MENTAL HEALTH, CARE PRACTICES, GENDER AND PROTECTION SECTOR

TECHNICAL GUIDANCE

FOR COVID-19 CRISIS

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LIST OF ACRONYMS

ACF: ACTION CONTRE LA FAIM

AAH : ACTION AGAINST HUNGER

GBV: GENDER BASED VIOLENCE

IASC: INTER-AGENCY STANDING COMMITTEE

MHCPGP: MENTAL HEALTH, CARE PRACTICES, GENDER AND PROTECTION

MHPSS: MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

MoH: MINISTRY OF HEALTH

PFA: PSYCHOLOGICAL FIRST AID

PTSD: POST-TRAUMATIC STRESS DISORDER

WHO: WHO HEALTH ORGANIZATION

I. OBJECTIVE OF THIS DOCUMENT

This document is a positioning document that aims to **clarify the strategy and the different activities officially approved by the "Mental Health, Care Practices, Gender and Protection" sector during the fight against Covid-19.**

Our interventions must be guided by the **two main objectives recalled by ACF's General Management:**

● the continuity of essential services with the adaptation of our approaches and services in relation to the pandemic and, in some cases, lockdown.

● the specific programs and activities developed by the MHCPGP sector in the context of prevention and response to Covid-19 as well as the consequences related to containment.

The document also aims to inform our partners about the specific positioning of Action Contre la Faim, in order to promote greater complementarity, more effective and effective coordination and finally a better collective impact.

This document is a living document according to the progress of knowledge on Covid-19 and the improvement of our experiences and skills. It is completed by a toolbox, which will be regularly updated.

List of available resources:

- Technical Library MHCPGP: online procedures, recommendations, ACF Tools => In NHF: https://actioncontrelafaim.sharepoint.com/csw/oper/covid-19/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fcsw%2Foper%2Fcovid%2D19%2FShared%20Documents%2FDaily%20updates%20%26%20Useful%20Documents%2FTECHNICAL%20LIBRARY%20%2D%20BIBLIOTHEQUE%20TECHNIQUE%2FMHCPGP&FolderCTID=0x012000D550BB1D1C232F49920E3D83E260199C
- Site mhpss.net (see also the Facebook page regularly updated), you will find in particular the documents developed by the IASC and their translations: https://actioncontrelafaim.sharepoint.com/csw/oper/covid-19/Shared%20Documents/Forms/AllItems.aspx?RootFolder=%2Fcsw%2Foper%2Fcovid%2D19%2FShared%20Documents%2FDaily%20updates%20%26%20Useful%20Documents%2FTECHNICAL%20LIBRARY%20%2D%20BIBLIOTHEQUE%20TECHNIQUE%2FMHCPGP&FolderCTID=0x012000D550BB1D1C232F49920E3D83E260199C
- The Alliance for Child Protection in Humanitarian Action (see also the Facebook page regularly updated): https://alliancecpha.org/en/COVD19
- UNICEF has developed a specific portal on Covid-19 that is translated and culturally adapted to each country. You will find there a lot of information about your country: https://www.unicef.org/coronavirus/covid-19
- Early Childhood: https://mailchi.mp/ecdan/ covid19
- For information on breastfeeding and nutrition (caution: recommendations change quickly!), ask your fellow nutritionists. You can also find information on the following websites: http://nutritioncluster.net/ and https://www.ennonline.net/fex/62/gtamcovid19
- For Francophones, you will find a lot of tools on the site: http://www.psycom.org/Espace-Presse/Actualites-du-Psycom/Epidemie-et-confinement-ressources-utiles-pour-notre-sante-mentale

II. INTRODUCTION

The Covid-19 is spreading rapidly and it is no longer a country or regional problem. It is a global problem requiring a global response. As part of the humanitarian community's contribution, Action Contre la Faim is increasingly committed to reducing the impact that Covid-19 has and will have on the population it works with. Covid-19 is not only a health problem but has a profound impact on many areas: political, social, human, environmental, economic and infrastructural. There is an abundant literature being developed on the various impacts of the pandemic and how humanitarian practitioners should take these into account, but the challenge is to translate this into actions and prioritize needs.

III. CONTEXT

COVID-19 is a coronavirus first identified in Wuhan, China. Cases have been reported around the world with person-to-person transmission. WHO has declared the coronavirus 2019-20 a public health emergency of international concern in February 2020.

WHO has defined four transmission scenarios for COVID-19:

1. Countries with no cases (No cases);

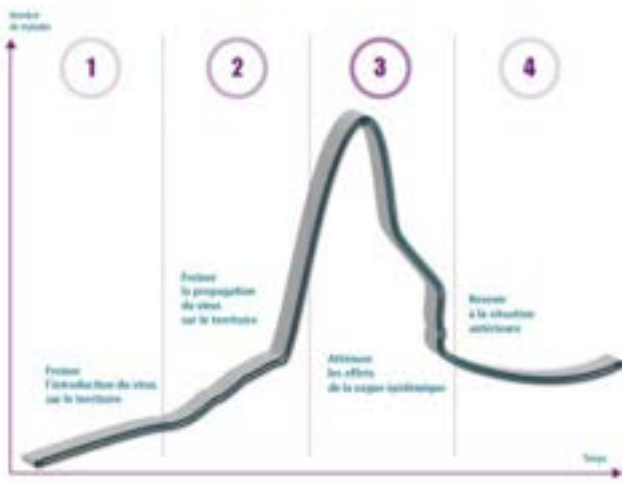
2. Countries with 1 or more cases, imported or locally detected (Sporadic cases);

3. Countries experiencing cases clusters in time, geographic location and/or common exposure (Clusters of cases);

4. Countries experiencing larger outbreaks of local transmission (Community transmission).

The response to the pandemic has been defined in 4 steps[1] detailed in the figure below. Stages 1 and 2 focus on containment and there is no active circulation of the virus, with cases being treated individually and direct contacts being monitored. The objective is to slow down the introduction of the virus and to stop its spread.

Phase 3 means that there is an active spread of the virus and that the health strategy focuses on individual detection and care, and collective action.



[1] French Ministry of Heath - https://solidarites-sante.gouv.fr/IMG/pdf/guide_methodologique_covid-19.pdf

IV. OPERATIONAL RECOMMENDATIONS FOR MHCPGP PROGRAMS AND ACTIVITIES

The operational recommendations define how ongoing activities for the missions can be adapted in the context of the COVID-19 epidemics and which specific Covid-focused activities can be developed based on the four transmission scenarios defined by WHO. All adjustments should also be made in alignment with country-specific guidance prepared and shared by the relevant health authorities, as well as in coordination with local actors. The decision-making process should also be discussed on a case-by-case basis with your pools.

