

A network diagram of the Asian continent, where the landmass is formed by a complex web of white lines connecting various circular nodes. The nodes vary in size and are colored in shades of red and white. The background is a solid dark red color.

*Building
resilience
to disasters*

Report on the 3rd Regional Conference on
**Bridging the Gaps in Mental Health
and Psychosocial Support in
Emergencies in Asia**

Organized by Asian Disaster Preparedness Center
In collaboration with the Center for Crisis Psychology of Norway
and Thammasat University's School of Global Studies in Thailand
With support from the Royal Norwegian Ministry of Foreign Affairs

List of Acronyms

ADPC Asian Disaster Preparedness Center

CBDRR Community-based Disaster Risk Reduction

CCA Climate Change Adaptation

CFS Child Friendly Spaces

CRISP-VNU Center for Research, Information and Service in Psychology - Vietnam National University

CWC Council for the Welfare of Children

DMC Disaster Management Center

DRC Disaster Recovery Center

DRR Disaster Risk Reduction

DSWD Department of Social Welfare and Development

GOSL Government of Sri Lanka

IEC Information, Education & Communication

IFRC International Federation of Red Cross and Red Crescent Societies

MDRD Mainstreaming Disaster Risk Reduction

MDRD Mainstreaming DRR into Development Policy, Planning and Implementation

MHPSS Mental Health and Psychosocial Support

MOET Ministry of Education and Training

MOH Ministry of Health

MOLISA Ministry of Labor, Invalids and Social Affairs (Vietnam)

NDPRM National Disaster Preparedness and response mechanism

NRCS Natural Resources Conservation Service

OFDA/USAID - Office of U.S. Foreign Disaster Assistance/ United States Agency for International Development

PSS Psychosocial Support

PTSD Post-traumatic Stress Disorder

SDGs Sustainable Development Goals

SFDRR Sendai Framework for Disaster Risk Reduction

ToT Training of Trainers

UN United Nations

UNFPA United Nations Population Fund

UNICEF United Nations International Children's Emergency Fund

Part 1 | Background

Addressing or providing Mental Health and Psychosocial Support (MHPSS) has become a growing priority in responding to emergencies and disasters not only for the Asia-Pacific region but globally. As disasters continue to hit countries, there is a growing need and realization of addressing and improving the neglected cluster of psychological support to populations at risk.

Building capacities of humanitarian actors in managing public health during emergencies covers a wide spectrum. In 2011, ADPC launched the Mental Health and Psychosocial Support in Emergencies Training Program to strengthen community safety and resilience through the capacity development of health personnel at various levels. Funded by the Royal Norwegian Ministry of Foreign Affairs, the objective of the training is to better manage psychosocial impacts of emergencies and disasters to increase the survival rate of disaster victims. ADPC organized the pilot training with BRAC Bangladesh, with the aim of establishing a system for enhancing the capacity of communities in psychological first aid to be able to manage victims immediately post-disaster; to strengthen the knowledge and skills of health workers in managing vulnerable populations; and to enhance the capacity of mental health professionals to assess, evaluate and manage the need for psychosocial support during a disaster. In 2013, the same program was successfully implemented in Vietnam in collaboration with the Hanoi School of Public Health and the Center for Research, Information & Service in Psychology of the Vietnam National University.

A series of regional conferences focusing on mental health and psychosocial support in emergencies in Asia were organized by ADPC. The first conference in 2010 on Psychosocial Response to Disasters focused on children during disasters, then the conference in 2013 promoted psychological recovery and evolved this year in bridging the gaps in the provision of mental health support across Asia. The conferences aimed at promoting awareness on mental health and psychosocial support in emergencies and increasing the region's and individual countries' capacity to respond to the psychological needs of those affected by disasters.

The conference was organized by Asian Disaster Preparedness Center (ADPC) in coordination with the Center for Crisis Psychology in Norway and Thammasat University's School of Global Studies in Thailand, and made possible through the financial support of the Royal Norwegian Ministry of Foreign Affairs. The event was an opportunity for experts on mental health, representatives from UN agencies, government organizations, NGOs and INGOs, media and academic institutions in the region to come together. Representatives from Bangladesh, Cambodia, Indonesia, Myanmar, Nepal, Philippines, Sri Lanka, Thailand and Vietnam shared lessons learned and recommendations for building resilience through the provision of mental health and psychosocial support in emergencies in the Asia-Pacific region.

Objectives

Expected outcomes of the conference:

- Present the gaps and challenges experienced by stakeholders dealing with mental health and psychosocial support in emergencies in Asia.
 - Exchange lessons learned from different countries to foster and build regional resilience.
 - Raise awareness of the psychosocial impacts of emergencies and disasters to increase the survival rate of disaster victims.
 - Discuss the formation of a Regional Coordinating Body to take the lead in advancing MHPSS.
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Participants of the Third Regional Conference on Mental Health and Psychosocial Support

Part 2 | Proceedings of the 3rd regional conference on Bridging the Gaps in Mental Health and Psychosocial Support in Emergencies in Asia

Day 1 | December 8



Mr. Shane Wright, Executive Director, Asian Disaster Preparedness Center, Thailand
Welcome address

Mr. Shane Wright Executive Director of Asian Disaster Preparedness Center introduced the Third Regional Conference on Mental Health and Psychosocial Support, welcoming the participants, experts and representatives of partner organizations from various sectors and countries. Mr. Wright affirmed that MHPSS has gained prominence in post-disaster response and cited projects on disaster recovery, emphasizing the rationale of providing psychosocial support to affected communities. He accentuated the conference objectives of sharing best practices among partners and forming a regional coordinating body to take the lead in promoting MHPSS across the region.



Prof. Marc Van der Putten, Associate Dean for Academic Affairs,
School of Global Studies, Thammasat University, Thailand
Opening remarks

Prof. Marc Van der Putten, indicated that the participation of various sectors in the conference is a reminder of the importance of MHPSS in the management of public health emergencies. He reflected on the consequences of global socio-political tensions particularly climate change as main reasons for addressing mental health and psychosocial needs through practical, step-by-step, and coordinated means. He recalled the focus of previous regional conferences and how those topics brought about the present theme of bridging the gaps of MHPSS underscoring the importance of focusing attention to

social issues by adopting a community resilience perspective. He urged the conference participants to be prepared to be challenged, excited and inspired while learning during the conference. He also emphasized the need to form a regional coordinating body for awareness raising and advancement of MHPSS in the region and expressed Thammasat University's interest in joint exploration on how to address specific needs in research and capacity building together with the conference partners.



Ms. Unni Marie Heltne, Director, Center for Crisis Psychology, Norway

Words of encouragement

Ms. Unni Marie Heltne, elaborated on bridging the gaps on MHPSS focusing in the period post emergencies, drawing lessons learned from prior experiences and using them to build strategies on how to overcome consequences of trauma after disasters have hit and how to build resilience in a population. Ms. Heltne pointed out that to be truly encouraged, it is also important to look on the challenges. She explained the process that after accumulating knowledge on the impacts and consequences of trauma after disaster, came the insight on the design of strategies and methods that will help reduce the reactions to trauma. Ms. Heltne outlined three steps in building resilience:

- knowledge of common reactions to trauma;
- spreading knowledge on methods to be taught to the population;
- tracking the environment of the population.

These strategies can be made into standard procedures that can be disseminated and learned by both public and professionals to help affected populations. She emphasized the need to put these good helping strategies into a system to help people build capacity and resilience to trauma.



Dr. Panpimol Wipulakorn, Deputy Director General, Department of Mental Health, Ministry of Public Health, Thailand

Words of inspiration

Dr. Panpimol Wipulakorn, reminded the participants of the importance of preparedness when man-made or natural disaster strikes in order to minimize the effects. She further stated that disasters directly affect the mental health of a population at the onset. The inability to identify the affected population will cause more problems to both survivors and providers of relief and support. In the context of providing MHPSS, participants should:

- learn, share and inspire each other with their experiences and skills;
- coordinate and collaborate instead of competing;
- help and support each other;
- think of how to sustain the efforts; and
- work with the government at all levels.

Session 1 | Global and regional perspectives on mental health and psychosocial support



Mr. Dan Rono, Regional Child Protection Specialist, UNICEF, Thailand
UNICEF priorities 2016 and beyond

Mr. Dan Rono provided an overview of UNICEF's current PSS flagship initiatives, which are the set up of child friendly spaces for traumatized children. UNICEF's partnership with enabling governments in the region, facilitated these child friendly spaces which accommodated close to 3.1 million children since 2013 and aimed to support as many children as possible.

Mr. Rono, introduced materials and documents developed by UNICEF such as the IEC Mental Health Guidelines, UNICEF Core Commitments for Children in Humanitarian Action and Minimum Standards for Child Protection in Humanitarian Action, among others. For more tools and guidelines related to child protection, he encouraged the participants to visit the MHPSS.net website which is a global platform for connecting people, networks and organizations, for sharing resources and for building knowledge related to mental health and psychosocial support. The network also has a team of online hosts, the current host for this region is based in the Philippines.

