

# Introducing the IASC Mental Health and Psychosocial Support Guidelines in Emergencies in Nepal: a process description

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*A rich set of reflections on experiences with the Inter-Agency Standing Committee Mental Health and Psychosocial Support Guidelines in Emergency Settings has recently been published in this journal. This paper describes a case study of using the guidelines in Nepal, which focused primarily on detailed implementation of preparatory steps. In effect, it describes a multi-agency process of using the guidelines as a tool to raise awareness, foster coordination and systematically integrate mental health and psychosocial considerations within the humanitarian cluster approach in Nepal. It argues that these steps make it possible to further operate and actually adhere to the guidelines more feasible in future situations.*

**Keywords:** psychosocial and mental health support, emergencies, guidelines, Nepal

## Introduction

Globally, there has been increased awareness of, and programs responding to, psychosocial and mental health needs in emergency situations. However, this growing field has lacked unified clarity and a common framework for effective coordination of practice and advocacy (IASC Task Force on Mental Health and Psychosocial Support

in Emergency Settings, van Ommeren & Wessells, 2007; Wessells & van Ommeren, 2009; Weiss, Saraceno, Saxena & van Ommeren, 2003). In 2005, the Inter-Agency Standing Committee (IASC) established a Task Force at the global level to address the need for concrete guidance on how to best organise mental health and psychosocial support in emergency settings. In 2007, the Task Force achieved its initial aim of developing practical, inter-agency, multi-sectoral guidance when it published the *IASC Guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings* (IASC, 2007a).

A recent special issue of *Intervention* was dedicated to these guidelines. A majority of authors viewed the documents as an extremely welcome development, with a few voices of dissent (Ventevogel, 2009). While reflecting the general acceptance of the guidelines, there is overlap between the authors and the group and institutions that developed the guidelines. It is perhaps more striking that the variety of perspectives on how the guidelines are used, or envisioned to be used, reflects the level of consensus that has actually been reached among different

stakeholders. The guidelines are praised for their accessibility (Garcia del Soto, 2009), systematic consideration of cultural factors (Abramowitz & Kleinman, 2009), their applicability within public health systems in post conflict settings (Baingana, 2009) and their relevance to displacement contexts (Schilperoord, Buffoni & Kouyou, 2009).

All these positive assertions lead to the key question: *'how can we best apply the guidelines in actual emergency settings?'* The practices and challenges of rolling out and implementing the guidelines have already been discussed by Melville & Rakotomalala (2009). In order to promote and implement the guidelines and to gather information on its strengths and weaknesses in actual emergency settings, the Task Force has initiated or supported several *'case studies'*, the rationale being that such case studies would yield useful suggestions and practical guidance regarding effective implementation of the guidelines. *A Case Study in Colombia* (Echeverri & Castilla, 2009) aimed to build capacity, promote a common language among MHPSS and humanitarian actors and test applicability. In Peru (Rivera et al., 2009), a multi-level approach towards capacity building and sensitisation was followed.

The methodologies of the previous case studies varied significantly, with common characteristics consisting of an overriding emphasis on sensitisation, capacity building or direct use (putting into operation at community level), mostly within a relatively short time frame. These initiatives are excellent examples of how the guidelines have created a platform for more effective inter-agency coordination around psychosocial and mental health care in field settings. At the same time it is important to keep in mind the feasibility or sufficiency of one-off or short term approaches in settings where

existing psychosocial and mental health care infrastructure (both institutional and those run by civil society) is limited. The Nepal context entailed a number of challenges that hampered effective implementation of the guidelines. These included a lack of overall MHPSS coordination and understanding between organisations, few organisations specialised in MHPSS and a lack of awareness regarding existence of the guidelines. As a result, the Nepal Case Study chose to emphasize the *process of initial putting into operation* of the guidelines over an initial period of 12 months. Melville and Rakotomalala (2009) reason that an extended, inter-agency and multi-stage process, which promotes a stimulating dialogue and shared reflection, may be an effective way of introducing the guidelines in settings where emergencies are likely to occur. Similarly, it was felt in Nepal that structural and comprehensive preparatory work was needed to make effective use of the guidelines.

