ACTION AGAINST HUNGER

MHPSS* NEEDS AND INTERVENTIONS'S IMPACT ASSESSMENT

RESPONDING TO THE EARTHQUAQUE AFFECTED POPULATIONS IN TURKEY: ADIYAMAN, KAHRANMANMARAS AND HATAY REGIONS.

REPORT JULY 2023

*Mental Health and Psychosocial Support

CONTENT

ACRONYMS AND ABREVIATIONS

ACF	Action Against Hunger
FSL	Food Security and Livelihoods
FGD	Focus Group Discussion
IASC	Inter-Agency Standing Committee
IYCF -E	IYCF in Emergencies
MBFS	Mother and Baby Friendly Space
MHPSS	Mental Health and Psychosocial Support
NFI	Non food items
OCHA	Office for the Coordination of Humanitarian Affairs
SRP	Solidarity Respect and Protect
STL	Support to Life
WASH	Water, Sanitation and Hygiene
UNHCR	United Nations High Commissioner for Refugees
UNFPA	United Nations Fund for Population Activities
WHO	World Health Organization

BACKGROUND

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CONTEXT

On 6 February 2023, two earthquakes of magnitude 7.8 and 7.5 on the Richter scale hit Türkiye. They affected 11 provinces in the southern and south-eastern parts of the country, killing 50,391 people, injuring 107.204 persons and destroying around 298,000 buildings. The affected provinces of Adana, Adiyaman, Diyarbakir, Elazig, Gaziantep, Hatay, Kahramanmaras, Kilis, Malatya, Osmaniye, and Sanliurfa were home to 14 million people, including around 1.8 million refugees (International Organization of Migration 06/03/2023[1]). **The four most severely affected are Adiyaman, Hatay, Kahramanmaras, and Malatya.** The impact of the quakes has affected 9.1 million people. Three million were forced to relocate from their homes in Türkiye, 1,6 million others are still living in informal settlements and almost 800.000 in formal sites (OCHA 17/05/2023[2]). 2.5 million children currently need humanitarian assistance (UNICEF 28/02/2023[3]). About 130.000 currently pregnant women are part of the directly affected population and 14.400 births are expected to happen within a month (UNFPA 19/06/2023[4]).

The Action Against Hunger Emergency Team was deployed to respond to the emergency on the 7th of February. The team contacted the longstanding Turkish local partner **Support to Life (STL)** to understand the context situation and to assess the needs of the most affected areas. The participation in coordination clusters and technical working groups allowed the identification of other key partners assessing and responding to emergency and collaboration with the local organization Solidarity, Respect and Protect (SRP) was stablished to reach more rural and remote communities.

The first assessments highlighted big needs in terms WASH, Shelter, Food Security and Psychosocial support to the affected populations.

[1] Support To Life. EMERGENCY SITUATION REPORT 12.07.2023

Nowadays, while approximately 5.4 million earthquake-affected people are receiving some form of humanitarian assistance, **significant needs remain.** The transition from informal tent sites to formal tent sites and container settlements is one of the pressing challenges and informal camp sites still report high needs of access to adequate water supply and sanitation, access to information on available public services, access to social protection programmes, and access to psychosocial support services[1].

MHPSS CONTEXT

Emergencies and humanitarian crises create significant psychological and social stressors that are experienced at the individual, family, community, and societal levels (IASC, 2007).

Dealing with uncertainty, grief and loss have been a priority of the MHPSS teams working with the affected populations.

The loss of homes, human capacities, livelihoods and the suspension of educational activities has led to drastic changes in family dynamics, where gender roles continue to perpetuate inequality and are the cause of major protection risks.

Consecutive aftershocks have hindered the recovery process, reliving the moment of the earthquake and reactivating fears and stress responses. Uncertainty about the future, the isolation of rural communities and the coexistence of different population groups have also been a major source of insecurity, stress and episodes of violence.

According to the WHO, in a crisis situation:

35 - 50%

of the population manifests light to moderate distress that may be remedied through psychosocial intervention and may be resolved in the first weeks;

15 - 20%

of the population present lasting light to moderate distress (psychosomatic issues, posttraumatic stress disorder, etc.). Specific mental health support intervention is necessary in this case.

3 - 4%

of the population suffer from a major psychiatric disorder (psychosis, severe depression, major anxiety disorder) and need psychiatric treatment.

This is why providing timely and effective MHPSS supports after an emergency, from ensuring that all responses to their needs are provided promoting safety and dignity, to more focused supports for those who are specially struggling, is essential to guarantee the recovery and prevent further psychosocial consequences in the affected population.

ACF INTERVENTIONS

As an immediate result of the destruction caused by the earthquakes, hundreds of tent and container camps are being managed by the government to house and provide basic services to people who have lost their homes. These account for the also known as "formal camps" and being government managed ensures also more regulation and oversight, provision of infrastructures and services and coordination with other actors to ensure the provision of basic needs.

However, the orography of the main affected regions means that many remote communities have been left virtually isolated, with little access to services and in highly vulnerable conditions. These are part of the "informal camps", together with others also set in urban areas by people who doesn't want to move to the formal ones. This is often a consequence of not wanting to leave their crops and animals or fear of their houses being assaulted before having the chance of going back to them. These settlements are spontaneous, can foster a strong sense of community as residents often come together to support one another in the absence of formal assistance but also increase their vulnerability to exploitation, health risks, and lack of access to proper medical care, food or hygiene services.

In this context, **ACF decided to support projects that could protect and promote the psychosocial well-being of the affected population both within the formal camps, as part of the essential services for the recovery of the population, as well as through a mobile intervention** that would allow access to these actions in rural and remote areas and smaller camps.

As part of the localization strategy, ACF has embraced implementation through local partners to support both the capacity development of national actors and to ensure the delivery of quality assistance thanks to their deep knowledge of the context and its communities.

In this regard, two partnerships for the coverage of mental health and psychosocial support needs have been stablished:

- **Three psychosocial mobile units have been set up with Support to Life**, an independent humanitarian organization active since 2005 with core activities focused in Emergency Response. They have extensive experience in methodological development and implementation of protection and psychosocial support actions for refugee communities and in previous emergencies in the country.
- **A camp-based psychosocial intervention has been implemented with Solidarity, Respect and Protect**, a humanitarian nonprofit founded in 2017, committed to disaster relief in crisis areas and experience in education, community cohesion and food security.

