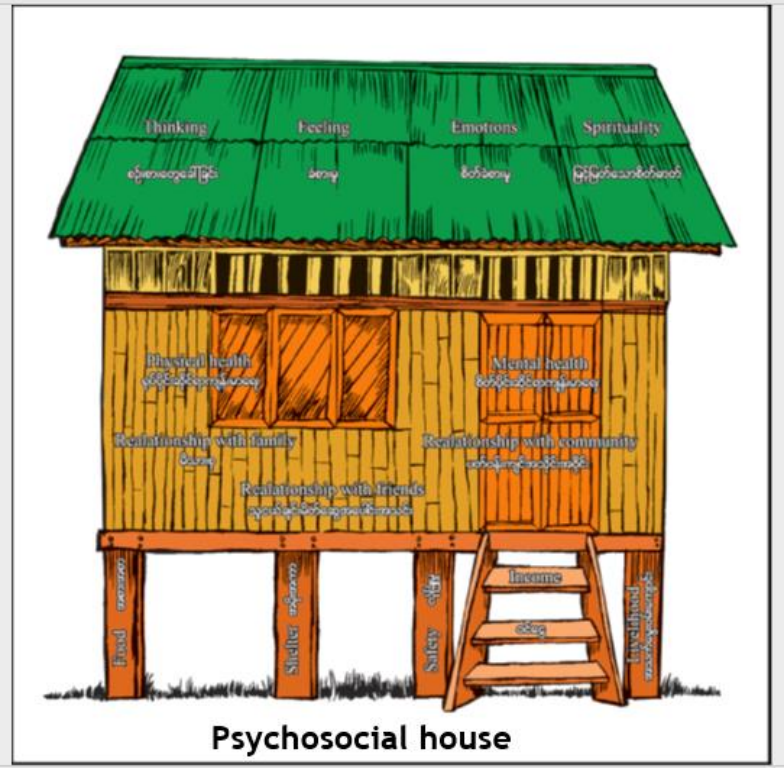
ACF Myanmar – Tanya Kullar, MHCP Program Manager Sittwe – December 2017

Mental Health and Psychosocial Support in Disaster Risk Reduction

MHPSS in DRR

Lessons Learned in ECHO X- MCCR program

In DRR-MHPSS sessions, we always use the analogy of a psychosocial house. We say: “For better understanding, let’s compare a person to a house. To build a house where people can live, we need different materials that we put together to make a complete structure, a good and strong house. If some elements are missing, taken away or destroyed, then the house can fall down, and it will not be longer a place for people to live in comfortably.”



Psychosocial house

The DRR-MHPSS collaboration first introduced in DIPECHO IX was an inspired experiment. It required first ever collaboration between ACF's Mental Health and Care Practices (MHCP) and Disaster Risk Reduction (DRR) departments, with MHCP in the technical or architectural role; and DRR in the line management or civil engineer role. We learned together how to, and how not to, build resilience.