## **Background, procedure and results**

### *Nepal Context*

Nepal is a country, situated between India and the Tibetan autonomous region of China, with a population of approximately 28 million people, of whom 90% live in rural areas. With a per capita gross domestic product of US \$270, Nepal is the poorest country in South Asia (World Bank, 2007). A decade long conflict, which ended in 2006, has exacerbated the humanitarian needs of people already at risk. Poor economic performance, entrenched caste, ethnic and gender based discrimination and social marginalization, ongoing communal violence or conflict, lack of infrastructure and high frequency of recurring natural emergencies (i.e. floods, landslides, earthquakes) have resulted in chronic and recurrent

humanitarian needs (IASC, 2008). A recent multi-disciplinary systematic literature review suggests that political violence in Nepal affects psychosocial wellbeing and mental health through a complex set of risk factors arising from increased poverty, loss of infrastructure, transformed social relations, and increased exposure to traumatic events (Tol et al., in press). Reviewing the mental health policy in Nepal, Acharya and colleagues (2006) concluded that while the health system was able to cope quite well as a result of past training, the existing emergency preparedness plans were not sufficiently thorough. There was no coordinated psychosocial and mental health strategy for disaster response to date in Nepal. Moreover, they argue that further strengthening of the mental health and psychosocial aspects of disaster preparedness is strongly recommended (Acharya, Uphadya, & Kortmann, 2006). Yet this review did not look into broader psychosocial programming. The country spends 0,08% of the total health budget on mental health, with virtually no formal mental health care in rural areas (Regmi, Pokharel, Ojha, Pradhan, & Chapagain, 2004).

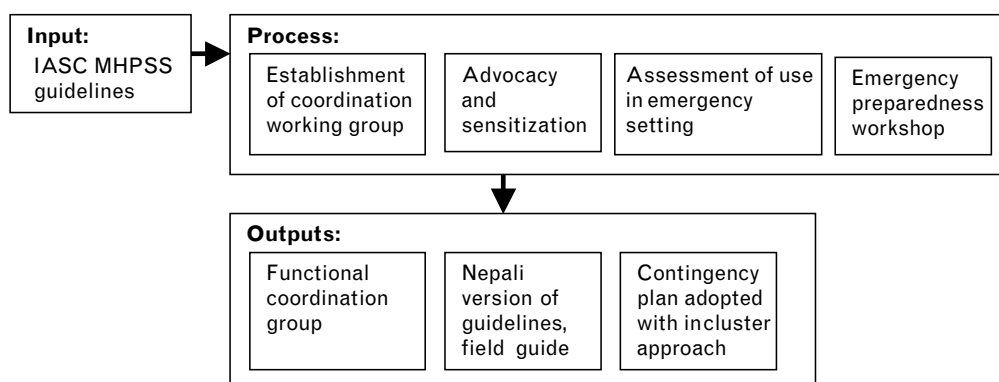
*Process description*

As mentioned above, the *case study* in Nepal emphasized the process of thorough preparation to facilitate more direct implementation at a later stage. After initial contacts between Nepal and the IASC Reference Group on the *MHPSS Guidelines*, it was principally decided to initiate a case study, which was followed by securing financing. Subsequently, these steps were followed, and have taken place between May 2008 and February 2009 (see *Figure 1*).

How these steps were conducted is described in detail below.

*Step 1: Formation of working group and technical committee*

Initially, a *working group* was established of representatives of the Government of Nepal; agencies that contributed to the development of the guidelines internationally and that were active in Nepal; and other international and national nongovernmental organizations (NGOs) and institutions working in MHPSS and/or emergency relief (here after referred to as: *'invited agencies'*). This group endorsed the initiation of the *case study*. A smaller *technical group* was formed to coordinate the case study, with members from



*Figure 1: Overview case study process.*

United Nations Children's Fund (UNICEF) Nepal, the World Health Organization Nepal, Healthnet Transcultural Psychosocial Organization (HealthNet TPO), Transcultural Psychosocial Organization Nepal (TPO Nepal), Terre des hommes Foundation (Tdh), International Rescue Committee (IRC), Centre for Mental Health and Counselling (CMC Nepal) and the Patan Mental Health Hospital. UNICEF Nepal and Healthnet TPO/TPO Nepal were designated co-chairs. An independent consultant was hired to facilitate the case study (Ramesh Maharjan). While formation of a steering group turned out to be quite a time consuming process, it proved essential for three major reasons:

- (a) to make the process an inter-agency and collaborative one from the start and ensure a broad platform for the case study;
- (b) to raise initial awareness of the guidelines, especially given the fact that almost all of the *'invited agencies'* were uninformed about the existence of these guidelines; and
- (c) to create a *de facto* coordination group for psychosocial and mental health issues in emergencies.

