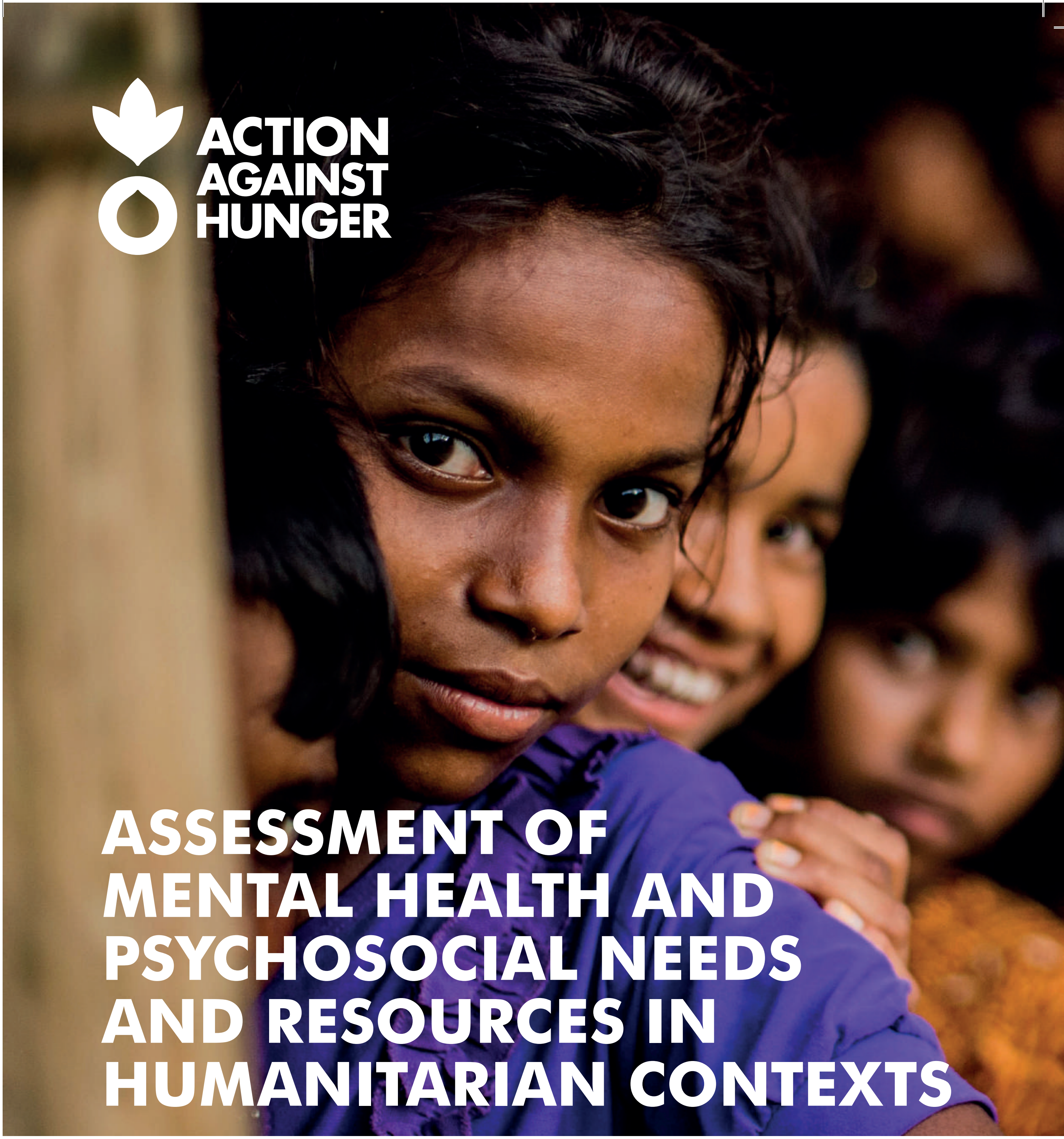
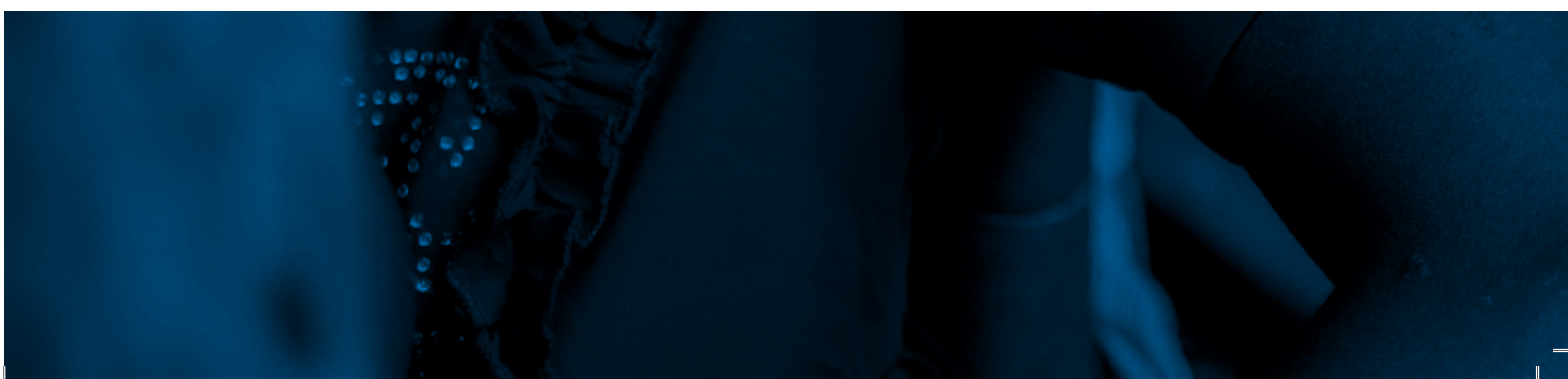


ASSESSMENT OF MENTAL HEALTH AND PSYCHOSOCIAL NEEDS AND RESOURCES IN HUMANITARIAN CONTEXTS

HOW-TO-GUIDE



ASSESSMENT OF MENTAL HEALTH AND PSYCHOSOCIAL NEEDS AND RESOURCES IN HUMANITARIAN CONTEXTS

TABLE OF CONTENTS

STATEMENT ON COPYRIGHT

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The present document aims to provide public access to information concerning the actions and policies of Action contre la Faim. The objective is to disseminate information that is accurate and up-to-date on the day it was initiated. We will make every effort to correct any errors that are brought to our attention. This information:

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PURPOSE OF MANUAL AND HOW-TO-USE IT

This manual is designed to assist Action contre la Faim (ACF) staff responsible for designing and undertaking a mental health/psychosocial needs and resources assessment in humanitarian contexts. An accurate and thorough needs assessment is a necessary step in developing and or identifying effective, efficient and socially acceptable approaches to addressing mental health/psychosocial needs. A good assessment can provide important information on the population ACF aims to assist: the problems they face, how they are coping, what resources they have – in order for ACF to make an informed decision on how to most effectively respond.