Both interventions focused **on alleviating psychosocial distress and strengthening people's coping skills through basic support to families and communities and focused, non-specialized support such as psychological first aid or individual counseling.**

Although both projects shared the approach and main desired objectives, some of the activities were different in each case depending on the context and experience of each team.

Main differences:

CAMP BASED	MOBILE
Integrated with other camp services	New- transitory service
Flexibility to adapt activities to people feedback and needs	Well-structured interventions
More work on building community cohesion	Focus at family level and connecting individuals with the needed resources
Young adults and adults	Children, youth and adults

Table 1. Main differences between the camp based and mobile interventions.

It is worth mentioning that the camp-based intervention did not include activities with children while the Mobile teams did. Activities with children were very much demanded in both contexts and the need was assessed, but the implementing partner SRP did not have the required experience and specific policies for child protection needed for which this intervention focused more on adult population.

Location and coverage:

The Camp-based intervention has covered 2 formal camps in the region of Hatay, in Arsuz during two months and Iskenderun during one month.

The mobile teams have been active April- July and covered a total of 20 locations in Adiyaman and 16 in Maras.

ASSESSMENT OBJECTIVES

The main objectives of this assessment have been to:

- **Assess the effectiveness of the MHPSS interventions developed** by ACF's partners in Turkey: STL and SRP
- Deepen onto the **relevance and differential impact** of mobile interventions versus camp-based ones.
- **Understand the evolving psychosocial needs** of the population.
- Identify **needs and opportunities for psychosocial integration** in WASH and Health/Nutrition programs.

METHODOLOGY

TARGET POPULATION AND SAMPLE SELECTION

The assessment has covered the provinces of Adiyaman, Hatay and Kahramanmaras.

For the purposes of this assessment, data collection was undertaken over 6 days in July 2023. The sample represented:

- MHPSS professionals implementing mobile and camp-based projects.
- Mother and Baby Friendly space's staff.

- Affected population, including pregnant and lactating women.
- Members of Camp Management and Coordination unit.
- WASH Committee members.
- A total of 149 people has participated in this assessment.

A total of **149** people has participated in this assessment.

	MHPSS Professionals		Other Aid professionals		Affected community members	
	Men	Women	Men	Women	Men	Women
Adiyaman	2	6	2	1	4	48
Hatay		2	2	5		48
Maras	3	10	3	3	1	9
TOTAL	23		16		110	
	149					

Table 2. Number and profile of assessment participants.

ASSESSMENT TOOLS AND DATA COLLECTION METHODS

Different tools from the Toolkit "Assessing mental health and psychosocial needs and resources" developed by the WHO and UNHCR and the "IFRC Monitoring and evaluation framework for psychosocial support interventions" have been used and adapted to the context and needs.

Key informant interviews have been conducted with the project leaders to have a deeper understanding of the project's operational aspects, the priorities and set up challenges, while Focus Group Discussions have been aimed at implementing teams as well as community members to gather their views and priorities in a more participatory way.

Data has been collected by ACF's MHPSS Expert Silvia Rodríguez and Turkey's mission's Health and Nutrition Coordinator Kenda Al Nsour, supported by Marah Jerrah and Emra Ergen for translations. Key informant interviews and Focus groups discussions have been conducted thanks to close coordination with Berivan Argunaga and Neval Güzel from Support to Life as well as Deniz Aslan and Cagla Coskun from Solidarity, Respect and protect.

RESULTS

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ANALYSIS OF THE PSYCHO-SOCIAL ACTIONS PUT IN PLACE IN RESPONSE TO THE EMERGENCY

BASED ON THE FOCUS GROUP DISCUSSIONS WITH MHPSS TEAMS

To "Why was this modality of intervention prioritized and which were the most effective actions during the first response"

During the first weeks after the earthquake, the most effective responses were to analyze the regions where the programs would be implemented and to establish close coordination with both public actors (the Ministry of Family and Social Affairs in Turkey is coordinating the psychosocial response to the earthquake at the national level) and other organizations in the region.

When deciding on the modality of intervention (camp-based or mobile) some of the points leading to it were:

ASPECTS TO CONSIDER WHEN DECIDING THE MODALITY OF INTERVENTION.

MOBILE	CAMP BASED
Reaching more people, from more places	Connected to other camp services
Reaching more vulnerable and isolated people	A reference service for community members
Providing a faster response	Easy and fast set up

Table 3

Project leaders interviewed agreed on the fact that a **camp-based intervention can be very relevant in big camps areas, as there are** now some of over 20.000 people but reaching remote, rural and informal camps requires a mobile set up.

Also, most of the public and private organizations were covering the needs in formal camps while rural and informal settlements reminded unattended.

While the psychosocial support activities delivered by each project were very similar, differences between those modalities of intervention are significant.

PSYCHOSOCIAL MOBILE TEAMS

Teams' composition, roles and responsibilities:

- **MHPSS regional leader:** in charge of identifying the locations, being in close contact with the government to secure the intervention permissions in every area, as well as supervising and supporting the mobile teams work. They also coordinate the overall response in close contact with the other sector's coordinators.
- **Psychologist:** developing the psychoeducation sessions which cover information about the earthquake, grief, trauma and selfcare topics. They also lead the individual counselling sessions.
- **Social worker:** responsible for the protections assessments and referrals, identifying household and individual needs.
- **Psychosocial workers:** involved in youth and children activities.