This document may evolve over time as knowledge about this new virus evolves. It is important to keep in mind that this is a new epidemic and it requires frequent adjustments.

Challenges at stake are:

- **Minimizing exposure risks for our teams, our beneficiaries, our partners and stakeholders in our projects;**
- **Minimizing the impact of the pandemic on implementation of essential activities;**
- **Contributing to collective efforts aiming at limiting the dissemination and the impact of the pandemic by strengthening/developing our interventions.**

4.1 CONTINUITY OF MHCPGP SERVICES

Below, some recommendations for the continuity of services according to the level of risk for Covid-19. Field access limitations, due to lockdown of staff and borders closures, can affect the team structure and therefore it may be difficult to guarantee minimum standards to ensure quality of care and to avoid harmful practice. For this, depending on the context and the skills of the teams, these recommendations may require adjustments, which will be evaluated on a case-by-case basis with regional technical advisors support. **Mental Health and psychosocial support, child protection, prevention of violence remain essential activities in the prevention and response to epidemics as highlighted by the IASC.** There is even often a resurgence of needs: the population we work with can be particularly affected (discriminated groups, pregnant women, children, etc.). **Epidemics and their management in terms of quarantine, stigma, lockdown, and isolation are increasing psychosocial difficulties and psychological distress, and can increase risks and dangerous situations, including violence against the most vulnerable**. At the same time, the various health care services may decrease. The programs implemented by ACF within MHCPGP sector must therefore be prosecuted to the extent possible and redesigned to respond to the Covid-19 crisis situation. Adaptations are necessary in terms of project content and modalities. For example, group trauma treatment will have to be reoriented towards smaller group or individuals (face-to-face or by phone when possible). This new modality implies not being able to follow as many beneficiaries and therefore to identify those most at risk, as well to include in the content of the sessions the psychosocial and psychological aspects related to Covid-19.

Teams of helpers can be particularly affected by this crisis and by the constant exposure to the suffering of people, and being placed in a situation of risk. Trainings and supervision of the teams must continue, but certainly new ways of conducting them must be found according to the local and/or mission restrictions. Specific support must be offered.

The table below lists the main models of ACF interventions and the recommendations for adaptation according to WHO levels. For specific programs, ad-hoc decisions should be discussed with the mission and the regional technical advisor.

Intervention models	Life-saving	Operational recommendations for adaptive programming and mitigation measures	Triggered when?	Sources and guidelines (documents will be updated regularly)
Baby Friendly Spaces	Yes. Need to identify the most at-risk cases and switch focus to Covid-19, breastfeeding counseling and psychosocial & psychological support from level 3	1) Limit groups to max 5 dyads parent/child at the same time (or as per government standards); 2) Provide hand washing options at distribution and ensure physical distancing norms are respected; 3) Ensure that everyone washed their hands very regularly during the activities; 4) Clean all the ground after each focus group; 5) Toys should not be used anymore as soon as Covid-19 is spread in the country; 6) Adapt messages and advices on breastfeeding that include sensitization and information on Covid-19 and confinement; 7) Identify dyads and babies at risks. Propose one to one consultation or breastfeeding	Level 1: "normal" BFS Level 2 and 3 (without cases within intervention area): include 1) to 6) Level 3 (with cases within intervention area) & 4: 7) and 8)	

		support and psychological support according to the possibility in the field; Staff will have to respect physical distancing of at least 2 meters and will have to wear protective equipment including a surgical mask. 8) When possible, propose or refer to hotline services for psychological consultations and BFS counseling;		
Support to persons in distress (psycho-education sessions, support groups, therapeutic groups, individual counseling and psychological support, Psychological First Aid)	Yes. Need to identify the most at-risk cases and switch focus to Covid-19 from level 3	1) Provide hand washing options in groups settings and ensure physical distancing norms are respected; 2) Ensure that everyone washes their hands very regularly before and after the activities; 3) Integrate in the sessions/protocols, topics on psychosocial aspects of the Covid-19 and Confinement; 4) Look at possible adaptation of group sessions. Reduce number of participants and ensure physical distancing norms are respected;	Level 1: support to persons in distress as usual Level 2 : 1) to 4) Level 3 and 4: 5) to 7)	Here the **PFA** guidelines for Ebola Virus Disease Outbreak, an adaptation for Covid-19 is going by the MHPSS group. Here: Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak

		5) Look at possible adaptation of groups sessions to individual sessions (face-to-face and by digital communication if possible). If face to face follow the protective measures (here). As the individual sessions will cover less persons, identify the persons the much in need of support; 6) When level 3 is reached, contents of the sessions will be focused much more on psychosocial aspects of Covid-19 and confinement; and the FU should focus persons with severe distress or risk of suicide who should be identified and supported; 7) After level 3, transform the response also to prevention and support for Covid-19 (see specific guidance on this) and include identification and FU of the severe cases and at risk of suicide;		
MH Gap programme: integration of MHPSS within the health system	Yes. Need to identify the most at-risk and switch focus to Covid-19 from level 3 and adapt according to the	1) Provide hand washing options in groups settings and ensure physical distancing norms are respected;	Level 1: support to persons in distress as usual Level 2: 1) to 4) At Level 3 et 4: 5) to 7)	Here the **PFA** guidelines for Ebola Virus Disease Outbreak, an adaptation for Covid-19 is going by the MHPSS group

	saturation of the health system due to Covid-19	2) Ensure that everyone washes their hands very regularly before and after the activities; 3) Integrate in the sessions/protocols, topics on psychosocial aspects of the Covid-19 and Confinement; Train the MoH staffs on psychosocial aspects of Covid-19 and confinement; 4) Look at possible adaptation of group sessions. Reduce number of participants and ensure physical distancing norms are respected; Organize with the health staffs the possibility for them for ensuring the FU of the MHPSS support; 5) Look at possible adaptation of groups sessions to individual sessions (face-to-face when possible and by digital communication if face-to-face is not possible anymore). As the individual sessions will cover less person, identify the persons the much in need of support. Organize with the health staffs the possibility for them to continue clinical FU		Here: Interim Briefing Note Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak

		6) When level 3 is reached, contents of the sessions will be focused much more on psychosocial aspects of Covid-19 and confinement; FU sessions should focus on persons with severe distress or at risk of suicide who should be identified and supported; 7) After level 3, transform the response also to prevention and support for Covid-19 (see specific guidance on this). Work with the health system to ensure that psychologically at-risk persons are identified and supported by health staffs;		
Integration of Care Practices in the treatment of SAM children	Yes. Need to identify the most at-risk and switch focus to Covid-19, BFS counseling and MHPSS support from level 3	1) Follow and adapt the rules with the nutrition and health teams. Limit the groups to 5 dyads parent/child maximum (it can be less according to available space, or as per government standards); 2) Provide hand washing options during distribution and ensure physical distancing norms are respected;	Level 1: “routine" programme Level 2: 1) to 6) Level 3 & 4: 6) and 7)	

		3) Ensure that everyone washes their hands very regularly before and after the activities; 4) Toys should not be used anymore from level 2; 5) Adapt messages and advices on breastfeeding and include sensitization and information on Covid-19 and confinement starting level 2; 6) Identify dyads at risks. Propose one to one consultation or breastfeeding support and psychological support according to the possibility in the field. Follow the same protectives measures as health workers of health facilities; 7) When feasible, propose or refer to hotline services for psychological consultations and BFS counseling;		
Prevention of under nutrition: groups with pregnant women and mothers of children under 2	Yes, for the most at-risk and switch focus to Covid-19, BFS counseling and MHPSS support from level 3	1) Limit the number of persons to 5 dyads parent/child (or as per government standards);	Level 1: "normal" activities Level 2: include 1) to 3)	

		2) Provide hand washing options and ensure physical distancing norms are respected; 3) Ensure that everyone washes their hands very regularly during the activities; 4) Toys should not be used anymore from level 2; 5) Adapt messages and advices on breastfeeding with Covid-19 and confinement information, from level 2; 6) Identify pregnant women, dyads and babies at risks. Propose one to one consultation on breastfeeding support, or psychological support according to the possibility in the field; 7) When possible, propose or refer to hotline services for psychological consultations and BFS counseling;	Level 3: 4) to 7)	
Needs Assessments	No	**Activities on stand-by from level 3 if local transmission and level 4** 1) Focus groups have no more than 10 people;	1) Level 2, stop at level 3 2) Level 2, stop at level 3 if transmission within intervention area	None

		2) For door to door evaluation, maintain social distancing norms and wash hands in between each home visit 3) Update mapping for referral to and from child protection and GBV services;		
Prevention and response to Covid-19	Yes	1) Sensitize and inform the staffs on Covid-19; 2) Integrate in all the projects considerations on Covid-19 and confinement; 3) Adapt recommendations on barriers actions; 4) Adapt all programs and activities according to the recommendations proposed for each program; 5) Develop specific MHCPGP projects and activities related to Covid-19 and confinement;	From level 2: 1) to 5)	

4.2 SPECIFIC MHCPGP RESPONSES TO THE COVID-19 CRISIS

While its full impact and long-term fallout is still unclear, there is one thing we do know: the impact of COVID-19 on mental health and psychosocial conditions, as well as on gender and protection of those directly or indirectly affected by the epidemic will be significant and will last after the end of the crises. This document will be updated regularly with new facts and information.

4.2.1. MAIN MHCPGP INTERVENTIONS FOR THE COVID-19 CRISIS

The recommendations in terms of MHCPGP sector specific interventions are based on the recommendations of the IASC MHPSS, the ACPHA, the UNICEF MHPSS document for children and families and the GBV sub-cluster, ACF experiences and manuals on epidemics, cholera and Ebola. For example, we have already conducted several activities for people in quarantine, psychological support to non-ACF medical staff in charge of cholera, etc... We have also produced a document that introduces the specific psychosocial impact on communities, families and children for each crisis situation[2].

The recommendations below are not exhaustive and depending on the context and the skills of the teams, these recommendations may require adjustments, which will be evaluated on a case-by-case basis with regional technical advisors support. Thus, it is important to bear in mind that the proposed programs and activities must be tailored to the context, HR capacity and risk level of the Covid-19. Given the exceptional and global nature of this pandemic, we must be creative and find specific ways and means of intervention.

You will find below a table with the 3 main operational objectives of COVID-related interventions in MHCPGP, activities and examples of indicators. The narrative below takes up all the objectives and activities in the table in more detail.

[2] https://www.actionagainsthunger.org/sites/default/files/publications/ACF_Psychosocial_Impact.pdf

Main objective: Contribute to helping countries prepare for, prevent and respond to the COVID-19 pandemic		
Specific Objective 1: Reducing the impact of the spread of Covid-19		
Logic of intervention	**Activities**	**Examples of Objectively Verifiable Indicators**
Outcome 1: Access to reliable, necessary and vital information on Covid-19 is improved	**A.1.1.1 Initial assessment of social representations, cultural norms, at-risk beliefs and practices around COVID and the measures put in place**	Study conducted
	A.1.1.2 Implementation of broadcasting tools to disseminate reliable information on Covid (the disease, the transmission, means to prevent it, psychosocial risks ...) adapted to the context	Number of people informed Number and types of tools used Percentage of the target population who can remember at least two barrier actions

	A.1.1.3 Awareness-raising, information and coordination with the different Protection and Health actors in the intervention zone	At least xx Health and Protection actors are informed and coordinate for the referral and follow-up of identified cases
	A.1.1.4 Community awareness and identification of community focal points (locally influential people such as community leaders, religious leaders, health workers, community volunteers) and local networks (women's groups, youth groups, business groups, traditional healers, etc.)	At least xx focal points and xx targeted local networks in the project area are informed about the different risks of propagation of Covid-19 and the right ways to communicate on the subject
	A.1.1.5 Establishment of a system for monitoring social representations and rumors	Monitoring system in place
Outcome 2: Activities are adapted to prevent the spread of the virus.	**A2.1.1 Continuation of MHCPGP activities adapted to the situation of the Covid-19 crisis (cf. continuation of activities table)**	
Specific Objective 2: Improving the prevention of the consequences and MHCPGP risks related to Covid and the measures taken for the management of the epidemic		
Outcome 1: Influential people in the community as well as local organizations are strengthened and supported in their MHCPGP risk prevention actions	**A.1.2.1 Train ACF staff (who are not part of the MHCPGP sector) and influential people in the community in psychological first aid (PFA)**	Number of ACF staff (who are not part of the MHCPGP) trained in PFA Number of community influencers trained on Psychological First Aid (PFA) % of PFA-trained individuals who increase their knowledge