This manual provides guidance on each step of undertaking a mental health and psychosocial needs and resources assessment for ACF. There is no "cookie-cutter" approach to assessments – but there are issues that you can be familiar with and recommendations as to a general approach that you can follow. In brief, an assessment aims to identify what individuals do not have that they need – and what they have and, moreover, which ACF might provide. It is essential to think through each step carefully as this information will be useful in guiding responses, and showing changes among beneficiaries and the effectiveness of ACF's work.

The outline of the manual corresponds to the "**Major Steps of a Needs Assessment (STEPS 1 – 6)**" and annexes provide additional guidance, useful documentation or direction to obtain further information. The "**Decision Tree**" diagram diagram (p. 9) shows the process that should be followed for STEPS 1, 2 & 3.[1] It is hoped that any bottlenecks you face can be effectively addressed using this manual (or through the resources it recommends), however, always communicate problems and direct any questions to the Mental Health and Care Practices Regional Technical Advisors or the Senior Technical Advisor for the Mental Health and Care Practices Department at ACF headquarter.

This manual should be read through entirely prior to beginning the needs assessment to get a general idea of the steps, resources and "flow". As you work on this assessment, you should complete Tool 5 "Decision Form" and Tool 6 "Timeline" (in Annex 6).

1 - These steps will require you to make some decisions – as there is no one "best method of assessing health needs" but rather "different issues and questions require different methods and approaches and degrees of detail..." (McEwan, Russell, & Stewart, 1995).

DESCRIPTION OF STEPS 1 TO 6

- **STEP 1. UNDERSTANDING YOUR NEEDS ASSESSMENT**
  Clarify purpose of assessment. Understand why ACF has planned this assessment: Does the assessment aim to describe specific needs, specific groups? Is it for the purpose of establishing a program or expanding a project? Is this information going to be used by other organizations? You also want to consider what resources are available to you and what constraints you may have: What is your timeline? Do you have people who can assist you? What skills do they have (what training would they need)? Are there security issues, which may hinder movement to certain areas and reaching specific populations?

- **STEP 2. GATHER INFORMATION**
  For information, look at various aspects of the setting –including at the event itself, as well as the economic, social and cultural context. As possible, you would want to consider answering the following questions: What do we know about mental health needs and implications already? Or about healing approaches and processes? What research/activities are other organizations supporting or undertaking? What surveys/instruments already exist to assess needs?

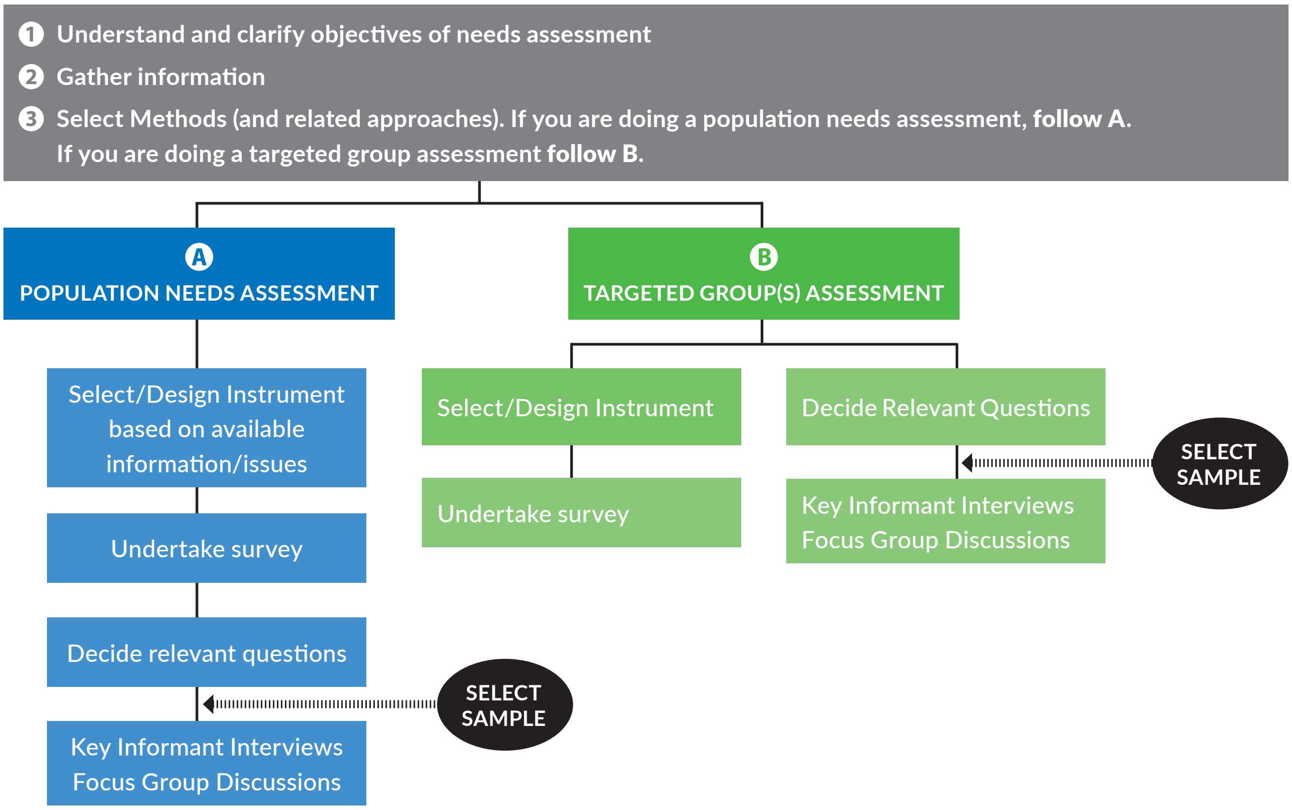
- **STEP 3. DETERMINE STUDY APPROACH/METHODS**
  On the basis of objectives, available resources, and a solid understanding of the setting you need to identify and select methods and, in tandem, an approach to analysis. You should review these decisions with ACF Mental Health and Care Practices (MHCP) staff and be able to explain and justify your decisions in this regard: Some questions you should consider are: How will data be collected (survey, focus group discussions, key informant interviews, a combination of these)? What type of survey/questionnaire(s) will be used (does it need to be culturally adapted?) What sampling methods will be used? How will you record, store and enter data? How you will ensure confidentiality?