The speaker further noted an increase in interest, engagement and collaboration especially among government actors in the region which would ultimately bolster efforts towards provision of sustainable MHPSS support; the prioritization of MHPSS program in humanitarian action has also led to better coordination and information sharing in emergency contexts. He pointed out the unfortunate gradual decrease of funding for child protection programs that has ripple effects on MHPSS programs. Despite the decrease in funding, he also informed the participants of the increasing number of complex emergencies that require long term responses.

On UNICEF's future direction, Mr. Rono mentioned new narratives on MHPSS and improvements that the organization aims to develop, one of which is moving away from child friendly space approach alone and looking at integrated community-based approaches. UNICEF is also investing on creating a global framework for monitoring and evaluation to develop evidence-based MHPSS. For these two key future initiatives, UNICEF is developing support packages at various levels which are child-focused, parent-focused, and community-focused.

Child-focused packages include Psychosocial First Aid, structured activities for children through school and community interventions, and peer-to-peer support.

Parent-focused packages include Psychosocial First Aid, parent support groups, and programs on positive parenting are planned.

Community-focused package include community messaging, strengthening community based structures, and psychosocial support through schools in collaboration with the education sector.



Dr. Atle Dyregrov, Head of International Issues, Center for Crisis and Psychology, Norway
Building community resilience after disaster: a realistic endeavor?

Dr. Atle Dyregrov shared a personal story of his experience in Rwanda of orphans taking care of their siblings to introduce the topic of human resilience. He provided a definition of resilience and mentioned aspects such as resilience on various levels, operational resilience and flexibility. He referred to a systematic review of intervention studies after disasters highlighting aspects of resilience such as strength of evidence, information on reactions after disaster, resilience strategies, unpredictability of disasters and the challenge of studying people's reactions after the disaster.

On building resilience, he suggested to reflect on the following questions:

- *Is it possible to foster protective family processes that mediate the impact of stress for its members following disasters?*
- *What barriers exist for developing community resources that buffer stress and facilitate resilience in the wake of disaster?*
- *How can transnational mental health responses be better coordinated to mitigate reactions over time?*

He further explained that shared mental models, common assumptions and expectations, and coordinated decision making strategies among various actors are important to ensure inter-agency cooperation that leads to improved resilience. He described the building stones, the influencing factors

and the barriers to resilience. He cited the lack of coordination among European countries in the current refugee crisis as an example of inadequate handling of mental health consequences. Lack of capacity and experience leads to social conflict instead of social connectedness.

He emphasized the need for psychosocial response capacity by addressing the population through media, reaching out to those with clinical needs, using adequate methods and establishing proactive response capacity. He pointed out the need to build community resilience through community leadership, caring neighborhoods, using community organizations, good public health care, and support from the society at large. Finally, he emphasized the need to improve knowledge on:

- individual, family and societal coping mechanisms;
- how psychosocial follow-up efforts can be tailored to the type of disaster and the affected population and
- how to move from basic to more effective interventions.



Session 1 | Q&A key points

- It is necessary to work more on educating the donors in order to address the funding challenges.
- Raise awareness on the effects of climate change on children; adopt climate change adaptation strategies for children affected by disasters may include child friendly responses.
- Factors that influence resilience vary from country to country. Cultural differences affect resilience. It is advisable to explore the role of faith-based organizations in providing MHPSS.

Panel 1 | Piloting of MHPSS in emergencies program in Asia

Lessons learned, scaling up and sustainability perspectives



Ms. Bithun Tasnuva Mazid, Senior Sector Specialist, Disaster Management and Climate Change Program, BRAC, Bangladesh
BRAC Experience on Psychosocial Counseling in Bangladesh

Ms. Bithun Tasnuva Mazid, introduced the work of BRAC among disadvantaged people. She provided an overview of BRAC's Disaster Management and Climate Change Program (DMCC) and its journey with psychosocial counseling. Her presentation elaborated on the pilot activities on psychosocial counseling conducted by BRAC applying the knowledge and skills developed from the ADPC training.

Trainees from BRAC, BRAC University and professionals from Sajeda Foundation initiated the pilot program by modifying the content of the ADPC training and producing the Bangla modules. Training of Trainers (ToT) was conducted for 36 head office and field office staff of BRAC. After the ToT program, the following activities were conducted:

- 1) Sensitizing women on self-help psychosocial counseling at community level through women groups for climate resilience capacity building.
- 2) Immediate support on the spot and in hospitals provided by trainees to over 400 survivors and family members of the deceased of the Rana Plaza tragedy.
- 3) Individual and group counseling provided to survivors and family members of the deceased of Rana Plaza tragedy during post-rehabilitation.

The following videos of the pilot program activities were shown:

- [Preparing for the Worst](#) Psychosocial counseling for women groups at community level.
- [Shiuly's Story](#) BRAC's intervention during the Rana Plaza tragedy.

Achievements of the pilot program activities:

- Psychosocial counseling training at community level proven to help women cope better during floods in Cox's Bazar in 2014 and 2015.
- Rana Plaza tragedy survivors:
 - began to understand and address PTSD.
 - were sensitized about anger management.
 - learned to cope with social pressure and support one another.
 - had better family affiliations.
 - showed ability to focus on work and livelihood activities.

Challenges and limitations faced during the implementation of the pilot program activities:

- Lack of experienced psychosocial aid workers
- Lack of awareness among the survivors
- Psychosocial counseling is a new concept which is difficult to introduce to the target group
- Negative social perspective on psychological issues
- Fear of entering buildings for counseling sessions
- Injury made travelling difficult, Amputees need more attention
- Arranging individual/group counseling for survivors scattered around the country
- Inadequate individual, family, and community sessions provided to survivors
- Timing of counseling sessions. Additional time required for survivors to open up
- Survivors could not concentrate on skill development trainings and livelihood activities prior to counseling interventions
- Families of survivors and the deceased required more assistance

Recommended follow-up interventions for the Rana Plaza tragedy survivors:

- Counseling of 450 survivors to be followed by livelihood support with at least six individual counseling sessions during 2015-2017.
- Research data collection on trauma conditions to be conducted during pre/post counseling periods.
- Counseling to be provided before any skill development training or livelihood interventions.
- Bring counseling closer to home.
- Family and community counseling to be considered to ensure integrated trauma management.



Asst. Prof. Dang Hoang Minh, Director, Center for Research, Information & Service in Psychology, Vietnam National University (CRISP-VNU), Vietnam
Gaps in MHPSS in Emergencies in Vietnam

Prof. Dang Hoang Minh, outlined the MHPSS initiatives in Vietnam, the main achievements and challenges, and the strategies for the sustainability of the initiatives. Among the early MHPSS initiatives were training programs on psychosocial support to children and teaching recovery techniques participated by non-mental health professionals; on tools and advanced psychosocial assistance attended by mental health professionals; and a Training of Trainers program. In addition to these interventions was [ADPC's iPrepare website](#).

These initiatives were conducted through the collaboration of ADPC, VNU, HSPH, and the Embassy of Norway. There were also other psychosocial support trainings conducted by UNICEF and MOLISA; and basic training and integrated psychological support in different programs under Vietnam Red Cross. The partnership of Vietnam MOH, VietHealth, and the Embassy of Norway also developed guidelines on assessment of mental health problems in disasters and on basic psychosocial support techniques for victims, both for grassroots medical staff.

The main achievements from the initiatives include:

1. raised awareness about MHPSS in emergencies among medical staff, teachers, women union staff, and other actors;
2. training programs in various agencies and
3. introducing MOH guidelines and training for provincial medical staff.

One of the main challenges faced in relation to MHPSS efforts in Vietnam is the fact that it is a very new concept for the country and the belief that MHPSS is a luxury. Inadequate financial and policy supports for rollout of training and lack of providers in provinces are also among the problems. The country is struggling with lack of policies for coordination of different sectors and organizations to facilitate the

provision of services. The government is more focused on the aftermath response phase, rather than prevention and preparedness, and on primary victims, on rescue and physical needs such as food and relief.

The tripartite (MOET, MOH, MOLISA) action plan, and protocol/guidelines for allowing experts to access affected areas during the period post disaster is recommended as an appropriate government policy which needs to be developed. MHPSS must be integrated in formal curriculum for teachers, general practitioners, psychologists, and social worker training.