	A1.2.2 Train and sensitize influential persons in the community in connection with local networks to detect persons at risk (psychosocial risks, psychological distress, violence, neglect and abuse) in need of psychosocial and/or psychological support	Number of community influencers trained to identify people at risk
	A1.2.3 Inform influential people in the community, in the case of confinement or movement restrictions, about the availability of services and how to access this support	Mapping of open services including services available remotely
	A1.2.4 Support at-risk and influential people in the community to put in place strategies and modalities to limit protection risks for children, women and other vulnerable people (including the risks of stigmatization)	Number of persons supported in this process of prevention of risks/dangers
	A1.2.5 Support the engagement and adaptation of existing protection networks with COVID management measures	Number of local organizations/partners supported
	A.1.2.6 Contribute to the adaptation of the implementation of a referral system in connection with the health measures related to COVID (towards local and health services, existing protection services, telephone assistance)	Referral system adapted to be functional with the health measures taken for the management of the epidemic

	A.1.2.7 Support for the adaptation of appropriate and adequate care practices to the context of the epidemic	% of people who are familiar with adaptive care practices with Covid
	A.1.2.8 Adaptation with communities of rituals according to specific measures to deal with the epidemic (greetings, funeral rituals, hygiene practices, etc.)	Number of exchanges with communities on adaptations of practices
Outcome 2: The preventive response provided by all sectors, mobilized around the epidemic, integrates MHPSS and Protection considerations	**A.2.2.1 Establishment of intersectoral coordination with other actors to ensure information sharing, coherence, collaboration and integration of MHPSS and Protection activities within the different sectors of intervention**	Number of intersectoral meetings
	A2.2.2 Strengthen and update the referral system between organizations and service providers by mapping existing MHPSS services, health services, child protection services, GBV services, telephone services, etc	1 regularly updated directory/mapping of existing services for identification, referencing and monitoring is set up and functional, integrating the new modalities of access to services
	A 2.2.3 Implementation of a surveillance system (SMPSGP impact of the covid, GBV cases, etc.)	Cf. Surveillance Document
Objective 3: Improving MHCPGP interventions through adapted and specific responses to the Covid-19 epidemic.		
Outcome 1: Skills of health workers and helpers are strengthened and adapted	**A.1.3.1 Train health professionals and helpers in psychological first aid (PFA)**	Number of health professionals and helpers trained in psychological first aid (PFA) % of PFA-trained individuals who increase their knowledge

	A1.3.2 Train and supervise health personnel and helpers in CERTAIN MHPSS management protocols. (Note that the protocols and interventions that can be implemented by non-ACF personnel are more limited than those that can be implemented by ACF teams. The protocols must absolutely be validated by headquarters to limit the risks)	Number of persons trained Number of indirect beneficiaries treated % improvement in patients treated Number of supervision set up
	A1.3.3 Inform health workers and helpers about MHPSS, child protection and GBV services that are open and competent so that they can refer people in need	Number of health professionals and helpers informed
	A1.3.4 Provide practice analysis sessions (space to share risks and problems encountered/ coping strategies) for health workers	Number of practice analysis sessions Number of participants in practice analysis sessions
Outcome 2: Families are strengthened and supported in their care practices and the detection of children at risk of protection is ensured	**A2.3.1 Support for care practices adapted and appropriate to the context of the epidemic**	% of people who are familiar with adaptive care practices with Covid
	A2.3.2 Provide and share child-friendly materials to inform children about Covid-19	Number of people who received this type of material/information
	A2.3.3 Explain to parents the signs of stress or anxiety in their children and how to respond to them	Number of parents informed about behaviors that reassure children

	A2.3.4 Establish or contribute to the establishment of a family and/or parenting support system	Parent support/support system in place
	A2.3.5 Personalized support for at-risk family situations (breastfeeding, neglect, emotional needs, etc.)	Number of people supported
	A2.3.6 Identification and referral of vulnerable persons at risk of protection	Number of vulnerable persons identified and referred
	A2.3.7 Psychological care of protection cases	Number of persons supported % of people whose mental health has improved
Outcome 3: Psychosocial support and mental health care is ensured	**A.3.3.1 Psychosocial and mental health needs assessment**	Assessment made
	A.3.3.2 Implementation of psycho-education sessions on stress symptoms and management, stigmatization, fear...	Number of psycho-education sessions organized
	A.3.3.3 implementation of individual or group MHPSS sessions	Number of sessions organized Number of participants % of people who improved their well-being
	A.3.3.4 Specific psychosocial and psychological support for people in quarantine	Number of people in quarantine receiving psychosocial support
	A3.3.5 Psychosocial and psychological support for people infected by Covid and their families	Number of sick people from Covid or their families monitored
	A3.3.6 Setting up MHPSS support for the bereaved persons, proposing in cases where it is not possible to attend the funeral rites, solutions allowing mourning and recollection	Number of bereaved persons followed up

	A.3.3.7 Activities to reduce stigma and promote family and community reintegration	Number of groups or information sessions on stigmatization
	A.3.3.8 Coordination or contribution to coordination in MHCPGP with other actors in order to ensure continuity of services	Participation in MHPSS and Protection coordination meetings
Outcome 4: Helpers (non ACF) benefit from psychosocial and psychological support	**A4.3.1 Information/psycho-education of health workers and helpers on stress management and psychosocial risks related to the management of Covid**	Number of people informed Number of information/psycho-education sessions held
	A4.3.2 Provide psychological support for health workers and/or helpers (for non ACF staffs)	Number of helpers who received psychological support % of helpers whose symptoms decrease as a result of psychological intervention

4.2.2. DESCRIPTION OF ACTIVITIES

The description of the activities is not exhaustive and does not represent exactly the headings in the table. Some activities are overlapping or are not specifically mentioned. The main purpose of the narrative is to provide guidance on the objectives and framework of some activities. The implementation modalities should be discussed with your regional technical advisor and be based on the guidelines recommended by ACF.

4.2.2.1. Raise Awareness about COVID-19

(Related to Objective 1 "Reducing the impact of the spread of COVID-19 ")
It is important to inform about Covid-19, its modes of transmission and the protection barriers to put in place. Messages should focus on accurate information: how the virus is spread, signs and symptoms of the disease, measures to be taken to stay healthy and keep the others healthy, etc.
Messages and modalities of information of the population and beneficiaries should be culturally adapted. Studies should be carried out beforehand to find out the social representations of COVID-19 and the protection barriers in the countries of intervention. ACF will work with existing public health and community networks to share messages through media campaigns, social media, influential people in the community, local network, etc. Social perceptions and rumors will be regularly monitored in order to adapt the messages if necessary.

