage problems in mental health and psychosocial well-being among staff and volunteers**

- Ensure the availability of a concrete plan to protect and promote staff well-being for the specific emergency.
- Prepare staff for their jobs and for the emergency context.
- Facilitate a healthy working environment.
- Address potential work-related stressors.
- Ensure access to health care and psychosocial support for staff.
- Provide support to staff who have experienced or witnessed extreme events (critical incidents, potentially traumatic events).
- Make support available after the mission/employment

**For a detailed explanation, see pages 87-92 of the IASC Guidelines.**

## **5. Community mobilisation and support**

### **5.1 Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors**

- Coordinate efforts by different stakeholders to mobilise communities.
- Assess the political, social and security environment at the earliest possible stage.
- Talk with a variety of key informants and formal and informal groups, learning how local people are organising and how different agencies can participate in the relief effort.
- Facilitate the participation of marginalised people.
- Establish safe and sufficient spaces early on to support planning discussions and the dissemination of information.
- Promote community mobilisation processes.

**For a detailed explanation, see pages 93-99 of the IASC Guidelines.**

### **5.2 Facilitate community self-help and social support**

- Identify human resources in the local community.
- Facilitate the process of community identification of priority actions through participatory rural appraisal and other participatory methods.
- Support community initiatives, actively encouraging those that promote family and community support for all emergency-affected community members, including people at greatest risk.
- Encourage and support additional activities that promote family and community support for all emergency-affected community members and, specifically, for people at greatest risk.
- Provide short, participatory training sessions where appropriate, coupled with follow-up support.
- When necessary, advocate within the community and beyond on behalf of marginalised and at-risk people.

**For a detailed explanation, see pages 100-105 of the IASC Guidelines.**

### **5.3 Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices**

- Approach local religious and spiritual leaders and other cultural guides to learn their views on how people have been affected and on practices that would support the affected population.
- Exercise ethical sensitivity.
- Learn about cultural, religious and spiritual supports and coping mechanisms.
- Disseminate the information collected among humanitarian actors at sector and coordination meetings.
- Facilitate conditions for appropriate healing practices.

**For a detailed explanation, see pages 106-109 of the IASC Guidelines.**

**5.4 Prevent separation and facilitate support for young children (0–8 years) and their care-givers**

- Keep children with their mothers, fathers, family or other familiar care-givers: prevent separation, reunify children and parents, and - only when necessary- facilitate alternative care arrangements.
- Promote the continuation of breastfeeding.
- Facilitate age and culturally appropriate play, nurturing care and social support that gives children a sense of routine and participation in normalizing activities.
- Care for care-givers by organizing meetings at which care-givers can discuss past, present and future; share problem-solving; and support one another in caring effectively for their children.

**For detailed guidance, see pages 110-115 of the IASC Guidelines.**

**6. Health services**

**6.1 Include specific psychological and social considerations in provision of general health care**

- Include specific social considerations in providing general health care.
- Provide birth and death certificates (if needed).
- Facilitate referral to key resources outside the health system
- Orient general health staff and mental health staff in psychological components of emergency health care, including psychological first aid.
- Make available psychological support for survivors of extreme stressors (also known as traumatic stressors).
- Collect data on mental health in primary health care settings.

**For a detailed explanation, see pages 116-122 of the IASC Guidelines.**

**6.2 Provide access to care for people with severe mental disorders**

- Assess existing services and identify people in need
- Build a relationship with traditional healers and facilitate the use of supportive traditional healing methods where appropriate
- Ensure sustainable supplies of psychotropic medication
- Initiate rapid supervised training for emergency PHC staff
- Establish an accessible advertised service
- Avoid the creation of parallel mental health services focused on specific diagnoses (e.g. posttraumatic stress disorder) or on narrow groups (e.g. widows)
- Provide biological, psychological, and social interventions to relieve symptoms, provide protection and restore function
- Educate and support existing carers

- Work with local community structures and groups to enable protection of those severely disabled by mental disorder
- With displaced populations, plan for return home (as appropriate)
- Collaborate with existing health services and authorities to facilitate sustainable care

**For a detailed explanation, see pages 123-131 of the IASC Guidelines.**

|            |   |
|------------|---|
| <b>6.3</b> | <b>Protect and care for people with severe mental disorders and other mental and neurological disabilities living in institutions</b> |
|------------|---|

- Ensure that at least one agency involved in health care accepts responsibility for ongoing care and protection of people in institutions.
- If staff have abandoned psychiatric institutions, mobilise human resources from the community and the health system to care for people with severe mental disorders who have been abandoned.
- Protect the lives and dignity of people living in psychiatric institutions.
- Enable basic health and mental health care throughout the emergency.