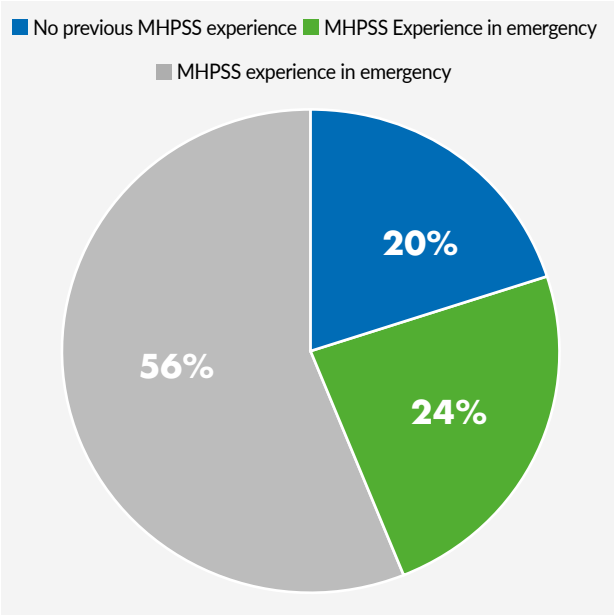


Figure 1. Expertise of MHPSS mobile teams.

Operational approach:

Locations are identified and permits secured for conducting the intervention. Activities are usually based in public buildings or well known areas for the community to facilitate their access.

Coordination with community leaders and Muhtars is key to activities acceptance and participation.

Activities are organized to last around 15 days in each location, but this approach may vary:

Some teams remain in the location for those 15 days, while in other cases they visit one location per day of the week, alternating locations but extending the intervention for more weeks.

Often, the schedule changed depending on the community needs and the commitment not to leave until they can support all those who may need it. Remaining flexible in this aspect is one of the key elements mentioned for an effective intervention. To this end, it is highly recommended to reach less locations but ensure that we can support all those who need it in each place we intervene, avoiding causing further harm.

The team is equipped with two caravans that can be used for counselling or children activities, but most are delivered in open air places which was one of the main difficulties reported by the team: finding appropriate places and dealing with quite extreme climate conditions.

To "Which are the main benefits and drawbacks of this type of intervention (set up, intervention and impact-wise)"

In all cases the intervention was perceived between quite and really effective to improve the psychosocial wellbeing and coping capacities of affected population.

More specific impressions from the implementing staff are captured in the following table:

BENEFITS	DRAWBACKS AND DIFFICULTIES
Covering more locations	Obtaining permits to intervene in each location.
Reaching places where no psychosocial support has ever arrived	Limited intervention time in each area, which makes it difficult to see the changes achieved.
	High exposure to field conditions: weather, noise, pollution...
Covering the needs of more vulnerable people, even those who work seasonally	Meeting the team demands when working in remote areas without food or WASH services available.
Easier outreach and acceptance of people	Difficulty in deeply understanding people needs.
	Dealing with people's expectations about the service continuation.

Table 4. Reported benefits and challenges of mobile interventions by the MHPSS teams.

CAMP BASED INTERVENTION

Team's roles and composition:

- **Psychologist/coordinator:** in charge of the weekly activity plan, supervision and support to the team and the coordination of the team, as well as of the individual counselling activities.
- **Psychologist:** responsible of the psychoeducation and individual counselling.
- **Social worker:** providing Psychological First Aid and identifying cases in need of internal or external referral.
- **Psychosocial workers:** cultural and group support based activities.

Operational approach:

During an initial phase (10th April to 24th May) the activity was developed in a camp based in Arsuz and managed by Bodrum's Municipality. The activities were then continued in a second location in Iskenderun managed by Kırkağaç municipality.

In close coordination with the camp management, activities are delivered in available tents and containers as well as in open areas.

To "Which are the main benefits and drawbacks of this type of intervention (set up, intervention and impact-wise)"

BENEFITS	DRAWBACKS AND DIFFICULTIES
Use of camp open areas for activities	Difficulties to manage attendance, some activities could be very crowded
Closer bonds with the psychosocial teams	
High acceptance and participation	High number of protection risks – Need of a specialized team member
Coordination with other camp services	

Table 5. Reported benefits and challenges of mobile interventions by the MHPSS camp-based teams.

INTERVENTION ANALYSIS

Considering the key differences in access to areas and groups of varying vulnerability, the timing of the intervention and the means to deliver it in each case, both interventions were based on the IASC pyramid of psychosocial interventions, providing primarily family and community-based supports, focused non-specialized supports and made referrals to specific psychological or protective services when necessary.

OUTREACH STRATEGIES

To "How did you learn about the MHPSS activities delivered in your community?"

Community members participating in both interventions reported to be reached through a **tent-by-tent approach,** that proved to be effective to engage them in other activities through individual talks and the provision of Psychological First Aid.

This type of outreach was considered particularly appropriate to **break down the barrier that the stigma surrounding mental health** and psychosocial wellbeing often creates. This makes it less likely that people will approach such a service of their own volition, but they are especially appreciative that they are approached for this purpose.

In the case of the mobile teams, **the activities organized by the STL team with the children** were also a strategy that generated great trust and acceptance of the intervention by the adult population, bringing them closer to the teams and facilitating the subsequent intervention.

During the focus group discussions and interviews, community members were also asked a) their main reasons for participating; b) accessibility and reasons why some people may not attend.

For most of the people interviewed, participation was motivated by:

- The opportunity to socialize again, to feel that they have someone to talk to about their problems.
- The need to o certain fears and negative thoughts.

While the accessibility of the organized activities was rated very positively, several reasons were mentioned why members of the community would not be participating as shown in the following chart:

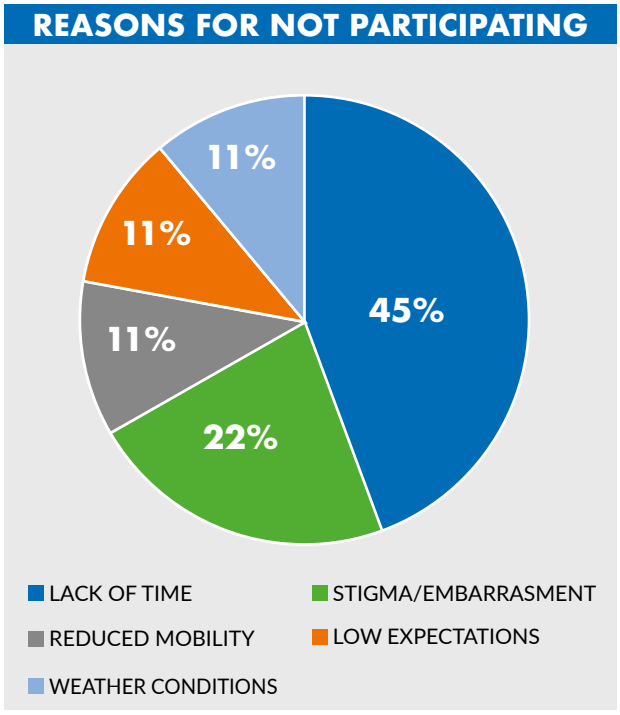


Figure 2. MHPSS participants' reported reasons for low or lack of participation.