4.2.2.2. Mental Health and Psychosocial Support

(Related to Objective 2 "Improving the prevention of the consequences and MHCPGP risks related to Covid and the measures taken for the management of the epidemic" and Objective 3 "Improving MHCPGP care management through adapted and specific responses to the Covid-19 epidemic").

4.2.2.2.1. Why a Mental Health and Psychosocial Support response in Covid-19 crisis management ?

As stated above, clear, simple and accessible information and communication about Covid-19 and the services still available are indispensable and can contribute enormously to reducing the stress of the population and ensuring compliance with the appropriate protective measures of Covid-19. An outbreak like the Covid-19 epidemic can cause a variety of emotional reactions and psychological effects. Psychological and social support should be provided for patients, their families, the communities, and the frontline workers. This support should be offered from the beginning of the intervention and throughout the post emergency phase. To be relevant, the support and the approach have to be tailored to the social and cultural context.
Psychosocial support is vital to ensure the wellbeing of the affected population but also to work on consequences of epidemics' outbreak, such as stigma, stress, fear and misconceptions. Moreover, health staffs, ACF staffs in particular, are working in very stressful conditions and a psychological support is essential for them as well (ensured by HR for ACF staff care).

As for an emergency related to a conflict or a natural disaster, in Covid-19 outbreak we have to consider significant problems of a predominantly social and/or psychological nature:

- Pre-existing (pre-emergency) social or psychological problems (e.g. extreme poverty; belonging to a group that is discriminated or marginalized, political oppression, severe mental disorder, alcohol and substance abuse).
- Emergency-induced social problems (e.g. family separation, disruption of social networks, destruction of community structures, resources and trust, increased gender-based violence, grief, non-pathological distress; depression and anxiety disorders, including post-traumatic stress disorder (PTSD).
- Humanitarian aid-induced social problems (e.g. undermining of community structures or traditional support mechanisms, anxiety due to a lack of information about food distribution).

4.2.2.2.2. What are the specific objectives of MHPSS Interventions?

The 14 recommended activities of the IASC MHPSS Covid Response can be implemented by ACF. You will find below some examples of specific objectives for the MHPSS intervention. This list is not exhaustive.

- To support affected families by reducing the impact of stress, fear and stigma and facilitate the social reintegration of recovering patients and victims' families into their communities.
- To facilitate the psychological process for families throughout various stages: identification, hospitalization, notification of death, burial, and bereavement.
- To improve the quality of care for the patient and family together with other team members of ACF sectors.
- To facilitate an understanding of the disease within the community and encourage acceptance of the epidemic control activities.
- To support staff working in health facilities.
- To support infants and mothers in breastfeeding to prevent transmission of the Covid 19.
- To contribute to coordination mechanisms for the identification and creation of a referral system for vulnerable patients.
- If feasible, to set up a hotline for support, to reduce the isolation of hospitalized patients.
- If the area affected by the epidemic is quarantined, to enhance access to communication with absent relatives and friends.
- Once the epidemic is over and assuming the activity is safe and it does not violate infection prevention procedures, to encourage the resumption of social activities that may have been interrupted as part of the effort to curb human-to-human transmission.

4.2.2.2.3. MHPSS interventions

Training on Psychological First Aid (PFA)

Communities can be severely affected by Covid-19 disease in many ways. People can be separated from their loved ones, due to illness, containment measures, death. They may experience fear and suffering that are intrinsic consequences of epidemics. People directly or indirectly affected by Covid-19 can be vulnerable to social stigma, worsening their distress and isolation. Health workers need to deal with a high workload and a lot of stress. In this situation, people can experience a wide range of reactions. They can feel overwhelmed, confused or very uncertain about what is happening. In general, someone's reactions depends on many factors. It is important to remember that Covid-19 can

influence how we normally provide support to each other (e.g., by not being able to touch people) and how we cope with the death of our loved ones (e.g., by not being able to engage in traditional burials). This can severely worsen people's distress.

Psychological First Aid involves humane, supportive and practical assistance for people who are distressed, in ways that respect their dignity, culture and abilities. PFA is an approach that can be learned by both professionals and non-professionals who are in a position to help people affected by very distressing events, such as a Covid-19 disease outbreak. They may include staff or volunteers of relief organizations (in health and non-health sectors), health workers, teachers, community members, local government officials and others. It is not necessary for helpers to have a psychosocial or mental health background in order to be able to provide PFA. Helpers can find useful PFA skills to include in their regular work. PFA training should be provided in order to strengthen skills of both professionals and non-professionals who are in a position to help affected people: contact tracers, community leaders, health workers, teachers, etc.

The objectives of the Psychological First Aid are to:

- Providing non-intrusive, practical care and support
- Assessing needs and concerns
- Helping people to address basic needs (food and water, information)
- Listening to people, but not pressuring them to talk
- Comforting people and helping them to feel calm
- Helping people connect to information, services and social supports
- Protecting people from further harm

In the case of Covid-19 disease, information is vital: those providing PFA can help to dispel myths and rumors, share clear messages about healthy behavior and improve people's understanding of the disease.

PFA training will be provided by MHCPGP teams to non-MHCPGP teams and actors; PFA will be implemented by other humanitarian actors/helpers. This will allow for the MHCPGP teams to focus on more specialized MHCPGP activities that required more specific technical skills.

People who are more in need than PFA in terms of mental health support include:

- People who are so in distress that they cannot care for themselves or their children;
- People at risk of hurting themselves;
- People at risk of hurting others.
- People with pre-crisis mental health and psychosocial difficulties whose symptomatology was amplified by Covid-19
- Persons with harmful coping mechanisms such as addiction, alcoholism, violence, etc.
- Persons who have lost multiple family members and loved ones due to Covid-19, particularly orphans who need extra care and protection.

Psycho-education

Psycho-education should be implemented to provide a better understanding of MHPSS and protection risks related to COVID and to the measures in place to limit the pandemic. Explanations on common psychological and social reactions (fear, anxiety, stigma...) that occur in stressful situations should be provided. Tools, exercises for stress management, positive coping strategies, might be proposed and discussed during the psycho-education sessions.