The latter was especially salient given the perceived lack of coordination within the psychosocial and mental health care field in Nepal, and the need for multi-sectoral coordination as recommended by the guidelines (Wessells & van Ommeren, 2009).

#### *Step 2: Rapid assessment*

A rapid appraisal was conducted at the start of the case study to assess what parts of the guidelines were being implemented, *prior* to any conscious effort to implement the guidelines. The assessment was conducted by a team of Nepali researchers and psychosocial

workers. The assessment was therefore not considered an evaluation, but rather an indication or baseline of *'natural'* adherence to the guidelines. Two field visits were completed to get a sense of, and to map, current coverage of issues in the guidelines in real life settings (July 2008; Goldhap Fire Disaster in Bhutanese Refugee Camp; August 2008, Koshi Flood Disaster – see Table 1 for a summary; both settings concerned camps for Internally Displaced Persons that were set up in the immediate aftermath of the disasters). This step was deemed important in order to:

- (a) to identify and demonstrate what is already being done and thereby acknowledge the existing tendency of agencies to adopt significant parts of the guidelines, making them less *'threatening'* to the status quo;
- (b) to identify gaps in the application of the guidelines in the future.

Moreover, the field level assessment meetings played an important part in incorporating emergency responders in the case study process.

#### *Step 3: Advocacy*

A significant period of time was spent raising awareness of the guidelines, and the need for psychosocial and mental health care in emergencies *per se*, targeting the humanitarian sector and the Government sector equally. First, a workshop was organised in September 2008 with the aim of introducing and advocating for the guidelines, as well as to raise the profile of the activities of the *working group*. The workshop included invited participants from the Government, mental health professionals, NGO's active in the field of psychosocial and mental health care, and international agencies involved in disaster response and in drafting the

**Table 1. Summary outcomes of pre-case study adherence to guidelines after the Koshi-Flood emergency**

Guidelines sectors	Emergency mental health and psychosocial support responses
Coordination	<ul style="list-style-type: none"> <li>- There is no coordination around MHPSS, but activities are de facto coordinated by the (child-) protection (sub-) cluster</li> </ul>
Assessment, monitoring and evaluation	<ul style="list-style-type: none"> <li>- Organisations are using their own guidelines, if any (no common guideline)</li> <li>- One rapid assessment of mental health and psychosocial support was conducted a week after the floods occurred, followed up 5 months later<sup>a</sup></li> </ul>
Human resource	<ul style="list-style-type: none"> <li>- Findings were not widely disseminated and only used within one programme</li> <li>- Most of the front line workers are mobilized from the affected communities</li> </ul>
Health	<ul style="list-style-type: none"> <li>- Significant involvement in aid activities by women and disadvantaged communities</li> <li>- No assessment conducted</li> <li>- There was no provision of mental health services, either in camps or in district hospitals</li> <li>- Mental health problems were referred to hospitals with psychiatric ward<sup>b</sup></li> <li>- Two health workers got a 10-day training in basic psychosocial support</li> <li>- A 3-day basic psychosocial training was provided for unemployed health personnel living near the affected community<sup>b</sup></li> </ul>
Community mobilization and support	<ul style="list-style-type: none"> <li>- Traditional leaders and religious support mechanisms not consulted</li> <li>- Classroom-based psychosocial intervention provided</li> </ul>
Education	<ul style="list-style-type: none"> <li>- Three organizations worked on psychosocial support from the beginning (geographical division of labor), covering psychological first aid, orientation to first-line aid workers and camp management staff, and counselling<sup>c</sup></li> <li>- Child-friendly and child learning centers were present in each camp</li> <li>- Basic psychosocial orientation training was provided for primary level teachers and facilitators of child-friendly centers</li> <li>- Flexibility in school enrolment (previous certificates and birth certificates not necessary)</li> <li>- Theme-oriented discussions for school-going children was provided</li> </ul>