At this point it is worth noting that the **low participation due to lack of time was mainly attributed to: men's professional lives and women's caregiving tasks.**

Regarding people with reduced mobility, either due to age or disability, it should be noted that they participated a lot in the field-based activities but in the mobile interventions did not always manage to find the most accessible sites.

ACTIVITIES' PARTICIPATION AND EFFECTIVENESS

To "What has been the effectiveness of each of the project activities with the different target groups"

A total of 23 MHPSS professionals participated in FGDs and were asked about the effectiveness of each of the interventions delivered for different target groups.

Also, the projects covered different activities depending on community's preferences and teams' expertise.

The **Table 4** shows the results of those Focus Group Discussions and yields some remarkable insights:

- **Very low participation of men in psychosocial activities.** As main causes the teams pointed out and gender roles and greater stigma around mental health, as men perceive they do not need this support as much as women. Also, many are returning to the work life, limiting their involvement and participation in community activities.
- **Psychological first aid as a very effective intervention with male participants**, especially older ones, who can open up more in a practical and individualized intervention. Overall, it is rated as a very effective outreach activity which increase the intervention's acceptance due to its personalized approach and potential to connect people to relevant resources.
- **Youth as a particularly vulnerable group in this context**, with very low participation in activities also caused in part by gender roles. Boys start working temporarily at a very early age (from 12 years old) and girls take care of younger siblings and assume household chores. They are also more introverted and less proactive to take part in group activities, but interven-

tions have proved to be effective when combined with one-one sessions with caregivers to prevent child labour and child marriages. Youth activities have emphasized on positive behavior, hope, friendship, awareness, nonviolent behavior...

- **Group activities (wellbeing plans) are especially effective with women**, who are more isolated but also more open to emotional expression and group support. Psychoeducation is valued as very effective, but they also demand more creative activities, where they can stop thinking and recover the feeling of usefulness.
- Both **psychosocial and protection assessments and referral to specialized psychological resources are perceived as fundamental**, especially in short-term projects where value can be added by ensuring that the needs of the most vulnerable people are met. The main protection issues identified are Gender Based Violence, violence against children and lack of access to social support, especially among people with disabilities. Specifically, psychosocial assessments are considered to be very effective when delivered within the individual counselling as an opportunity to speak about symptoms and feelings and to identify where to focus on the following counselling session.
- **Psychoeducation has been key to increasing awareness of certain reactions but also on people's rights to access protection services.** A structured curriculum has been provided by the mobile teams covering: basic information related to the earthquake, grief, trauma and self-care. Women value the opportunity to exchange concerns and support each other. Also, young girls find in it a safe space to ask questions they would not dare to ask in other spaces.
- **Individual counseling has been considered as very effective and much needed**. It involves 4 sessions per person to cover: relevant information on the earthquake experience, stress management, trauma and selfcare. If other topics are needed can be addressed as well.
- **Targeted interventions with children are very effective and highly demanded by parents**. As classes have been suspended and children are having more difficulties to adapt to the new situations, play activities to raise awareness and increase their coping mechanisms have been conducted in Adiyaman and Kahramanmaras.

INTERVENTION'S IMPACT

The main objective of these projects has been to improve the psychosocial well-being and coping capacity of the affected population.

The impact of the activities has been measured by the reach of these services, based on the number of people who have participated in the various activities.

MOBILE INTERVENTION REACH

ACTIVITY	PEOPLE REACHED
Psychoeducation and awareness raising sessions to caregivers	320
Youth Psychosocial activities	4834
Psychological First Aid	1138
Protection assessments	1335
Protection referrals	260
Individual psychosocial assessment	45
Psychosocial referrals to specialized services	25
Individual Psychological Counselling	253

Table 6. People reached by the MHPSS mobile activities.

CAMP BASED INTERVENTION REACH

ACTIVITY	PEOPLE REACHED
Cultural activities for the whole community	117
Psychoeducation and awareness raising sessions	199
Youth Psychosocial activities	53
Psychological First Aid	73
Psychosocial wellbeing monitoring plans	50
Individual psychosocial assessments	35
Sport activities	60
Group support sessions	128
Referrals to specialized services	36

To "What has been the effectiveness of each of the project activities with the different target groups"

The qualitative impact has been given by the feedback from the people receiving these services throughout the project and the observations and findings of the psychosocial professionals.

COMMUNITY	MHPSS TEAMS
Increased socialization	Increased knowledge and access to key services to meet their needs
Cohesion	Increased awareness about mental health protection and coping skills
Feelings of relief	Increased cohesion among community members and different groups
Discovery of new skills	

Table 6. *People reached by the MHPSS camp-based activities.*

ACCORDING TO THE MHPSS TEAM

1. Increased knowledge and access to key services to meet their needs.

This include specialized mental health and protection services, more information on where to go when they experience violence episodes or support to refugees in getting their registration.

2. Increased awareness about mental health protection and coping skills.

Teams reported individuals have gained knowledge on how to help themselves. They have normalized psychosocial symptoms and minimized misconceptions. They also feel more valued, have increased their self steem and there have been positive behaviour changes in children.

3. Increased cohesion among community members and different cultural groups.

Decrease in peer bullying, improved community members' support to each other, reduced discrimination and increased understanding and friendship among children of other cultures.

When asked about which of these impacts will be long-lasting, the greater capacity to access the services they need, and the strengthened coping skills were highlighted.

In contrast, community members who regularly attended the MHPSS activities remark specially the increased socialization and cohesion.

"My prejudice against people was broken, I learned that we share the same pain as people, my approach to people has changed."

There were also numerous allusions to the feeling of relief, to feeling more relaxed and to having discovered new abilities in them.