Panel 1 | Q&A key points

- Facilitating access to health care is an important dimension to consider for rural communities.
- Counseling work should take place before livelihood training.
- A project should not be driven by direct beneficiaries only. Interplay of other actors, stakeholders, and sectors is necessary for sustainability of pilot project. The continuum cycle of helping intervention requires scaling up to a national level implementation.
- To enhance capacity and scale up from grassroots/community to national level, a wider network for collaboration is being developed, including training of university clinical psychologist, ToT of university staff, and working with the government. Because of this network, other organizations started working on psychosocial support issues through the BRAC initiative.
- One of the key success factors in scaling up a project is the selection of an appropriate partner organization in the country.
- Addressing the limitations of storm shelters from cyclones in Bangladesh that traumatized children, the village was rebuilt with disaster resilience houses called psycho-shelters with the support of the Ministry of Health's policy on mental and psychosocial health.
- To overcome barriers to program implementation, it is important to make government leadership understand the required processes. Political support and political signals are important for formulating integrated psychosocial support plans.
- Prioritizing government cooperation should be encouraged, although it is a complex process in some countries due to the government organizational structure. Through discussion with concerned agencies such as the Ministry of Health. Consultative meetings with government with other stakeholders such as the Embassy of Norway is important in ensuring buy-in. ADPC's role as catalyst is important to bring in various stakeholders in the discussion table.
- Exit strategy by working with the Ministry of Education and Training (MOET) for support in the rollout of training for in-service teachers. This can be integrated in the education reform, also suggesting including MHPSS in school counseling.
- Extending discussion on MHPSS in emergencies among students is necessary.
- Teaching skills together with therapy is important.
- 'Caring for the Caregivers Training' is effective so that teachers are able to help students.
- Psychosocial support should be integrated in disaster training programs.
- Increase in national capacity on MHPSS, increasing number of trainers; address the challenge in coordination among sectors/agencies.

Panel 2 | Country presentations



Ms. Patrizia Giffoni, Regional Psychosocial Support Delegate for Asia,
Danish Red Cross, IFRC Cambodia

Psychosocial support programming – resilience in disaster management in Nepal

Ms. Patrizia Giffoni, used the earthquake in Nepal in 2015 as a metaphor for more reflection on psychosocial programming and resilience. She introduced the International Strategy of the Danish Red Cross 2015-2020 by mentioning the organization's strategic ambitions and global goals. She highlighted the organization's shift for psychosocial wellbeing to become part of the protection of human rights and social cohesion. She clarified that the Danish Red Cross focuses on psychosocial support and not mental health.

She referred to a recent conference entitled '*Resilience for Real*' that emphasized on resilience not as a program or a sector but a way of thinking and working that needs to be integrated in what we do. She underlined the importance of using focused approaches to produce concrete results. She highlighted the need for immediate response when disaster strikes, recovery and risk reduction, and strengthening resilience before and after disaster happens by continuously addressing the radical drop of resilience.

Shifting from the IFRC to the national level Nepal Red Cross, she elaborated on the DRC intervention before the Nepal earthquake. She described the emergency preparedness program which included basic to more specialized trainings for volunteers, who are the core part of the program and the strength of the organization. Since retention of volunteers is challenging for the organization, these trainings are used to reinforce their capacity and to offer them opportunities. At the same time, these programs are used to address humanitarian needs at all levels that require response from the organization. The volunteers are provided three levels of training starting with the basics after which the volunteers select the more specialized trainings.

After the volunteers completed the basic training, which also includes PSS, the earthquake happened in Nepal. The NRCS-DRC PSS intervention was conducted at the emergency response phase. During this stage, a specialist was hired to do the assessments and a PSS program was done, mainly on stress and coping, volunteers training and care for volunteers. Activities for the recovery phase will start soon with the children resilience program.

In terms of challenges, Ms. Giffoni mentioned that the initial assessment often focused on PTSD symptoms and few focused on individual/community resilience and resources. This was partly due to the lack of tools for specific types of assessments. This led to another challenge in terms of gaps between assessments and interventions (research and practice). Since the scope of assessments was too narrow, there were also limitations in terms of applying specific interventions to address the problem.

Difficulties were found in the monitoring and evaluation system which was often improvised, with indicators and tools which were not field-tested and standardized leading to inconsistencies and some confusion. Eurocentric interpretations of grieving processes, PTSD, cultural differences in the way of suffering and child care also posed challenges. A participant from the conference noted the lack of cultural sensitivity in these interventions, often without consideration of community resources in the country. The participatory approaches focusing on empowerment were often inconsistent. Other challenges include the lack of coordination, the malfunctioning of the referral system, often due to lack of services, and the sustainability of service provision.

The discussions on the perspectives and reflections on future possibilities within the organization recommended that PSS assessments should include individual and community resilience indicators/tools. There should be substantial investment on increasing emergency preparedness and response capacity. Three days of training is not enough and sustaining, refreshing and following-up should be followed through. Other recommendations include:

- increasing coordination efforts,
- integrating PSS into other programs to develop empathetic/listening attitude,
- include young men in PSS programming,
- use of participatory methodologies, and
- expanding the activities to work more at the community level.



Mr. Ko Ko Tin, Director General, Department of Human Resource and Education Planning, Ministry of Education, Myanmar

MHPSS experienced during cyclones and other disasters in Myanmar

Mr. Ko Ko Tin provided an overview of the various MHPSS interventions and initiatives, lessons learned and challenges for building resilience on MHPSS as experienced during the cyclones and other disasters in Myanmar. These interventions were conducted by the Ministry of Health, Ministry of Social Welfare and Ministry of Education in collaboration with other agencies, NGOs and development partner organizations during and after the Nargis disaster and earthquake that caused flooding and landslides in affected areas.

One very important initiative was the development of legislation on disaster management for effective response in emergencies and effective system management after the Nargis disaster. MHPSS interventions and initiatives conducted right after the cyclone in Nargis-hit areas, collected data for assessment of psychological health, conducted MHPSS-related training activities for medical officers and government officials, and developed manuals on psychological care in Burmese for medical officers, provincial health workers and community level workers, safety learning kits and material packages were provided to children after the disasters.

Relief and resettlement activities were also conducted in collaboration with development partners as well as dispatching mobile teams for psychosocial care in affected areas. A national natural disaster management center was formed with eleven sub-committees and emergency operation centers. Support was also provided for the creation of child-friendly spaces with entertainment activities. Mr. Tin identified key challenges:

- insufficient capacity of MHPSS team as well as insufficient number of teams sent to field areas affected by disasters;
- weak coordination and cooperation among all stakeholders involved in MHPSS; and more importantly,
- insufficient budget for emergencies.

In terms of lessons learned from post-Nargis joint assessment, Mr. Tin informed that from the survey of respondents with psychological problems, only 11% had received treatment. It is therefore essential that MHPSS be done during the recovery period. It was also observed that after Nargis, Myanmar improved its national capacity and resilience on MHPSS in the succeeding disasters unraveling in 2015.



Panel 2 | Q&A key points

- The training conducted before the earthquake in Nepal was only at the basic level. Three-day training duration is a minimum. Effectiveness in the application of learning and skills gained when the earthquake struck was limited. The trained volunteers were not ready for other aspects on the ground.
- On the retention of volunteers, career development on different areas and specialized trainings are good strategies to adopt.
- In Myanmar, DRR is included in the primary and secondary level curriculum. Parents are involved to support DRR education quality and emotionally help children to learn at home.



Mr. Atiq Kainan Ahmed, Program Specialist, Asian Disaster Preparedness Center
The Sendai Framework for Disaster Risk Reduction and linkages to MHPSS initiatives

Mr. Atiq Kainan Ahmed, outlined the focus of his presentation as follows: a) Process of Post-2015 DRR framework; b) Synoptic look into the outcome document of SFDRR 2015-2030 (contents, targets, languages); and c) Making the linkages to MHPSS and uptake.

On the first part of the presentation, Mr. Ahmed provided an overview of the type of disasters around the world, the economic impacts, number of displaced people by disasters, and the risk of losing home to disasters. He pointed out that mental health and psychosocial impacts are often unclear and supports remain inadequate.

As a background to the creation of SFDRR, the post-2015 era was mentioned in which new set of policies are to be developed. This is the era when the various global frameworks namely, the Kyoto protocol (climate change), MDG (development), 2015 agenda (Rio+20), and the Hyogo Framework for Action (HFA) are ended. With the world's exposure to extreme, mega disasters, the Sendai Framework on DRR was agreed upon in March 2015 followed by rigorous negotiation process leading to the world's agreement on the SFDRR.

Furthermore, the main SFDRR outputs namely, the Four Priorities for Action and the Seven Global Targets were discussed.

The Four Priorities for Action

- 1) Understanding disaster risk;
- 2) Strengthening disaster risk governance to manage disaster risk;
- 3) Investing in disaster risk reduction for resilience; and
- 4) Enhancing disaster preparedness for effective response and to "Build Back Better" in recovery, rehabilitation and reconstruction.

The Seven Global Targets

- 1) Substantially reduce global disaster mortality;
- 2) Substantially reduce the number of affected people globally;
- 3) Reduce direct disaster economic loss;
- 4) Substantially reduce disaster damage;
- 5) Substantially increase the number of countries with national and local disaster risk reduction strategies;
- 6) Substantially enhance international cooperation to developing countries; and
- 7) Substantially increase the availability of and access to multi-hazard early warning systems and disaster risk information and assessments to people.

