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DEUTSCHE ZUSAMMENARBEIT

Guiding Framework for Mental Health and Psychosocial Support (MHPSS) in Development Cooperation

As exemplified in the context of the crises in Syria and Iraq



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Background and history of the guiding framework

This paper was commissioned by the *German Federal Ministry for Economic Cooperation and Development (BMZ)* in 2015, and produced by the *Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH*, in cooperation with German civil society actors and freelance psychologists working in the field of *Mental Health and Psychosocial Support (MHPSS)* with refugees and *internally displaced people (IDP)* in both the Middle Eastern region and Germany. The commission arose from BMZ's wish for guidance on the characteristics of good working practices in MHPSS and the desire expressed by GIZ's civil society partners in the regional programme *Psychosocial Support for Syrian and Iraqi Refugees and Internally Displaced People* for more intensive dialogue to promote MHPSS in the context of the Syria and Iraq crises.

This paper was based on international guidelines and lessons learnt, along with input from the *Arbeitsgemeinschaft Psychosozialer Zentren für Flüchtlinge und Folteropfer [German Association of Psychosocial Centres for Refugees and Victims of Torture]*, the *Charité – Universitätsmedizin Berlin [Charité teaching hospital in Berlin]*, *Haukari*, the *Jiyan Foundation for Human Rights*, *medica mondiale*, *medico international*, *Misereor*,

the *Sigmund Freud University Berlin* and the *Zentrum Überleben*. Sixty-six different governmental and non-governmental organisations and institutions operating in Syria, Lebanon, Turkey, Iraq and Jordan gave feedback on a first draft of the paper between July 2017 and March 2018. The findings from workshops and interviews held with over 120 individuals during this period on the principles of good psychosocial support in the context of the Syria and Iraq crises were also incorporated into the paper.

This guiding framework is therefore a contextually adapted, joint position paper for German development cooperation that reflects the current status of the debate among the institutions and experts involved as to what constitutes good psychosocial work with refugees and IDP, and what risks need to be taken into account in the course of that work. It is designed for actors in the MHPSS sector who are working with refugees and IDP in the Middle East in the context of the Syria and Iraq crises, as well as ministries and research institutions. It should be understood as a basic document offering guidance on the design, planning, implementation, and evaluation of activities. It can also support donor organisations by offering a sound basis for assessing interventions and project proposals for psychosocial support for refugees, IDP and host communities. To this end it includes a number of quality principles designed to support the development of measures for the mental and social stabilisation and treatment of persons who have experienced displacement and violence, as well as trauma-sensitive development cooperation.

Unlike standards, which carry a risk of restricting flexibility and creativity and neglecting specific cultural, geographical and political/social factors, the paper is designed as a **living document** that must always be adapted to the current context. Since political and social circumstances are constantly changing the document needs to be updated, and its principles can be deviated from, should circumstances warrant it.

In addition to providing guidance on measures, the document is also designed to support communication with local partners. Although it emerged from within the German discourse, other international actors can also use it for positioning purposes.

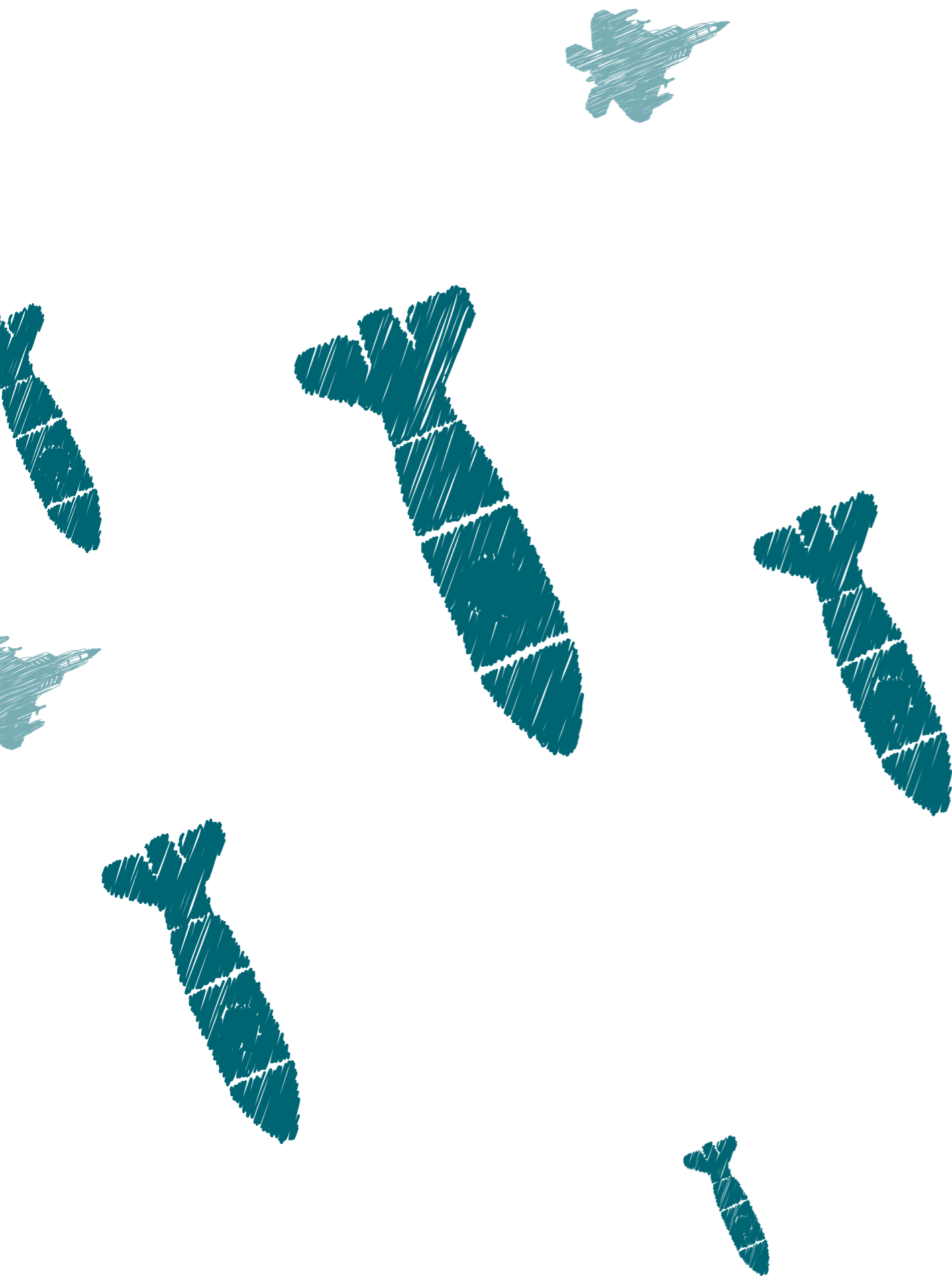
Working on a trauma-sensitive basis, and organising activities in a way that is also trauma-sensitive, means avoiding anything during implementation that might in itself be traumatic, or lead to retraumatisation. In other words, it means avoiding anything that might cause displaced persons to feel threatened or at the mercy of others, experience extreme anxiety and powerlessness, or a loss of trust and control. Such work therefore focuses on creating frameworks that offer a maximum degree of safety, predictability and trust, so enabling those affected to exercise control and self-determination at every step. Anyone working with refugees and IDP should be familiar with the basic patterns of trauma dynamics (e.g. the fact that there are factors which can re-voke traumatic memories). They should also understand the need to adapt frameworks to suit the professional group and traumatic context involved.

List of abbreviations and acronyms

BMZ	German Federal Ministry for Economic Cooperation and Development
cfw	Cash for Work
DC	Development Cooperation
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH
IASC	Inter-Agency Standing Committee
ICD	International Classification of Diseases
IDP	Internally Displaced Person(s)
IFRC	International Federation of Red Cross and Red Crescent Societies
IS	so-called Islamic State
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
MEAL	Monitoring, Evaluation, Accountability and Learning
MHPSS	Mental Health and Psychosocial Support
PFA	Psychological First Aid
PSS	Psychosocial Support
PTSD	Post-Traumatic Stress Disorder
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

Contents

1. What are the psychosocial effects of violence and displacement?	9
2. What particular ambivalences apply to the psychosocial needs of victims of human-made violence?.....	11
3. What are the particular psychosocial needs of refugees and IDP in the context of the Syria and Iraq crises?	12
4. What does MHPSS mean in the context of conflict and displacement?.....	15
5. What understanding of trauma should German development cooperation be based on?.....	19
6. What have we learned about MHPSS approaches in the context of war and forced displacement, and what might psychosocial support for refugees and IDP look like in the context of the Syria and Iraq crises?	24
7. What form does German development cooperation take in practice?	28
8. What steps can be taken to ensure the psychosocial wellbeing of MHPSS staff?.....	35
9. What principles of high-quality services apply to measures designed to promote mental health and psychosocial support in development cooperation?.....	37
10. What added value do psychosocial approaches offer for German development cooperation?.....	44
Closing remarks.....	46
References	48
Recommended further reading.....	52
Annex – Supplement to Chapter 10	54



1. What are the psychosocial effects of violence and displacement?

Armed conflicts have a devastating effect not only on a country's infrastructure, security, and economic development, but also on the mental and social wellbeing of the people affected. A failure to recognise and deal with mental suffering at both an individual and collective level has a detrimental effect on a society's cohesion, economic productivity and stability (*see References (1)*). The link between violent conflict and psychological distress is complex and often unpredictable (*2*).

Forced displacement in the context of armed conflict and violence has material consequences, but also leads to severe experiences of loss. These include the loss of relatives and friends, a sense of belonging, control and autonomy, and access to resources. Refugees and IDP also experience increased vulnerability, and a greater exposure to violence in domestic and societal settings, as well as poverty, a lack of prospects and uncertainty as to what the future holds.

People fleeing from a crisis region often undergo painful and unsettling experiences not only in the crisis region itself but also en route, and afterwards in refugee camps and host countries as victims of discrimination, or when facing deportation. Arriving in a host country often brings new challenges such as difficulties when dealing with the authorities, uncertainty regarding residency status, insufficient language proficiency, and conflict with local populations. The pressure of expectations from the country of origin can also create additional stress. Ordeals of torture and other human rights violations disrupt people's functional conceptions of the world and their self-image. Experiencing rejection or xenophobia reinforces a perceived sense of constant threat, on top of which competition for jobs places a strain on whatever social relationships are still intact (*3*). Feelings of rootlessness and homelessness make it harder for people to integrate, and can make them view their life as merely an interim. While many people long to return to their home country following reconstruction, this is often impossible. And even if they do, they frequently find that making a new start is complicated and painful due to the massive changes in circumstances such as the destruction of infrastructure, the loss of family members, and the establishment of new hierarchies (*4*).

In sum, the experiences that displaced people undergo can be described as extreme disempowerment, often accompanied by feelings of shame and guilt, as well as hatred and thoughts of revenge. Apart from living under difficult conditions, those affected frequently also suffer from feelings of grief, worry, anxiety, desperation, hopelessness, loneliness, homesickness, alienation, helplessness, powerlessness, and aggression, all of which can shape their behaviour (*5*) (*6*). The effects of displacement are not restricted to the individuals affected; they also extend to their immediate relationships with others, as well as their wider social networks. People's interactions are also affected by things such as avoidance behaviour, social withdrawal and lethargy. Couples may find it difficult to maintain trust and intimacy, while parents are often less able to offer their children safe and stable bonds and attachment. Suffering that remains unspoken between family members can lead to an atmosphere of silence and secrecy.

At the same time, experiences of violence and displacement are also manifested in the wider social structures of communities and societies. Individuals' anxieties, mistrust and social withdrawal disrupt social cohesion and solidarity, and can lead to violence and social numbness. In turn, this means that the community and society are no longer able to perform their key stabilising roles. The effects at an individual and collective level are of course interlinked, and often form a vicious circle that progressively destabilises the individuals and groups concerned. This is why measures to strengthen mental health and psychosocial wellbeing must address all these levels simultaneously.

Survival skills, personal strength and ability to cope often develop together and are intertwined with mental, psychosomatic and/or somatic symptoms and illnesses (such as depression, anxiety disorders and *post-traumatic stress disorder* (PTSD)¹). The WHO estimates that the number of severe cases of mental illness can double in the context of conflict. Moderate forms of mental disorder within the population also rise from 10% to 15-20%. The increased prevalence of mental disorders may affect every part of society's ability to function and perform its role.

Alongside the negative effects described above, however, we should not forget that reactions to potentially traumatizing experiences, and the ways people cope with difficulties in their current life situation, vary from individual to individual, and many refugees do develop skills and personal resources that help them to survive under these difficult conditions. In recent years the discourse of the international expert community has moved towards abandoning the concept of PTSD in favour of a more resource-based approach which looks at the individual's response to stress along a continuum between functional (adaptive) and dysfunctional (maladaptive) responses to various challenges and stressors to better reflect the personal resources and strengths of the people affected. For instance, the ADAPT model (ADAPT = *Adaptation and Development after Persecution and Trauma*) explores the potential for individuals affected by trauma to successfully adapt in the fields of safety/security, bonds/networks, roles and identities, and existential meaning (7).

¹ The International Classification of Diseases (ICD) states: 'Typical features include episodes of repeated reliving of the trauma in intrusive memories ("flashbacks"), dreams or nightmares, occurring against the persisting background of a sense of "numbness" and emotional blunting, detachment from other people, unresponsiveness to surroundings, anhedonia, and avoidance of activities and situations reminiscent of the trauma' (20). It should be borne in mind, however, that these symptoms are only a manifestation of a disease if they persist over a prolonged period 'which may range from a few weeks to months'.

2. What particular ambivalences apply to the psychosocial needs of victims of human-made violence?

Survivors of violence and destruction that was caused by human beings usually perceive their experience as a massive injustice. They often have a strong need for that injustice to be recognised, along with a desire for empathy and solidarity. Diagnoses of disorders such as depression or PTSD can be experienced as pathologising labels and lead to stigmatisation, which creates further obstacles to the need for acknowledgement, and interventions that only address the symptoms of suffering and illness can cause a renewed sense of disempowerment. However, models of illness also have the potential to relieve the burden on the individual by showing that it is both natural and normal for certain responses to occur after violent experiences¹.