To "Which MHPSS needs have not been able to be covered by this intervention"

The MHPSS team reported among the key needs that the project has not been able to cover:

- **Referral to specialized services:** due to great difficulties to access them from rural areas and to the very long response times.
- **Access to services for refugee population.** The availability of MHPSS services in Arabic has also been a barrier during the project.
- **Youth psychosocial risks:** their low participation due to work and care duties, the need to have parental consent for under 18 years old and the importance of family based interventions for tackling these issues leave many aspects that need further intervention.

INTERVENTION			TARGET GROUP	PERCEIVED EFFECTIVENESS		
				ADIYAMAN	HATAY	MARAS
Collective		**Psychoeducation and awareness raising sessions** Sessions aimed at increasing awareness on psychosocial reactions toW crisis and how to deal with them. The aim is to provide relevant information on topics such as stress, anger, grief or trauma.	WOMEN	★★★★★	★★★★★	
			MAN	★★★☆☆	★★☆☆☆	★★☆☆☆
			YOUNG GIRLS	N/A	N/A	★★★★★
			YOUNG BOYS	N/A	N/A	★★★★☆
			CHILDREN	N/A	N/A	★★★☆☆
Collective		**Youth activities** Aimed at 14-18 year olds, focusing on life Skills development, psychoeducation and group support to build resilience.	YOUNG GIRLS	★★★☆☆	N/A	★★★★★
			YOUNG BOYS	★★☆☆☆	N/A	★★★☆☆
Individual		**Psychological First Aid** Help aimed at coping with intense distress, identify key needs and link them with the necessary services for meeting their basic needs.	WOMEN	★★★★★	★★★★★	★★★★☆
			MAN	★★★★★	★★★★★	★★★★☆
			YOUNG GIRLS	★★★★☆	N/A	★★★★★
			YOUNG BOYS	★★★☆☆	N/A	★★★★☆
			CHILDREN	★★★★★	N/A	★★★★★
Collective		**Wellbeing plans** Activities fostering healthier routines through physical activity, cohesion, art-based activities...	WOMEN	N/A	★★★★★	N/A
			MAN	N/A	N/A	N/A
			YOUNG GIRLS	N/A	★★★★★	N/A
			YOUNG BOYS	N/A	★★★★★	N/A
			CHILDREN	N/A	N/A	N/A
Individual & Collective		**Protection assessments and referrals** Individual and household assessments to identify and refer protection needs when appropriate.	WOMEN	★★★★★	N/A	★★★★☆
			MAN	★★★★★	N/A	★★★★☆
			YOUNG GIRLS	★★★★★	N/A	★★★★★
			YOUNG BOYS	★★★★★	N/A	★★★★☆
			CHILDREN	★★★★★	N/A	★★★★★
Individual		**Psychosocial assessments and referrals** Delivered individually to identify risk cases and to better target the intervention.	WOMEN	★★★★★	N/A	★★★★★
			MAN	★★★★★	N/A	★★★★★
Individual		**Individual counselling** Focused intervention to further address distressing psychosocial issues and develop better coping strategies.	WOMEN	★★★★★	N/A	★★★★★
			MAN	★★★☆☆	N/A	★★★★★
			YOUNG GIRLS	★★★☆☆	N/A	★★★★★
			YOUNG BOYS	★★☆☆☆	N/A	★★★★★
			CHILDREN	N/A	N/A	★★★★★

EVOLVING NEEDS

To "What do you think are the main and most urgent psychosocial issues to be addressed in the coming months?"

The present study aimed to analyze the **new psychosocial needs of the population six months after the earthquake.** While in the first few weeks it is essential to be able to contain emotional responses, report the most acute cases and raise awareness of the importance of protecting psychosocial well-being, the pass of time makes more lasting psychosocial impacts visible and reveals the groups that are having the most difficulty adjusting to the new situation.

When asked about **those in the community that need more psychosocial support** in this moment, both MHPSS workers and community members agreed about:

- **WOMEN**
- **TEENAGERS**
- **CHILDREN**
- **PEOPLE RESCUED FROM THE RUBBLE OR WITH DISABILITIES**

It is worth noticing that **people from the community prioritized children and teenagers,** as they believed adults have better coping skills and strategies and also considering that big part of their own suffering comes from not knowing how to better support them.

Also, **refugees are a prioritized group by MHPSS workers but were not mentioned by communities.**

Discussions with community members shed light into some of the affected people's current issues, which were mentioned to be:

- **OVERTHINKING, CONSTANT WORRY AND FEAR OF FUTURE EARTHQUAKES**
- **TIREDNESS**
- **ISOLATION**
- **ANXIETY AND STRESS**
- **DEEP SADNESS AND MELANCHOLY**

When asked about the kind of supports they would need in the coming future to overcome these, responses were very much aligned:

COMMUNITY	MHPSS TEAMS
Job opportunities for women	Job-related training Cash and livelihoods
Handicrafts and skills courses	Skills to support themselves
Education for children	Education
Psychologists	Long term psychological support for trauma case management, also for suicide and addiction
Religious practices: learn how to read the Quran	Legal support Increased health access

Table 8. *Perceived future MHPSS needs by community members and MHPSS teams.*

TOWARDS MHPSS INTEGRATION

Per the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, MHPSS is not a stand-alone area, but one that should be integrated into all sectors.

While stand-alone interventions may be a faster response to emergency relief, **it is critical to ensure that all first responders have the ability to identify and refer cases of psychosocial distress and to promote well-being through basic support skills,** covering a first step towards integration. However, as we move into a recovery process it is essential that psychosocial integration goes beyond this and becomes a key component of other sectorial responses.