Mr. Ahmed pointed out some of the new language and terminology in the SFDRR for Disaster Risk Management, highlighting the multiple types of stakeholders, the focus on types of countries, and debated dichotomies such as technology transfer vs development.

Positive areas of the SFDRR are the strong political interest and commitment, link with economic development, enhancement of cooperation and technology transfer in various levels, inclusion criteria and strategies, protection issues and early warning systems.

Some recommendations for the uptake of SFDRR include: strategic roll-out and planning (consultative); discussion on new areas; extending collaborations; facilitating technology transfer; research and development; carrying out innovative campaigns; liaising with donors; and many more. He also mentioned WHO's positive take on SFDRR focusing on health. He strongly urged the participants to read the SFDRR document thoroughly and find synergies for application into their work. Finally, he encouraged the participants to push forward the application of SFDRR in the global arena.



Ms. Unni Marie Heltne, Director, Center for Crisis Psychology, Norway

Lessons learned from implementing low threshold psychosocial aid after war and disasters

The presentation covered a brief overview of the Center for Crisis Psychology activities, results found and lessons learned in the training and implementation work. The Center for Crisis Psychology is a non-governmental organization having a small department conducting research. Its four main activities include clinical work with crisis and disaster situations both local and international, educational training

such as lecturing to health professionals and aid workers, conducting research on various aspects of stress, trauma, and bereavement, and emergency preparedness agreements with companies and organizations.

The Center is involved in teaching recovery techniques developed after discussion with colleagues from King's College in London. The group came together and shared their frustration over a variety of interventions without any kind of evidence and evaluation and with some concerned of doing harm. The Norwegian and British experts developed a manual targeting on teaching children survival or recovery techniques after being traumatized.

These manuals are developed to help professionals to work with children in groups. Along with the manuals, appropriate measures are included standardized for several countries to identify children stress level and to evaluate the effect of the group approach. The goal of the training of trainers (ToT) is to provide trainees the knowledge and skills so they can run children groups, train their colleagues, and to evaluate the effectiveness of the groups by using the manuals. When asked to come to work in another country, the Center collaborates either with an NGO as in the case of BRAC in Bangladesh or with a government agency in the case of Vietnam. The Center builds capacity of local trainers who can immediately apply their learning with groups of children, train others and evaluate the effect of the intervention.

Ms. Heltne described the intervention's five sessions targeting the main problems experienced by both children and adults after being traumatized. According to research findings, the symptoms are similar in many countries and cultures. The target of the intervention is to get rid of flashbacks of a horrific experience, which can last for a lifetime according to research studies, if not dealt with. The last two sessions of the approach deal with helping children take back activities, areas and things that they avoid.

The approach is developed for places where the amount of professionals is very low or non-existent. The manuals are simplified so that the method can be taught to both professionals and aid workers on the ground – even to teachers, nurses, engineers, economists, computer programmers, etc. This intervention has been evaluated in places in the Middle East and seems to have been successful in reducing trauma, conflict and depression among children, as well as improved concentration and achievements in school. Overall, it is a promising approach according to results of research studies.

Summing up the lessons learned, Ms. Heltne concluded that professionals ranging from very different backgrounds could offer psychosocial help to traumatized children. The basis of success of the intervention is following the proposed manuals and that training has to be built on evidence-based knowledge as much as possible. When implementing a new method, it is necessary to start creating evidence for it. The training should be clear on what problems are targeted and what outcomes to expect, preferably using measurements for effect. To avoid confusion among training participants, there should be clarity on what intervention to be used for a problem and what intervention comes first, to avoid mixing up the interventions. Focus must be kept simple and practical for children, not using too much theoretical concepts.

Ms. Heltne recommended that the intervention should be based either in large NGOs with resources to carry out the implementation, or in a respective government agency. Based on her experience, participants need to have access to good supervisors or should form networks who can give peer-to-peer support.



Mr. Anothai Udomsilp, Director of Academic Institute of Public Media, Thai PBS
Responsible journalism during emergencies and disasters

The presentation covered the different types of media, roles and responsibilities, functions and impacts of media during emergencies and disasters. Mr. Anothai Udomsilp provided an analysis on the various types of media such as conventional and traditional media, new/now media, citizen and digital media (user-generated content). He enumerated the functions of media to educate, inform and entertain and its roles serving as a watchdog, a gatekeeper by selecting and screening, a mirror by constructing illusory perceptions, and as a window with a selected frame of perspectives.

Are media using power responsibly?

He elaborated on the relationship of responsibility to impacts, such as violence that may cause or solve problems. Mr. Udomsilp discussed the responsibility of media during disasters, pointing out the need for news report with news value: being recent, having cultural proximity, the element of surprise, concerning elite nations, degree, size and number, scandal, drama, tragedy, crime, and terrorism in order to create and retain interest and attention. He also mentioned the tendency of media to focus on negativity that normally creates news.

Regarding the work of the media during natural disasters, he gave an example on how the Thai media operated during the 2011 flood situation that affected thousands of people. The public could have been informed better on what went wrong and what information was missing. During the flood crisis, information from the media came in patterns of news reports on updates, impacts, content analysis, comments and critics. Media responses to the floods created anxiety, panic and fear.

Linking to the Sendai framework, the speaker suggested that the responsibility of the media is to increase awareness and make complex issues comprehensible to the communities. Media reports caused panic due to the lack of experience, knowledge and understanding of the issue. The lack of comprehensive information, competition for rating, speed, and immediacy or dramatization, rather than accuracy amplifies stress. To avoid negative effects, the media must understand the situation before

reporting about it. What should be emphasized in reporting during disasters are more technical, scientific research, and more analysis on prevention and safety, encouraging people to become 'citizen scientists': citizens with critical thinking skills.



Session 2 | Q&A key points

- The Sendai framework is not a legally binding document. We have to share knowledge and have technical collaboration to understand the incentives and achieve realization as well as to protect affected population.
- Local people may adapt local interventions and techniques if they serve similar aims. However, some local interventions may be harmful. It is necessary to be careful and to evaluate local techniques whether they are evidence-based.
- Training on how to work with the media should also be conducted. In reporting news, media is regarded as an enemy, instead of a friend. This is due to lack of understanding on how to talk with the media, to make them interested in our work. It is also important to improve systematically our interaction with the media, especially for the purpose of making them understand and use technical language.
- It is difficult to find experts with technical knowledge works as journalists. It is important to provide training to increase understanding of technical content. Technical experts should know how to work with media to avoid different ways of talking which is confusing.
- An example of irresponsible journalism is the terrorist in Paris in 2015 that increased anxiety level.
- Co-regulation and self-regulation will improve media responsibility.
- One positive role of the media in Bangladesh was decreasing the loss of lives during disasters.

Presentation and judging of Mental Health and Psychosocial Support poster exhibits



All of the countries presented unity in MHPSS ideas, initiatives and interventions amidst diversity of disasters experienced by individual countries.

Prizes for representative countries:

- Indonesia for being the most systematic.
- Philippines for being the most integrated.
- Bangladesh for being the most relative.
- Myanmar for being the most unique.
- Vietnam for being the most creative.
- Sri Lanka for being the most dynamic.

Panel 3 | Country presentations

Day 2 | December 9



Dr. Fidelita D. Dico, Medical Officer IV - Health Emergency Management, Regional Coordinator, Department of Health, Philippines

MHPSS: The Typhoon Haiyan experience – moving forward

Dr. Fidelita D. Dico, presented an overview of the super typhoon Haiyan which occurred in 2013 in region 8 Tacloban and its physical and psychosocial impacts on the affected areas and population in the Philippines. She covered the significant MHPSS initiatives, issues and challenges, lessons learned.

The typhoon Haiyan brought disaster on its path affecting many areas in the Philippines. Along with the massive destruction was the complex mental and psychosocial crisis leading to a challenging MHPSS task. International response teams and national MHPSS teams provided various mental and psychosocial services to affected population such as psychosocial first aid, community and family support, counseling, psycho-education session, psychosocial processing, defusing, stress management program, referral of cases, and other mental health services.

MHPSS activities were integrated in the Haiyan recovery in evidence-based DRRM for a resilient health system. Culture and arts activities were organized by the MHPSS teams of the Department of Health in partnership with other government agencies, and national and local theater groups. The activities included art therapy, games, psychosocial processing, 'letting go' ritual for children, and care for the care-givers. The theater arts presentations provided psychosocial relief for both performers and audience and stage plays brought back laughter to the children as well as imparted a message to work for a resilient community.

Issues and challenges:

- a) Failure to account all local, national and international responders due to poor coordination.
- b) Different methods used by different responders to the same community did more harm than good. Recipient of services complained of crying each time a new team visits them.