To deliver a trauma-sensitive response in the face of these ambivalences, it is essential to ensure that those affected retain control of and decision-making power over intervention processes and interpretations. It is also crucial to respect their autonomy and potential for finding their own ways of dealing with their experiences, and to support the creation of new perspectives. In this context, however, we should also remember that traumatised individuals often have a strong need for safety and security alongside this need for autonomy. This can inhibit their ability to be proactive and take the initiative and, when surrounded by unfamiliar sociocultural norms, may lead to them having a preference for clear guidelines (8).

A further pivotal element of ambivalence when dealing with human-made violence is the issue of trust and mistrust, particularly in the context of conflicts that are decades old, highly complex, and rapidly changing. These usually generate a variety of front lines and victim-perpetrator relationships, making it extremely difficult to develop trustful relationships even when external threats have been eliminated. The violence which people experience often reflects political and historical conflicts, and regional dynamics are played out in psychosocial work at the micro level. A precise understanding of the target groups and the various national, regional, political, denominational, ethnic, and gender-specific lines of conflict is therefore absolutely essential in order to avoid asymmetrical, conflictual relationships that generate mistrust. Individuals suffering stress as a result of displacement find it helpful when others create an atmosphere of predictability, credibility, and appreciation. This enables them to overcome their feelings of being uprooted and at the mercy of others, and to develop a fresh outlook. Focusing on an individual's resources and strengths can facilitate their process of coping and regaining a sense of control over their current life situation.

3. What are the particular psychosocial needs of refugees and IDP in the context of the Syria and Iraq crises?

The devastating and prolonged civil war in Syria and the conflicts in Iraq have led to one of the largest movements of displaced persons of our times. Since 2011 some 12 million Syrian (9) and 4.3 million Iraqi (10) citizens have been displaced from their regions of origin. Around 5.6 million people have left Syria for neighbouring countries, including 1.9 million children. More than 6.1 million Syrians and just under 3 million Iraqis are currently IDP (11) (12). As well as requiring humanitarian support for the latter, Iraq faces the twin challenges of hosting Syrian refugees and taking back approximately 46,000 Iraqi citizens returning from Syria. Since local infrastructure had already been weakened before the crises in Syria and Iraq, the huge strain placed on the host communities means that many of them are unable to guarantee the provision of basic services for refugees and IDP. In the neighbouring countries of Turkey, Lebanon and Jordan, hosting refugees due to the armed conflict has directly affected politics, the economy, and society in general.

The management of refugees and IDP in the context of the Syria and Iraq crises is not only shaped by the current political and societal context in the host countries and communities, it also reflects the complexities of a decades-long shared history of experiences of violence along numerous lines of conflict involving groups with various political, ethnic and religious affiliations in the Middle East. The history of the conflicts in Syria and Iraq is just as heterogeneous, complex and varied as those two countries' relations with their neighbours. Whereas the war in Syria began in early 2011 – following the Arab Spring – and escalated rapidly, Iraq has faced (repeated) armed conflicts, repression and persecution of various sections of the population based on their political, confessional, territorial and/or ethnic affiliations over the last three decades.

Syrian society before the armed conflict was already characterised by pronounced social, socio-economic, ethnic, and religious diversity. Along with demographic factors such as age and gender, this diversity is now also reflected among Syrian refugees. These various characteristics affect feelings of belonging and loyalties within the refugee community, and affect people's psychosocial needs, mechanisms of adaptation, and help-seeking behaviour. As the state has become weaker, for instance, religious and tribal affiliations have become more important (13). The host communities are unable to integrate all the many children who were attending school in Syria prior to the onset of the conflict into their school systems, or those who were born as their parents took flight or thereafter and have now reached school age, which has a negative effect on the sense of normality among the children and teenagers, and their prospects for the future. Overall, the conditions under which the refugee population live are highly dependent on both the will and the capacity of the host countries and communities to integrate them. This will is often stronger in those countries where cultural and economic links already existed prior to the crisis (13).

The vast majority of those seeking refuge live in urban areas: approximately 88% in Turkey and 80% in Jordan and 100% in Lebanon, where there are no official refugee camps for Syrian refugees (14). The psychosocial support they need often differs from what people in the camps need, due to their different life circumstances. The number of refugees living in overcrowded accommodation has risen continuously, and is contributing to increasing vulnerability among the refugee population (15).

Most refugees from Iraq and the large number of IDP had already been experiencing systematic persecution for decades. Some population groups were repressed, terrorised, tortured, and murdered because of their political, religious or ethnic affiliations. The Iran-Iraq war in the 1980s and the Gulf War in the 1990s claimed hundreds of thousands of victims and displaced huge numbers of people. The US invasion in 2003, and the dissolution of the Iraqi army and collapse of state structures which followed, led to the formation of countless state and non-state militia that from 2005 onwards played a role in the escalation of violence in many parts of Iraq that involved murder, rape, enslavement, and starvation. These circumstances led to a further wave of displacement among affected sections of the population – chiefly to the northern provinces of Iraq and to other countries. Iraq's long and complex history of violence has left its society fragmented, which explains the tensions and deep mistrust between various groups of IDP, as well as between displaced persons and host communities. As with Syria, only a minority of Iraqi refugees live in camps; most live in temporary accommodation across cities in the region.

Many refugees and IDP witnessed massacres, executions and bombings when the so-called *Islamic State* (IS) gained strength in Iraqi-Syrian territory, and went on to endure displacement, kidnappings, detention, torture, and rape. Countless people lost relatives and friends, and many live in a state of uncertainty as to their fate. The collapse of social structures, precarious life circumstances and a lack of prospects in refugee camps and emergency shelters often leads to renewed violence, chiefly against women and children. Forced marriages, child marriages, sexual assaults, and forced prostitution are widespread. In the current situation of displacement, conflicts arise in the collision between the different gender constructs and legal codes of the host communities and refugees. IDP in particular suffer siege situations and attacks on hospitals, making it more difficult to access food and medical care. Poverty and unemployment are also key factors that generate psychosocial stress.

Vulnerable population groups constantly redefine themselves in response to continuously changing contexts and economic frameworks, so measuring vulnerabilities requires an iterative analysis of the circumstances. As well as women and children, examples of highly vulnerable groups include (radicalised) youths, elderly people, people with physical disabilities, learning difficulties, or mental disorders, people at risk of suicide, orphans, male and female survivors of sexual violence, and other marginalised population groups such as *lesbian, gay, bisexual, transgender, and intersex* (LGBTI) people (13).

Attempting to gather empirical data on the psychosocial impacts of experiences of violence – some persisting over many years – is extremely difficult, both methodologically and ethically. Clinical studies and the diagnosis of particular mental disorders among refugees are often somewhat culturally and contextually inappropriate. Hardly any attempts have been made to measure the results of easily-accessible psychosocial activities, due to a lack of appropriate evaluation tools. In the context of displacement, this is compounded by people's greater mobility, which makes long-term analyses more difficult.

Even in clinical psychology and psychiatry literature, hardly any reliable figures on prevalence rates are available. Wide variances in study results mean that only tendencies can be identified. In a random sample of refugees in Turkey and Lebanon, a high level of psychological stress accompanied by anxiety and depression was identified in 42% of respondents (16). The authors found symptoms of PTSD in one third of a group of Syrian refugees in Turkey. Values were higher among women and those who had experienced multiple traumatic events (17). According to UNHCR, 8.5% of the refugees in Zaatari refugee camp in Jordan who were treated for psychological distress show symptoms of PTSD (18). A study conducted by the *International Medical Corps* (2015) showed that one third of respondents displayed persistently high anxiety values (6). Especially high prevalence rates of 45% for PTSD (and 44% for depression) were found in Syrian refugee children in Turkey (19).

In the future, to assess both the psychological distress and psychosocial problems and needs of refugees and IDP, it will be necessary to adapt and contextualise existing methods for research and evaluation, and to continually discuss alternative forms of impact measurement and fundamental concepts such as psychosocial wellbeing and the importance of a holistic concept of psychosocial health.

4. What does MHPSS mean in the context of conflict and displacement?

The term 'MHPSS', which stands for **Mental Health and Psychosocial Support**, has become established in the international discourse. It represents the outcome of a broad debate on psychosocial work, and also formed the context in which the guidelines of the *Inter-Agency Standing Committee* (IASC) were drawn up (32). MHPSS describes all measures designed to preserve and improve psychosocial wellbeing. At the same time, various kinds of support are provided that are interlinked to respond appropriately to the wide range of problems and needs.

The term wellbeing is closely linked to mental health, but is broader in scope. How it is defined largely depends on the individual's language, culture, social context, and value system. The term psychosocial combines psychological (thoughts, feelings, behaviours) and social (significant others, life circumstances, culture) aspects of human experience. Linking mental health with psychosocial wellbeing in the term MHPSS makes it clear that social circumstances and psychological dispositions go hand in hand. Social conflicts or plights and mental health problems must always be seen in relation to each other, and neither can be neglected when problems are addressed. Psychosocial wellbeing refers to a positive physical and mental state that fosters personal growth, enabling the individual to relate constructively to other people. It is a lifelong, dynamic process.

MHPSS-focused approaches seek to preserve and improve people's psychosocial wellbeing, and prevent or counteract mental disorders. Delivering the right support is based on needs, and involves an array of complementary interventions (20).

The approaches pursued in **psychotherapeutic interventions** are based on conceptions of the human being that vary according to different therapeutic schools of thought. These conceptions determine the methods and therapeutic steps that should be applied in each case. Psychotherapy for people who have undergone traumatic experiences also focuses on psychosocial aspects, and treats the patients' difficulties in regulating dysfunctional thoughts and feelings, and/or building and maintaining constructive interpersonal relationships. Therapy usually focuses on the disorder (deficiency) itself and how to deal with it, as well as on alleviating suffering. Psychotherapy should only ever be performed by properly trained and experienced experts, whose work should always be accompanied by guided self-reflection. **Psychiatric interventions**, i.e. the medical treatment of mental disorders, include pharmaceutical treatments, and must therefore only be performed by doctors and qualified medical professionals. When working with refugees and IDP, more and more psychologists and psychiatrists are becoming interested in integrating a broader range of psychosocial aspects into their therapeutic interventions to take the multidimensional nature of their clients' problems into greater account.

The generic term **psychosocial support** encompasses numerous empowering approaches that increase people's psychological wellbeing and ability to function emotionally, socially, spiritually, cognitively, and behaviourally without having to draw on a medical therapeutic model. **Psychosocial support in the context of forced displacement and violence** aims to create safe spaces where people can become more able to process events which threaten their self-esteem in such a way that they are largely able to prevent or reduce the negative effects of stressful and potentially traumatic circumstances on their everyday lives. This meets the special needs of people whose lives are burdened by a history of stress, while also responding to the social, economic and political dimensions of the problems they suffer.

The distinctive feature of psychosocial support measures is that they see the following ways of approaching the issues as key to promoting the wellbeing of refugees and IDP:

- promote stability and reduce stress by firstly trying to satisfy basic needs such as shelter, security and safety, and reliable supplies of food and water
- actively strengthen and rebuild constructive interpersonal relationships that enable social recognition and mutual support
- create a framework in which the individual and/or group can experience their own self-efficacy and a positive role in their social environment, and perceive themselves and others in the context of their needs, strengths and weaknesses
- mobilise the individual's personal and social resources to support them in dealing with their problems on a day-to-day basis and integrating what they experience into their conception of themselves and the world
- restore dignity, justice, control, and autonomy
- support the establishment of new goals and life plans so that people can experience their lives as meaningful and enriching and live in harmony with their values (and the values they share with a socio-cultural group)

These support activities are for the most part easy to access and often based at the community level. They aim to reach as many people as possible. They are often delivered in the health, education and social work sectors, or are integrated into measures in other sectors as one component – for example income generation, employment promotion, or capacity building. If someone is no longer able to cope with their problems on a day-to-day level despite having accessed readily-available psychosocial support structures, experts then speak of a mental disorder or disease. Like all somatic diseases, these disorders are included in international classification systems and are addressed through psychotherapeutic or psychiatric measures (20) (21).

Psychosocial support services are often performed by social workers², teachers, spiritual care givers, or staff of non-governmental organisations. These individuals should possess personal competencies and technical skills which, though they may differ from psycho-therapeutic training, nevertheless provide a basis for positively influencing destructive social interactions and supporting people in building constructive new views of themselves and the world. They might, for instance, do this through interventions involving stabilisation, empowerment, or the creation of safe spaces where people can work through their experiences and develop relationships constructively.

As well as technical skills and competencies (including a knowledge of psychological theories and models, the psychosocial consequences of conflict and forced displacement, legal issues, problem analysis and diagnosis, intervention approaches, documentation, and evaluation), plus detailed knowledge of the political and cultural context, people who provide psychosocial support require core personal competencies that are developed primarily through guided self-reflection on their own counselling practices, values, and personality (e.g. through mentoring). The key elements for training in MHPSS skills must therefore be experience-based learning and self-reflection. The core competencies include:

- a capacity for self-reflection and a willingness to question one's own behaviour, relationship to power, and patterns of thoughts
- empathy and an ability to build relationships
- an open, contextually-sensitive attitude and an ability to switch perspectives
- an egalitarian, supportive, non-judgemental, resource-based, and empowering attitude towards clients/patients
- neutrality, impartiality and confidentiality
- an ability to communicate and work towards conflict resolution sensitively and respectfully
- the willingness and ability to care for oneself
- an ability to build on and strengthen the resources available at community level
- a transparent approach to clients/patients

In practice, the lack of conceptual clarity on MHPSS that exists in some cases presents a major challenge for the actors involved. This is compounded by the fact that the growing number of services available is also making the landscape of activities and actors increasingly complex. Among other things, some organisations are operating in the field with inadequately-trained staff. Although their projects do not include any (effective) psychosocial components, the fragmentation of and lack of conceptual

² Since there is no uniform professional training of social workers in the Middle East (different skills are transferred in each country), we should not assume that there is any standardised approach to PSS in the region.

clarity in the sector mean that their work is nevertheless labelled as MHPSS. At the same time, many MHPSS actors are taking a conscious decision not to use the term officially to prevent stigmatisation of the target group, and so make it easier for them to access the support services offered. Both trends are making the MHPSS-sector increasingly complex, and making it more difficult to communicate a coherent and consistent understanding of the holistic MHPSS concept.