- **STEP 4. PREPARE AND IMPLEMENT STUDY**
  You will likely need to provide training to those people assisting with the study – related to their roles and responsibilities. How can each staff person help? What are the expectations for each person in terms of their roles and responsibilities (including the timeframe for completing their assigned tasks)? What essentials do they need to know about interviewing individuals or leading focus groups (ethical issues, e.g. informed consent)? How will you supervise data recording and entry? A well-planned study will adhere to a schedule and there should be adequate supervision and resources to address any bottlenecks. It is important during the study to ask yourself: Are procedures being followed? Are individuals sampled participating in study? Are data being entered correctly? And to respond accordingly to address any identified issues.

- **STEP 5. ANALYZING AND INTERPRETING DATA**
  Since you have decided what issues and which individuals the study will focus on, your instruments and surveys should collect data that you need. Based on the objectives, you can create variables from these data which can be analyzed – and use quantitative (means, regression, etc.) and/or qualitative (content analyses, case studies) analyses. Does your analysis correspond to the questions you initially asked? Can you find additional information in the data, which provides insight into needs? Do you see important issues/themes emerge that are relevant for ACF or others using this assessment? What would they be?

- **STEP 6. DESCRIBING YOUR FINDINGS**
  On the basis of your objective and the questions the study sought to answer, you should provide information that provides answers to these questions in a simple and clear manner. Can you present this material better in writing? How might visual representations demonstrate your point? Did the findings confirm or refute your initial hypothesis or hypotheses? Why or why not? What important information was obtained? What other information is needed (in the short- or long-term)? On the basis of these findings, and your own knowledge and experience, what steps do you recommend ACF take and why?

DECISION TREE



KEY POINTS TO REMEMBER

- **Know the organization:** Familiarize yourself with ACF's mandate and objectives in mental health and psychosocial support. You should also be familiar with previous assessments in the country, local approaches, and practices in place. You should have an understanding before beginning the assessment as to whom ACF can assist and what type of assistance could be offered as this will influence the design of study and the focus of recommendations.
- **Stay organized:** Keep information collected during the course of the study organized and stick to the planned steps and timeline for the assessment. This will ensure that you have adequate time for each step and are able to access necessary information throughout the assessment as needed.
- **Keep and maintain records:** Keep accurate, readable and current records. It is best if information collected (e.g., findings, data, etc.) can be recorded during the day while in the field. Remember, it is essential in any meeting with people to indicate that this information will be confidential. Since recording information may not be possible throughout the day, it is useful to spend at least ½ hour per evening compiling your findings, including notes on meetings, next steps, and observations.
- **Acknowledge existing limitations:** Pace yourself. There are time constraints to undertaking a needs assessment – and these should be acknowledged. Not every issue can be identified, assessed and described. This is okay as this is not an anthropological dissertation. The purpose of the needs assessment is to give ACF an assessment based on data that can be feasibly collected, analyzed and presented during the allotted timeframe.

STEP 1

UNDERSTAND YOUR NEEDS ASSESSMENT

ACTION 1.1

ACQUIRE OR STRENGTHEN YOUR UNDERSTANDING OF ACF'S OBJECTIVES AND APPROACH TO MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

ACTION 1.2

CLARIFY VARIOUS ASPECTS OF YOUR ASSESSMENT

STEP ❶ - UNDERSTAND YOUR NEEDS ASSESSMENT

THIS MANUAL FOCUSES ON GENERAL POPULATION ASSESSMENTS AND ASSESSMENTS OF VULNERABLE GROUPS - WITH PARTICULAR ATTENTION TO MENTAL HEALTH AND PSYCHOSOCIAL NEEDS AND RESOURCES OF INDIVIDUALS (ADULTS, ADOLESCENTS, CHILDREN AND INFANTS).

IT IS IMPORTANT TO HAVE A CLEAR IDEA OF VARIOUS ASPECTS OF YOUR NEEDS AND RESOURCES ASSESSMENT, INCLUDING YOUR ROLE, ITS OBJECTIVES, AVAILABLE RESOURCES (INCLUDING TIME, STAFF AND MATERIALS) AND YOU SHOULD NOTIFY LOCAL COMMUNITIES AND AUTHORITIES AND ENSURE THEIR APPROVAL BEFORE BEGINNING.

ACTION 1.1

ACQUIRE OR STRENGTHEN YOUR UNDERSTANDING OF ACF'S OBJECTIVES AND APPROACH TO MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

In order to conduct a needs and resources assessment, you should be familiar with ACF's objectives, mandate and activities. In conflict-affected and natural disaster settings, many of the people have experienced a traumatic event coupled with depression, stress or bereavement. In many settings, the family unit has broken down and may be less able to care for their children – due to limitations in resources and poor mental health outcomes. The interaction and care provided by the caregiver has a significant impact on the cognitive, motor and language development and mental health of an infant and child – as they grow into adulthood.

ACF aims to support and improve mental health and psychosocial support (including child care practices) through its various activities. This is consistent with the fact that ACF works in areas where these are often important issues and given the strong relationship between poor mental health and absence of necessary care practices. More specifically: (1) ACF intervenes in emergency situations where populations often experience psychological distress and trauma which, in many instances, can lead to mental disorders; (2) ACF aims to address malnutrition which can often be driven by poor child care practices and maternal mental disorders, which in turn can have negative consequences for infant and child development.

Before looking towards solutions. It is essential to better understand mental health and well-being – with consideration for individuals' beliefs, practices and socio-cultural relations. Thus, it is important to first understand child care practices – which include breastfeeding and young child feeding; psychosocial care of an infant/child; preparation of food; hygiene practices; care for women; and home health practices - specifically the current care practices used by families in the setting where you are undertaking the assessment with attention to how they are different from those employed prior to the natural or man-made disaster.