- c) Failure to follow-up and formulate closure. Limited time was allotted by authorities to team responders and failure to properly endorse to the next responding team.
- d) No established referral system for MHPSS. The basic MHPSS providers were unsure where to refer and few experts on higher forms of MHPSS (e.g. counseling, psychiatry) were available.
- e) No clear protocols or practices on the 'care of carers'. The MHPSS providers also needed "unloading".
- f) Feedback mechanism was not established. Many MHPSS documents, data, reports, and studies were not shared to the local authorities.

Main lessons learned from the MHPSS initiatives during the Haiyan experience are:

- People responded well to the blend of the local culture and religious/spiritual aspects in the psychosocial processing.
- The MHPSS process is a successful strategy in disaster risk reduction management as a way of teaching the community to be more resourceful and responsive, thus, becoming resilient in the face of climate change and disaster.

For the way forward, Dr. Fidelita recommended to have MHPSS policies and protocols on:

1. Structures to link international and national levels to the local level for coordination.
2. Capacity building of local teams.
3. Sustainability of MHPSS integration in the DRRM system.
4. MHPSS strategies in the phases of disaster: preparedness, response, recovery, mitigation, to include:
 - Coordination
 - Protocols on deployment and decampment of teams
 - Guidelines on team service based on expertise (per level of MHPSS care)
 - Guidelines on response based on socio-cultural consideration
 - Provisions for care of the care-givers



Ms. Chollada Jarusirichaikul, Public Health Technical Officer,
Bureau of Mental Health Service Administration, Department of Mental Health, Thailand
MHPSS during the 2011 floods in Thailand

Ms. Chollada Jarusirichaikul focused her presentation on the psychosocial service provided to people in flood shelters during the 2011 flood crisis in Thailand. The impacts of the flooding were severe, the flood shelters and the psychosocial service provided were described along with key success factors and lessons learned from the initiatives.

The factors that contributed to the 2011 flood crisis in Thailand ranged from natural to manmade. There was an estimated impact on 13 million lives in 65 provinces. The total damages and losses reached 1.43 trillion Thai baht (USD 46.5 billion) and 652 death tolls from the flood. There were six large evacuation shelters of 10,000 people and more than fifty small shelters of 5,000 people around Bangkok. Shelters were set up for flood disaster victims from different organisations such as universities, schools, and temples. Due to different organisation and shelter management, the mental health service systems were varied.

The psychosocial services provided in the shelters include pre-service activities, provision of mental health interventions, and closure. The pre-service activities include registration (one stop service and need assessment) and training of helpers on basic communication, basic screening and understanding of the mental health risk and referral channel. The provision of mental health intervention followed a process from screening and assessment to the application of interventions such as counseling, consultation and referral to psychiatric nurse for provision of continuous care. The closure phase included provision of clear-cut communication, referral of data, and prioritization on the illness and the risks.

The key success factors of the MHPSS initiatives were:

1. The preparation of available human resources, registration process, rules and regulations on the basis of psychosocial health,
2. Self-empowerment and group empowerment activities in the process of returning home.

In summing up the presentation, Ms. Chollada Jarusirichaikul concluded that the agreement among MHPSS team members on the importance of mental health integrated in disaster management was a key lesson learned. She also stated that a good evacuation shelter is a closed system with effective monitoring of the affected people.

Panel 3 | Q&A key points

- For follow-up activities, those people who received psychosocial interventions in Thailand were to be referred to public health officials in their areas for 2 years, regarding progress and recovery.
- During the flood disaster in Thailand, affected population were provided with both general medical services and mental health services. Seventeen teams from different mental health hospitals/ institutes were mobilized.

Session 3 | MHPSS resilience following disasters



Prof. Richard Bryant, Scientia Professor & NHMRC Senior Principal Research Fellow, School of Psychology, University of New South Wales, Australia

Advances in resilience and how to implement them after disasters

Prof. Richard Bryant, introduced his presentation with the following key points:

1. We don't really *know* what is the best way to boost resilience after disasters.
2. We must be doing research to develop better methods we can disseminate.
3. We must be doing this in a way that can be scalable in *all* countries.

The vast majority of aid is provided in the initial year after a disaster. This neglects the evidence about the long-term effects of disasters on individuals and communities. To elaborate on this, he referred to research studies in Australia on the long-term effects of PTSD and implied the need for programs that can assist people at any time after disaster and that immediate reactions are insufficient.

In terms of what is happening globally to build resilience in disasters there is an increasing recognition that most countries lack the resources to provide the needed psychosocial services. Because of this, he pointed out the need for realistic programs. He cited research findings suggesting that although there's good evidence on the usefulness of high-intensity interventions in LMICs, the use of these methods in those countries are limited because of the following reasons:

- Lengthy duration (10+ sessions)
- Reliance on complex and intensive strategies
- Typically provided by specialist practitioners
- Requires considerable (and costly) training
- Not affordable in most of the world
- These are rarely implemented in LMICs

He indicated that there is a need for low intensity interventions, which must be scalable, cost-effective and feasible and effectively reduce stress. Interventions are scalable when para-professionals can be easily trained and the methods are understandable to local health providers. On cost effectiveness and

feasibility, the interventions must be affordable to LMIC governments, amenable to local capacity development and reasonably short to enhance engagement, attendance and completion.

Prof. Bryant cited the Skills for Psychological Recovery (SPR) as an example. The method was developed when the US authorities requested for a new protocol for mental health problems after Hurricane Katrina hit the United States in 2005. It is based on the premise that insufficient practitioners have the skills to deliver specialist interventions.

The SPR is a five-session program with the following components:

- Information gathering – obtain important information about needs and concerns
- Problem-solving – enhances ability to reduce current stresses and problems
- Activity scheduling – reduces depression
- Managing reactions -- minimizes arousal
- Helpful thinking – reduces maladaptive appraisals
- Healthy connections – engages social networks

The problem with SPR is that it has never been validated and the US has been reluctant to allow it to be adapted and disseminated globally.

The World Health Organization recognized the need for evidence-based and low-intensity interventions. It had to develop programs that can be readily disseminated anywhere in the world. WHO developed the Problem Management Plus (PM+), which is a five-session program with the following components: psycho-education, managing stress, managing problems and building social support. This program was evaluated and got evidence from two separate trials indicating effectiveness of the program. The PM+ program is now being used in ongoing studies in different countries with a pilot study in Kenya showing positive results.

Prof. Bryant also referred to a research done on the importance of attachment among children affected by the Australian bushfires. Specialists assessed eight year-old children's reactions after the bushfires and re-assessed them 28 years later. The findings indicated that separation from parents during fires predicts fragmented attachment 28 years later, mediating ongoing PTSD. From this he indicated the importance of social connectedness.

In a study on analyzing the importance of social networks effectiveness, people are connected through social networks. The following questions were asked:

- *Thinking about your life at the moment, is there a person or organisation you feel particularly close to?*
- *Do you provide practical assistance or emotional help and support to anyone?*
- *Do you receive practical assistance or emotional help and support from any person or organisation?*
- *Thinking about your life at the moment, is there a person or organisation that makes you feel upset, or makes it difficult for you to receive practical assistance?*

The findings from this research indicated that:

- The more that you're saying *"I am close to other people"*, the less PTSD I have.
- The more other people are saying *"They are close to me"*, the less PTSD and depression I have.
- This means depressed people are actually mixing more with other depressed people.
- When I know people who don't know each other, my PTSD goes up. My PTSD goes down when I know people who know each other.
- This indicates that social network is very protective.

From this, he also concluded that resilience is contagious. In order to know how to respond after disasters, the speaker pointed out the need for customer feedback, trauma research, disaster research, expert consensus, experience, and program evaluation.

For the next steps, the speaker mentioned that they are developing a program focused on children to be tested in multiple sites (Syrian refugees), testing group PM+ in Pakistan and Nepal, and developing an e-book PM+ in Lebanon. He also emphasized the importance of capacity building and indicated that the real issue is working out how to train, supervise, and build capacity. In relation to this, they are developing training and supervision programs that allow local providers to be proficient and train others. The ultimate goal is that locals must not be dependent on external experts. There's a need to increase our knowledge of what is the best way to help people so the research must be practical and applied to real-world settings.

Before closing, he also mentioned about an initiative in collaboration with Prince Charles under the Prince Charles Charities to conduct an international trial comparing and evaluating low intensity interventions. This is in relation to Prince Charles's interest in mental health issues after disasters.

Finally, Prof. Bryant invited the participants to be part of the research. He made the participants aware that WHO and the Australian initiatives are keen to work with Asian countries. He added that ADPC plays an important role, particularly in the potential for research outcomes to be tested in many ADPC representative settings.



Ms. Adelaida G. Chavez, Coordinator, National Child Protection Working Group, Council for the Welfare of Children, Philippines
Evolution of the Child Friendly Space - Philippine National Guidelines

Ms. Adelaida G. Chavez, focused her presentation on the evolution of the guidelines/policies on children friendly spaces, lessons learned, and challenges during the development process. The Council for the Welfare of Children (CWC) was introduced as the focal inter-departmental government agency for children attached to the Department of Social Welfare and Development (DSWD) in the Philippines. It formulates and advocates for policies and programs, monitors and evaluates policies and measures, builds strong networks, partnerships and coordination mechanisms. It is composed of key government agencies that have mandate in relation to children rights.