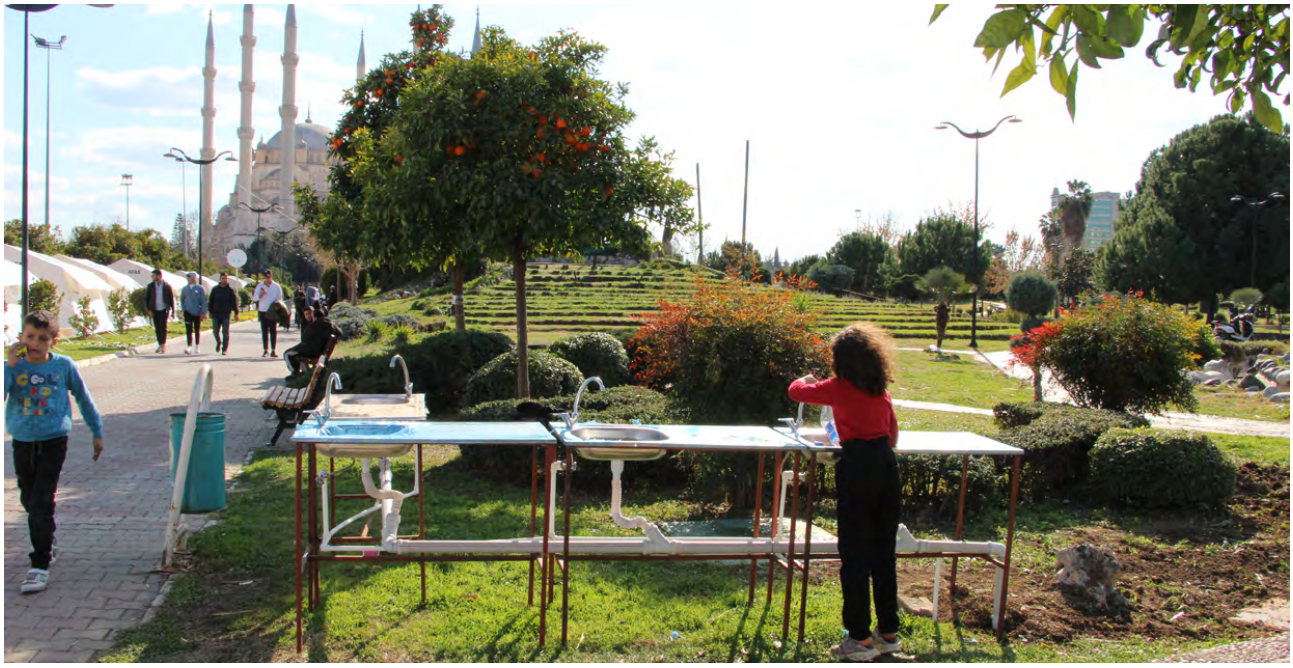
From including the mental health and psychosocial well-being of target communities in their needs assessments to providing MHPSS services a part of the programs, the MHPSS Minimum Service Package offers a set of guidelines and recommendations for integrated programing, across different sectors and areas of work.

Consistent with these recommendations and ACF's commitment to MHPSS mainstreaming towards more holistic programming, greater coverage of psychosocial services and strengthened results, this study has included professionals from other sectors in its activities to better understand the needs and opportunities for an integrated approach.

Specifically, a WASH committee in Adiyaman and SRP's Mother and Baby Friendly Space team in Hatay have participated in FGDs. Also, pregnant, lactating women, and mothers of children under two in both provinces have been consulted.

These two sectors (WASH and Nutrition) have been prioritized as the ones where ACF's action in Turkey is currently most active and is expected to remain so in the coming months. However, the need to integrate this approach in the FSL sector, especially in livelihood programs, is equally priority and recommended.

MHPSS INTEGRATION IN WASH



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These two sectors are linked in two broad areas: support for care practices through improved access to WASH at the household and community levels; and psychosocial aspects of WASH interventions, including aspects such as culturally sensitive design of interventions, protection and security of care giv-

ers, and channels for feedback from affected populations.[2]

Some of the links between them in emergency settings include:

- **Mourning and trauma may affect the course of infrastructure projects in the WASH sector.**
- The **standard of hygiene in emergency** settlements influences not only people's health, but also their psychosocial well-being. At the same time, it is often difficult for people suffering from the effects of trauma to devote adequate time and effort to personal hygiene and to the cleanliness of their environment. Their difficulty in practicing adequate hygiene behavior can also impact their sense of well-being.
- **Menstrual Health Management** usually involves high levels of stigma which MHPSS teams can reduce by facilitating appropriate responses. These responses can include activities such as focus-group discussions with men and with women and girls, supporting women's groups, and advising on behavior-change communications.

However, integrated programming and implementation in the sector is not the most common approach and different barriers may hinder the process.

The main activities that the WASH committee has been engaged in include:

1. **Identifying community needs,** mostly WASH related but as they are part of the community it makes it easy for people to approach them with other concerns.
2. **Fixing problems** with appliances: electricity, refrigerator…
3. **Setting up facilities** and ensuring the proper cleanness and maintenance of like a community sink.
4. **Hygiene promotion** activities with the communities.

To "Which would you say are the three main WASH practices affected by people in distress in your community?"

Handwashing and children's hygiene as well as household and community level toilet cleaning and maintenance were mentioned as the key practices which declined. This is in great part due to the lack of motivation to engage in self-care.

The team interviewed expressed some difficulty in identifying ways in which their work could further protect and promote people's well-being. Still, during the discussion they identified some MHPSS considerations to be included in their work:

- The committee members, as part of STL staff, have received **basic training in psychosocial support.**
- They coordinate with the STL MHPSS teams in order to conduct **assessments together,** thus ensuring better identification of people's needs.
- Also, since the committee members belong to the community, they have an opportunity to identify other kinds of needs and support structures which they **refer to as the needed services.** The WASH committee refers cases to the MHPSS team when needed.
- They were aware of numerous **conflicts coming from a lack of sensitivity** during the distributions of nonfood items (NFIs). For example, they distributed NFIs tent by tent, at the most suitable time for avoiding crowds.

However, and despite having received initial training, the committee members reported that it is not always easy to identify people in distress. **Regular MHPSS orientations could be helpful to this end.**

[2] 1 + 1 = 3 - How to integrate WASH and MHCP activities for better humanitarian projects. ACF International, 2013.