ACF, by better understanding caregivers' practices and constraints to adequate nutritional and psychosocial care, can strengthen the child-parent relationship and support those practices and attitudes, which are most beneficial for infant and child development as well as for mother's well-being. This can be achieved through community activities including focus group discussions on various issues (e.g., breastfeeding, how to wash and massage a baby), psychosocial support for mothers, and community strengthening activities.

CHILD MALNUTRITION AND MATERNAL MENTAL HEALTH:
If a child is not given adequate nutritional and psychosocial care and begins to engage less, and reduce his/her activity level, a caregiver may, in return, provide less stimulation – leading to a vicious negative cycle. Since a child's brain is most active during the first two years of life, the implications can be serious whereby nutritional deficits and psychosocial dysfunctions can lead to poor health outcomes, long-term impairment and disability. Indeed, research shows that maternal common mental disorders (CMDs), in particular, depressive and anxiety disorders pose a serious public health concern because of their adverse effect on infant development. Infants of mothers with these disorders have been found to have poorer motor, cognitive and socio-emotional development than children of mothers without CMDs in many studies.

IN THE AREA OF MENTAL HEALTH AND PSYCHOSOCIAL, ACF SPECIFICALLY AIMS TO:

1. Prevent acute malnutrition by reinforcing positive child care practices and caregivers well-being
2. Prevent deterioration of child care practices during crises
3. Improve treatment and limit negative impacts of malnutrition on child health
4. Provide psychological care for populations in crises
5. Reinforce quality of its programs and its impact on the beneficiaries' health and well-being

The overarching aim of these activities is to "restore, maintain and improve child care practices and to reduce child malnutrition as well as to participate in improving the mental health of populations in crisis."

ACTION 1.2
CLARIFY VARIOUS ASPECTS OF YOUR ASSESSMENT

Technically speaking, an assessment is a collection of data and analysis of information to examine country or sector context to inform project design, or an informal review of projects. Assessments should always cover the sociocultural context (setting, culture, history, and nature of problems, local perceptions of illness and ways of coping), available services, resources, needs, etc. (Van Ommeren, et *al*, 2005).[2] For more information, see Action 3.2.

GENERALLY, A MENTAL HEALTH/PSYCHOSOCIAL NEEDS AND RESOURCES ASSESSMENT AIMS TO ANSWER THE FOLLOWING QUESTIONS

1. Who is suffering? (and what are the most vulnerable groups impacted by the situation?)
2. How has the crisis affected the population well-being?
3. What are their coping mechanisms/how are they different than prior to the disaster?
4. What support do they have/what are they missing?
5. What is needed and what can ACF potentially do to help?

This is not a guide for a *rapid assessment*. This assessment should go further in-depth to understand needs and resources in both the short- and long-term.

For your assessment, you may be focusing on identifying the needs and resources of an entire population **OR** a targeted group (or groups). If there is already a population-based needs and resources assessment, you can use these data to guide more focused assessment. If there is no needs and resources assessment on the population or on the group you aim to study, you will need to begin with an initial population needs and resources assessment. This can then be followed by a more focused assessment of the needs and resources of a specific group you have identified.[3]

BE ABLE TO CLEARLY ARTICULATE THE FOLLOWING ASPECTS OF THE NEEDS ASSESSMENT

OBJECTIVES AND AUDIENCE

Pinpoint as precisely as possible both the objective of the assessment and the audience for the findings. Consider the following questions – *Have some of the objectives been specified? For example, has a population (or population sub-group) been identified as the target group or has information on specific needs[4] been requested? Why is this assessment being done now? When is the intervention planned (is it for immediately after the crisis phase ends?) It is helpful to complement your needs and resources assessment objective with a hypothesis/hypotheses.[5]* Think: *what is happening here? What are the issues? Is one thing affecting, causing or producing a change? Why is this?*

TIMELINE

Regardless of when you are doing this assessment, you need to be sure there is adequate time allotted for each step of the needs assessment. Regardless of the timeline, a "quick and dirty" approach is not recommended (using only, for example, samples of convenience). It is important to consider the following questions: *What is your timeline? And at what time point in the disaster is this assessment taking place (immediately after, one month after, etc.)?* – this will influence the methods you select and data you will aim to collect.

TEAM

It is important that you consider the different tasks that will be carried out and the support you would need to effectively carry out your assessment. Ask yourself, *what human resources do you already have that can support you in carrying out this needs and resources assessment? Are they adequate for the required tasks or do you need more support? Is your staff local or expatriates? What is there time availability? What are their skills?*

2 - Van Ommeren, M., Saxena, S., & Saraceno, B. (2005). Aid after disasters. BMJ (Clinical research ed.), 330(7501), 1160-1161. doi:10.1136/bmj.330.7501.1160.

3 - See "Decision tree" (above in this document) which shows Tier 1 and Tier 2 Needs Assessments. Tier 1 refers to the population needs assessment and Tier 2 illustrates the targeted group needs assessment. An assessment can include either Tier 1 or Tier 2 assessments, or can include Tier 1 assessment followed by a Tier 2 assessment.

4 - A discrepancy between a target state and an actual state (i.e. what should be versus what is).

5 - A hypothesis is a statement, which asserts a relationship between concepts. An example of a hypothesis for a study could be: Mental disorders are more prevalent among (X) (who) because of (Y) reasons. A study would explore this with consideration for the null hypothesis that the statement is not true.

PERMISSION AND APPROVAL FROM LOCAL COMMUNITY/AUTHORITIES

It is important to ensure that you have discussed with the local communities and authorities the purpose of your research and its methods – and the findings should be shared with them. Have the authorities/local organizations been made aware of the assessment? Are they supportive? Do they have preferences with regards to aspects of your assessment?