5. What understanding of trauma should German development cooperation be based on?

The context of constant threat and not being integrated into a protective social group requires refugees to adapt and reorient their lives to an extreme degree. In many cases, proven coping strategies are no longer sufficient for dealing with the persistent challenges. Many refugees and IDP hope more than anything else that their difficult life circumstances will get easier. They are focused on immediate survival, and their past experiences of persecution and destruction sometimes appear to play a less prominent role, although they can come to the fore at any time. The concept of PTSD often fails to fully capture the suffering experienced by those affected, because the focus on a specific and restrictive list of symptoms (*as in footnote 1 on page 10*) does not do justice to the complexity of the manifold and continuous experiences of stress. What we need to focus on are the specific traumatic experiences suffered by each particular individual, the process of integrating these experiences (which can take years), the attempts to survive, the losses, and the repeated attempts to come to terms with all of this.

The advantage of understanding trauma not as a single event with pre-determined consequences, but as a long-term process within a given societal, political and legal context, reflects the reality of the lives of refugees and IDP more accurately than a static, exclusively symptom-based perspective that largely neglects societal, political, economic, and legal contextual factors. This broader understanding of trauma also offers the potential for improving the clinical treatment of traumatised individuals in psychotherapeutic or psychiatric settings. The needs of the target group can be better understood and addressed when clinical interventions complement or are integrated into social support activities, and when the treatment also focuses attention on the specific psychosocial dimensions and characteristics of forced displacement. German development cooperation should focus first and foremost on reaching as many people as possible through psychosocial support services, though of course without neglecting specific clinical needs. Targeted and contextually appropriate capacity development should be pursued in response to the strong demand for services across the entire range of MHPSS.

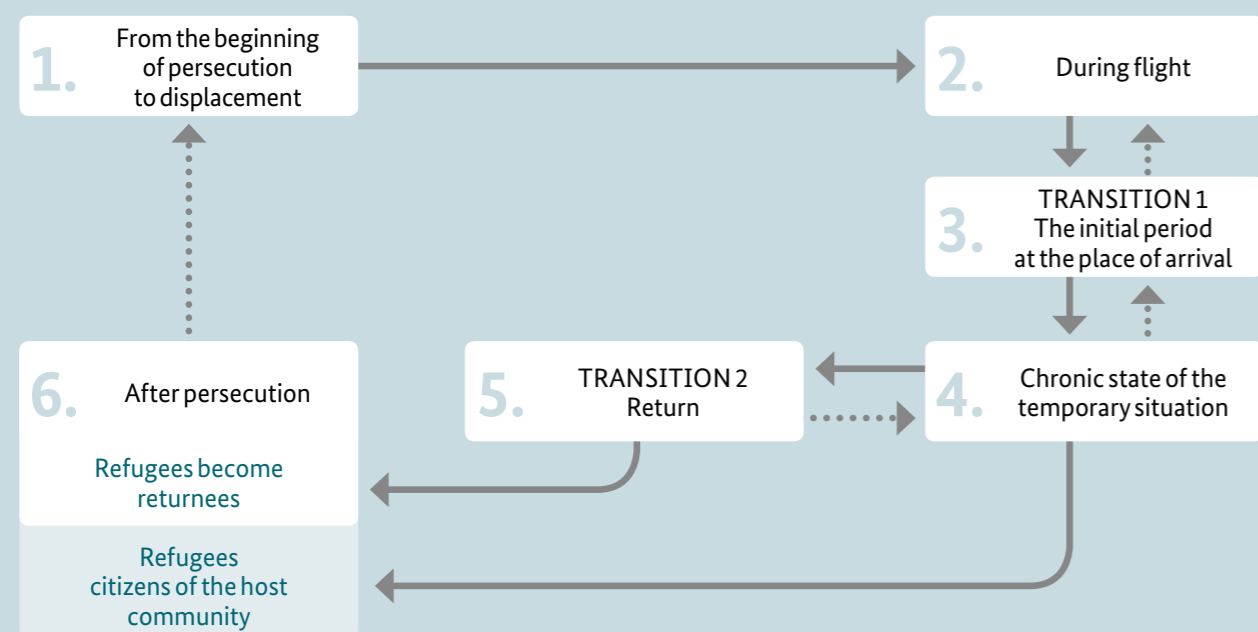
Hans Keilson's model of sequential traumatisation (22) has pointed the way forward for German development cooperation, partly due to its contextually and socially aware approach. Keilson's understanding of trauma as a chronological sequence of phases, as opposed to a focus on a single primary experience of violence, provides a more comprehensive picture of the long-term and multi-layered processes of traumatisation and its impact on the individual's psychosocial wellbeing (23). In his research with Jewish children orphaned during the Second World War in the Netherlands, Keilson showed that the experience of trauma was not restricted to the initial, more palpable phases (i.e. the enemy occupation of the Netherlands and the onset of terror against the Jewish minority, followed later by direct persecution involving deportation and separating children from their parents), but that the period after the persecution had ended also had a significant effect. This latter phase was "described by many as the most intrusive and painful traumatic experience of their lives" (23). Keilson was

able to demonstrate that the post-war phase was more pivotal for the survivors' health prospects than the severity of traumatising during the preceding phases (24) (25). Keilson's approach marks a fundamental shift in the understanding of trauma: "Rather than an event with pre-determined consequences, we now have a process with a changing traumatic situation. The description of these changes is the framework that defines how we understand trauma" [translation by the authors] (25).

This new focus on the process is more complex than the concept of a single traumatic event, but it does more justice to the survivors' situation because it always also considers the aspect of a society's responsibility, which especially in light of Germany's past is an ethical imperative. The increased potential for support arising from this different awareness comes from assigning responsibility for coping with traumatic experiences not just to the individual affected, but also – in a normative sense – to society and policy-makers. For development cooperation in particular, this is of the utmost relevance. At the same time, involving the political dimension and society also holds the potential to reduce the burden of responsibility on the individual, while fostering social cohesion and peace-building processes.

THE SEQUENTIAL TRAUMATISATION OF REFUGEES AND IDP

Adaptation of a model by Hans Keilson



We have adapted Keilson's model to the context of forced displacement *as shown in the diagramme on page 20*, and identified the relevant phases to reflect the salient traumatic situations (25) (3):

The paths traced during the **six phases** described in this extension of Keilson's model may differ in terms of detail and, as the dotted lines on some of the arrows show, may go back in the direction from which they came. For example, the **second traumatic phase** of displacement may recur on more than one occasion. Arrival in another country or a different location within the same country may mark the beginning of a **third traumatic phase** – the initial period at the new place of arrival. Alternatively, if the individual concerned remains at that location for a prolonged period this may lead to the **fourth traumatic phase** – a chronic state of temporariness. What is important to note, however, is that refugees' lives should be understood as a sequence of such phases, constantly being affected by political, societal and legal factors. According to this logic, the assumption that refugees and IDP were only traumatised in their places of origin would be incorrect. Quite the contrary, in fact. This logic would indicate that their reception in a safe host community, which might take place in the **third traumatic phase**, may merely constitute the phase; for instance, prolonged uncertainty regarding the granting of asylum and uncertain prospects for the future might generate a demoralising state of temporariness, leading to feelings of profound uncertainty during a **fourth traumatic phase**.

In **phases five and six**, the key issue is also how a comprehensive (re)integration of the refugees into the host community might be best managed to prevent these periods becoming further phases of trauma. Here, political and societal responsibility means creating prospects for the future and enabling the new arrivals to participate in society so that they can once again feel safe and experience a sense of belonging. To ensure the psychosocial wellbeing of refugees and IDP, it is essential that they are able to choose the point in time at which they will return, and to make the necessary arrangements for themselves. A huge amount of pressure is lifted from returning refugees and IDP when both the host region and the region of origin actively support the process. Designing return measures that make those seeking refuge and vulnerable people feel coerced or threatened, or that compromise the autonomy of the displaced individual, or get them to return against their will, can entail a further existential experience of loss of security, and thus initiate another phase of trauma. The exercise of genuine free will, i.e. a real choice between the options of returning or remaining in the host community, is a key precondition for rebuilding trust and prospects, and for regaining control and self-efficacy. Promoting organised return with no alternative, and so compromising the decision-making autonomy of those involved, jeopardises not only the individual but also societies' capacity to maintain peace by weakening the societies' engagement with the principles of humanity, justice and solidarity. The social consequences of a lack of alternatives that are perceived as degrading are far-reaching, fostering a political climate in which the people affected experience exclusion and rejection.

The extent to which experiences of violence and loss in certain situations result in emotional stress or even mental disorder is therefore crucially dependent on both the decision-making autonomy of an individual and the societal environment. A social setting that responds supportively by offering understanding and recognition presents refugees and IDP with an empowering environment for addressing their own suffering in a relatively healthy way, enabling the individual to rebuild a sense of confidence in themselves and trust in others recognises the quality of their suffering without encouraging pathologisation. Factors that work against this include additional problems such as insecurity, stigmatisation, perceived rejection, a further fight for survival, and yet more experiences of abuse, loss of control and betrayal.

While psychosocial interventions must acknowledge the severity and depth of the survivor's wounds, they must also acknowledge and nurture their ability to continue acting autonomously. Psychosocial services must therefore be geared to available resources, and should incorporate existing family and social support structures. Ultimately, they must always focus on acknowledging and empowering the individuals concerned, and must do so not only with respect to the aim of the psychosocial intervention, but also always with respect to the methods and techniques applied in the services.



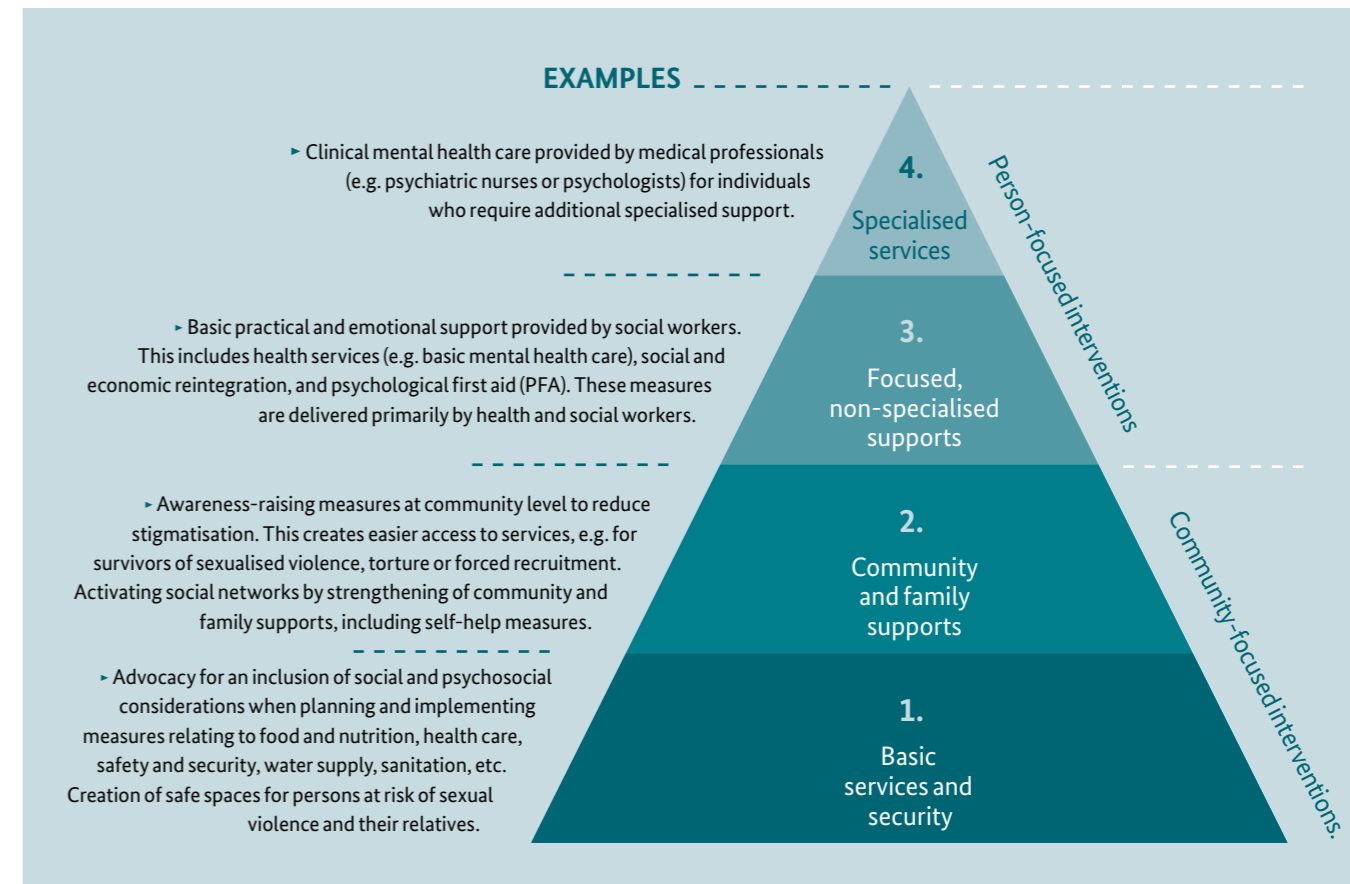
6. What have we learned about MHPSS approaches in the context of war and forced displacement, and what might psychosocial support for refugees and IDP look like in the context of the Syria and Iraq crises?

The *Inter-Agency Standing Committee* (IASC) developed a model that has served as an international framework of reference for psychosocial services and activities in contexts of crisis and conflict since 2007. The model looks at **four interlinked layers of intervention** that are visualised in the form of a pyramid *as shown on the opposite page (26)*. This pyramid does not imply any qualitative hierarchy; rather, MHPSS is ideally expected to take place on all four layers simultaneously.

Psychosocial work in **layer 1** often involves advising service providers on how to integrate the MHPSS approach into their interventions. These interventions encompass the supply of basic goods and the reconstruction of basic infrastructure to guarantee basic physical needs (food, shelter, water, basic health care). The services are often delivered along a continuum between humanitarian aid and long-term development cooperation. Integrating the MHPSS approach into activities which guarantee basic needs ensures that negative consequences are avoided (for instance, they are designed to prevent the creation or reinforcement of dependencies). The measures are needs-based, and the actors involved pursue a conflict- and trauma-sensitive approach (for instance, by ensuring that women and girls in refugee camps can access and use latrines without risk, and that relief goods are distributed in a dignified manner that doesn't make the recipients feel that they are reduced to begging for help).