**For a detailed explanation, see pages 132-135 of the IASC Guidelines.**

|            |   |
|------------|---|
| <b>6.4</b> | <b>Learn about and, where appropriate, collaborate with local, indigenous and traditional healing systems</b> |
|------------|---|

- Assess and map the provision of care.
- Learn about national policy regarding traditional healers.
- Establish rapport with identified healers.
- Encourage the participation of local healers in information sharing and training sessions.
- If possible, set up collaborative services.

**For a detailed explanation, see pages 136-141 of the IASC Guidelines.**

|            |   |
|------------|---|
| <b>6.5</b> | <b>Minimise harm related to alcohol and other substance use</b> |
|------------|---|

- Conduct a rapid assessment.
- Prevent harmful alcohol and other substance use and dependence.
- Facilitate harm reduction interventions in the community.
- Manage withdrawal and other acute problems.

**For a detailed explanation, see pages 142-147 of the IASC Guidelines.**

## **7. Education**

### **7.1 Strengthen access to safe and supportive education**

- Promote safe learning environments.
- Make formal and non-formal education more supportive and relevant.
- Strengthen access to quality education for all.
- Prepare and encourage educators to support learners' psychosocial well-being.
- Strengthen the capacity of the education system to support learners experiencing psychosocial and mental health difficulties.

**For a detailed explanation, see pages 148-156 of the IASC Guidelines.**

## **8. Dissemination of information**

### **8.1 Provide information to the affected population on the emergency, relief efforts and their legal rights**

- Facilitate the formation of an information and communication team.
- Regularly assess the situation and identify key information gaps and key information for dissemination.
- Develop a communication and campaign plan.
- Create channels to access and disseminate credible and valid information to the affected population.
- Ensure coordination between communication personnel working in different agencies.

**For a detailed explanation, see pages 157-162 of the IASC Guidelines.**

### **8.2 Provide access to information about positive coping methods**

- Determine what information on positive coping methods is already available among the disaster-affected population.
- If no information on positive coping methods is currently available, develop information on positive, culturally appropriate coping methods for use among the disaster-affected population.
- Adapt the information to address the specific needs of sub-groups of the population as appropriate.
- Develop and implement a strategy for effective dissemination of information.

**For a detailed explanation, see pages 163-167 of the IASC Guidelines.**

## **9. Food security and nutrition**

|            |  |
|------------|--|
| <b>9.1</b> | <b>Include specific social and psychological considerations (safe aid for all in dignity, considering cultural practices and household roles) in the provision of food and nutritional support</b> |
|------------|--|

- Assess psychosocial factors related to food security, nutrition and food aid.
- Maximise participation in the planning, distribution and follow-up of food aid.
- Maximise security and protection in the implementation of food aid.
- Implement food aid in a culturally appropriate manner that protects the identity, integrity and dignity of primary stakeholders.
- Collaborate with health facilities and other support structures for referral of recipients who need special attention (e.g. under-stimulated, malnourished children; mentally ill persons)
- Stimulate community discussion for long-term food security planning.

**For a detailed explanation, see pages 166-173 of the IASC Guidelines.**

## **10. Shelter, site planning**

|             |   |
|-------------|---|
| <b>10.1</b> | <b>Include specific social considerations (safe, dignified, culturally and socially appropriate assistance) in site planning and shelter provision, in a coordinated manner</b> |
|-------------|---|

- Use a participatory approach that engages women and people at risk in assessment, planning and implementation.
- Select sites that protect security and minimise conflict with permanent residents.
- Include communal safe spaces in site design and implementation to enable social, cultural and religious educational activities and dissemination of information.
- Develop and use an effective system of documentation and registration.
- Distribute shelter and allocate land in a non-discriminatory manner.
- Maximise privacy, ease of movement, opportunities for social support and maintenance of social relations through site and shelter planning.
- Balance flexibility and protection in organising shelter and site arrangements.
- Avoid creating a culture of dependency among displaced people and promote durable solutions.

**For a detailed explanation, see pages 174-178 of the IASC Guidelines.**

## **11. Water and sanitation**

|             |  |
|-------------|--|
| <b>11.1</b> | <b>Include specific social considerations (safe and culturally appropriate access for all in dignity) in the provision of water and sanitation</b> |
|-------------|--|

- Include social and cultural issues in water and sanitation and hygiene promotion assessments.
- Enable participation in assessment, planning and implementation, especially engaging women and other people at risk.
- Promote dignity, safety and protection in all water and sanitation activities, ensuring that latrines and bathing areas are lockable and well-lit.
- Prevent and manage in a constructive manner conflict over water between affected families or between displaced groups and permanent residents.
- Promote personal and community hygiene.
- Facilitate community monitoring of, and feedback on, water and sanitation facilities, being sure to talk with people at risk.

**For a detailed explanation, see pages 179-182 of the IASC Guidelines.**