LEARN MORE

Before going any further, you may want to consult the following resources[6]:

- Action by Churches Together (ACT) Alliance, Lutherhjalpen, Norwegian Church Aid and Presbyterian Disaster Services (2005). *Community assessment of psychosocial support needs. Chapter 6, Community-based psychosocial services: A facilitator's guide.*
- Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) (2003). *Participation of crisis-affected populations in humanitarian action: A handbook for practitioners. Assessments, Chapter 3*. London: Oversea development Institute.
Available at: http://www.alnap.org/resource/5271
- European Commission, the United Nations Development Group, World Bank. (2013). *Post-Disaster Needs Assessments (PDNA). Volume A. Guidelines.*
Available at: http://www.undp.org/content/undp/en/home/librarypage/crisis-prevention-and-recovery/pdna.html
- Inter-Agency Standing Committee (IASC) (2007). *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.* Geneva: IASC.
Available at: https://interagencystandingcommittee.org/product-categories/mental-health-and-psychosocial-support
- IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings. (2012). *Mental Health and Psychosocial Support Assessment Guide*, IASC RG MHPSS. Geneva: IASC.
Available at: https://interagencystandingcommittee.org/system/files/iasc_rg_mhpss_assessment_guide_.pdf
- ICRC and International Federation of Red Cross and Red Crescent Societies (2008). *Guidelines for assessment in emergencies.* Geneva: ICRC.
Available at: http://www.ifrc.org/en/what-we-do/disaster-management/responding/disaster-response-system/emergency-needs-assessment/
- International Organization for Migration (IOM) (2010) *Psychosocial Needs Assessment in Emergency Displacement, Early Recovery, and Return*. Geneva: IOM.
Available at: http://health.iom.int/sites/default/files/pdf/Psychosocial-Needs-Assessment-Emergency-Displacement-Early-Recovery-Return-IOM-Tools.pdf
- Josse E. (2006). Guide pour un assessment rapide des besoins psychosociaux et en santé mentale des populations affectées par une catastrophe naturelle.
Available at: http://www.resilience-psy.com/IMG/pdf/guide_assessment_net_e.josse.pdf
- Médecins Sans Frontières. (2011). *Field assessments: Chapter 1, Part III in Psychosocial and Mental Health Interventions in Areas of Mass Violence. A Community-Based Approach.* Amsterdam: MSF
Available at: https://www.msf.org/psychosocial-and-mental-health-interventions
- World Health Organization & King's College London (2011). *The Humanitarian Emergency Settings Perceived Needs Scale (HESPER): Manual with Scale*. Geneva: WHO.
Available at: http://www.who.int/mental_health/publications/hesper_manual/en/
- World Health Organization & United Nations High Commissioner for Refugees (2012). *Assessing mental health and psychosocial needs and resources: Toolkit for humanitarian settings.* Geneva: WHO.
Available at: http://www.who.int/mental_health/resources/toolkit_mh_emergencies/en/

You will also find more references in *Annex 1* of this document.

6 - None of these resources provides all the guidance that is found in this manual – but they might have more information on specific aspects that may be useful for carrying out the assessment.

STEP 2

GATHER INFORMATION

ACTION 2.1
UNDERSTAND EVENT CONTEXT/EXPOSURE

ACTION 2.2
OBTAIN INFORMATION ON MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING

ACTION 2.3
BECOME FAMILIAR WITH KEY ASPECTS OF THE CONTEXT AND CULTURE

ACTION 2.4
LEARN ABOUT ORGANIZATIONS AND SERVICE PROVIDERS AND ABOUT THEIR ACTIVITIES

ACTION 2.5
ACTION 2.5 UNDERTAKE EXPLORATORY RESEARCH BASED ON WHAT YOU HAVE LEARNED UP UNTIL THIS POINT

ACTION 2.6
COLLECT, COMPILE AND SUMMARIZE AVAILABLE INFORMATION

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STEP 2 - GATHER INFORMATION

IT IS ESSENTIAL TO UNDERSTAND VARIOUS FEATURES OF THE SETTING WHERE YOU ARE PLANNING TO CARRY OUT THE NEEDS AND RESOURCES ASSESSMENT.

EVEN IF YOU KNOW OR ARE FAMILIAR WITH THE AREA/SETTING, YOUR KNOWLEDGE SHOULD BE UPDATED, SUPPLEMENTED AND CONSOLIDATED.

KEEP YOUR OBJECTIVES IN MIND TO GUIDE YOU IN SIFTING THROUGH AVAILABLE RESEARCHES.

ACTION 2.1
UNDERSTAND EVENT CONTEXT/EXPOSURE

You should be familiar with and knowledgeable of the specifics of the disaster[7] in terms of details of the event, as well as its timeline and geography. In addition, you should look at the context in which the event took place.

EXAMPLE

In Sri Lanka, the December 2004 Tsunami had a devastating impact on the population. However, in order to understand the population and their needs and resources, it is also important to consider that the population had been previously and continuously exposed to political strife and high-levels of insecurity and violence.

You may be carrying out your assessment in the aftermath of any of these types of disasters:

- Natural disaster (tornados, fires, landslides, earthquakes), either:
  - Rapid onset disaster (earthquake, tsunami)
  - Slow onset disasters (drought, erosion)
- Technological disaster (nuclear explosions, radioactive leakage)
- Man-made disaster (conflict, war, terrorism, forced displacement)

In a large part, when gathering information – and in the study you undertake – you want to obtain the following information:

- Relevant demographic and contextual information[9]
- Type/experience of the disaster/emergency
- Issues among population related to three domains
  - Mental/Emotional
  - Social/Functioning
  - Skills/Knowledge
- Psychosocial resources
- Support and activities provided by local, national and international organizations
- Needs and resources
- Opportunities

You can obtain a portion of this information from background research[10] (that is, a desk review[11], reading organizational literature, meeting with organization representatives, community leaders, etc.) – what you cannot find and/or want to study further should be specifically explored studied in the body of your study (the survey, focus groups, etc.) that you will design and plan.

LEARN MORE

One extremely useful tool is the Mental Health and Psychosocial Support Network, where you can find information on organizations, ongoing innovative projects, researches, situation reports, etc.
You can subscribe at: http://mhpss.net/

7 - A disaster is an unexpected natural or man-made catastrophe of substantial extent causing significant physical damage or destruction, loss of life or sometimes permanent change to the natural environment, or an unforeseen event causing great loss, upset or unpleasantness of whatever kind. Originally meaning "unfavourable to one's stars", from dis-, bad (compare dys-), + astro, star, celestial body, from Latin astrum, from Greek astron.

8 - The Cambodian definition of the term torture: = tieruna kam (tierun = cruel, savage); (Kam, Kammea, Karma = action, dead, act, activity, a work; calamity; fate; Karma; an action or thoughts (often of an evil nature) in prior existence that produce effects in subsequent existence). Cambodians who have been tortured generally feel they are somehow responsible for their suffering, because of their karma.