Services are also delivered with a broad awareness of psychosocial issues. A reliable supply of basic goods to satisfy basic human needs is absolutely essential for peoples' psychosocial wellbeing. Without guaranteed access to vitally important resources, people find themselves in a state of permanent tension and worry as to how they can survive. One regional example for this layer is the increased awareness of sensitive camp management. Measures that are already being implemented in several countries, for instance, include the targeted and regular dissemination of information for those arriving, and the adaptation of standards for accommodation in the camps to create comparability in national camp management and prevent conflict.

Alongside supporting the establishment of stable relationships and social networks, **layer 2** involves creating and strengthening safe spaces for community dialogue, the promotion of family reunification, and measures to generate income and promote employment. Projects in the region have implemented measures to foster social cohesion, including the creation public spaces such as 'family gardens', improving access to the use of mobile telephones, and delivering psychoeducation to youth through sport and music projects.



Layer 3 is where more focused psychosocial supports are provided for individuals, families or groups by trained and supported social workers, community workers and multipliers. For instance, crisis management protocols and self-help instructions have been developed and adapted in some countries.

In **layer 4**, medical and psychological professionals provide specialised/clinical services for people who, due to severe impairments in their everyday functioning, require long-term psychological, psychotherapeutic or psychiatric treatment. Measures which, for example, are currently being implemented in the region are measures to scale up therapeutic interventions and further develop academic curricula to meet the need for specialised clinical treatment.

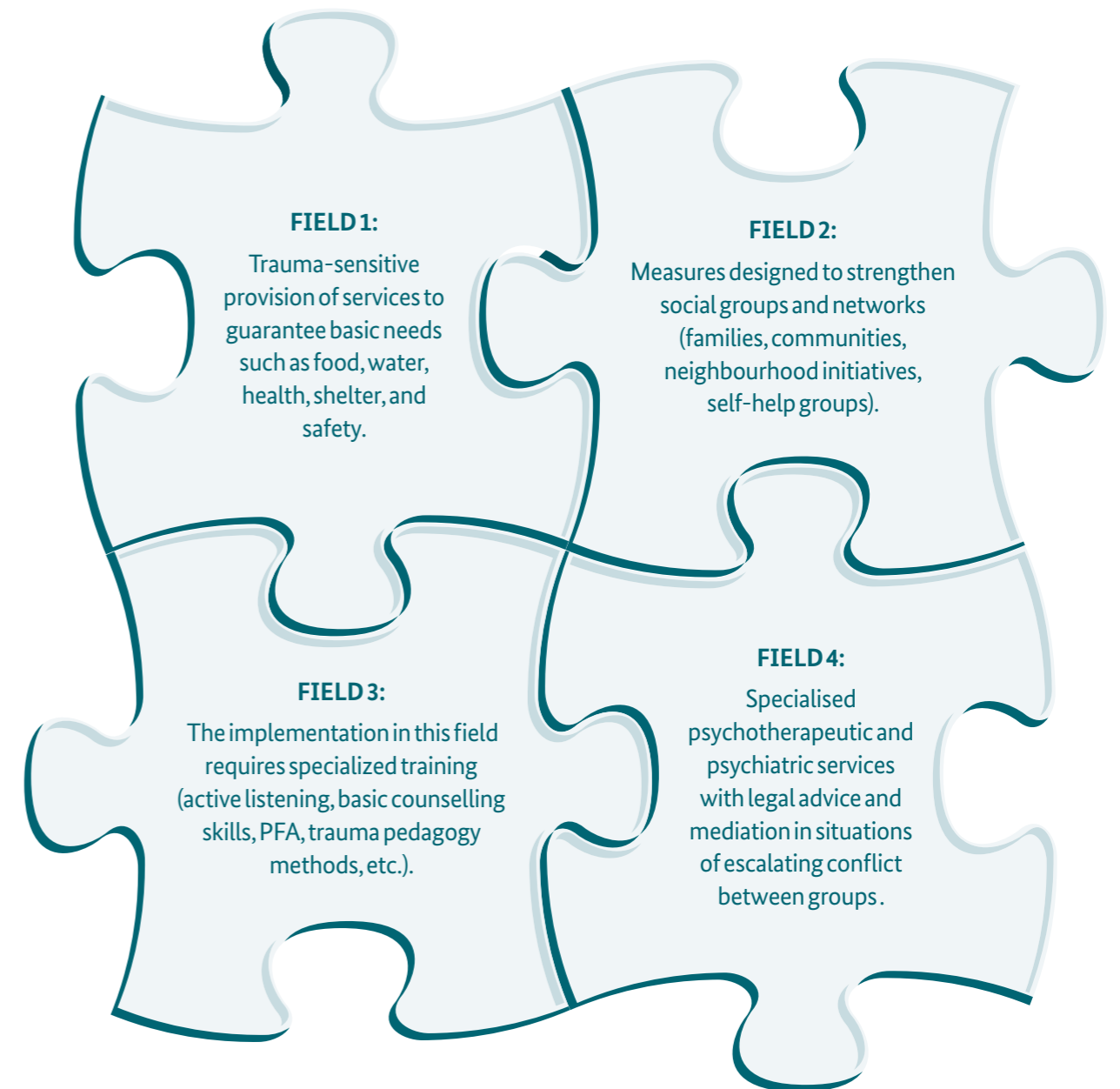
The pyramid should be seen as a holistic model in which simultaneous interventions are required on all four layers in order to address different needs and to take full account of target group heterogeneity. A trauma-sensitive approach is needed across all layers, and is pivotal in strengthening constructive interpersonal interactions in everyday situations. The model does not state or imply that measures at any particular layer of the pyramid are generally more appropriate or effective than measures at any other. Rather, users are encouraged to decide which measures are appropriate on a context-specific basis to make them as inclusive as possible, and to ensure that they are interlinked.

The pyramid reflects a holistic approach to psychosocial wellbeing. This means that human rights such as mental health and personal development, as well as food, water, shelter, sleep, etc., must be respected and protected simultaneously and accorded the same degree of importance. Equipped with this understanding, actors in the German development cooperation system who are operating in the field of MHPSS in the context of the Syria and Iraq crises should be guided by the IASC intervention pyramid. To avert the risk of misinterpreting the pyramid, one can also imagine the model as a set of inter-linked services (see diagramme on page 27) whose components have different foci, but are all linked by the fact that different kinds of specialisations are required in all fields in order to configure and deliver a holistic set of psychosocial services. In this alternative model, unlike in the IASC pyramid, **field (= layer) 4** includes additional highly specialised interventions alongside the clinical services.

In a context of persistent violence and displacement, where resources are so scarce in the countries of first arrival that adequate psychosocial support is usually not even available for the local population, measures should be designed to be as inclusive as possible. This is usually best achieved through community-based activities. In uncertain and highly dynamic contexts, it is also necessary to bear in mind that psychotherapeutic treatments in **field 4** should not be started unless they can also be completed, which is rarely the case among displaced people due to their unstable life situations or continuing displacement³. Consequently, in development cooperation in the context of the Syria and Iraq crises, measures for the psychological support of refugees in **fields 1 to 3**, which reach large numbers of people using scarce resources, will often be more appropriate and sustainable.

However, this certainly does not mean that a more specialised psychiatric or psychotherapeutic form of support at the individual level would not be necessary. Many people have symptoms for which the special attention of experts would certainly be indicated – but this is often not possible due to the lack of resources for providing specialised services. This is also why individuals with no professional psychological or psychiatric expertise are often the first point of contact, even for serious problems (e.g. in camps or schools). It is therefore all the more important to raise awareness of mental disorders and psychosocial approaches among actors whose work is not in specifically therapeutic settings, but who operate in **field 1 to 3**. In fact, the majority of psychosocial problems do not require any clinical therapeutic intervention in **field 4**. They are a result of stigmatisation, hopelessness, grief, uprooting, chronic poverty, lack of access to care services, and the destruction of a protective social network (27) (13). These difficulties can also be addressed in the three lower layers of the pyramid, where strengthening the social community can help to activate the individual's self-healing capabilities (28).

³ The continuity of psychopharmacological treatment of patients (with pre-existing disorders) should of course be guaranteed.



7. What form does German development cooperation take in practice?

There are various approaches to MHPSS in refugee work. These range from exercises in self-regulation and social skills, and the expression of experiences of displacement through theatre, poetry, art, educational games, sport, dance, and relaxation techniques, to highly specialised clinical and trauma-centred therapies. MHPSS approaches also address topics such as access to legal aid and the disclosure of crimes, acknowledging what happened, and prosecuting perpetrators, all of which can aid psychological healing. One method of fostering psychological wellbeing that has proven particularly effective in this context is the establishment of community centres where refugees can gather in a safe setting, interacting with each other socially and have access to relevant information. These centres can also be used to provide counselling on certain aspects of everyday life, such as medical care and schooling for children.

The following examples from German development cooperation can be assigned to the different layers of the intervention pyramid:

Layer 1 – Psychosocial approaches in the provision of basic services and security

The aim within the context of humanitarian aid and development cooperation is to increase the awareness, understanding and acceptance of MHPSS interventions within the donor community and in local communities (advocacy). Further aims, which relate to rebuilding systems that have been destroyed such as infrastructure, education and health, are to ensure (and actively advocate) that MHPSS is seen as a cross-cutting issue and that measures are implemented in a considered and dignified manner in accordance with the psychosocial needs of those affected. Evidence that MHPSS approaches incorporate such awareness would include:

- those affected are actively involved in the provision of services, and are always in control of their own situation
- the use of services does not result in stigmatising service users, or portraying them as victims
- measures for the provision of basic services take account of the fact that aid supplies often do not reach severely distressed individuals due to their deep mistrust and need to withdraw, and that other pathways of contact must therefore be explored
- educational measures for young people who have suffered traumatic experiences must be tailored to their reduced capacity to concentrate and process information
- women and men who have experienced violence often avoid the health system for fear of stigma when health care provision does not include informed psychosocial (i.e. outreach) approaches

An example from German DC in the Middle East. GIZ's *Waste to (Positive) Energy* project in Jordan was commissioned in 2015. This *Cash for Work* project aims to

provisionally secure the incomes of refugees and vulnerable members of host communities through temporary jobs, while at the same time supporting local infrastructure and social cohesion. The dramatic increase in Jordan's population following the crises in Syria and Iraq has stretched existing waste disposal and street cleaning capacities to the limit. At the same time, host communities feel that international funding is being used primarily for refugees, which is increasing the potential for conflict. The *Waste to (Positive) Energy* project therefore incorporates a psychosocial approach when implementing measures to promote employment in the labour-intensive field of collecting and processing recyclable materials, with the primary aim of avoiding conflict. It works equally with both refugees and vulnerable members of host communities, and incorporates specific measures for the promotion and participation of women in participatory dialogue forums. Through private sector involvement and the construction of recycling facilities, for example, the project aims to ensure that measures are sustainable, and to facilitate the transition to long-term jobs. It provides a sense of control – despite the short-term nature of the jobs – through the transparent and comprehensive development and updating of information materials that reflect and address their employees' worries and concerns. It also enables monitoring and participation through focus groups, regular feedback sessions and anonymous complaint mechanisms. Once the temporary employment has ended, the project offers support and counselling to help the beneficiaries look for work. This takes place in community centres run by implementation partners, and takes the newly-acquired skills into account. Health and safety training is also provided to protect the beneficiaries' rights.

Layer 2 – Community and family supports

Measures at this level aim to strengthen mutual support and social cohesion in families and communities. The (re)establishment of social networks can help individual members of target population to process their experiences and deal with current challenges. A thorough knowledge of cultural and contextual characteristics is essential in this context.

Measures at this level include:

- family tracing and reunification
- campaigns on constructive ways of coming to terms with the past
- livelihood activities
- family planning methods
- supportive programmes for the development of non-violent family dynamics
- women's groups
- youth clubs

- formal and non-formal educational activities
- collective mourning processes
- reintegration of ex-combatants into their villages through traditional cleansing and atonement rituals
- restoration of social relations between polarised groups

Example: Football as a psychosocial measure. A football match between young people supervised by a coach who has been trained in *providing psychosocial support* (PSS) would be an example of a level 2 psychosocial measure if it is designed, supported and managed in such a way that it offers the players the scope to experience:

- empathy
- fairness
- cooperation
- control
- empowerment
- a sense of belonging and being part of a group
- The experience of following rules, without feeling restricted by them
- opportunities to test non-violent and creative problem-solving
- use of constructive communication and target-achievement strategies
- reflection on handling one's own emotions
- being able to both enjoy success and cope with frustration, etc.

If such a match were not supervised by a properly trained person, it could instead lead to reinforcing enemy stereotypes, threatening behaviour, mistrust, marginalisation, and bullying. It could also magnify feelings of loss of control and powerlessness, encourage displays of aggression, and feed destructive tendencies towards the opposition or even one's own team mates. In this case the football match would not be a PSS measure, but would in fact be increasing the potential for conflict and can be perceived as disempowering for the players.

An example from German DC in the Middle East. *Save the Children* has been supporting projects that promote community-based child protection systems in Lebanon since 2011. The country is currently home to almost 1.5 million refugees, more than 50% of whom are children. Many of these children need psychosocial support to process their experiences of displacement. *Save the Children* uses a tried-and-tested concept for the provision of shelter and safe play areas to respond to the immediate and pressing needs of refugee children and their families. These child-friendly spaces are set up next to

registration centres and, through targeted activities and a needs-oriented spatial concept, enable children to establish a stable routine and be children again. They also serve as a point of entry, allowing trained support workers to identify cases in which children have specific needs, have experienced violence or abuse or are at risk in other ways and, where necessary, to make plans for individual case management. Depending on the specifics of the case, and in discussion with the families, individual cases are passed on to specialised service providers and cooperating organisations. Qualified staff from *Save the Children* also use the shelter and safe play areas to inform caregivers about health services and risks to children. As a second support component, *Save the Children* helps existing Social Development Centres to expand their capacity to offer child protection and social services. Having evolved locally, these centres are intended to provide – on behalf of the government – social, medical and psychological community services for local people and refugees. In many cases, however, they lack expertise and equipment. *Save the Children* offers social workers training on the concept of shelter and safe play areas and on *psychological first aid* (PFA) at the centres, establishes support networks with other service providers, and helps the centres to draft local action plans for enhancing their services. This ensures participation and empowers local structures. Another step forward was the formation of mobile teams at these centres, so that children in remote areas are also able to benefit from protective services. The process is embedded in the Ministry of Social Affairs' National Plan to Safeguard Children and Women in Lebanon, thereby ensuring nationwide coordination and sustainability.