Psychosocial activities

In order to mitigate the negative effect of COVID-19 on the communities and to strengthen the coping mechanisms at individual and community level, psychosocial activities will be adapted taking into consideration the context of the COVID-19 epidemic on the basis of the four transmission scenarios defined by WHO. If lockdown strategies and movement restrictions exist, MHCPGP interventions will need to be adapted, sometimes carried out remotely.

Prefer short-term support approach. Work on increasing internal and external resources as the priority. These interventions should be based on strengthening local resources already existing (when possible) within the community and community leaders have to be engaged since the beginning of COVID-19 outbreak.

- Community members and leaders should be engaged to understand the sources of stigma and the steps that can be taken to dispel any unnecessary fears and misconceptions. At the same time, it should be recognized that empowerment of those who have survived and are affected by COVID-19 is essential to overcoming stigma, including self- stigma, and discrimination.
- Engage with community leaders and existing structures to develop community- focused
- Interventions. Empower the community to develop and implement their own response plan, as appropriate, including the identification of isolation areas and roles and responsibilities within the community members.
- Engage with community members, including religious/traditional leaders, as soon as possible during the outbreak to promote acceptance of the need for safe funerary rites and to reach consensus on how to take care of bodies in a manner that is culturally acceptable and safe.

At operational level different psychosocial activities can be proposed, mainly:

- Organization of focus group discussions on the main topic linked to COVID-19 (stigma, fear, acceptance, burial rituals, local mechanisms of help and support etc.). Community members can identify the problems, sharing their opinions and try to find efficient solutions.
- Implementation of MHPSS support for the bereaved, adaptation of funeral rites that allows grief and mourning.
- Facilitate the creation of inclusive community-based self-help groups. As mental health and psychosocial effects tend to last much longer than the acute crisis phase, the development of these self-help groups can represent a long-term perspective focused on establishing a sustainable mechanism of support at community level. The objective of these groups is to provide social / emotional support, sharing of experiences, good practices and problem solving skills to help individuals to develop their own behavioral strategies, and to receive emotional and social support during transitions or difficult periods of life.

Psychological support

Psychological support services should be available for the persons who are facing important psychological difficulties. Psychological support is organized in individual or group sessions, depending on the beneficiaries' needs, the culture and the qualifications and training of the staff. Modalities should be defined according to the possibility of applying physical distances as well as hygienic measures; remote and online psychological support might be proposed. Pay attention to risk of discrimination in terms of access to online communication and to the balance risks/benefits when

taking decision on modalities of intervention (keeping possibility of face-to-face interview in case of risk of suicide for example should be planned)
In any case, the availability of external services providing psychological support should be assessed, in order to explore the possibility to refer the beneficiaries to these services and for coordination purposes (information can be found through MHPSS working group if existing in the country).
ACF protocols for psychological support are available. They need to be adapted to the Covid situation, the persons' needs, the staffs' capacity and the cultural context. Adaptation has to be discussed and validated with the regional technical advisor in charge. If the psychological support is provided by non-ACF staffs, only CERTAIN protocols will be used (please refer to reginal technical advisor) and on-going supervision of practices/cases need to be in place (as for ACF teams).

4.2.2.2.4. Specificities of MHPSS interventions by targeted groups

Psychosocial and psychological support activities have to be organized for people and communities directly and indirectly affected by COVID-19.
Previous experiences showed that in COVID-19 outbreak, most affected people are quarantined people, survivors and their families, children, grieving families, frontline health workers/helpers. This list is not exhaustive and needs should be evaluated before setting the intervention in a determinate area. The difficulties faced by the groups might be different according to the measures in place in the zone (targeted containment or lockdown for everybody for example might lead to very different feeling on the situation of quarantine) and by the socio-economic situation of the persons. It is clear that Covid-19 exacerbates previous inequalities. And in each group, the persons might experience different feelings. The information by group described below is from ACF experience in previous non Covid epidemics and literature on COVID-19 and other epidemics.

Quarantined people
All the countries affected by Covid-19 have imposed various restrictions, which can range from a restriction on certain movements, the closure of schools and certain public places, bans on gatherings of people for cultural, religious or sporting events, etc. For some countries, in addition to these measures, they have adopted either lockdown of people infected with the virus or suspected of being infected, or total lockdown of the entire population.
Containment, whether or not one is infected with the virus, can be a stressor and some studies have shown that duration of more than 10 days is predictive of post-traumatic symptoms, avoidance behavior and anger[3]. Persons ill and placed in quarantine may suffer from stress and stigma. They may experience fear and be anxious about their future and about the health status of loved ones.
Neighbors in the communities may become mistrustful and be aggressive towards families in quarantine leaving them aside and without support. During the quarantine, it is essential to provide to contained persons a MHPSS support according to their main preoccupations and emotional suffering. Previous experience showed the importance to visit them at least twice per week, and to continue supporting them after the quarantine period to be sure that their internal resources have been strengthened enough.

Survivors and their families
Persons that were ill may have faced fear of dying. For those who have hospitalized, they have been alone in hospitals without the support of their loved ones with the permanent anxiety of dying alone, having contaminated others, etc. They sometimes have to learn basic things after artificial coma. When they survived COVID-19 and come back home from hospitals/treatment centers, they can experience stigma, discrimination and rejection by their communities, even sometimes by family members.

[3] https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)30460-8/fulltext

Stigmatization is not experienced by individuals only, but by families and whole communities as well, resulting in people losing their jobs and sometimes their homes. It is important to address the specific needs of persons who have survived COVID-19 in the emergency phase, providing them with specific psychosocial support, involving their families and communities members in order to reduce stigma and to facilitate the reintegration process.

Children and their families

Children can experience psychological and emotional difficulties related to COVID, changes in the daily life, and protection measures in place. They may fear of being infected, fear that the parents become sick or die. Lack of information can have negative effects on children**.** Lockdown, which creates a rupture in space and time and leads to a lack of contact with classmates and friends, can confront the child with a loss of bearings and a feeling of loneliness. Children also witness people being taken away from their communities. In addition, children are very sensitive to their parent's feelings and emotional state. The parents' mental health and their capacity to face the situation and to explain it to their children is a key element for protecting children's well-being and mental health. Providing a targeted psychosocial support for children and their families is very important, helping the parents to explain to children the situation, providing support to organize planning and activities, to support mental health of the parents and of the children, etc.

Furthermore, the Covid-19 virus can leave many children orphans, in need of social and psychological support and protection.