9 - This would include: basic population information, land size, threats to mortality and morbidity, access to basic physical needs, human rights violations, social, political, religious and economic structures, changes in livelihoods/activities since the disaster, and cultural norms.

10 - Some of this information may be obtained prior to arrival in the country, some cannot as can be seen from the descriptions below.

11 - Some examples of desk review can be found here: https://mhpss.net/emergency-toolkit/#mapping

ACTION 2.2

OBTAIN INFORMATION ON MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING

You do not want to duplicate efforts – so it is essential to see what is already out there and what may be useful to your assessment. Currently, there is a large amount of research on mental health and psychosocial, needs, resources and interventions in various contexts and for different populations worldwide.

LEARN MORE

Some resources are available at:

- Reliefweb: *http://reliefweb.int/*
- Mhpss.net has desk reviews for different contexts: *http://mhpss.net/groups/current-mhpss-emergency-responses/emergenciescrisis-briefs/mhpss-desk-review-reports/*
- ALNAP: *http://www.alnap.org/*
- EvidenceAid: *http://www.evidenceaid.org/*
- World Health Organization & United Nations High Commissioner for Refugees (2012). *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings*. Geneva: WHO. *Available at: http://www.who.int/mental_health/resources/toolkit_mh_emergencies/en/*

You should look at various types of data including published and unpublished studies and reports (i.e. survey/surveillance system data, census data, program-based data, screening instruments, anthropological research, etc.). A number of screening tools have also been adapted to various contexts/cultures and used to assess mental and psychosocial well-being. Some of the cross-cultural research and available tools can be found in Annex 2. You should also look for any instruments that have been developed more recently. You can do this by searching by population, country, or author or individual who has already published on this. You can always contact an author to ask for more information and to request a copy of a screening tool, for example.

You want to pay attention to:

1. the manifestation, prevalence and severity of mental health issues
2. coping mechanisms/functioning before and after the event
3. ongoing or planned studies and/or assessments
4. ongoing and/or effective psychosocial interventions

A number of other resources can provide information on mental health and psychosocial reactions in the aftermath of natural and man-made disasters.[12] Though there is no standard mental health and psychosocial response to disasters, there are a number of problems and conditions that have been found in their aftermath, which are described below.[13] It is also important to consider the strong linkages between culture and mental health (see: Action 2.3)

Among disaster- and conflict-affected populations, often a high prevalence of depression, post-traumatic stress disorder (PTSD) and symptoms of psychological distress have been found – as a result of traumatic events, loss of loved ones, forced displacement, etc. For some individuals, the reaction may be mild, for others far more severe. While certain people experience an immediate reaction, mental health effects can also lie dormant for months or even years after the crisis. The impact, severity and duration of mental health problems faced by survivors depend on a range of factors – the extent and nature of the disaster; pre-existing mental health problems and prior traumatic experiences; the loss of relatives, friends or personal property; extent of physical injuries suffered; type of violence experienced and/or witnessed, and the possibility of accessing family and community support.

12 - Centers for Disease Control and Prevention (CDC) (2011). Disaster mental health primer: Key principles, issues and questions. Available at: https://stacks.cdc.gov/view/cdc/29151

Leon, G.R. (2004). Overview of the psychosocial impact of disasters. Prehosp Disaster Med, 19(1), 4-9.

Murthy, R.S. & Lakshiminarayana, R. (2006). Mental health consequences of war: a brief overview of research findings. World Psychiatry, 5(1): 25-30. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1472271/

World Health Organization (2003). Mental health in emergencies. Department of Mental Health and Substance Abuse Dependence. Geneva: WHO. Available at: http://www.who.int/mental_health/emergencies/en/

13 - These are not the only issues you may want to explore, but some of those most frequently found in available research. In any population, there will be some variation in terms of the impact of a disaster on the mental health of a population. There will likely be: 1) severely affected individuals (e.g. individuals who have developed a mental disorder); 2) at risk individuals (e.g. individuals who are psychological distressed but who have not developed a mental disorder; and 3) generally affected individuals (e.g. those who may not have been directly affected but they may be suffering, for example, from mental and physical exhaustion).

Remember that this assessment is likely occurring immediately after a disaster or a conflict period. Often following the disaster, in the "post-disaster" phase, disillusionment can settle in reducing the functioning of a community. People may become more irritable, less tolerant and poor behaviors may reappear as the realization that "normal" of the pre-disaster period will never really be reestablished. Disillusionment comes from the knowledge that there is no quick fix and that the reconstruction and recovery period will take a long time. The greatest need for culturally appropriate interventions is during this period. Further, it is important to remember that a disaster is not just a point of impact – and individuals may be in different phases of recovery, etc. depending on a number of variables.

FOCUS ON THREE DOMAINS

Following other organizations, we have broken down the mental health and psychosocial issues to consider and to assess into three domains:

- **Mental/Emotional issues**
- **Social/Functioning issues**
- **Skills/Knowledge issues**

You want to consider and assess the target population on each of these areas in your assessment, which are broadly described below.

1. MENTAL/EMOTIONAL ISSUES

SYMPTOMS OF DEPRESSION AND DEPRESSION are experienced by children[14], adolescents, adults and the elderly[15]. Depression can manifest as a combination of feelings of sadness, loneliness, irritability, worthlessness, hopelessness, agitation, and guilt, accompanied by an array of physical symptoms (this is more common in non-Western settings). People who are depressed often have difficulty continuing to carry out some of their daily tasks (reduced functioning, see below). Persons who are depressed may not recognize that they are depressed though they describe having symptoms of depression including fatigue, sleep problems, pain, loss of interest in sexual activity, or multiple, persistent vague symptoms. Depression is associated with an increased risk of physical illness as well as interpersonal and psychosocial difficulties that can persist long after the depressive episode is resolved. It is also associated with an increased risk of substance abuse and suicidal ideation.

IMPORTANT INFORMATION TO REMEMBER ABOUT MATERNAL DEPRESSION
Maternal depression is common during perinatal period. It disrupts the care giving environment and, in turn, an infant[15] and child's development (through either poor care practices and/or maltreatment). When a mother is depressed, difficulties can arise in the mother-child relationship. Research shows that depressed mothers often have less vocal and visual communication with their infants and infants of mothers with Common Mental Disorders (CMD) have been found to have poorer motor, cognitive and socio-emotional development than infants of mothers without any disorders.