Layer 3 – Emotional and social support for individuals, families and groups

The third layer of the pyramid includes support measures that require a higher level of counselling and relationship-building work than layer 2. The focus is on alleviating the suffering of those who have experienced extreme distress as a result of violence, war or disasters, and for whom second-layer measures do not go far enough. People in this situation also tend to socially withdraw, and so do not take part in layer 2 activities. As a support concept for distressed individuals who have recently faced an existential threat, PFA is mainly (but not exclusively) anchored at this level.

Psychological first aid is a technique developed by international experts that aims to restore stability after emotional breakdowns, while also preventing further harm. This is being done by active listening and by helping those affected to meet their immediate needs (29).

An example from German DC in the Middle East. Since 2016, *medica mondiale* and *HAUKARI e.V.* have been involved in projects designed to strengthen the local government and civil society structures that provide counselling for women who have experienced gender-based violence in the Kurdish region of Iraq. They operate in Dohuk Province and in the Germian district of Sulaymaniyah Province, from which tens of thousands of

young men and women were abducted and murdered in 1988 as part of the *Anfal campaign*, and in which survivors were imprisoned and later transferred to resettlement camps. The region continues to suffer from the effects of this mass violence today. Since the rise of IS in 2014, it has once again become a conflict region; tens of thousands of refugees from Al Anbar, Saladin and Diyala Provinces have sought refuge there and still have no prospect of return. Host communities are caught between solidarity with the IDP and a growing sense of resentment due to the history of violence. To defuse these tensions and support dialogue, the project focuses on women who have experienced sexual and gender-based violence and overlapping political/social violence - both in refugee camps and in host communities. It combines direct counselling for women via mobile teams of local partners with measures designed to strengthen the Regional Government's Directorate of *Combating Violence Against Women*, which runs counselling centres that offer police protection and psychosocial counselling for women affected by violence. The project provides logistical support for these centres. Employees from government and civil society partners benefit from capacity development through trainings and guided self-reflection, while police and security forces receive training in how to interact with women affected by violence in a trauma-sensitive manner. In the Germian district, the project also harnesses synergies with the HAUKARI project with a view to strengthening accessible government counselling centres for families and building alliances that facilitate the early identification and prevention of gender-based violence. The advisory approach is holistic, resource-oriented and empowerment-oriented, and combines psychosocial, legal and medical counselling. Training and information courses help to reduce the stigma associated with accessing counselling services. Locally adapted family mediation strategies that actively involve male family members contribute to the development of social prospects for women. Capacity development measures for local experts focus on enhancing and systematically utilising existing local knowledge and practical approaches. All projects ensure sustainability by supporting government structures. By strengthening civil society partners and their capacity to work with government agencies, they also support women-focused counselling services that are geared to transforming gender relations.

Layer 4 – Specialised and clinical services

These services include specialised clinical intervention strategies, implemented by psychiatrists or psychotherapists, for coping with experiences of violence, loss, grief, human rights violations, and trauma. People suffering from varying degrees of psychosocial disorders or mental health problems sometimes need expert specialised support to help them adjust to their extremely fragile living situations, rediscover their identity, and regain their emotional equilibrium and will to live. This can take the form of individual or family psychotherapy, psychiatric and drug therapy, or pharmacological recommendations. Medication and psychopharmacological recommendations should only be provided by specialised professionals, in connection with psychotherapy. Trauma-focused techniques should not be applied out of context - the specific circumstances of

the person should always be taken into account. The general effectiveness of an intervention must not be the sole criterion for its use. The method must be a good fit with the individual's daily reality to have the intended stabilising effect. Therapeutic approaches that view confrontation with individual suffering as key to overcoming such suffering should be reviewed and adapted to the specific context. The temptation to use a fully standardised and manualised intervention in each and every case fails to take account of socio-political and intercultural issues as well as issues relating to the causes of violence. This should be counteracted by designing the intervention to be multidimensional (30).

Examples from German DC in the Middle East. The *Balsam Project*, which was launched by *Help e.V.* and *Charité – Universitätsmedizin Berlin* in Jordan in 2014, is aimed at both Syrian refugees and Jordanians in need of psychological interventions. The support it provides for local infrastructure includes offering basic psychological and psychiatric care at three selected health centres in conjunction with the *Ministry of Health*, and in close collaboration with more than 40 local institutions. In addition, at least four training courses for local experts are held annually using structured online and traditional classroom formats, and over 30 psychoeducation and awareness-raising events are held in schools and community centres each year. The psychiatrists and psychologists used in the project come from both Syria and Jordan. The overarching objective of the project is to enable people to assert the right to mental health. Greater empowerment is achieved through participation in joint project implementations in conjunction with the Ministry of Health, and on the basis of a needs analysis. Training and therapies are particularly aimed at vulnerable groups, and take account of gender- and trauma-specific factors. In addition to accessible community services, the project provides targeted counselling services, specialised psychological and psychiatric therapies, and an effective referral system.

A holistic concept – the dovetailing of all four layers

Measures to strengthen existing MHPSS services in all four layers of the pyramid and, where necessary, to fill any gaps are provided simultaneously to offer refugees a range of services that meet their specific needs to the greatest possible extent, while alleviating the strain on development workers.

An example of the holistic approach from German DC in the Middle East. The emergency aid measures for refugees supported by *medico international* in the Kurdish region of Iraq since the IS attacks in 2014 are built on many years of cooperation with *HAUKARI e.V.* and local partners (*Khanzad Centre for Women* and *Kurdistan Health Foundation*). They have been implemented from the outset by local committees and in cooperation with refugee self-help structures. Through continuous dialogue, the project identifies needs and develops and enhances measures in a process that consistently observes the specific psychosocial requirements of trust, reliability, and the

experience of taking action and self-efficacy, while at the same time promoting stable, supportive structures. In the German region, *medico international* and *HAUKARI e.V.* have combined acute emergency aid for refugees from the IS-occupied provinces of Al Anbar, Saladin and Diyala with the promotion of joint cultural community-based activities for host communities and refugees. Building on this process-oriented refugee aid, a cultural centre for young people has now been established in a property in Kifri that was formerly used as emergency accommodation. This centre enables young local people and refugees (men and women) to meet and exchange views, with the aim of learning how to cope with experiences of violence, displacement and extremist mobilisation together, and to discuss their hopes and dreams for a different future.

An example of the holistic approach from psychosocial practice in Germany. Staff in psychosocial treatment centres for refugees and torture victims in Germany work as multidisciplinary teams to provide accessible psychosocial and legal assistance and guidance as quickly as possible and facilitate networking through the assignment of mentors, along with specialised therapies and treatments. They also act as multipliers, mediators and trainers in communities and in the health, social and education sectors (31).

8. What steps can be taken to ensure the psychosocial wellbeing of MHPSS staff?

The mental health and professionalism of MHPSS staff – whether seconded or national staff members of international organisations or local partner organisations – is essential for the provision of good psychosocial support. On a daily basis, MHPSS staff are exposed to suffering, injustice and human rights violations in, for the most part, volatile environments. To ensure that employees remain supportive and empathic on a long-term basis, it is a professional necessity for every MHPSS organisation to protect its staff's psychosocial wellbeing. If they cannot recognise and reduce their own stress levels, staff cannot help others to reduce their anxiety and process traumatic experiences. An inability to reflect on and regulate oneself may result in tensions being transferred from support workers to people who are already distressed. The successful implementation of measures to protect all employees within an organisation requires the (ongoing) development of an organisation-wide strategy for staff care, and the internalisation and implementation of this strategy at all (hierarchical) levels.

Organisations can contribute to the psychosocial wellbeing of their staff through, for example, support services that are firmly anchored in the organisation, giving employees scope for mutual support and reflection on their own worries and concerns. These services should be integrated into work flows from the outset, and be linked to existing self-care strategies for staff. Physical activity, creative measures and regular case-supervision are proven, effective approaches in this context. The establishment of areas for reflection and protected spaces to allow peer support structures to be incorporated into project management are also good examples from the field. These spaces create an atmosphere of trust, offering employees a sense of security and a place where they can safely express feelings such as vulnerability, helplessness, insecurity, and guilt.

However, staff care requires more than just stress reduction activities. Organisations should arrange to have their structures and practices reviewed with a view to explicitly identifying risks to psychosocial wellbeing. Staff care strategies must also consider the composition of teams and dynamics within an organisation, which often mirror the social context of the working environment. In organisations operating in areas where social groups are deeply fragmented (e.g. due to complex experiences of violence), this fragmentation is often reflected in the organisation itself. These dynamics therefore need to be carefully analysed, and stress relieving measures must be adapted to the needs of all members of the organisation. A professional and supportive organisation also needs a stable and predictable support framework for its employees. This can take the form of reliable links to the central structure for field staff in outposts, measures to prevent staff feeling isolated in remote areas by working in fixed teams, clearly defined responsibilities and limits of responsibility for all positions, staff deployment based on careful consideration of their suitability in conjunction with continuous training measures, relaxation areas for staff in all workplaces, transparency and – where possible – the promotion of job security, and reliable security management.

Moreover, the impact of management styles on psychosocial wellbeing should not be underestimated. Managers within organisations play a key role in implementing staff care measures. As role models, they can increase understanding and lead by example in terms of respectful interactions with colleagues and target groups, and in terms of practising a mindful attitude towards oneself. Encouraging critical self-reflection within the team to assess one's own vulnerabilities and limits is also essential. Opening up about vulnerabilities as a manager is not a sign of unprofessional behaviour. Rather, asking for support helps to preserve one's resilience and capacity for empathy, and counteracts employees' fear of stigma. To enable managers to support their employees without compounding stress, it is crucial that organisations see themselves as learning organisations and view the implementation and enhancement of self-care and staff care as a necessity.

An organisation's ability to provide appropriate psychosocial protection for its employees depends on the specific project context and the financial framework under which projects operate. All MHPSS initiatives should have access to sufficient funding to provide suitable remuneration for staff and regular stress-reduction activities. Greater workplace security and scope for team-building can be fostered by making project terms as long as possible. It is also important to budget for sufficient staff with the variety of skills needed to perform the various tasks. The provision of support for field staff in administrative processes, especially when applying for additional funding, and the provision of capacity development measures for employees, has been shown to help them deal with (daily) challenges more effectively. Furthermore, the identification and networking of existing MHPSS initiatives with actors operating in the local and regional context can contribute to an exchange of expertise on good practices and thus to increased professionalism.



9. What principles of high-quality services apply to measures designed to promote mental health and psychosocial support in development cooperation?

The following table presents the general consensus among international practitioners on the principles for successful interventions, and offers pointers for the pitfalls to avoid (32) (33) (34). It is advisable to reflect on the individual principles when designing and planning measures, and consider them when implementing and evaluating interventions. It should be noted that these principles are not static criteria: they have been and will be continuously developed and contextually adapted on the basis of practitioners' experiences and discussions, and are sometimes pushed to their limits in project work, partly due to a lack of resources. Contradictions between individual principles can also arise in specific contexts. Thinking about hurdles of this kind when designing activities/interventions can also facilitate subsequent implementation. Based on information provided by local and international MHPSS actors, the table therefore lists challenges in specific contexts and suggests possible ways of dealing with them, in addition to definitions of the individual principles.

No.	Principle	Description	Challenges	Best practices
1	People focus/ attitudes	<p>When this principle is observed, an expectation of the self-efficacy and dignity of the individual is strengthened and enabled in every step of the intervention. Members of the target group have scope for action and have agency and control over their decisions, which helps them to cope with and overcome experiences of violence and loss. Prospects for the future are opened up.</p> <p>When this principle is not observed, refugees/IDP are not seen as autonomous individuals with skills and resources, but instead are collectively pathologised as part of an incapable and needy group. There is a risk that experiences of powerlessness and loss of control will be repeated, and dependencies established or compounded.</p>	<p>Demand for trained and experienced staff with a supportive and open attitude towards the target group – and who have internalised this attitude – cannot be met in practice. It is often impossible to provide supportive supervision due to a lack of financial and human resources. The impact of employee behaviour on the target group is rarely reviewed or monitored. In many cases, the short-term nature of projects prevents the target group from becoming actively involved in and assuming responsibility for decisions.</p>	<p>Project design and planning should be based on the needs of the target group, and should also encourage the target group to provide regular feedback during implementation. Autonomy and control can be fostered by transferring responsibility and thus demonstrating trust; e.g. by giving families in camps their own financial assets instead of food vouchers/tokens. Reliability, confidentiality and transparent processes and decisions on the part of organisations are key to building mutual trust.</p>