Guidelines sectors	Emergency mental health and psychosocial support responses
Shelter and site planning	<ul style="list-style-type: none"> <li>- Involvement of affected community on site selection</li> <li>- Separate toilets for females in most camps</li> <li>- Local culture, traditions, norms and values were assessed and implemented in site selection and design</li> <li>- Rotary box (special tents) were provided for some families, persons with disabilities and single women in some camps.</li> <li>- Huts were distributed without discrimination.</li> <li>- Bathing areas were covered</li> <li>- Information centers in all camps included information on water and sanitation</li> <li>- Formation of water management groups in each camp to manage possible conflicts</li> <li>- Joint coordination group (headed by Chief District Officer) to control conflict between local community and internally displaced persons (IDP)</li> <li>- Local culture, traditions, norms and values were assessed and considered in planning and response</li> <li>- No training provided for food-provision staff</li> <li>- Food distributed carefully, however, due to fake cards and other verification issues there was dissatisfaction among real victims</li> <li>- Security was ensured at the time of food distribution.</li> <li>- Local culture, traditions, norms and values were assessed and adhered to in food distribution</li> </ul>
Water and sanitation	<ul style="list-style-type: none"> <li>- Formation of camp management committees and sub-committees in each camp to manage all activities</li> </ul>
Food and nutrition	
Shelter and site planning	

<sup>a</sup> Conducted by TPO Nepal, available upon request.

<sup>b</sup> B.P. Koirala Institute of Health Services.

<sup>c</sup> TPO Nepal, Women Rehabilitation Center (WOREC) & Center for Victims of Torture (CVICT); no information on domain 8 (dissemination of information) available.

guidelines internationally. Participants appreciated the workshop as a good start to introducing the guidelines within the Nepalese setting, but advocated for greater Government representation. As a result, the *working group* opted for ongoing and targeted advocacy. A number of meetings were held, focusing especially on government departments (targeting the secretaries of the Ministry of Health (MoH), Ministry of Home Affairs, and the Ministry of Women, Children and Social Welfare), as well as NGOs working during disasters, in order to promote endorsement of, and inclusion in, the process. This step was deemed important because of the lack of awareness regarding the existence of the guidelines, and psychosocial and mental health supports in general, as well as the relative lack of coordination and concerted efforts in this field. Additionally, repeated sensitisation was deemed essential to actually create a momentum among core agencies to take the guidelines seriously. Finally, in response to challenges in engaging government, targeted sensitisation of specific government officials proved effective in prompting official assignment of government officials as a focal point (especially from the MoH Disaster Management Section), albeit with little active participation thus far.

*Step 4: Translation of the guidelines and the accompanying field guide*

Experience in transcultural research has demonstrated that issues of translation are sensitive and challenging, and that a thorough procedure is indispensable in order to capture the meaning and essence of the original text. This process is complicated by the relative novelty of most of the technical terms, and also by the need to have a translation that can be used by both policy makers and implementing staff.

This is not easy in a setting like Nepal, with vast differences in educational level between these user groups, and different local languages in target areas. Furthermore in Nepal, there is a difference between 'official' Nepali (e.g. spoken at high level meetings, on the radio and TV) and the more commonly spoken 'lay' Nepali. As a result, a slow and thorough translation process was followed, based loosely on recommendations for translations for transcultural research use (van Ommeren et al., 1999). A first direct translation was completed, but proved too academic and inadequate in expressing the key content in comprehensible lay Nepali. This was identified by asking feedback on the applicability of the translated version from psychosocial workers in the emergency settings. Further steps included editing by bilingual mental health professionals and bilingual translators. A thorough review by a group of mental health and psychosocial field workers and researchers has resulted in a final version that is printed, after endorsement from the co-chairs of the global IASC Reference Group, as a formal translation of the guidelines (in addition to the existing formal translations into French, Arabic and Spanish). The importance of a good translation cannot be overstated when considering the use of the guidelines in field settings. A straightforward direct translation would have made the guidelines, and more importantly the field guide, useless for people working in emergency settings. Secondly, the process of involving the broad *Working Group* in all steps was valuable in promoting local ownership of the Nepali version. For the same reason it was decided to contextualize the main front cover with a photograph from Nepal, whereas all other layout and presentation was kept identical to the original.