POST-TRAUMATIC STRESS DISORDER (PTSD) a type of anxiety disorder may occur soon after a major trauma, or it can be delayed for more than 6 months after the event.[17] PTSD can occur at any age and can follow a natural disaster, war, assault, domestic abuse, or rape. PTSD changes the body's response to stress affecting the hormones and chemicals that carry information between the nerves (neurotransmitters). PTSD is characterized by "re-experiencing" of the event (dreams, flashbacks, physical reactions to reminders of event), avoidance (numbing, lack of interest in normal activities, hopelessness) and arousal (irritability and outbursts of anger, hypervigilance, and difficulty concentrating).

14 - It is rare to see depression in children younger than six years old. It is harder to identify since limited language abilities make it necessary to integrate information from multiple sources though there are various screening instruments that can be used.

15 - Depression frequently goes unrecognized and is even commonly dismissed as part of the normal aging process. It is often difficult to address given the decline of cognitive and functional capacity. Minor depression is also a critical issue amongst the elderly; 25% of all suicides occur within the elderly population (and the risk increases with age).

16 - During the first two years of life, infants grow and develop in many ways. Two types of motor development occur at this stage: cephalocaudal and proximodistal. Motor development has a powerful impact on the social relationships, thinking, and language of infants. Large motor development allows infants to have more control over actions that help them move around their environment while small motor development gives them more control over movements that allow them to reach, grasp and handle objectives. The sequence of these developments is similar in most children; however, the rate of growth and development varies by individual.

17 - When it occurs soon after the trauma, it usually gets better after 3 months. However, some people have a longer-term form of PTSD, which can last for many years.

Physical symptoms may include dizziness, fainting, fever and headache, among others. While research has shown that symptoms of PTSD are found in most (if not all) populations exposed to traumatic stress, as some have also noted, the presence of PTSD symptoms in a particular culture does not necessarily mean that PTSD represents the primary expression of psychological trauma in that context, or that the syndrome – even when clearly present – represents the most pressing mental health concern relative to other forms of war-related suffering. For more information on cultural and mental health, see Action 2.3.

ALCOHOL/SUBSTANCE ABUSE AND DEPENDENCE. Adults exposed to a range of traumatic events, including large scale disasters, are vulnerable to developing substance abuse/dependence issues. It is often used as a strategy (negative) for coping with the negative emotional responses associated with prior traumatic events (e.g. PTSD is associated with greater frequency of heavy drinking). Though it may seem to provide some immediate relief from either anxiety or pain, in reality, it complicates and confounds the healing and recovery process.[18] Substances can disrupt sleep, especially stage four or deep sleep, and they can increase nightmares and make them more vivid and believable. A person who abuses substances can easily be re-traumatized because of impaired decision-making, furthering a use-abuse-trauma-use cyclical dynamic.

Among a portion of the population, mental distress will manifest in physical symptoms through the process of somatization (experiencing physical symptoms with no underlying biological cause). This should also be considered in the context of an assessment.

2. SOCIAL/FUNCTIONING ISSUES

REDUCED FUNCTIONING can be a serious consequence of mental disorders and of trauma itself. A large body of research describes the consequences of depression in terms of reduced functioning (or dysfunction[19]). Depression and PTSD are associated with social and functional impairment – with impairment comparable to or worse than the level associated with other chronic illnesses. Often, functioning is compromised through a reduced level of energy and an inability to concentrate. Both depression and PTSD are associated with reduced functioning (in terms of employment and/or day-to-day activities).

COPING MECHANISMS. Coping describes an individual's approach to dealing with positive and negative events that are perceived to be stressful. In those situations, life changes require adjustment and adaptation that may affect psychological and physical health. Appropriate coping mechanisms will help to prevent and alleviate psychological distress and physical illness. For example, maintaining emotional social support and problem solving can help an individual coping with stressful events. Besides, some coping mechanisms are more efficient than others in protecting the person's psychological integrity: denial, repression and splitting are mechanism encountered in cases of trauma.

CONFLICT MANAGEMENT SKILLS. Managing conflict is an important social skill that allows relationships to be strengthened, problems to be solved more efficiently and tension to be reduced while handling a difficult situation.

QUALITY OF LIFE refers to more than personal health status – it also takes into account social well-being. Quality of life is measured and understood by looking at the following variables: one's functional ability, social role functioning, the degree and quality of social and community interaction, psychological well-being, somatic sensation (e.g. pain) and life satisfaction.

SOCIAL WELL-BEING is measured and understood by looking at: one's attachment with caregivers, relationships with peers, sense of belonging to a community, access to socially appropriate roles, resuming cultural activities and traditions. It is more difficult to measure and assess and may be more easily understood through qualitative research.

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18 - First, substance use only provides temporary relief, if any at all; it often blocks necessary psychological processing and can prevent or delay the natural completion of the grieving process; Second, it often results in lower functioning capacity resulting in poor choices and poor decisions and even behavioral dysfunction; third, rather than calming nerves, alcohol and other drugs can actually increase both anxiety and fears, they intensify and exaggerate emotions so they come out drug-affected... and long term use can even cause emotional stagnation.

19 - The term dysfunction is used rather than disability in order to distinguish it from reduced mobility/physical disability described above. The terms impairment, disability and dysfunction are often used interchangeably in the literature. A distinction in the present study is made between physical disability/reduced mobility or impairment (inability to perform essential physical tasks of daily living due to limited mobility, strength, etc.) and dysfunction (inability to perform essential as a result of depression). For example, reduced functional impairment (which we refer to in this study as dysfunction) is a criteria of depression in the DSM IV TR (APA, 2000), whereas specific limitations in terms of mobility and strength are not. Though they are not necessarily discrete phenomena (e.g. dysfunction might lead to physical impairment), this study considers them to be discrete.