No.	Principle	Description	Challenges	Best practices
2	Human rights	<p>When this principle is observed within the measure, human rights are considered inalienable and universally applicable regardless of nationality or residential status (35). As such, it is compatible with the 'right of everyone to the enjoyment of the highest attainable standard of (...) mental health'.</p> <p>When this principle is not observed, avoidable discrimination against certain social groups such as asylum seekers or people without legal residential status is often seen as unfair, but is only addressed through individual measures. There is no recognisable human rights approach.</p>	<p>The human rights approach can be met with resistance in certain contexts, as it may be seen as having its origins in a Western discourse and as contrary to local concepts such as social cohesion, collectivity, and family values. When implementing measures, it may therefore be difficult to strike a balance between cultural sensitivity and the intended promotion of human rights that support individual decision-making capacity.</p>	<p>Every implementing organisation should have its own ethical work guidelines that take account of local concepts of community and mutual support. Target groups should also always be given the opportunity to report any perceived violations of dignity. It is important to avoid situations in which different groups must compete for resources, and instead focus on encouraging solidarity and empowering people to demand the rights to which they are entitled.</p>
3	Alignment with existing approaches	<p>When this principle is observed, the project is needs-oriented (based on international assessments in the sector) and works on a coordinated and complementary basis with the activities planned by national and international actors. It is integrated into existing community-based initiatives and structures, and does not run the risk of establishing parallel structures.</p> <p>When this principle is not observed, the project is a stand-alone intervention that has not been preceded by an actor/intervention analysis, thereby running the risk of duplicating and competing with existing efforts.</p>	<p>(National) coordination of MHPSS actors and coordination with government institutions is problematic in general. In addition to the networking of services, which is intended to facilitate direct referrals and prevent the duplication of or competition between services, a further problem is often the lack of common standards for MHPSS interventions. Responsibilities – which differ from one country to another and are often distributed between numerous ministries (including health, education and social affairs) and clusters – also hamper the coordination of interventions and the development of conceptual clarity in the MHPSS sector.</p>	<p>Both international standards and national strategies should be factored into the design and planning of measures. Moreover, coordination and cooperation between actors in the field of humanitarian and development aid should be stepped up. Regularly updating 4-W-mapping tools (who is doing what, where, and when) can help in this regard. Gaps in coordination between field staff, management and donors should also be identified. Further fragmentation of the sector can be prevented through cooperation between government institutions and collaboration between international and local actors in conjunction with the responsible ministries, with the aim of strengthening local structures.</p>
4	Cultural and contextual sensitivity	<p>When this principle is observed, the project is based on useful, culturally appropriate and context-sensitive practices that local and international actors consider to be effective and valuable.</p> <p>When this principle is not observed, the project is based on universal intervention approaches and competes with local coping strategies and structures. Western approaches are adopted without integrating approaches or adaptations relevant to the culture or context.</p>	<p>Society and family play a key role in MHPSS work. The fear of stigmatising the entire social network and generating misunderstanding within the community can prevent people from seeking help. Traditional attitudes and values can sometimes be at odds with MHPSS measures that seek to promote the empowerment of vulnerable groups, which can lead to mistrust. The religious and cultural background of employees can therefore play a crucial role in reaching the target group, and their ideologies and unconscious assumptions can influence (psychosocial) work. Target groups themselves are also extremely culturally diverse and varied depending on the religious, political, geographical, social, and economic context.</p>	<p>Possible problems can be prevented through respectful dialogue with members of the target group and by involving local staff in planning and implementation. The concerns of the target group can be allayed at an early stage through religious and cultural diversity and awareness-raising measures for employees (about the risk of stigma). Interacting with target groups in a way that inspires confidence and handling critical issues that may affect family structures in a sensitive manner are essential. It can be helpful to analyse the psychosocial effects of traditional practices and local coping strategies, and tie into collective approaches. Projects that aim to bring about social change must also address the family, religion and politics, and key local figures must be involved in their promotion.</p>

No.	Principle	Description	Challenges	Best practices
5	Participation, ownership	<p>When this principle is observed, the activities are developed on the basis of context and conflict analyses prepared with the involvement of women and men from the target group, and in conjunction with representatives of the refugees/IDP or the target community, thus increasing the acceptance, ownership and sustainability of the intended project. The activities are offered together with or by representatives of the target group.</p> <p>When this principle is not observed, the activities are exclusively based on studies or experiences from other contexts. The circumstances of the specific context are not taken into account. The activities are not planned or implemented in conjunction with refugee/IDP representatives.</p>	<p>Target group participation is extremely rare due to insufficient personnel and financial resources, short project terms, and restricted flexibility when implementing measures (particularly in organisations with strict hierarchical structures). In most cases, no comprehensive needs analysis is conducted and there is no consensus as to how the intervention should be adapted. Donors often prefer approaches that are based on evidence (usually from other contexts) to community-based approaches. On the target group side, participation is hampered by the stigma associated with the issue of MHPSS. In addition, democratic co-determination cannot be taken for granted in all societies and can, in certain circumstances, prove overwhelming. The involvement of vulnerable groups with limited mobility owing to social or geographical factors is especially difficult. This can lead to the re-selection of privileged individuals and further isolation of vulnerable individuals.</p>	<p>The needs of the target group should be the key consideration when designing and implementing interventions. This is facilitated when needs analyses and qualitative monitoring have previously been part of project applications and are requested by donors. Further options include partnerships with local community-based organisations and capacity building for local employees. Regular involvement of the target group and community (e.g. through focus groups or local champions) can increase ownership of projects. Pilot projects can also be used to raise awareness. Overall, it is important to ensure that active participation does not result in any additional stress factors or cause individuals to feel overwhelmed.</p>
6	Diversity and inclusion	<p>When this principle is observed, the measure is inclusive and explicitly considers the needs of vulnerable groups (e.g. women, children, older people, young men, people with disabilities, radicalised individuals or those at risk of suicide, orphans, and other marginalised groups such as LGBTI persons). The measure considers the diversity of the target group and factors this into a differentiated intervention design.</p> <p>When this principle is not observed, no distinctions are made between individuals and groups (e.g. 'the refugees are all traumatised'), which can lead to stigma and counteract the desired strengthening of resources. The specific needs of vulnerable groups are not taken into account.</p>	<p>In practice, access to vulnerable groups can be limited for geographical, political, socio-economic or cultural reasons. This can further exacerbate existing discrimination and isolation. Similarly, various vulnerable groups (including host communities) may have to compete for resources, a situation that is often compounded by (international) organisations' focus on one target group. This can lead to further stigma and an increased risk of conflict. Employees are sometimes caught between neutrality and their own and/or society's attitudes and values. Moreover, organisations often have no joint position towards inclusion.</p>	<p>Inclusion should be prioritised in the planning of interventions, and strategic consideration should be given to accessibility. Cooperation between local and international organisations and, for example, setting up helplines with referral options can help to improve access to remote areas in particular. Raising awareness and providing services for both host communities and refugees can contribute to conflict prevention. Successful active inclusion should be anchored as a goal within organisations and monitored continuously.</p>
7	Gender sensitivity	<p>When this principle is observed, projects are planned and implemented to ensure that the specific and differing needs of men and women are taken into consideration, e.g. with regard to handling experiences of sexual or gender-based violence.</p> <p>When this principle is not observed, the project implicitly assumes that men and women will benefit from it equally. It does not consider the specific needs of men and women who have experienced violence.</p>	<p>The work with the target population is impeded by social and political hurdles that manifest themselves in different ways, depending on gender. Participation can be hampered by traditional values (e.g. when women are unable to leave the house unaccompanied or men must not show weakness), or lead to conflict due to the emergence of new hierarchies in the (family) system. The gender of employees can also affect participation. Despite this, interventions are rarely tailored to gender-specific needs.</p>	<p>The design and framework of interventions should reflect the different needs of female and male participants and address obstacles to accessibility (e.g. through the provision of child care). Employees should be made aware of the impact that their own gender can have. In the best-case scenario, services should be provided by both men and women. The concerns of the target population should also be taken into account during the implementation of measures.</p>

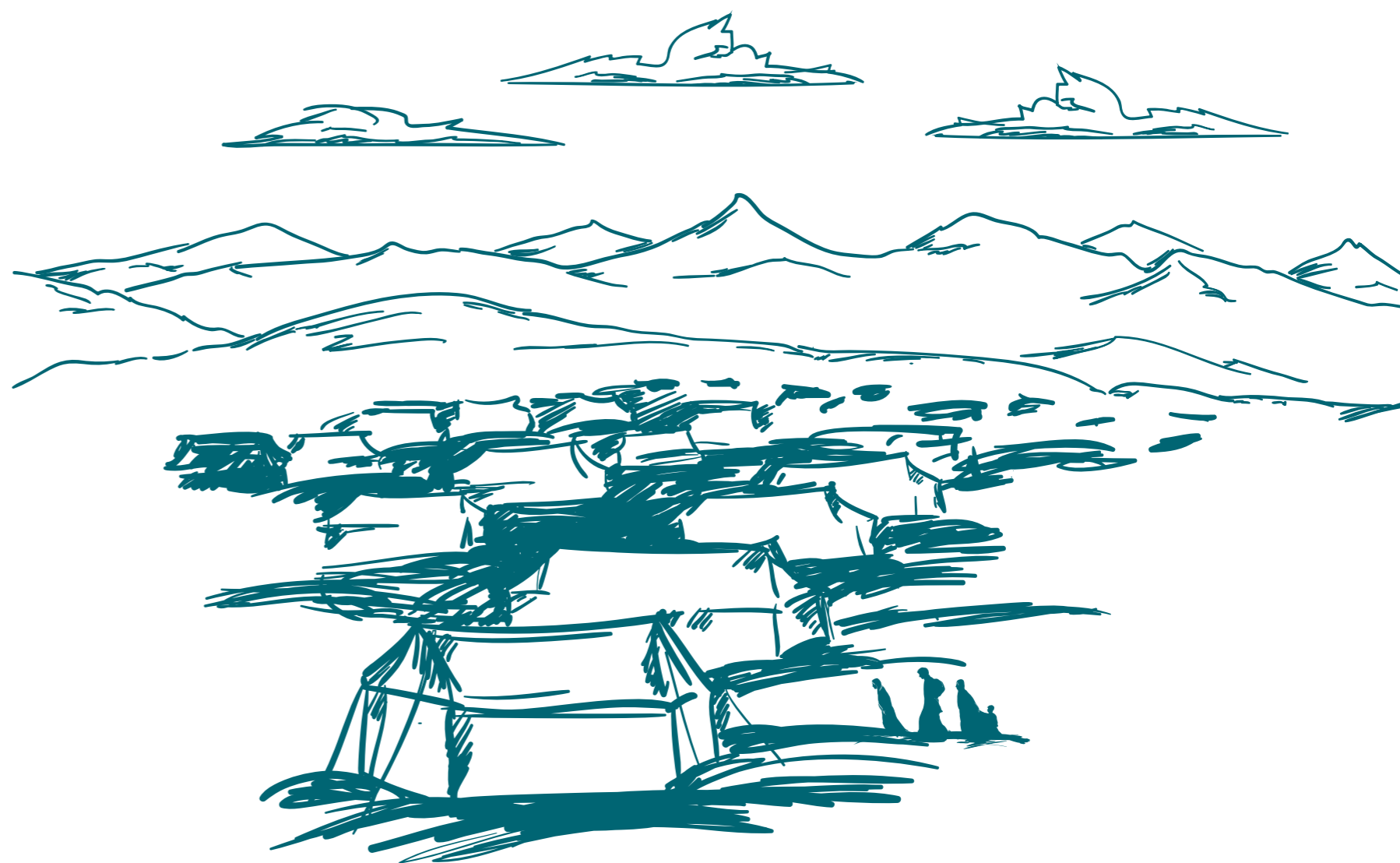
⁴ If current participatory MHPSS studies already exist in the intended intervention context, these should be used rather than replicated, to prevent refugees/IDP from being exposed to excessive research.

No.	Principle	Description	Challenges	Best practices
8	Trauma sensitivity	<p>When this principle is observed, the specific needs and characteristics of people who have experienced (potentially or actually) traumatising events are taken into account in a project's planning, implementation and evaluation. Efforts are made to prevent retraumatisation and avoid any increase in emotional distress.</p> <p>When this principle is not observed, the project does not consider the specific needs and characteristics of people who have experienced traumatic events. This can lead to retraumatisation.</p>	<p>Employees often lack awareness of the emotional and behavioural effects of potential trauma and the associated needs of those affected. When individual reactions to potentially traumatic experiences are not taken into account, this leads to target groups being prematurely pathologised and disempowered. Insufficient knowledge and stigmatisation can cause additional distress for the target population and for employees themselves, and have an adverse effect on work in the long term.</p>	<p>Education measures for all employees who engage with the target population can raise awareness of the effects of their work. Organisations should maintain standards for interacting with those affected by trauma, and management and donors should insist on this. Confidentiality and respect for individual strengths and resources can strengthen the sense of control on both sides. The burden on staff can be reduced through guided self-reflection and (peer-) supervision as well as guidance for referrals to specialised services.</p>
9	Do no harm/ conflict sensitivity	<p>When this principle is observed, the 'do-no-harm' principle is respected. Duplications and gaps in care are avoided. Potential unintended negative effects are taken into account. Consideration is given to where such effects could arise, and precautions are taken to prevent/reduce the occurrence of unintended effects (e.g. strengthening existing power structures, prioritising one specific group over others, failure to treat unequal groups equally, discrimination).</p> <p>When this principle is not observed, no analysis of potential negative effects is conducted, and there is an increased probability of causing harm.</p>	<p>The target group can be adversely affected when, among other things, activities are not geared to the needs of refugees and host communities, or when interventions are not adapted individually or contextually. Negative effects are also caused by employees interacting with traumatised individuals in a harmful or discriminatory way, or by incorrect assessments of capacities and limits. Risks for employees arise when their workload is high and they have no organisational support.</p>	<p>In keeping with the context, programmes should always aim to promote local (infra)structures and members of host communities (in addition to other structures/groups). It is important not to exacerbate local and regional conflicts by prioritising or exclusively/unilaterally focusing (international) attention on one specific target group. In multi-ethnic/multi-faith dialogue projects, extremely careful consideration should be given to disputes between survivors of violence and perpetrators/opponents. Organisational guidelines for employee conduct should be binding. Organisations should monitor their projects closely, collect feedback and any complaints from target groups, and communicate their rights transparently, especially when implementation activities have been outsourced.</p>