Stages of the evolution of the Philippines' Implementation Guidelines on Child Friendly Space (CFS):

1. Rapid review of the CFS activities;
2. Organization of an inter-agency core team;
3. Development of the guidelines and tools;
4. Approval;
5. Dissemination and utilization sessions.

During the stage of rapid review of CFS activities conducted on the 4th quarter of 2013, different names on CFS (Child Care Center, Child Care Services, Child Care Spaces, etc.) were discussed in different sessions/activities. Competition on the amount of allowances and honoraria for CFS service providers was a highlight during this stage.

During the organization of inter-agency core team on CFS was organized on the 4th quarter 2013-2015, regular, special and emergency coordination meetings were done, the first draft of the CFS guidelines was developed, reviews and recommendations on needed action were given. The tasks and activities in this stage were led by the core team who also served as expert on CFS concerns.

During the guideline development on January-August 2014, core team workshops, validation and consultation sessions took place. Internal reviews by concerned offices proceeded. Council board resolution was issued and signed by the head of concerned agencies. The dissemination and utilization sessions were done from May-July 2015. During this stage, national and local stakeholders were involved. Roll-out plans were developed and monitoring and evaluation sessions were held.

Ms. Chavez announced that the Philippine Guidelines for the Implementation of the Child Friendly Space (CFS) was the first in Asia in terms of localizing the guidelines based on the Minimum Standards for Child Protection in Humanitarian Action.

Essential lessons learned during the process of developing the guidelines:

1. Build on existing structures (national and local levels)
2. Availability of feedback and accountability mechanisms
3. Proactive champions from the government
4. Transparency in decision-making process
5. High value of participation and coordination

Session 3 | Q&A key points

- Using low intensity interventions is one part of the solution. Scale up with additional services.
- Capacity building is not only from bottom-up but also from top-down.
- Giving incentives to those who need psychosocial services can be done during assessment but not during provision of interventions.
- During the research study, there were significant dropouts. Not all control groups received intervention in some areas. Ethical issues have to be addressed later when the intervention is working.
- On attachment, encouraging people to come together. Reduce negative social interactions.
- Sustainability, addressing threats to continuity of implementation, illuminating the process of developing guidelines is some of the key points in this session.

Session 4 | Perspectives on the Sendai Framework for Disaster Risk Reduction



Mr. Atiq Kainan Ahmed, Program Specialist, Asian Disaster Preparedness Center

- **Building resilience**
- **Bridging the gaps**

This session builds on the previous SFDRR presentation. It is focused on how the framework can be applied or integrated in MHPSS work to build resilience and bridge the gaps – local, national, international. For building resilience, the speaker asked the participants to identify ways and instruments and to contextualize the SFDRR into their work. In bridging the gaps, Mr. Ahmed encouraged the participants to start within their own discipline and extend to other sectors and levels.

The session was conducted through a two-step participative group discussion process. During the first step, the participants wrote down specific actions under each general priority. Participants were given the opportunity to contribute their ideas on each of the four Priorities. After doing this, a group was assigned to discuss on the ideas posted under each flip chart and to select a representative to report the summary of the ideas. During the second step, each group was assigned to discuss specific actions for building resilience and bridging the gaps for all four priorities of action.

All discussions within the groups were related to the participants' work on MHPSS. The summary of discussion outcomes are shown below:

Four Priorities for Action

Framework	Specific MHPSS-related Actions/Issues
Priority 1: Understanding disaster risk	Experts have to be acknowledged Low priority given to mental health Identification of vulnerability
Priority 2: Strengthening disaster risk governance to manage disaster risk	Political commitment Government leadership Policy and practices in place Close coordination among various agencies – local, regional, global
Priority 3: Investing in disaster risk reduction for resilience	Ensure there is capacity Involvement of community Proactive support Involvement of parents and children Local capacity building
Priority 4: Enhancing disaster preparedness for effective response to 'build back better' in recovery, rehabilitation, and reconstruction	Awareness of pain Volunteers are important to address immediate needs Teamwork and involvement of stakeholders Develop attitudes towards disaster

Specific Actions for each priority focusing on MHPSS

Building resilience	Bridging the gaps
<ul style="list-style-type: none"> -Work on social cohesion -Development of standardized guidelines, protocols, SOPs for integrating MHPSS into preparedness, RR, response, recovery -Utilize approaches sensitive of culturally-based practices -Put in place gender-sensitive strategies -Provide training/activities -Use participatory approaches -Development of framework and tools -Identify hazards -Vulnerability assessment -Coordination among stakeholders, service providers -Community participation 	<ul style="list-style-type: none"> -Standardization of protocols -Coordination -MHPSS consideration within decision making process -Gap in information -Gap between providers and beneficiaries -Funding -Research plus M&E -Government support -Partnership involving all sectors at all levels -Standardization of capabilities -Communication strategies -Leadership and political will -Inter-country commitment -Structural linkages -Dialogue among stakeholders -Establishing steering committee for MHPSS

Panel 4 | Country presentations



Dr. Samantha Kumara Kithalawaarachchi, Director to the H.E. President, Presidential Secretariat, Sri Lanka
MHPSS in complex emergencies in Sri Lanka

Dr. Samantha Kumara Kithalawaarachchi offered an overview of the various impacts of cyclones have had on affected areas and population in Sri Lanka, the stress and trauma from the disasters and indigenous practices for building resilience and MHPSS initiatives.

Sri Lanka is extremely vulnerable to hydro-meteorological hazards such as floods, cyclone, droughts, and derivative disasters such as forest fires and landslides. This vulnerability is compounded by socio-economic conditions such as population growth, environmental degradation, investments in infrastructure in hazard prone areas and extreme weather events caused by the effects of climate change. Cyclone or extreme wind is experienced annually. Most locals are dependent on an agriculture-based economy and livelihood. The cyclones destroy most of the agricultural crops leading to huge economic losses in the community.

The stress experienced by the affected population after the cyclone disasters include: relapse and low threshold disorders that trigger substance abuse; withdrawal symptoms; discontinuity of alcohol, drugs/medicines. The trauma symptoms include acute stress reaction to death experiences, PTSD, flashback of the experience and dreams when seeing the relevant scenes and places such as wind, water and flooding. There are very few cases reported regarding resilience during recovery and rehabilitation phases.

MHPSS initiatives

- The Government of Sri Lanka, the Ministry of Health and the Disaster Management Center identified MHPSS as mandatory in post-disaster and relief phases.
- Identification of people needing special MHPSS from the victims.
- Special MHPSS training given to all the field level health-care workers and aid agencies.
- Strict implementation of the UN and Sphere (Humanitarian Charter and Minimum Standards in Humanitarian Response) guidelines for the refugee and disaster victims.

- Establishment of specialized units for mental health in all hospitals under the supervision of qualified psychiatrists and staff with all admission, rehabilitation, and follow-up facilities.



Dr. Albert Maramis, Psychiatrist
Psychiatric Association/ MMC Hospital, Indonesia
MHPSS in emergencies in Indonesia

Dr. Maramis, started by showing a map of risk of disasters across Indonesia illustrating different areas and levels of risks. He pointed out that most of the areas are high risk, indicating that Indonesia experience most types of disaster. Conflict is also included in the hazard mapping.

MHPSS is integrated during every disaster in Indonesia. There are many actors such as UN agencies, national and international NGOs, the academia, professional organizations, as well as individual volunteers with different experiences spending their own funds to help, but many come for only a few days to a few weeks. This is an unfortunate situation considering that the need for MHPSS is long-term, not only in the emergency response period but all the way through recovery and reconstruction phases.

Several MHPSS interventions have been implemented such as screening, some form of counseling, nurse's intervention, and psychiatric treatment addressing target population such as children, women and adults. There are a number of interventions that are not evidenced-based, such as groups which introduced massage as trauma healing.

Aside from the direct support, assistance and interventions, the country managed to integrate MHPSS in some legislation such as in Law 24 (2007) on disaster management, specifically mentioning that MHPSS should be provided. Under this law, there are government regulations with implementation instruments, which are more technical. In 2014, a new mental health legislation came out, mentioning the provision of MHPSS during emergency and disaster. The Ministry of Health developed guidelines in a form of three pocketbook series, guidelines on management of mental health and psychosocial programs including psychosocial first aid, and other forms of psychosocial interventions.

Some of the capacity development initiatives are the dissemination of mental health issues and how to deal with the psychological impact of disaster for the public and line ministries. In addition, there were training on mental health in disaster and emergencies and training on psychological first aid conducted by the Ministry of Health and universities. The University of Indonesia through the Crisis Center of the Faculty of Psychology pioneered the training on psychological first aid. Three years ago, disaster

management curriculum was integrated in the Faculty of Medicine of UI for first year medical students and health cluster students.