Older people

Older adults are particularly vulnerable to COVID-19. Pay specific attention to high-risk groups, i.e. older people who live alone/without close relatives, who have low socioeconomic status and/or comorbid health conditions such as cognitive decline/dementia or other mental health conditions. The epidemic may lead to or even increase emotional and psychological disorders among the elderly, especially those who are most isolated and do not have direct access to covid information. In addition to their medical and daily living needs that need to be addressed and met, they need support to alleviate their anxiety and stress. Providing them with accurate and accessible information and facts about the COVID-19 epidemic can reduce anxiety and also prevent risky and inappropriate behaviors to protect themselves from the epidemic. Support should be provided through regular contact, which may be proposed by phone, or home visits where possible.

Girls and women

Pandemics exacerbate existing gender inequalities and vulnerabilities, increasing the risk of neglect, deprivation, coercion, discrimination, abuse, exploitation and violation of rights. Women and girls may be more exposed to, for example, intimate partner violence and other forms of domestic violence due to increased tensions within the household. In these situations, they also face increased risks of other forms of violence, including sexual exploitation and abuse. To address the psychosocial needs, it is critical to provide protection activities and MHPSS support.

Grieving families

Individual and/or family psychological support may be provided for children and adults in difficulties after death of beloved ones. In COVID-19, families may not the possibility to respect the cultural funeral rites. The sudden separation of family members, the death occurred away and in isolation, without the possibility to see the loved ones one last time; all of these factors make the grieving process very complex.

A combination of family and individual support sessions is needed to most effectively address family emotional difficulties. Particular attention to cultural aspects is necessary in choosing the psychosocial approach and technics.

Frontline health workers/helpers

It is important that health workers/helpers have access to psychosocial and psychological support for themselves. Health workers directly involved in the diagnosis, treatment and care of patients with COVID-19 are at risk of developing psychological distress[4]. See below the specific sources of stress for staff related to Covid-19:

- Strict bio security measures that put pressure on the daily work
- Increasing number of confirmed and suspected cases
- High workload
- Depletion of personal protection equipment
- Lack of specific drugs
- Feeling inadequately supported
- Risk of being contaminated
- Fear of being infected when encountering a physical symptom
- High mortality rate amongst health workers
- Stigmatization when working with Covid-19 patients
- Global consequences of the outbreak for everyone at community level

Helpers that are not health-staffs might also be directly affected according to the tasks they are supposed to do and the situations they are confronted to. Support can be provided through psychological support (psychological treatment protocol in groups or in individual) or emotional supervision (opportunity to express their feelings, stress and difficulties in order to find adapted solutions and emotional relief). Choice of modalities of support has to be decided according to needs, feasibility of the approach, etc.

Caution: **ACF MHCPGP teams provide psychosocial and psychological support to non ACF-frontline workers or helpers. In any case, the ACF MHCPGP teams should provide MHPSS support to their ACF colleagues. This task is under HR responsibility and is implemented within ACF staff care support.**

4.2.2.3. Care practices and Child Protection

4.2.2.3.1. Why Care Practices and Child Protection in Covid-19 Response ?

COVID-19 can quickly change the context in which children live. Quarantine measures such as school closures and restrictions on movements disrupt children's routine and social support while also placing new stressors on parents and caregivers who may have to find new childcare options or being forced to absent themselves from work. Stigma and discrimination related to COVID-19 may make children more vulnerable to violence and psychosocial distress. Disease control measures that do not consider the gender-specific needs and vulnerabilities of women and girls may also increase their protection risks and lead to negative coping mechanisms. Children and families who are already vulnerable due to socio-economic exclusion or those who live in overcrowded settings are particularly at risk.
Children might face risks such as:

- Reduced care and neglect of children
- Increase in child abuse and domestic/interpersonal violence

[4] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2763229

- Childcare/school closures, continued work requirements for caregivers, illness, quarantine/isolation of caregivers
- Increased psychosocial distress among caregivers and community members
- Girls' gender-imposed household responsibilities such as caring for family members or doing chores
- Quarantine measures can create fear and panic in the community, especially in children, if they do not understand what is happening
- Loss of parents/caregivers due to disease
- Isolation/quarantine of caregiver(s) apart from child(ren)
- Pressure on or lack of access to child protection services
- Increased risk of sexual exploitation of children, including sex for assistance, commercial sexual exploitation of children and forced early marriage
- Distress of children due to the death, illness, or separation of a loved one or fear of disease
- Worsening of pre-existing mental health conditions
- Social stigmatization of infected individuals or individuals/groups suspected to be infected
- Closure/inaccessibility of basic services for vulnerable children and/or families

As in any emergency contexts, very young children are vulnerable and the parental capacities to respond to their need can be impacted, potentially leading to a degradation of childcare practices.
The contagiousness and mode of transmission of COVID-19 through the respiratory tract implies a significant impact on the parent-child relationship and on the way in which children are cared for, shown affection and stimulated. Nevertheless, family dynamics can be strengthened and care practices adapted to the needs of the child.

4.2.2.3.2. Care Practices and Child Protection Interventions

The interventions proposed below are examples of interventions. They should be adapted according to the needs, previous experiences and activities within the communities and families, the culture and of course, the COVID specifics protection measures.

<u>Supporting adequate child care practices and protection focused-activities</u>

- Providing families with information5 about the impact of the covid-19 is essential to protect themselves and their children and support to reduce their stress levels.
- Families should be supported through psychosocial activities aiming to maintain and strengthen the relationship and interactions with their child. Care practices will be adapted by adopting protective measures to reduce the spread of the virus.
- Care practices will need to include explaining to parents the signs of stress or anxiety in their children and how to respond to them.
- Provide and share child-friendly materials to inform children about Covid-19
- Establish or contribute to the establishment of a family and/or parenting support system. This involves engaging other people who can provide support. These may include other family members and religious leaders who can support families.
- Identification of children, high-risk families that may require additional support including MHPSS services
- Identify strategies for providing psychosocial support to children, especially to those under quarantine
- Psychological support of child protection cases

[5] https://www.unicef.org/stories/novel-coronavirus-outbreak-what-parents-should-know

- Link with social services and community-based protection networks that seek to reduce emergency induced rights violations, especially those affecting children, such as child labor, early marriage and sexual abuse.
- Collaborate to establish a well-documented referral system for organizations focused on child protection, where mental health referrals may need to be made.
- Together with communities, carry out activities to end stigmatization, promote safe coping mechanisms, and support affected populations
- Work with communities to identify strategies to prevent and protect vulnerable groups (e.g. refugees, children in alternative care, those at risk of stigmatization and social exclusion)
- Facilitate referral for other specialized services including GBV services
- Ensure that the full range of children's rights are protected and observed in health facilities, including the need for caregiver/parental consent when media or public information is involved.
- These interventions can be implemented at community level or in health units, as in particular in the treatment of severe acute undernourished children.