BRIEF PROJECT SUMMARY

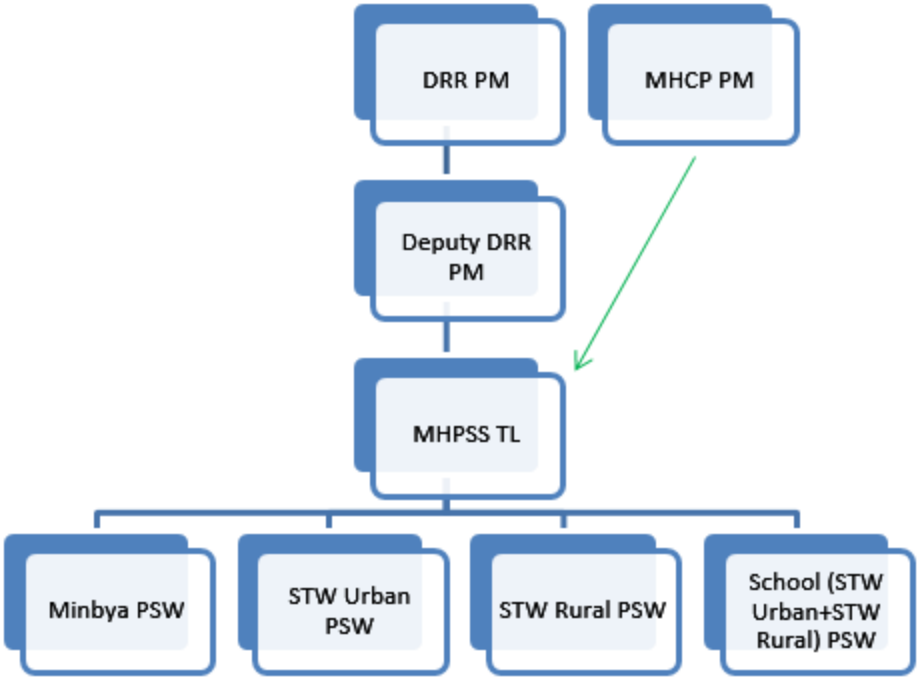
Coverage

Through DIPECHO IX and ECHO X, DRR-MHPSS interventions have served the 8 rural and 6 urban locations and engaged a total of 75 MHPSS focal persons. Through the SDC project complementing the ECHO X project, the DRR-MHPSS interventions have served 3 rural, 3 urban and 4 Minbya locations and engaged 60 MHPSS focal persons. As of late 2017, the DRR-MHPSS interventions have been introduced in schools as well. The intention is to cover the 3 rural ECHO schools, the 3 urban ECHO schools and both SDC schools (one rural and one urban).

Activities

- **Awareness sessions for community members**
  The VDMC and key community members of a location served by the project is invited to attend awareness sessions run by the DRR team at the start of the project. Several DRR topics are covered including an awareness session on DRR-MHPSS by the DRR-MHPSS team.
  Four members of the VDMC comprise the MHPSS task force and are called MHPSS focal persons. Through the project cycle, VDMC strengthening activities are done. Some such as planning exercises are designed for the VDMC main committee members only, which includes the leader of the MHPSS task force but not the entire task force. Some such as information sharing workshops and validation meetings are for the entire VDMC and hence the entire MHPSS task force.
- **Training sessions for MHPSS focal persons**
  MHPSS task force of a few locations are invited together for a concentrated two days of classroom training. In ECHO X, the topics covered were IYCF-E and PFA. Pre and post testing was done.
- **Community rollout sessions**
  The DRR-MHPSS team and MHPSS focal person share key messages from trainings done for the MHPSS focal person with particularly relevant members of the community. For example, pregnant and lactating women were invited for the session on IYCF-E.
  Similar initiatives were made for trainings done for other task forces of the VDMC such as practice sessions following the first aid training for the First Aid task force in urban.

Human Resources



In DIPECHO IX, DRR had the same team serve communities and schools. For ECHO X, as the comprehensive safe school framework was being applied, and to ensure specialized service for children, a specific school-based team was created.

A psychosocial worker was appointed for Minbya and for schools, with the DRR-MHPSS team leader to supervise.

Chronology ECHO X

1. Orientation on MHPSS and capacity assessment was done for the DRR-MHPSS staff in mid-November 2016.
2. Training on IYCF-E (emphasizing messaging and rationale, with training) and PFA was done for the DRR-MHPSS staff in late December 2016. Pre and post testing included.
3. The capacity assessment was conducted in the DIPECHO IX villages by the DRR-MHPSS staff in January 2016.
   In this assessment, all but one of the MHPSS focal persons reached reported continuing to provide MHPSS services after the DIPECHO project ended. Retention of the IYCF-E concepts tested was good; retention of helping skills tested through role play was fair; and retention of the PFA concepts tested was poor. The content of the entire capacity assessment is appended.
4. Two large scale, formal trainings-one for focal points from rural locations of DIPECHO IX and one for urban on IYCF-E are done in late February 2017. A session with the team on simplifying the training for this audience was done.
5. In August 2017, a simplified PFA training was done for DRR-MHPSS staff.
6. In October and November 2017, the simplified PFA training was rolled out by the DRR-MHPSS staff on the field.

Lesson One

For a strongly reinforced structure, harness existing technical resources for implementation.

What we observed :

Based on experience in other new project development, it has always been been very fruitful to rely on experienced technical staff, especially when launching a project, rather than recruit a full new team

How we did it:

- Community members with whom we had worked as crisis managers in a previous MHCP programme were prioritised for selection as MHPSS focal persons on the field in DIPECHO IX.
- Experienced MHCP staff were absorbed into the newly formed MHPSS-DRR team for DIPECHO IX and ECHO X.
- To make a meaningful pre and post test for the IYCF-E trainings planned in ECHO X, the highly experienced MHCP in Nutrition treatment team prepared test items based on their experience in the context. We included these in addition to standard items from the DG ECHO Inspire knowledge assessment and the ACF care practices references.

How we will (or can!) do more:

- We have expanded the DRR-MHPSS team to include more experienced MHCP staff.
- Project budget should include high level technical resources to ensure full training/supervision process required for a sector that has so few/limited skilled resources

Lesson Two

To truly build capacity, technical people must build, break down and rebuild capacity building modules and styles.