### *Step 5: Contingency plan*

Following the steps outlined above, the final step of the first phase of the *case study* was aimed at putting the guidelines into operation in Nepal. The *working group* decided to develop a national psychosocial mental health emergency preparedness plan to translate the international guidelines into a direct action framework specific to the Nepal setting. Although we realise the guidelines are not an implementation manual, we aimed to translate the guidelines into a contingency with practical relevance. This, as mentioned earlier, is challenging given the wide variety of humanitarian settings that have occurred and may occur, in Nepal. Such a contingency plan would make it easier to integrate psychosocial and mental health issues, and thereby the guidelines, into the broader humanitarian emergency response efforts. The Nepal Government has adopted the United Nation's Humanitarian Reform Framework. A two day workshop was organised and attended by some 23 agencies, including UN agencies, national and international NGOs (including MHPSS and emergency relief agencies), and modest government representation (the Disaster Management Section, MoH) in close collaboration with the protection cluster. The workshop was co-facilitated by the United Nations Office for the Coordination of Humanitarian Affairs (OCHA) and UNICEF (AM). The process included the following steps; introduction to the rationale and detailed content of the guidelines, reflection of strengths and weaknesses of MHPSS responses during previous disaster settings, and group work to develop draft *standard operating procedures* following the domains set out in the guidelines. The workshop resulted in a draft MHPSS contingency plan with *standard operating procedures* based on selected action sheets of the guidelines, covering all

11 domains. More specifically, the plan sets out chains of actions, detailing various agencies' responsibilities for targeted actions during emergencies. As there was insufficient time to fine tune the output during the workshop, the draft contingency plan was refined within the *working group* and subsequently sent for review, comments and/or approval to all workshop participants. The contingency plan currently remains a working document and more details are still required to make the plan complete. In the next phase of the case study, a more detailed version will need to be reviewed by all members of the process (and additional stakeholders) and approved to ensure agencies' consent. However, even in current form, the document will likely increase emergency preparedness and is a significant change for the better since no plan existed. Parallel to this process, the psychosocial and mental health contingency plan was structurally included and adopted within the contingency planning processes of the *protection cluster*, and the *child protection and sexual and gender-based violence* sub-clusters. The *health cluster* is equally important and will be approached as a second step. In effect, this was a first step towards making the MHPSS considerations and the *working group* cross-cutting within the humanitarian response mechanism. This step was therefore essential for a number of reasons:

- (a) to establish policy, which was largely lacking (see: Acharya et al., 2006), while directly acknowledging that government representation was too limited to assume adoption of the developed plan within the government system;
- (b) to ensure the structural integration of mental health and psychosocial considerations as a cross-cutting issue



within the cluster approach, while noting that there are still many divisions between the formal mental health sector and the more psychosocially oriented NGO's;

- (c) to ensure inter-agency collaboration from the beginning of the planning process in terms of coordination, service provision and capacity building was also a key reason; and
- (d) the planning process was essential to ensuring that a mechanism for actual and practical application of the guidelines was developed and will be followed.

## **Discussion**

We believe this detailed account of steps taken to introduce the IASC guidelines in Nepal can serve as a point of reflection and departure for other countries. While there are obviously many country dependent mechanisms for adopting and applying the guidelines (Melville & Rakotomalala, 2009), we argue that for settings with scarce MHPSS infrastructure and policy, the thorough preparatory phase initiated by the *working group* is essential. In the Nepal *case study*, this process has resulted in a sense of momentum for coordination in a fragmented MHPSS field, and achieved increased understanding of the overall importance of MHPSS and specifically the integration of MHPSS within emergency response systems (cf. use of the guidelines in Kenya, as described by Horn & Strang, 2009). It is likely that this would not have been achieved if the focus had been on direct capacity building and implementation, without first laying the necessary groundwork of emphasising the process of initially putting it into operation.