Focus on promotion and support to adequate IYCF

In the Covid-19 context, several concerns have been raised about infant and young child feeding. At the time of writing this paper, the recommendation is that breastfeeding is the best way to feed infants less than 6 months and should be continued, with adequate complementary feeding, up to 2 years or beyond. According to the guidance shared by UNICEF (https://www.unicef.org/eap/breastfeeding-during-covid-19), symptomatic mothers who are sufficiently able to breastfeed, should wear the mask when close to a child (including during feeding), wash their hands before and after contact with the child (including feeding), and ensure that contaminated surfaces are disinfected. This should be done in all cases where a person with confirmed or suspected COVID-19 interacts with others, including children. If a mother is too ill to breastfeed, she should be encouraged to extract her milk and give it to her child in a clean cup and/or spoon - while following the same infection control methods all along. In any case, please refer to the Health and Nutrition sector colleagues of ACF to obtain the latest information on this.

4.2.2.4. Protection of People affected by violence, including GBV

During the 2014–16 West African outbreak of the Ebola virus, given their predominant roles as caregivers within families and as front-line health-care workers made women were more likely to be infected by the virus[6]. Having to take care of persons infected with the virus (feeding, washing them, etc.) increase the risk women face of contracting the disease. Majority of health care workers and health facility service staffs (eg. cleaners, cooks), particularly at a community level, tend to be predominantly women, which contributes to higher exposure and possible higher infection rates for women in most countries. In fact worldwide, women represents 70 percent of the health and social sector workforce[7]. Current data on Covid-19 in China and Europe show that women are not considered to be more at risk of being sick than men. Explanations for this are unknown at the time of writing this document and it is difficult to predict if this will be the same in other countries.

Women, girls, and vulnerable groups are at an increased risk of gender-based violence (GBV) during public health emergencies such as COVID-19, who might face increased risks of sexual violence. Cases

[6] The Lancet, COVID-19: the gendered impacts of the outbreak
[7] UNFPA 2020: COVID-19: A gender lens: Protecting sexual and reproductive health and rights, and promoting gender equality (March 2020)

of violence are already high in humanitarian settings and are likely to increase during COVID-19 outbreaks. Epidemics, particularly of unknown diseases, can cause significant stress and anxiety. MHPSS interventions can alleviate the stress, anxiety and irritability produced by the outbreak and can support in the management of those, which can have a positive impact on diminishing instances on intra-familiar violence and intimate partner violence.

Restrictions on mobility, during lockdown, potentially expose women to intimate-partner violence at home, with limited options for accessing support services. In addition, having law enforcement and security forces in the streets to monitor the movement of people can in some countries lead to higher levels of physical violence especially against the most vulnerable men, boys, women and girls, including sexual harassment. Life-saving care and support to GBV survivors may be disrupted when front-line service providers and systems, such as health, policing and social welfare, are overburdened and occupied handling COVID-19 cases.
Thus, protection activities should be implemented to protect women, girls and vulnerable groups during this pandemic period. As systems that protect women and girls, including community structures, may weaken or break down, specific measures should be implemented to protect women and girls from the risk of intimate partner violence with the changing dynamics of risk imposed by COVID-19.

Continuous support to the management of GBV cases

- Promote the integration of GBV risk mitigation measures (as indicated in the GBV guidelines of the Inter-Agency Standing Committee) in the communication on COVID-19 implemented by other sectors / clusters.
- Provide psychological support to people affected by GBV and other types of violence
- Refer protection cases to basic services as needed (health, nutrition, education, legal, FSL, etc.)
- Disseminate information to the community on how to access services with accessible communication methods
- In collaboration with communities, carry out activities to end stigma, promote safe coping mechanisms and support affected populations
- Work with communities to identify prevention and protection strategies for vulnerable groups (for example, refugees, children at risk, groups at risk of stigma and social exclusion)
- Facilitate referral to other specialized services, including gender-based violence services
- Participate in protection coordination, including the GBV sub-cluster coordination to update available services and referral systems, including for GBV survivors, taking into account any change in availability / access with the COVID. Inform the main groups and actors of the services available.

4.2.2.5. Coordination & Referral system

As in any emergency, coordination and referral systems are compulsory. They will be adapted to each context.

- Establish or contribute to a detailed mapping of actors in order to avoid duplication of efforts in some areas, while other areas are neglected.
- Refer urgent psychiatric and neurological complaints (e.g. psychoses, severe depression) to appropriate services, if available in the area.
- Participate actively to the MHPSS, child protection and GBV coordination groups
- Attend other sectoral coordination groups (health, protection, etc.) to ensure the integration of MHPSS, child protection and GBV activities into different sectors.
- Ensure coordination with GBV coordination mechanism and/or other GBV service providers to update available services and referral pathways
- Link with child protection services and referral pathways

- Strengthen or establish referral/coordination mechanisms between mental health and social welfare and ensure frontline staffs are aware of these procedures for GBV and Child Protection cases.
- Possibility to contribute to a surveillance system to measure through indicators direct and indirect impacts of the epidemic on MHCPGP (see ACF document on multisectorial surveillance during Covid Crisis).

4.2.2.6. Advocacy

Advocacy is an important component of ACF response to Covid and is depending of the needs in the country. It might be related to ensuring that MHCPGP are included in national preparedness and response plans, avoid discrimination or stigma of some groups, fight against misuses of protection COVID measures for other purposes, being sure that the response is inclusive and mitigate the potential exacerbation of inequalities, etc. Data from the MEAL system can feed into advocacy actions.

4.2.2.7. Research

The Covid-19 crisis raises many research questions on consequences for populations and for health staffs and helpers, prevention and response strategies to COVID, impact of operational responses in SMPSGP, etc. It is essential to properly measure and document the situations and interventions implemented by a robust MEAL system and by research actions. The latter may be descriptive research (e.g., mental health problems of caregivers or the population), research on impact measures (e.g., improvement of mental health symptoms after a psychological support protocol in 6 phone sessions), etc. To be scientifically valid, studies and research protocols must have robust and specific methodologies and meet specific ethical and deontological criteria. They must be discussed and validated with headquarters. The objective of evidence-based research is thus to monitor the effectiveness of treatment plans, with the aim of providing people with treatments that have strong evidence of their effectiveness.

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