No.	Principle	Description	Challenges	Best practices
10	Monitoring, evaluation, accountability and learning (MEAL)	<p>When this principle is observed, the intervention provides for in-process participatory monitoring (e.g. regular feedback from target groups, continuous supervision of MHPSS staff, evaluation of results), the findings of which are used to steer and (re)adapt the project. Monitoring should be conducted on a gender-disaggregated basis, with a focus on particularly vulnerable groups. The intervention has sufficient design flexibility to meet individual needs within the project context.</p> <p>When this principle is not observed, findings regarding negative effects that could affect projects in crisis and post-crisis situations (e.g. regarding the increase in intimate partner violence often experienced in camps) are not taken into account. No provisions are made for reflection on how the project is progressing or for deviations from the intervention plan in response to target group input/feedback.</p>	<p>In practice there is often a lack of suitable, contextually appropriate and validated indicators and instruments for evaluation of impact. In addition, there is often no universal definition of wellbeing and how it can be improved. Prior needs analyses and the long-term measurement of effects are rare. The quantitative surveys demanded by most donors do not give a complete picture of MHPSS work, and the wide range of instruments used makes comparison between measures impossible. Monitoring and evaluation work, which is generally seen as an additional burden by employees, rarely has an impact on the further implementation of a project due to organisations' lack of resources and flexibility.</p>	<p>Recent years have seen the development of various reference frameworks for MEAL (36) (37). To map positive changes and identify negative, unintended effects at an early stage, regular target group involvement and use of feedback mechanisms can be used as additional sources for MEAL, facilitating adaptation in project implementation. In dialogue with donors, greater exchange of information can lead to the development of alternative, context-appropriate MEAL formats. In addition to (or instead of) linear models such as log frames, these can be process-oriented, qualitative methods. For specialised and target-group-oriented MHPSS projects in particular, it is important to minimize the time pressure applied by donors.</p>
11	Multidimensional approach	<p>When this principle is observed, the IASC's multi-layered approach is taken into account. The offer is holistic and reflects the various needs of a diverse population. It includes the provision of trauma-sensitive and conflict-sensitive basic services and accessible community services, as well as targeted counselling services for specific target groups and specialised clinical therapies.</p> <p>When this principle is not observed, measures are one-sided and include only specialised treatment services, for example, or only accessible community-based services.</p>	<p>Appropriate placement on the IASC pyramid, including recognition of the limits and opportunities of one's own actions, requires the projects to conduct a careful analysis of the holistic MHPSS approach. The successful networking of actors (including the exchange of knowledge and information) and functioning referral mechanisms (e.g. between community-based layer-two and specialised layer-four interventions) are also required for multidimensional offers. This is often hampered by organisations' complex bureaucracy and by sector fragmentation.</p>	<p>Needs within the respective target groups should be identified individually and carefully. The resulting information can be used to identify the right intervention for a specific individual or group and/or to organise referrals across the various layers of the pyramid. Project design should be based on comprehensive actor mapping. Employees ought to be aware of the services implemented by other actors and maintain contact with them (through, for example, joint coordination groups), so that they can provide information on the (complementary) services of other actors.</p>
12	Referral mechanisms	<p>When this principle is observed, support/referral structures are in place for severe clinical cases. It is possible to refer individuals to clinical experts and other support services. Social and community-based needs are also taken into account in clinical facilities.</p> <p>When this principle is not observed, the project has no access to appropriate referral mechanisms should the need arise during project work, and cannot provide adequate care for the target group or for individuals.</p>	<p>Coordination between individual MHPSS actors is extremely challenging owing to the fragmentation of the MHPSS sector. Furthermore, clear referral pathways to other services are rarely established due to high turnover of staff and short project terms. Because all systems and services are overstretched, some referral requests are rejected. Cooperation can be hampered by latent competition between services. Once individuals have been referred, service quality can no longer be ensured.</p>	<p>Joint guidelines for referrals and case management (including data protection regulations, standardised referral forms and documentation) can provide orientation. Work flows can be facilitated by minimum training for employees and networks with referral focal points. It is essential to use 4-W-mappings, with regular updating of contact details. After a referral has been made, requests for follow-up information from the accepting organisation ensure quality of service provision, strengthen the network, and reduce competition.</p>

No.	Principle	Description	Challenges	Best practices
13	Support structures/ Staff Care	<p>When this principle is observed, support structures for MHPSS staff are in place from the outset and are firmly anchored in day-to-day work, in projects, and on all levels of the organisation. Professionalism is increased through continuous, active reflection on work. Burnout processes and secondary trauma are avoided through organisational mental health measures. Ideally, interventions should include a package of measures to maintain the long-term psychosocial health of employees. This should cover topics such as guided self-reflections, peer coaching and the promotion of self-care, as well as organisational variables such as security of funding, job security, recovery/recuperation structures and security management.</p> <p>When this principle is not observed, no support structures are in place and staff care is not seen as necessity. There is no way of knowing whether provisions have been made for mental hygiene and maintaining the professionalism of implementing MHPSS staff. The project budget has no funds earmarked for measures to reduce employee stress.</p>	<p>At the organisational level and on the donor side, staff care is not yet seen as a priority or a necessity. When responsibility for maintaining mental health lies exclusively with an organisation's employees, this can lead to additional stress and a perceived loss of control.</p>	<p>Within organisations, employees should be able to speak out if they are feeling overburdened. Support structures must be created by organisations themselves and recognised by management. Access to self-care (which is perceived as relaxing for employees) and staff care measures should, as an organisational responsibility, be factored into the planning of measures and budgeted for accordingly. Examples of staff care measures include an appreciative and respectful corporate culture that enables relationships to be formed on equal terms, transparent services that are available to all employees (e.g. individual and group psychosocial counselling sessions) and stress reduction measures (sport and relaxation courses), a workload that allows for self-care and secure jobs that provide planning certainty. Donors should insist that staff care measures are planned and implemented.</p>
14	Professionalism	<p>When this principle is observed, the MHPSS staff (preferably local) implementing the intervention are verifiably experienced, trained and culturally competent.</p> <p>When this principle is not observed, the intervention is implemented by an international team that is not familiar with the relevant context (often consisting of experts from a different culture or region). Local staff do not receive adequate training in MHPSS interventions.</p>	<p>Staff shortages are a major challenge in the specific context. The immense demand for experienced, trained and supervised staff outstrips the low level of supply. Training and guided self-reflection are hampered by time pressure and financial constraints. Qualified staff often choose security and higher pay over work in a crisis context. Moreover, the professionalism of employees often suffers as a result of high workload, frequent job rotation, and contextual uncertainty. Further stress factors include the challenges of finding a balance between donor interests and the needs of the target population, and between neutrality and empathy. In many cases, professionalism is not monitored.</p>	<p>An internal MEAL format for organisations' work can contribute to professionalism. Stress levels can be reduced through long-term mentoring and guided self-reflections of employees and peer coaching. Structural professionalism and flexibility within organisations also facilitate work. Experience shows that the provision of training is essential. Any analysis of working conditions in crisis contexts should be based on academic research. Staff recruitment should be based on transparency and clear job descriptions and definitions of responsibilities. A more comprehensive definition of professionalism (relative to context) is also required.</p>

No.	Principle	Description	Challenges	Best practices
15	Exit strategy and sustainability	<p>When this principle is observed, the sustainability of projects is ensured through the gradual handover of a project to local structures and actors in the target population. An exit plan for the project that counteracts long-term dependency on external funding is drafted or planned.</p> <p>When this principle is not observed, the project has no exit strategy, and sustainable results cannot be ensured.</p>	<p>Any type of well-prepared exit is a huge challenge in the context of ongoing crises with ever increasing needs. This is even more relevant in the case of MHPSS, where the impacts are usually only felt in the long term. In handing over services to government structures, the fear is that MHPSS needs will not be prioritised or that individual groups will be excluded. In handing over services to the target population, there is a risk that new power hierarchies will emerge. In both cases, the quality of services can no longer be ensured.</p>	<p>Experience shows that it is essential to involve actors from target communities at an early stage and to provide capacity development. Equally, care should be taken to ensure that sufficient time is allowed for testing, using and consolidating newly acquired knowledge before multipliers become trainers themselves. This requires time, patience and thus adequate project terms (at least four years) (1). Exit strategies should be prepared and planned in a transparent manner: vulnerabilities and responsibilities should be identified at an early stage, and synergies with other ongoing services should be harnessed. Consideration should be given to options for alternative funding and remote management. In cases where needs are likely to be long-term and ongoing, emphasis can be placed on strengthening local (infra)structures and systems. The timing of withdrawals and the form they take should be decided on a project-specific basis.</p>



10. What added value do psychosocial approaches offer for German development cooperation?

Traumatic experiences, sustained fear and diverse, violent experiences of loss all shape the lives of people in conflict areas. This has consequences, not only in terms of individual psychological problems that might stem from the experiences, but also for the overall social and learning behaviour of those affected. Chronic experiences of persecution, death and destruction mould the dynamics of personal relationships within families, communities and society as a whole. As such, psychosocial problems are not purely health, psychological or social issues, but need to be addressed and reflected upon in almost all areas of society (28).

Accordingly, development cooperation should take these dimensions into consideration in areas of projects which might at first seem to have little to do with aspects of psychology. People affected by such experiences have often learnt to mistrust others, keep their own opinions to themselves and to function in seemingly normal ways, while inwardly they often suffer long-term anxiety and are affected and hurt by too much loss. Many are more susceptible to physical diseases and less able to cope with strain; they suffer insecurity and nervousness, and sometimes develop a strong desire to withdraw from others. Their experiences often result in avoidance behaviour and despair, and in some cases to increased aggressiveness and a propensity to violence. People burdened by their life stories are often cognitively affected by reduced powers of concentration and poorer memory. Many find it difficult to motivate themselves, to assess their skills positively, or be willing to take risks when it comes to taking charge of their lives again. None of this should be seen as the expression of an illness, but rather as the consequence of learned survival mechanisms that may have made sense during the war but now have an inhibiting and destructive effect on the behaviour of those affected and on their potential for personal development.

To guard against the adverse psychological consequences of armed conflict and violence, consideration should be given to promoting the incorporation of MHPSS in the design and implementation of projects in all sectors of development cooperation (3). In contrast to MHPSS interventions, whose primary objective is to improve and maintain the psychosocial wellbeing of the target group, development cooperation interventions generally pursue other primary objectives (18). Given the incorporation of MHPSS and the pursuit of an MHPSS approach, the added value to society is seen not just in the easing of the suffering of affected individuals, but also in political stabilisation, violence prevention, a higher probability that development projects will succeed, greater sustainability of social and material reconstruction, and the consistent application of a human rights-based approach, to which German development cooperation is committed. Projects that combine psychosocial elements and income-generating activities are particularly significant for making the best use of synergy effects that aim to ameliorate difficult living conditions, while also developing new prospects. This works both ways: income generating activities alone are less effective than if they are combined with psychosocial elements (1).

Incorporating MHPSS considerations in other sectors of development cooperation serves to strengthen the potential of the people whom the development projects are intended to reach, thereby making their objectives more realistic.

The following list provides an overview of the general risks that development cooperation projects face if they fail to take MHPSS into consideration, and also shows the options for avoiding those risks by including MHPSS-related approaches. *In the annex* to this document you can find a more detailed presentation of the opportunities, risks and good practices related to individual development cooperation sectors.

Psychosocial risks	MHPSS approach
When mental distress manifests itself in somatic complaints and/or inappropriate behaviour which is not identified as being of a psychosocial nature, the affected members of the target population do not receive the support they need. As a result, they come under increased stress, impairing their capacities and hindering their participation in the project.	Training for employees in the respective sectors to increase their awareness of signs of psychosocial stress and trauma-specific needs, in conjunction with the provision of functional referral mechanisms, enhances their psychosocial wellbeing and helps in the early recognition of clinical needs.
The dignity of individual members of the target population is violated and their feelings of security are diminished due to a disregard for a project's particular trauma-specific and culturally relevant aspects.	Establishing safe spaces by making allowances for trauma-specific and culturally relevant needs when choosing the locations and structures for development projects makes it easier for people to access the products and services, and promotes their acceptance.
Impinging on the privacy of affected people and rushing them into conflict transformation processes too quickly can place too much pressure on them, and even reevoke the trauma.	Establishing trust depends on acknowledging the (past) suffering, creating enough space for the target population to act within, and transferring (decision-making) responsibilities. It is also a good idea to set up anonymous complaint mechanisms.
A lack of transparency in the actions taken and a disregard for the needs of both local people and the target population lead to renewed feelings of loss of control, of disempowerment, and of dependency on arbitrary systems. Moreover, perceived injustices could trigger an increase in the potential for conflict.	Repeated analysis of needs, the early and continuous (active) inclusion of the target population and the host community, and the adaptation of the measures to the local context all lead to the empowerment of the affected people. A regular and comprehensive supply of information creates trust and a sense of justice.
Integrating only selected members of the target population into the services leads to the isolation of vulnerable groups and further discrimination against them, as well as an increased competition for resources.	The targeted inclusion of vulnerable groups through the adaptation of measures to their needs and living conditions, as well as the inclusion of host communities and the avoidance of all activities that might reinforce (existing) conflicts, serves to promote mutual solidarity.
A lack of appreciation of the stressors that an organisation's staff experience can result in them feeling overstrained and exhausted. This can ultimately have adverse consequences for the psychosocial wellbeing of both the employees and the target population.	The stressors that affect employees due to their work in individual projects have been identified, and staff care strategies are developed and implemented. In addition, the employees receive support in carrying out self-care measures.

Closing remarks

In 2018, the war in Syria is in its eighth year, and it seems there is no prospect of peace and security returning to the country in the near future. At the same time, other armed conflicts are continuing in the Middle East. As a consequence, an immeasurable number of people have fled, been displaced, or have survived violence. Refugees and internally-displaced people seek protection either in their own country or in neighbouring countries. In many places, the host communities' resources have been exhausted and the infrastructure is overburdened.

Taking into consideration the basic human right to health and dignity, it is important to support the refugees, IDP and host communities, not only by meeting the basic needs of the target population but also by strengthening care systems for psychosocial support and mental health.

Much like the context in which this paper was written and adapted, the burdens and the needs of the refugees and communities are constantly subject to change. As such, it is the role and responsibility of the media, politicians and international donors not only to raise awareness of the topic of mental health and psychosocial wellbeing, but to work towards communicating those needs, closing gaps in the provision of care, and improving existing MHPSS systems and interventions on a continuous basis (38). In the spirit of such ongoing adaptation, there is also a need for regular discussions and revisions of this guiding framework.

If you have any questions or suggestions regarding the guiding framework, please contact the head of the regional project:

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Annex – Supplement to Chapter 10

Employment Promotion - Capacity Development - Entrepreneurship

The support through private-sector promotion and the extension of product areas, creation and improvement of vocational education activities and jobs, promotion of individual initiatives, creativity, passion for innovation and willingness to invest, and competitiveness.