OPPORTUNITIES FOR FURTHER INTEGRATION

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Coordinated assessments and basic psychosocial training to the WASH teams has proved to be effective for securing the first level of the Mental Health and Psychosocial Support intervention pyramid: basic services and security.[3]

To take one step further, potential actions to be integrated towards psychosocial promotion and protection in this context include:

- **Recurrent training and guidance to WASH field workers on psychosocial support promotion.** Beyond the initial basic training, it is important to provide these committees with more specific support and guidance on how they can identify cases of greater psychosocial vulnerability and existing referral mechanisms outside the organization itself. Also, additional training can introduce key messages and specific actions aimed at reducing stigma and motivating more lasting changes in habits.

- **Strengthening WASH committees' capacities for leadership and conflict management.** Committee members are part of the community and usually highly motivated to identify and make visible their challenges. Different studies[4] highlight the difference effective leadership can make to WASH outcomes and for this reason, investing in strengthening their capacities to find and implement effective solutions can have a great impact. Legitimizing their power and strengthening their agency to mediate and resolve conflicts from a peaceful perspective is also an essential component of a peaceful and more resilient recovery.

- **Identifying those WASH activities where MHPSS can have the greatest impact in achieving the desired outcomes and prioritizing their integration.** In this project, clear opportunities for integration were observed in initiatives such as:

  - **The mobile laundry service:** this is mainly attended by women and the time they wait while the washing cycle is completed presents an excellent opportunity for psychoeducation, psychosocial assessments or protection actions.

  - **Hygiene promotion:** These activities, organized in groups, allow the integration of

[3] IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. 2008.
[4] Local leadership development and WASH system strengthening: insights from Cambodia. Tum Nhim; Claire Mcloughlin. 2022.

key messages about how hygiene practices and habits help us maintain psychosocial well-being. Coordinating teams to identify cultural barriers and designing actions in a way that promotes motivation for behavioral change can be very effective.

- **Menstrual Health promotion:** MHPSS teams can discuss with women and girls about their needs and priorities and reduce stigma associated with menstruation. Both sectors could work together on the design and siting of facilities for washing, drying and disposing of sanitary materials, while construction of these facilities could then be managed by WASH. This can also be a good opportunity to discuss safety when using WASH facilities and ensuring safety is considered in the design. Both sectors could work on sensitization, creating positive social norms and challenging myths on menstruation.

MHPSS INTEGRATION IN NUTRITION

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In particular, the activities of this assessment have focused on the integration of psychosocial support in a specific Nutrition program which aims to protect and promote infant and young child feeding in emergencies (IYCF-E), which includes support for exclusive breastfeeding practices during the first 6 months, when appropriate, and proper introduction and preparation of complementary feeding up to 2 years of age, especially in emergency contexts. This is achieved through establishing **Mother and Baby Friendly Spaces (MBFS)** which serve as a private, safe, accessible place for all mothers and caregivers to approach, breastfeed their children and engage in different awareness raising activities, practical assistance, counselling, and support. However, beyond promoting these feeding practices, the question of caring for their mothers and/or their caregivers should be a central point, especially considering the huge **impact of the mother's physical and psychological state on her child's health, development and nutritional status.**[5]

The integration of MHPSS actions into this program was assessed with a team of nurses and medical coordinators working in a MBFS. Also, MBFS participants and female community members were involved from different regions were involved, including pregnant, lactating women, mothers with under 3 years old children and other women from different age groups.

[5] Baby Friendly Spaces. Holistic Approach for Pregnant, Lactating Women and their very young children in Emergency. ACF-International 2014.

Through these actions we tried to assess:

- The main psychosocial problems of pregnant, lactating women and mothers in this context.
- The type of psychosocial activities that would be best received, both by the staff and by the women who come to the space, and that could be most effective in alleviating their psychosocial suffering.

MOTHER AND BABY FRIENDLY SPACE PROGRAM ANALYSIS

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The integration of this component requires a good understanding of the current acceptance of the program, the cultural beliefs and practices surrounding breastfeeding in the community as well as the main perceived psychosocial needs.

In the specific Mother and Baby Friendly Space assessed, the team reported very positive attitudes from the community since the space was first set up. It was received with curiosity and valued as a safe place for learning. These impressions were confirmed by the women participating in the space, who, when asked about the main reasons why they participate stated:

- *"There are many things they don't know, so we come for information."*
- *"It is a nice place to learn about child nutrition and to socialize."*
- *"To learn how to better breastfeed"?*

In this community, breastfeeding is valued very positively and is taught from mothers to daughters. This means that some misconceptions are carried over for generations, and that key breastfeeding practices receive little to no questioning outside the household.

MBFS activities include awareness raising sessions and workshops on different health and nutrition care topics and feeding practices and breastfeeding counselling.

To "What kind of psychosocial problems do pregnant and lactating women have in your community because of the current situation? "

To this question, women highlighted the following:

- Stress
- Horror, fear of inside/closed places
- Worry: About health issues, about children being more affected
- Grief

All women seemed aware of the impact that the current situation is having in their wellbeing and were very open and willing to engage in activities that could support them in this regard.

When asked about which activities they believed could be integrated in the MBFS to support them in this regard, the answers included:

- Psychological support
- Talking to someone and explaining their problems
- Sessions on how to support their children. They misbehave and they want to learn how to better support them.
- Learning activities focused on protection and sexual and reproductive health.
- Awareness raising and psychosocial support activities designated for the male members in their families (husbands).

On top of these, the acceptance of other activities were assessed and they all found very much needed the integration of **psychoeducation** group activities in other to better understand and manage their feelings and emotions, and **circle chats** with other women on specific topics to support each other.

The MBFS' team agreed these activities could suit very well the program's content and build on the already existing confidence they have developed with participant women. Although they considered that the integration of a psychologist for specific counselling would be ideal, they also agreed that psychosocial support actions could easily be integrated with:

- Training on MHPSS basics
- Reference materials
- Workshops implementation guidelines
- Support and follow up in the integration

OPPORTUNITIES FOR FURTHER INTEGRATION

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MBFS is an intervention that counts with great acceptance in the community and promotes a close, supportive and trusting relationship with the implementing staff. These together make caregivers more willing to share their situation, their present difficulties and their actual needs making this an ideal setting for MHPSS integration.