The curriculum includes basics of DM, first aid, and MHPSS during emergencies. With this curriculum, the students have the capacity to assist in the disaster areas when needed.

Challenges to implement MHPSS in Indonesia:

1. Decentralization of health services to sub-national government – the provincial and district governments not giving the same emphasis or priority to health and much more to MHPSS
2. Ignorance on MHPSS issue – advocacy to policy makers and public education have to be done
3. Collaboration and coordination - within the Ministry of Health and with other ministries and among all stakeholders
4. All the efforts tend to be more reactive than proactive – although disaster preparedness has been integrated into the law, in reality this effort has not been given enough attention.

Ways Forward:

1. To have a firm legal basis for MHPSS – the two existing laws are not enough. There are related laws and regulations that have to be developed for implementation.
2. To make policy makers understand MHPSS and put into their consideration when making decisions. Perhaps there should be an MHPSS person in each level of decision-making.
3. To have clear goals and program indicators in planning documents
4. To have guidelines on evidence-based psychosocial intervention
5. To have orchestrated efforts and collaborations among stakeholders in delivering interventions
6. Capacity building in doing research and implementing interventions is needed.

Panel 4 | Q&A key points

- Many studies support that meditation has equal effects to narrative exposure therapy. Meditation can be taught in groups while narrative exposure therapy puts lots of demand on individual therapists. We need ease and we need things that can easily reach out. We should choose methods that are economically sound and can be taught in groups and not try to have these more advanced. We also need to have methods that don't have too narrow focus on diagnosis. We should have methods that have been proven in many studies and can be used to reach out to many.
- Large percentage of people is unwell and others are resilient. We need to find a way to detect those who need treatment through low-intensity interventions.
- In places with no proper interventions, religion may have a role. We need to be respectful of religion, culture and local practices but we should also be careful when using traditional practices or in concluding that religious practices can make people well.
- Grassroots health workers can be trained to do diagnosis, detecting and referring to experts.
- On studies in Aceh of those who experienced conflict and tsunami - tsunami victims are more acceptive while those affected by conflict-based disaster show more long-term effects.
- Some countries are more vulnerable but have developed more resilience. Mental health should be everybody's responsibility.

Session 5 | Development partners' perspectives on MHPSS



Dr. Yvonne S. Duque, Senior Public Health Specialist,
Asian Disaster Preparedness Center, Thailand

Moderator



Mr. Michael Ernst, South Asia Regional Advisor,
U.S. Agency for International Development, Regional Office, Thailand

Donor Perspectives

Mr. Michael Ernst, expressed his appreciation for being able to hear the participants' perspectives, in order for him to better understand the technical issues, especially when it comes to communicating these issues to his colleagues who may or may not be MHPSS specialists. It helps him to think about how all these issues fit into their context. He stressed the importance of also hearing about donor's perspectives, as they have certain constraints and resource limitations, since they can provide funds only for those projects that are appropriate and meet their organization's mandate.

He provided an overview of the Office of US Foreign Disaster Assistance (USAID/OFDA) in terms of their mandate and budget priorities. The organization's mandate is to save lives, to alleviate suffering and to reduce the socio-economic impacts of disasters overseas. He mentioned that the organization's annual budget is roughly a billion dollars, which has been primarily spent on conflict related emergencies in recent years. He discussed Syria's and Yemen's humanitarian needs as the type of disasters that are dominating their support requirements.

He acknowledged Asia's advantages and disadvantages related to humanitarian assistance, and recognized the need for MHPSS. He cited the unique situation in Asia, of a very high capacity but also very high vulnerability, due to extreme poverty in some areas. Some countries like India have more

billionaires than Switzerland and yet have half of the world's poor. The region also has high capacity in education, while many of the Asian populations remain uneducated. In relation to this, he appreciated the discussions in the conference about capacity building, solid evidence-based interventions, sustainability of initiatives, building sustainable capacity, and addressing negative impacts of interventions, among others. He stressed the need for solid evidence of the benefits MHPSS interventions to justify funding of projects that some may think are beyond his organization's mandate, or are simply not effective or efficient uses of very limited resources.

He tried to deconstruct the topic of MHPSS and link it to the cluster system structure that his office also follows, regarding the separation of Mental Health and Psychosocial Support. He mentioned that in their perspective, mental health in the sector of health is not considered a top priority for disaster response, although this doesn't mean that mental health is not important. In relation to this, he indicated that when funding emergency response and relief, mental health and psychosocial support is not prioritized, as immediate life-saving needs dominate. Since the strongest need for PSS often comes later, during the recovery process, there is a need for community-based efforts in psychosocial support that can assist this recovery process by helping people recover their lives and livelihoods. In this regard, he said he would tackle the problem by expanding on the social supports first and build up from them to strengthen Mental Health care and referral systems.

Because of funding limitations, he suggested that local resources must be built upon. He proposed an event where donors come together to share experiences and develop the best practices for funding psychosocial support preparedness programs at the community level. Funding these types of programs could build community capacity to recover and require fewer resources. In relation to this, he mentioned that one of the biggest gaps right now in disaster response is the early recovery process, which is terribly under resourced due to the extreme financial pressures on the humanitarian system. Perhaps, psychosocial support preparedness training programs could be undertaken at the community-level, building on community-based disaster preparedness efforts, so that communities will be better prepared to face the recovery process.



Ms. Sarah Martin, Inter-Agency Regional Emergency GBV Advisor (REGA) for SE Asia and Pacific. GBV Area of Responsibility under the Global Protection Cluster
Addressing Mental Health and Psychosocial Support in gender-based violence (GBV) in humanitarian situations in the Asia-Pacific region: challenges and approaches

Ms. Sarah Martin, provided an overview on the Gender Based Violence (GBV) situation in the Asia-Pacific region in the context of disaster and humanitarian situations. She focused on the threats to

women and girls in everyday life. The primary causes of GBV in the Asia-Pacific region are the abuse of power and gender discrimination and inequality. Many countries in Asia have deeply rooted gender inequality; discriminatory socio-cultural norms and practices that lead to high rates in violence and horrible practices such as honor killing, sex selection, boy preferences, child marriage, etc.

Due to these issues, women and girls face increased vulnerability to violence during humanitarian emergencies. GBV in disasters has been overlooked in the past. In the humanitarian settings, she said that GBV is life-threatening and responding to GBV can also become life-threatening and protection efforts go amiss. The initiatives on GBV in humanitarian situations focused on prevention and response. However, there are gaps in the area of prevention. She added that addressing GBV requires a comprehensive approach illustrating a multi-sectoral model for GBV response related to a survivor-centred model. The four sectors that provide services that a survivor may need include: health care, mental health and psychosocial response, legal and justice, and safety and security.

The first stage of healing is returning power to the survivor and allowing him/her to make decisions about their care. There is a need to abide by the GBV guiding principles, meaning that in every service provided, it is necessary to respect the survivor, maintain confidentiality, ensure safety, and provide non-discriminatory services. MH and PSS interventions are based on the Inter-agency Standing Committee (IASC) pyramid. In general, in most emergencies, we struggle to get beyond the base of the pyramid. Common emergency interventions include: providing setting up women safe spaces, establishing multi-sectoral referral mechanisms for GBV and increasing quality of health and MHPSS services. There are also trainings for health care providers on clinical management of rape, providing post-rape kits and improving survivor-centered care. Training of police on how to provide psychological first aid is also conducted.

Ms. Martin provided country examples of the Philippines, Vanuatu, Myanmar and Nepal on various initiatives such as women friendly spaces, implementing the IASC GBV Guidelines which outline the responsibilities of the different clusters and sectors to prevent, mitigate and respond to GBV, providing training on psychological first aid and case management, training local women to provide support to survivors, etc.

The challenges to addressing MHPSS in GBV in emergencies include:

- Lack of evaluation of MHPSS programs appropriateness (there are different needs for support depending on the type of gender-based violence experienced)
- Victim-blaming is deeply embedded in many cultures, including the culture of the service providers
- Supervision of those providing MH interventions – are we sure that we are not causing harm?
- Issue of stigma for rape survivors and their families
- Need for continuous training and capacity building to provide good MHPSS
- The lack of focus on adolescent girls' for MHPSS needs

Recommended tools [Inter Agency Standing Committee Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience, and aiding recovery](#)

Session 5 | Q&A key points

1. Donors should prioritize interventions in emergencies that address GBV across all clusters.

Steps forward

For this session, the participants were asked to provide recommendations on:

1. How to create a regional coordinating body on MHPSS
2. Plan for the next conference (responsibilities, duties, communication platforms)
3. Select a country organization to lead an MHPSS working committee

The participants came from diverse backgrounds representing governmental and non-governmental organizations involved in MHPSS at various levels, from implementing state procedures to working on the community level in providing services. This diversity secured fruitful discussions as the total group had knowledge of both opportunities and challenges that could foster or hinder resiliency. This conference, as well as the two previous, has created a momentum in this field that can foster transnational cooperation in the region securing that MPHSS becomes an integral part of disaster planning and intervention.