What we observed:

Our approach in DIPECHO IX had been to cover a comprehensive set of training topics. In ECHO X, we factored in staff and MHPSS focal person capacities; and the time staff and MHPSS focal persons would reasonably take to learn not just MHPSS content but skills too, and chose to work with only two of the original five topics. We considered these two (IYCF-E and PFA) the building blocks of MHPSS in DRR and designed intensive trainings on them in such a way that more advanced levels of the trainings could be planned at subsequent stages.

After we trained the DRR-MHPSS team on PFA for the first time, though we'd adapted the training to be relevant to the context, we found that two of the five staff did not meet the criterion for minimum improvement. These were relatively new recruits, and it would have been a violation of do no harm principles to let them carry out PFA trainings on the field. So we held on till we could do better.

How we did it:

- From DIPECHO IX to ECHO X, we streamlined the training package from five to two topics (IYCF-E and PFA). These two topics were considered fundamental.

- Within ECHO X, we weren't satisfied with the experience and post tests of our staff the first time we ran a PFA training developed especially for them. We realized that we hadn't been able to adapt the content well to our staff's skill levels. So we went back to the drawing board, prepared a simpler and more practical training, executed it and felt more satisfied with the results; and only then did we let our staff cascade the training to the field.

How we will (or can!) do more:

- The vision is for repeated and follow up trainings on the two fundamental topics of IYCF-E and PFA to be designed to achieve higher and more complex conceptual understanding and skills. For instance, ideally the IYCF-E training, which emphasized concepts, will be followed up by a practical training on breastfeeding counselling.

- The standard PFA pre post test from the WHO field workers' manual clearly loses meaning in translation. It confuses rather than clarifying trainings. Through the MHPSS WG we could work on better translation; or, if sufficient technical resources are available for the DRR-MHPSS programmes, we could work on a capacity measure bottom up. Skills monitoring requires more technical support/mobilization compared to knowledge monitoring, but proves to be a much more relevant MEAL system in this sector.

Lesson Three

Ensure that staff and beneficiaries are finding your help helpful.

How we did it (and why):

We've all noticed that people in developing environments ask for concrete things. In risk assessments, for example, communities want roads and cyclone shelters and pipelines. Not skills.

Even experienced MHCP/MHPSS staff prefer to be able to give something concrete to beneficiaries, much as they value the abstract psychosocial support they are giving.

For new MHCP/MHPSS staff, the thought of abstract psychosocial support or skills being valuable and something worth giving in itself is particularly daunting.

ACF's technical MHCP staff elected not to see this as inexperienced staff not valuing our expertise, but identify with the feeling we had as early stage psychologists expected to help people with no tangible tools. And changed the order of training topics for the staff and beneficiaries so that they could start with the most concrete aspects, feel confident and then move on to the more abstract. Hence we start with the concepts of IYCF-E.

How we will (or can!) do more:

- In 2018, while DRR intends to expand to new locations with ACF's WASH and Nutrition departments, the DRR-MHPSS interventions will stay put in existing locations to deepen the work there; and move to the newer ones when the communities are able to associate ACF with both concrete WASH type of aid and more abstract support like DRR-MHPSS.
- With more intensive technical support, the teams can work on context/culturally-adapted metaphors to communicate on the concrete outcomes of psychosocial support – experience sharing workshops can be organized with psychosocial workers working in nutrition centers, to base these metaphors on real cases follow-up by MHCP teams in the same area.

Lesson Four

Separate the funding cycle from learning curves. And track distinct learning curves for distinct groups.

- ECHO project cycles are not long enough for the skill transmission through the cascade to occur: i.e. for (1) field staff to acquire skills through contact with technical staff and practice on the field; (2) for field staff to transmit these skills to MHPSS focal persons; (3) for MHPSS focal persons to apply these skills. For example, in the internal departmental learning exercise, the *MHCP Impact Analysis Workshop 2016*, the experienced members of the DRR-MHPSS team projected that at best 50% of MHPSS focal points learned skills from the DIPECHO IX project activities.

What we have done/can do:

- Compare skills of the same staff member/MHPSS focal person across project cycles through repeated pre and post testing.

Lesson Five

We must be innovative and responsible about the ways in which we expect people to demonstrate learning.

How we did it:

- Literacy levels of MHPSS focal persons varies. So we constantly adjust our pre and post tests to them: we maximize on images, we read and explain questions and mark out answers.
- Rather than a large scale SIMEX which people find interesting but makes them very conscious; and to cut down on paper and pencil testing for skills; we had DRR-MHPSS field workers assess capacity by doing a role play with the MHPSS focal people.
- Using different styles of assessment is always helpful. We found in our capacity assessment that when asked verbally, over two-thirds of the MHPSS focal persons could not recall the term "link" but in the role play, two-thirds spontaneously referred ("linked") to appropriate external services.