Of note, following the launch of the international guidelines in 2007, the guidelines

were not systematically distributed to offices of Nepal humanitarian actors, even for those agencies that were involved in developing the guidelines internationally. While this observation exceeds the reflection on this particular *case study*, it is important to keep in mind when starting such processes in other settings. Furthermore, the emphasis on a participatory based process of application of the guidelines was instrumental in engaging a large variety of actors. At the same time, the smaller coordinating group proposed the majority of decisions and made most of the time investment. Moreover, a major limitation of the *case study* has been the difficulty in structurally engaging Government stakeholders, both policy makers and the mental health care system. This issue needs to be addressed in the future. It can be explained by a lack of Government prioritisation for mental health *per se*, as there is no official mental health authority/focal point office, nor an operational mental health act for Nepal. Also, government functioning in the last decade has been severely constrained by continuing political instability. In addition, the *case study* and, in particular, the development of the contingency plan, did not exclusively focus on any specific emergency. As a result no distinction was made between natural hazards and political violence, both of which affect Nepal. For the purpose of this case study, this was not an obstacle. However, in the future, and as the guidelines become mainstreamed and systematised, such distinctions may become more relevant and should be considered. The dominant opinion within the *working group* was that application of the guidelines for political violence requires significant adaptations regarding use of the guidelines, mostly due to the fact that key segments seem more readily suited to a sudden onset disaster, as

opposed to long term complex emergencies. Overall, the Nepal *case study* is comparable to the other case studies in Peru, Colombia and Kenya, in that it has demonstrated that the guidelines are perceived as a valuable tool for facilitating coordination and lobbying for the importance of MHPSS considerations. Moreover, the initiative demonstrated the importance of ensuring that rolling out of the guidelines should be structurally integrated in the general social protection and health clusters for sustainability and state ownership.

Future planned steps in implementing the IASC guidelines in Nepal include:

- (a) the systematic inclusion of, and ownership assumed by, the government in the processes and continuation of the *working group* as a focal point to oversee the process;
- (b) multi-level capacity building of MHPSS human resources based on the guidelines, separately for front-line humanitarian workers, MHPSS workers and policy level personnel, building upon experiences in Sri Lanka (IASC, 2007b) and other countries;<sup>2</sup>
- (c) development of Nepal specific materials, such as posters with key messages, building upon the experiences in Peru (Rivera et al., 2009); Pictorial contextualisation of the guidelines will also be a strong tool in increasing accessibility, particularly given the Nepalese context of multiple languages and high levels of illiteracy (Prewitt Diaz & Dayal de Prewitt, 2009);
- (d) harmonisation and integration of current MHPSS contingency plans within the Health Cluster;
- (e) actual implementation of the guidelines as a tool for coordination,

planning and preparedness in emergencies, building upon the experience in Colombia (Echeverri & Castilla, 2009); and

- (f) conducting an external evaluation that reviews the developed contingency plans and their application in the field setting will be key in working towards an increased, and much needed, evidence base for the guidelines (Lopes Cardozo, 2009).

The utilisation of the guidelines should ultimately improve the way in which MHPSS programs are provided. The external evaluation will make a first step in assessing that in Nepal.

### Conclusion

The *case study* thus far, has resulted in Nepali translations of the guidelines and field guide and an increased awareness of relevant humanitarian actors and stakeholders on the existence and content of MHPSS considerations and the guidelines within emergency settings (i.e. that, and how, psychosocial issues are cross-cutting across sectors); the establishment of a functioning *working group* that serves as a network and coordination group for mental health and psychosocial support in emergencies; and the development of a draft contingency plan and structural integration of MHPSS within the cluster approach. The case study so far has contributed to an increased level of preparedness for MHPSS response mechanism for imminent disasters. In emphasising initial preparatory steps and a participatory decision making process, the case study was effective in creating an increased momentum for coordination, understanding and integration of MHPSS within the humanitarian system in accordance with the spirit of the guidelines. At the

same time, it points clearly to the next steps that need to be taken, focusing on broader inclusion of the government and mental health sector representation, capacity building of MHPSS human resources, and on using and testing the guidelines (and contingency plan) in actual emergency settings. The *case study* in Nepal is a small but valuable step forward in promoting and enhancing the actual application of the guidelines in Nepal and thereby aiming to improve the quality, relevance and effectiveness of mental health and psychosocial support available to affected populations in emergencies.

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<sup>2</sup> An internationally developed training and resource package is available for this purpose.