In this context, the key actions to maximize integrated programming include:

- **Integrate MHPSS considerations in nutritional assessments.** Understanding the main reasons behind women's psychosocial distress, their believes and perceptions around mental health and natural coping strategies is a cornerstone of an integrated approach.
- **Include a budget line in the project proposal that can cover a psychosocial worker in the MBFS team.** This position can be key to delivering more in-depth psychosocial assessments, delivering individual counselling, developing specific MHPSS materials and activities suitable for the group and conduct regular orientations to the rest of the team.
- **Train all Mother and Baby Friendly Spaces' staff** on identification of risk cases, referral mechanisms, psychological first aid and community and family support such as peer and group support. Prepare and share with them regularly key awareness raising messages, structured sessions for delivering psychoeducation on stress, problem solving, social support, nurturing care and psychostimulation. Ensure the training is not a one-time activity: the team will be able to deliver non-specialized supports as long as they are regularly oriented and supported.
- **Involve the MBFS's team in active clusters and technical working groups for health, protection and MHPSS.** Ideally each of the members can join the most suitable depending on their expertise and interest. This should foster mutual collaboration, potentially inviting experts from this sector to share specific information with women and making and building an effective mapping and referral system for women's and family services.
- **Integrate specific MHPSS activities in the weekly space's program.** Group discussions on shared stressors and effective coping strategies, relaxation techniques, awareness raising on the positive effects of breastfeeding in women's psychosocial wellbeing.
- **Involve men and other caregivers.** It is important to alleviate women's burdens which are a common trigger of their distress. Exploring with women the possibility to decrease the workload and facilitating awareness raising and discussions during home visits can make a big difference.

CONCLUSIONS AND WAYS FORWARD

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CONCLUSIONS ON MHPSS EMERGENCY RESPONSES

Both mobile and camp-based intervention have a very positive impact in promoting early recovery and preventing the development of mental disorders as a consequence of the emergency.

Camp-based interventions can be more accessible to people living in these settings and easily integrated with other educational, health and protection services available. This model has wider potential for involving different groups and can have very good results in generating community support and cohesion. However, interventions should avoid generating dependency on the MHPSS service which may happen when they are delivered for a long time without thoughtful planning. Activities should emphasize on generating or reactivating existing community supports and building on the individuals and families capacities to support each other (peer and group supports, parenting skills…) once the intervention finishes and provide individual and more specialized services only when psychosocial challenges persist over time.

On the other hand, **Psychosocial Mobile Teams** can also play a fundamental role in facilitating people's access to basic services when they are living in rural areas with difficult access. The coverage in terms of population will be bigger and it will also ensure reaching the most vulnerable, including those not reached by other agencies. However, interventions will be more time-limited, proper needs and impact assessments will be harder to conduct and activities should be more structured to ensure efficiency. They will also imply lots of logistics and administrative work to grant the proper transportation and secure the permissions to intervene in every location. In this regard, new, little experienced organizations or those without a strong coordination structure may find this intervention more difficult to set up.

Recommendations when deciding between both interventions include:

- Number of the population residing in the camps.
- Number of remote and rural areas with limited access to services.
- Existing community supports and/or conflicts.
- Budget, as mobile interventions will be more expensive.
- Organization's MHPSS experience and overall staff capacities.

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WAYS FORWARD

The current assessment has made it possible to learn from professionals and people directly affected by the earthquake about:

- the most effective psychosocial strategies and interventions in this context.
- the limitations of the programs in responding to certain groups or needs.
- the main current vulnerabilities, concerns and problems of the affected communities.
- the opportunities for future MHPSS interventions through integrated programming.

The insights gained on these aspects lead to a set of considerations that could improve future MHPSS interventions in similar contexts.

ENSURE INTERVENTION'S OUTREACH TO ALL POPULATION GROUPS: Stigma around mental health and gender roles prevent some segments of the population from benefiting from these actions. Men and youth seem to be especially prone to fall in the hard-to-reach groups. Assessments should focus on the main reasons that can hinder these groups' participation and interventions flexible enough to adapt and respond to them. Additionally, ensuring the provision of psychosocial support in the language of present minorities is a must and should be granted through the involvement of trained volunteers and collaboration with other organizations.

ENSURE CULTURAL CONSIDERATIONS AND RISKS ARE CONSIDERED IN THE DESIGN. Psychosocial experience and reactions are largely dependent on cultural factors. The impact of crises is also more intense in minority groups or in cultures that are less integrated in the context. It is essential that MHPSS interventions take this into account, favor cohesion and coexistence between different groups, ensure that psychological support is provided in a culturally and religiously adapted and appropriate manner and that the other sectors (WASH, FSL, Health and Nutrition...) also include these considerations that minimize the risks of discrimination and conflict.

PRIORITIZE THE SETUP OF EFFECTIVE REFERRAL SYSTEMS. Although this is one of the key steps to delivering quality psychosocial support, often interventions start without having a clear and/or comprehensive referral pathway. This is not limited to specialized psychological services but to other sector's programs that can ensure the coverage of basic needs. This should not be considered an exclusive task of the MHPSS professionals and should be stablished in coordination with other organizations in the field. Referral pathways should be mainstreamed and made an essential part of any training to field workers.

INCREASED PROTECTION. Emergencies make individuals more vulnerable to protection risks. Often, affected populations are not aware of their rights and fail to exercise them. The procedures for reporting cases of violence and neglect are not always clear and this may discourage the efforts to identify them. When building psychosocial teams, either for camp-based or mobile interventions, integrating a protection expert is highly recommended. This can support the team on cases identification foster the integration of Human Rights awareness in psychoeducation and counselling.

FOCUS ON STRENGTHENING COMMUNITY AND SELF-SUPPORTS. MHPSS assessments and interventions often focus on the needs and vulnerabilities overseeing communities' capacities to support each other. This can lead to approaches aimed at "healing", where individuals are only victims with no capacities to cope. In this sense, when psychosocial interventions' finish people may be left with a false sense of empowerment but completely unaware of the inner and external supports they have to overcome the current situation.

INTEGRATING MHPSS IN OTHER RESPONSES PROGRAMMING: As mentioned in the report, this is a great opportunity for reaching those that may be more reluctant to participate in psychosocial stand-alone programs. It has the potential to increase other sectors' reponses through an approach that considers and addresses the psychosocial factors that may impact on the results.

VIDEOS

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