A continuous focus on natural disasters is recommended, as the region is prone to the consequences of climate change. However, man-made disasters, such as transportation disasters and acts of terror should also be included. The format for this conference had sections covering earthquake, floods, tsunami and cyclone, and complex emergencies, having county specific contributions under this structure. It would be important to ensure the participation of more countries in the next conference. Many countries were unable to attend due to visa restrictions, which should be addressed in order for the whole region to be equally represented.

Furthermore, more presentations should focus on lessons learned regarding interventions for children. Another theme that should be put on the agenda is 'helping the helper', ensuring that care for helpers at various levels is an integral part of psychosocial efforts following a disaster. Further perspectives could be shared by organizing a 'Night with the donors' event in order to succinctly present a measurable comprehensive approach to MHPSS and its pivotal role in disaster management. Two keynote addresses, one at the beginning of each day that gives a general overview of the state of the art would be advisable. The country presentations seems very well received and should be kept as the backbone of the program, but organized by type of disasters as indicated above.

Three countries came forward, namely Indonesia, Myanmar and the Philippines, indicating their interest in hosting the next conference with the help of ADPC. It was recommended that a community visit to a site near the conference venue should be arranged if possible. However, such a visit should only be planned if there is a good program involving MHPSS. It was also advised that if countries are to present projects through posters, they should if possible include research going on and documentation on how projects are being evaluated. Few of the countries presented formal research into the psychosocial effects of intervention. It is of importance that interventions are more knowledge based, i.e. better evaluated.

There was unanimous backing for establishing a regional coordinating body to take the lead in raising awareness and advancing MHPSS in the region. The regional coordinating body suggested at this conference can ensure that MPHSS is prioritized in planning for disasters, and can coordinate activities following transnational disasters, as well as act as a resource when countries face country-specific disasters. Sharing of resources among participants was encouraged, while groups on social media, teleconference/Skype as a way to continue knowledge sharing on MHPSS were suggested.

The need for a strategic plan for the following conference was stated working on a practical, outcome-oriented and relevant theme to further MHPSS with representatives for all countries in the region being tasked with a) identifying research needs regarding mental health and psychosocial support, b) securing transnational coordination when disasters cross borders, c) securing better coordination between international, national and local level, d) ensuring awareness raising among politicians, and high officials, even see if a firm legal basis for MPHSS could be established, e) communicating lessons learned to all countries in the region following an agreed upon structure for this. For these tasks, the regional body is consisted of both field workers, i.e. those involved in disaster assistance through Governmental organizations and NGOs, and representatives from academic institutions in the respective countries. The coordinating body should look at the tasks that were identified for building resilience and bridging the gap in the conference session on 'Building resilience: perspectives on the Sendai Framework for Disaster Risk Reduction'.

Closing ceremony



Ms. Janette Lauza-Ugsang, Senior Project Manager,
Asian Disaster Preparedness Center, Thailand
Master of Ceremony



Mr. Sajedul Hasan, Director,
Asian Disaster Preparedness Center, Thailand

Mr. Sajedul Hasan closed the ceremony by thanking the participants and representatives and summing up the conference outcomes.



Prof. Dr. Krasae Chanawongse, Chairman of the Board of Foundation, Asian Disaster Preparedness Center, Thailand

The closing message by Prof. Dr. Krasae Chanawongse encouraged the delegates to strive to become good leaders and apply what they learned in the conference to their own work and country. He expressed his appreciation to the partners and to ADPC's organizing team for making this conference successful.



Closing ceremony of the Third Regional Conference on Mental Health and Psychosocial Support

ANNEX A | Participant List

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ANNEX B | Post conference evaluation

What went well	Something New?	What needs to be improved?
<ul style="list-style-type: none"> Good opportunity for exchange of ideas, learning, experiences and challenges (2) 	<ul style="list-style-type: none"> Drawing interlinkages with other sectors in issues of MHPSS 	<ul style="list-style-type: none"> Presentations could have been shared before the conference. (3)
<ul style="list-style-type: none"> Mini group work made us internalize knowledge 	<ul style="list-style-type: none"> MHPSS should be incorporated in ALL DRM initiatives. 	<ul style="list-style-type: none"> Early invitation and more time for preparation of presentations to have quality products (4)
<ul style="list-style-type: none"> Well done, logistics ok, arrangements ok, Timing is OK, Excellent. Good job! (3) 	<ul style="list-style-type: none"> Meeting different professionals and learning from their different experiences (3) 	<ul style="list-style-type: none"> More activities during sessions.
<ul style="list-style-type: none"> The networking platform was great (3) 	<ul style="list-style-type: none"> Learning from others paved opportunities for developing approaches (2) 	<ul style="list-style-type: none"> More activities, group work and energizers (2)
<ul style="list-style-type: none"> Continue to work and dialogue together (2) 	<ul style="list-style-type: none"> Gender Based Violence and MHPSS (2) Clear concept and links with GBV 	<ul style="list-style-type: none"> Very short notice. Please inform in advance next time (4)
<ul style="list-style-type: none"> All topics in the conference were useful 	<ul style="list-style-type: none"> Donors perspectives 	<ul style="list-style-type: none"> Sitting arrangements could have given opportunities for organizations to debate.
<ul style="list-style-type: none"> Very effective group work and group activities 	<ul style="list-style-type: none"> Increased awareness on MHPSS 	<ul style="list-style-type: none"> More information and strategies of coordinating. Collaborating organizing.
<ul style="list-style-type: none"> Multi sector and different disciplines of participants, lots of perspectives on political and FBO information 	<ul style="list-style-type: none"> Low intensity intervention (2) Manual on evidence based intervention Sendai Framework (3) 	<ul style="list-style-type: none"> Please add presentation from Faith Based Organizations (FBO) and spiritual leaders next time.
<ul style="list-style-type: none"> Intergovernmental, development practitioners and Academe should work together. 	<ul style="list-style-type: none"> Gained better understanding of MHPSS which could be worked on as research. 	<ul style="list-style-type: none"> Need more donors perspectives
<ul style="list-style-type: none"> All sessions were covered 	<ul style="list-style-type: none"> Very much updated information sharing on MHPSS 	<ul style="list-style-type: none"> Make MHPSS attractive and interesting.
<ul style="list-style-type: none"> TIME keeping and number of presentations was great. Everything was well with TIME(4) 	<ul style="list-style-type: none"> Model of Building resilience in the community 	<ul style="list-style-type: none"> Academic practitioners and development practitioners should have equal emphasis. Understand theory and practice.
<ul style="list-style-type: none"> Good quality of presentations and 	<ul style="list-style-type: none"> Roles of Social Networks post disasters 	<ul style="list-style-type: none"> More workshop on Planning

presenters		
<ul style="list-style-type: none"> ▪ Excellent group work 	<ul style="list-style-type: none"> ▪ New Ideas on MHPSS 	<ul style="list-style-type: none"> ▪ Technical glitches (microphones and power point presentations)
<ul style="list-style-type: none"> ▪ Diversity of participants was excellent. Most sectors were represented. 	<ul style="list-style-type: none"> ▪ Good practices in monitoring 	<ul style="list-style-type: none"> ▪ All presentations should be stored in one laptop of the organizer ahead of time.
<ul style="list-style-type: none"> ▪ Good input from USAID, UNICEF 	<ul style="list-style-type: none"> ▪ Educate all levels on DRM 	<ul style="list-style-type: none"> ▪ Lunch time should be longer
<ul style="list-style-type: none"> ▪ Expert moderators, well chosen, fun and not boring, easy to synthesize things at the end of each session. 	<ul style="list-style-type: none"> ▪ Faith Based Interventions (FBOs) 	<ul style="list-style-type: none"> ▪ Speakers should practice use of tech gadgets ahead of time.
<ul style="list-style-type: none"> ▪ Cohesiveness and complementation of each topic 	<ul style="list-style-type: none"> ▪ ADPC and Norway may want to bring donors and development partners to gather and discuss interests and limitations for potential partnerships. 	<ul style="list-style-type: none"> ▪ Exposure trip in the next MHPSS conference would be great.
<ul style="list-style-type: none"> ▪ HONESTY in identifying and accepting problems and issues on Lack of evidence and based monitoring and evaluation. 	<ul style="list-style-type: none"> ▪ Session to discuss and focus on achieving sustainability and scale with training program. 	<ul style="list-style-type: none"> ▪ Flash drive for content and pictures
<ul style="list-style-type: none"> ▪ Very well organized and facilitated Conference. Congratulations! 		<ul style="list-style-type: none"> ▪ More countries and partners to be involved in the region ▪ Include Private partners and how their teams can be trained on PFA



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