Psychosocial benefits	Psychosocial risks	Good practices
Empowerment and building trust in the system and in relationships, as well as (re)gaining self-confidence	Consequences of psychosocial stress, such as concentration problems, aggressiveness, somatisation etc., impair work (quality) and productivity and lead to overwork	Supervisors and employers are made aware of possible psychosocial stressors, and the working environment is adapted to the specific needs
Higher quality of life and autonomy thanks to more independence	Job creation with the inclusion of specific groups could trigger new hierarchies and increase conflict potential (within families – e.g. if a woman gets a job but her husband does not)	Consideration is given to a target group's environment/context when planning and implementing projects; consideration given to needs and preconditions for employment of the target group
Ownership and agency through daily employment	Mistrust and feelings of helplessness arise from dependency on the implementing organisation	Regular feedback is obtained and complaint mechanisms are in place; and the implementation is adapted on the basis of the feedback
New prospects created through capacity development for learning of new skills and through investment	Increased anxiety and impaired self-confidence limit the willingness to learn and take risks, as well as the passion for innovation	Learning materials are adapted, and training courses are designed in a trauma- and stress-sensitive manner; awareness is raised among teachers; beneficiaries are encouraged

Education

Education ranges from early childhood education to school education, vocational training, universities, adult education, and a diverse range of education-oriented community projects. It represents an important development opportunity for individuals and society as a whole.

Psychosocial benefits	Psychosocial risks	Good practices
Central places are established where past events can be reappraised	Increased stress, anxiety and (repeated) experiences of helplessness due to a lack of security	Careful choice of location and means of transport that guarantee safety and dignity
A society's stability is enhanced and trusting relationships are developed, in order to cope with stress and (past) experiences	Mistrust derived from teachers' disempowering/demeaning attitudes and the overall circumstances for teaching	Consideration is given to trauma-oriented teaching approaches for the implementation of education measures at all levels of the intervention
(Re)construction of social coexistence; promotion of cooperation/social skills	Withdrawal, isolation and a dearth of experiences of positive relationships result from a lack of understanding for an individual's distress	Access is made easier, vulnerable groups are actively included; awareness is raised by campaigns to reduce stigmatisation
Early recognition of psychosocial needs of children and youth, and the arrangement of appropriate support	A lack of psychosocial support leads to inappropriate behaviour such as aggressiveness, social withdrawal, reduced ability to concentrate, and increased stress on the part of those affected	Preventive support measures and training for staff to recognise signs of psychosocial distress and make referrals to specialised care providers; establishing a network with other MHPSS actors
Passivity and anxiety are overcome; self-confidence are increased	Repeated experiences of loss of control, disempowerment and deprivation of decision-making rights happen due to authoritarian teaching styles and a disregard for specific needs	Empowerment of pupils through support for critical thinking; resource-orientation through skills-based teaching and supported learning
Learning behaviour and experiences of self-efficacy are improved; curiosity, interest, engagement and self-confidence are encouraged	Lack of prospects, frustration and declining self-esteem due to regression/stagnation in (educational) development, and a lack of success in school	Development of learning and teaching materials that promote concentration and make learning easier

Camp Management

Security and the provision of emergency assistance for refugees and IDP living in camps need to be ensured by establishing and keeping to standards, enabling affected people to observe their basic rights. Gaps are closed in the availability of care, while targeted coordination between camp residents, organisations and clusters avoids the duplication of services.

Psychosocial benefits	Psychosocial risks	Good practices
A feeling of control and a sense of fairness derive from positive experiences with the camp management structures	Reinstatement of the feeling that the rule of might prevails and return to dependence on (arbitrary) structures (e.g. doubts about the fair distribution of resources)	Implementation of comprehensive, standardised, regular information management; dealings with residents are respectful and processes are designed clearly and transparently (e.g. registration at the camp)
Development of self-confidence and experiences of agency, thanks to feelings of autonomy	Mistrust of organisational structures and of one's own abilities	Trust is built up actively through the conscious and mutually agreed transfer of (self-)responsibility to the camp residents (e.g. by issuing reloadable cash cards instead of food vouchers)
Development of trust, reduced sense of threat and an improved ability to cope with stressful events and experiences	Intrusions of privacy; increase in the threats and actual violence that people experience, due to inadequate planning/organisation of facilities and accommodation in the camp	Planning is trauma-sensitive and conflict-sensitive; (gender-)specific needs as well as the ethnic and religious diversity of the target group are taken into consideration in the design of the camp's infrastructure (e.g. location of washing facilities)

Cash for Work

Temporary offers of employment for refugees, IDP and members of the host communities, with the aim of temporarily stabilising incomes, ending passivity, and strengthening local infrastructure. This mostly includes simple tasks in sectors such as waste management and the development and extension of infrastructure.

Psychosocial benefits	Psychosocial risks	Good practices
Promotion of social cohesion through the repair of communal infrastructure	Employment might create unrealistic expectations and prompt hopes which end in disappointment due to the limited duration of jobs	From the outset, the project's target population is given regular information which is standardised, comprehensive and explanatory
Autonomy and feelings of control and self-confidence thanks to flexibility in households and economic independence	The lack of job security can increase feelings of loss of control and helplessness, and worsen the stress	Planning and implementation of the measure are transparent and open; follow-up activities are carried out after the period of employment comes to an end, perhaps with placements through job centres and community centres or training measures are carried out
A fixed daily routine/daily employment strengthens the ability to cope with ongoing stress	Dependency on the (implementing) organisations conflicts with the need for autonomy	Responsibility and control in carrying out the work are transferred, resulting in more respectful interaction with the target population
Strengthened feelings of belonging due to working within a team and the community	Lack of inclusion of a wide range of (vulnerable) groups causes increasing isolation	Vulnerable groups are integrated in a targeted manner through adaptation of the project to their needs

Food Security – Rural Development

The right to food is viewed as inalienable and as decisive for the promotion of health and general development.

Psychosocial benefits	Psychosocial risks	Good practices
Winning (back) control and self-efficacy through the long-term development of one's own business	Focusing purely on technical details and circumstances leads to rein-statement of relationships of dependency	Long-term strategies for food security are designed, taking into consideration family structures and hierarchies

Peace Work – Social Cohesion

In cooperation with local partners and with the involvement of other actors, a sustainable contribution should be made to peace work and social cohesion is strengthened through civilian, non-violent conflict management activities.

Psychosocial benefits	Psychosocial risks	Good practices
Experiences of self-efficacy and a sense of belonging are strengthened through processes of (re)building identity	Lack of integration into projects results in perceptions of discrimination, isolation and tension between individual groups within the target population	The target population and host communities are encouraged to participate actively in the project as voluntary helpers
(Re)instatement of trust in a constructive idea of humanity and in social reflection	Repeated confirmation of mistrust of other people and withdrawal of individual members of the target population, or increasing conflict potential due to marginalisation or the reduction of certain groups to their vulnerability	Efforts are made to achieve healthy grieving processes and recognition of individual suffering, while at the same time planning projects collectively and encouraging dialogue between groups
Successful efforts to integrate experiences through collective processes of dealing with the past and the promotion of mutual empathy	Re-traumatisation due to confronting (former) opponents and facing pressure to deal with the past too soon	The choice of timing for reconciliation processes is well thought through; the processes are implemented gradually and with the possibility of pulling out

Health

Alongside WHO, numerous other state and non-state actors are committed to promoting blanket health coverage and comprehensive improvements to healthcare, including the provision of health education.

Psychosocial benefits	Psychosocial risks	Good practices
Relief through the (early) recognition of the need for psychosocial/psychiatric/psychotherapeutic support, and a higher quality of life thanks to better matching of individuals and interventions	Frustration and helplessness due to incorrect diagnoses, resistance to treatment and lengthy periods of illness due to a lack of consideration for the two-way relationship between mental and physical health	Primary health care staff receive training on the links between (psychological/psychosomatic) symptoms and a patient's history (of suffering), and/or stressors in their current situation; functional transfer mechanisms are set up
(Returning) experiences of control and the development of trust in other people and systems	Mistrust and renewed feelings of loss of control because of (repeatedly) having to undergo (complicated) examinations and a lack of transparency in the decisions and behaviour of healthcare staff	Healthcare staff receive training in dealing with affected people and their concerns in a trauma-sensitive manner (especially with former prisoners and victims of torture)
Improved wellbeing and reduced stigmatisation thanks to awareness-raising activities and sensitive approaches	Greater discrimination and stigmatisation as a consequence of ignoring the context	MHPSS awareness-raising activities are provided for the community and employees are made aware of affected people's fears of stigmatisation

Good Governance – Media – Security – Rule of Law

The usual means of decision-making pursued by a state, the formulation and implementation of policies, the design of legal and judicial systems, and the functioning of the administrative bodies. Reform processes should be encouraged through support for more efficient, legitimate, transparent and effective state institutions which counteract corruption and the arbitrary use of power. Participation by the entire population is a prerequisite, and the people's opinions must be taken into consideration.

Psychosocial benefits	Psychosocial risks	Good practices
Promotion of personal coping processes and social cohesion; creation of new prospects for the future	The personal experiences and narratives of leading political figures guide the way the past is dealt with; division into groups of survivors and perpetrators leads to discrimination and isolation of affected individuals	Support is provided for dialogue with and between groups who have different affiliations and convictions, assuming they are willing to engage in this. Complementary MHPSS intervention increase levels of empathy and reflection
Development of mutual trust; promotion of empathy through exchanges within the population	One-sided, stark and dramatic representations and reporting, and insensitive questioning and quoting of affected people impinges on their autonomy and privacy, increases conflict potential, and ultimately can (re)evoked trauma	Public and political efforts to deal with the violence and suffering of the past are conducted in a sensitive manner; while protecting individuals, conflict-sensitive journalism supports processes of reconciliation and actively drives them forward
Reinstatement of trust through comprehensive, conflict- and trauma-sensitive reforms of state institutions and through well considered reconciliation approaches	Increased delinquency and security risks due to the overloading/poor functioning of the legal system lead to genuine feelings of threat and insecurity	The fears of those involved and the feelings of the people affected are taken into consideration in the course of reforms to the legal institutions and in approaches for dealing with the past

Infrastructure – Construction Measures – Reconstruction

Sustainable promotion of infrastructure through the implementation of construction measures, with the involvement of local people, local architects and local construction companies. If required, the intervention is complemented with training measures. The aim is also to promote the local economy, while at the same time minimising energy consumption and protecting resources.

Psychosocial benefits	Psychosocial risks	Good practices
Construction measures are adapted to the needs of the users, leading to their empowerment and ownership of the new buildings	Lack of ownership leads to destruction or poor maintenance of the buildings by the users, even resulting in conflicts (e.g. if culturally/religiously significant locations are chosen as construction sites)	The subsequent users and their (cultural) needs are included in the planning of the measures
Identity and sense of belonging are strengthened through the retention and reconstruction of the urban landscape in line with the residents' wishes	Measures implemented too soon or too quickly for the (re)construction of functional infrastructure destroy traditional urban landscapes and, in so doing, undermine the residents' identity	The focus of the construction measures lies not only on the (re)construction of infrastructure, but also on retaining what is traditional and recognising the significance of buildings and places to the residents (e.g. rebuilt or new bridges/links between urban neighbourhoods)
The users and the target group involved in the building work may experience increased wellbeing and dignity through context-sensitive and trauma-sensitive implementation	Ignoring specific needs can result in the isolation of vulnerable groups and hurt their dignity again	The special needs of vulnerable groups, such as elderly people, women and children, are taken into consideration for the architecture and construction
Future prospects and autonomy are established through job opportunities on the ground	A failure to involve local people generates competition and conflict potential vis-à-vis skilled workers from outside	Measures for capacity development are organised for the local population
The creation and maintenance of collective places serves to promote social cohesion and encounters between (former) parties to the conflict	The destruction of infrastructure or the pursuit of construction measures in places with potentially positive symbolic power, without involving all the population groups	Residents of differing ethnic and religious identities are included in the planning of construction measures, which can in turn promote reconciliation and rapprochement between population groups
Active participation in the planning of construction measures and the design of places with negative associations leads to empowerment and participation for the survivors of violence and persecution	Lack of consideration for the survivors of violence in the planning of construction measures in places with negative associations serves to repeat disempowerment and leads to increasing alienation and isolation	In places linked to human rights abuses, for example, survivors are included in the planning of their (re)design. Space is created for remembering the victims, and attempts to deal with the past events are encouraged, e.g. through an architectural style that emphasises light and openness

Environment - Biodiversity - Energy - Climate and Water

Water is a vital resource for life and it plays a decisive role in meeting the growing challenges of climate change. Maintaining functional ecosystems requires activities in all the crosscutting areas of water, species diversity, energy and climate.

Psychosocial benefits	Psychosocial risks	Good practices
Promoting social cohesion through the collective installation of communal infrastructure and use of shared resources	Competition for resources increases the potential for (renewed) conflict between population groups and within communities	Planning takes place in a conflict- and context-sensitive manner, and all implementing activities and environmental projects are preceded by information-sharing with community members, in order to avoid resistance
Increased psychosocial wellbeing and greater quality of life through the improvement of hygiene standards in settlements, camps and communities	A lack of consideration given to passivity as a possible consequence of traumatic experiences results in a lack of interest in changes and, in certain circumstances, to self-destructive and neglectful behaviour	All employees receive training in maintaining constructive contact with the target group, in encouraging people to overcome passivity and in self care measures
Empowerment of women and other members of the community	Ignoring the responsibility and the knowledge of women with respect to the water supply or overburdening them with work lead to disempowerment and helplessness	The know-how of different community members is included early on in the planning of measures, and their needs are taken into account in the implementation of measures

Cross-cutting Issues: Human Rights – Gender – Inclusion of vulnerable Groups

Psychosocial benefits	Psychosocial risks	Good practices
Protection is experienced; stress, threats and perceptions of stigmatisation are reduced	Sustaining taboos around gender-based violence, torture, forced recruitment, kidnapping and child abuse leads to marginalisation, to emotional and social isolation, and to attacks on the identity of the survivors	The function and psychosocial consequences of sexualised violence must be exposed through a combination of research, advocacy and rehabilitation, and perpetrators must be brought to justice
Promotion of self-esteem and self-confidence, empowerment of the survivors	Feelings of helplessness with respect to the danger of future attacks	Measures to prevent future occurrences of violence are implemented with the active participation of survivors

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