3. SKILLS/KNOWLEDGE ISSUES

LIFE SKILLS are *"abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life"* as defined by WHO (2003). *"In particular, life skills are a group of psychosocial competencies and interpersonal skills that help people make informed decisions, solve problems, think critically and creatively, communicate effectively, build healthy relationships, empathize with others, and cope with and manage their lives in a healthy and productive manner. Life skills may be directed toward personal actions or actions toward others, as well as toward actions to change the surrounding environment to make it conducive to health".*[20]

VOCATIONAL SKILLS are empirical skills that individuals acquire in a specific area that would be relevant to a job. To perform a specific role in the labor market, knowledge, practical competencies, know-how and attitudes are necessary. Developing relevant skills can allow an individual to contribute to the local economy and this can be helpful to individuals who have experienced psychological distress or mental disorders. For more information, please refer to "Skills development through community-based rehabilitation (CBR). A good practice guide" developed by the International Labour Organization (2008).[21]

CHILD CARE PRACTICES refers to those interactions, behaviors and activities performed or practiced by a caregiver for the well-being of an infant/child, examples of such practices include: breastfeeding and young child feeding; psychosocial care of an infant/child; preparation of food; hygiene practices; care for women; and home health practices. Normative practices and current practices can be understood through desk review, observation and interviews with individuals/community members. They can be assessed with indicators related to breastfeeding for infants less than 6 months, family psychosocial stimulation at home, mother-child interactions, women's empowerment, etc.

20 - World Health Organization (2003). Skills for health: skills-based health education including life skills: an important component of a child-friendly/health-promoting school. Geneva: WHO. Available at: http://www.who.int/iris/handle/10665/42818

21 - International Labour Organization (2008). Skills development through community-based rehabilitation (CBR). A good practice guide/Geneva: ILO. Available at: https://digitalcommons.ilr.cornell.edu/cgi/viewcontent.cgi?article=1538&context=gladnetcollect

ACTION 2.3

BECOME FAMILIAR WITH KEY ASPECTS OF THE CONTEXT AND CULTURE

General information about the context should be obtained, including information on the population and setting and about any specific group whose needs and resources you are assessing. This might include: demographic information, religious beliefs, the political system and socio-economic status among different groups. One useful guide is "Strengthening the Social Analysis Component in Rapid Impact and Vulnerability Assessment" (IFRC, 2007).[22]

SOME GENERAL ISSUES YOU MAY WANT TO CONSIDER TO UNDERSTAND THE CONTEXT INCLUDE:

- Safety and security in the area
- Features of vulnerability of different groups
- Education and recreation practices
- Community networks, traditions, cultural norms and habits
- Major changes since the conflict

It is very important to consider culture. Culture refers to the following aspects of life: language, arts and sciences, thought, spirituality, social activity and interaction. It is formally defined as the *"customary beliefs, social forms, and material traits of a racial, religious, or social group"*. (Merriam-Webster).

It is particularly important to consider culture in the context of understanding health needs – given that the manifestation of health and illness – as well as the healing process endorsed – are influenced, to a great extent, by culture. Culture, therefore, must be considered in order to understand needs and resources, how these needs and resources are expressed and potential issues to consider in providing assistance. **More specifically, culture impacts psychosocial dynamics and is thought to domains including:**

- Prevalence of mental illness
- Etiology of disease[23]
- Phenomenology[24] of distress
- Diagnostic and assessment issues
- Coping styles and help-seeking pathways
- Treatment and intervention issues

It is important to explore the cultural meaning attributed to trauma: the community diagnosis describes the cultural and socio-political meaning of traumatic life experiences, including torture, mass violence and natural disaster and cultural specific symptoms: these symptoms include the manner in which members of the society express their emotional suffering and being upset. *"Folk diagnoses"* are those cultural/linguistic definitions which categorize these symptoms (this is from the Cultural Influences on Mental Health (CIMH) model).[25]

SPECIFICALLY, YOU SHOULD SEEK TO UNDERSTAND CULTURAL NORMS RELATED TO:

- Who is considered helpful and sought out for help when suffering?
- What are rites of passage, cleansing or spiritual activities practiced?
- When someone suffers from a traumatic event and dies, what rituals/practices are held?
- How does the community understand the event (its meaning)?

22 - IFRC & Prevention Consortium (2007). Strengthening the Social Analysis Component in Rapid Impact and Vulnerability Assessment. Workshop report 29-31 January. Panama. Available at: http://proventionconsortium.net/?pageid=37&publicationid=137

23 - The etiology of disease is defined as the cause of a disease or abnormal condition (Merriam-Webster).

24 - The discipline of phenomenology may be defined as the study of structures of experience (ranging from perception, thought, memory, imagination, emotion, desire, and volition to bodily awareness, embodied action, and social activity, including linguistic activity), or consciousness (Stanford Encyclopedia of Philosophy, 2013).

25 - Hwang et al. (2008). A conceptual paradigm for understanding culture's impact on mental health: The cultural influences on mental health model. Clinical Psychology Review, 28(2), p. 211-27. Summary available at: https://www.ncbi.nlm.nih.gov/pubmed/17587473

Though one cannot learn everything about a culture prior to a needs and resources assessment, there are a number of places to find more information on culture and particularly how it pertains to health (including mental health) and coping. You may want to explore family and gender relations, societal roles and related expectations, developmental stages, religion and traditional activities and beliefs, concepts of health, wellness, and illness and explanatory models of illness. Your understanding of culture can be strengthened by dialoguing with and observing the community. In order for assistance to be effective, culture must be adequately considered and this can be done largely through input from and interaction with the local community.

Further, in most societies, psychological distress and mental disorders are highly stigmatized, resulting in a different interpretation of the cause and consequence of such disorders, the type of treatment, and negative and stereotypical views of persons with these disorders. In Australia, Brazil, Canada, Croatia and Turkey, studies revealed that people with mental health conditions experience and find deeply distressing ignorance, prejudice and discrimination among general health workers and mental health workers.

The following example shows that the perceived cause can be culture-specific and can be used to inform responses: In Afghanistan, mental health conditions are commonly believed to be caused by *Jinns*, witchcraft, possession, the evil eye, or *saya*. In severe cases, people are brought to traditional healing centers where the "treatment" consists of chaining individuals concerned to a wall for 40 days with minimal food and water, and no sanitation facilities.

EXAMPLE

One illustrative example of how religion influences the experience of a "traumatic event" can be found in the context of Buddhism. The meaning of torture[25] in the Khmer life is articulated through language and historical and culturally constructed traditions. The word torture in Cambodian and English are strikingly different. The English derivative of the term is from the Latin root, tortum (i.e., to cause to turn, to twist, hence to physically torture). Torture in the Western world has consistently been associated with the use of physical or mental pain. The Cambodian term, in contrast, is derived from the Sanskrit/Pali words "daruna" and "kama" (i.e., savagery, cruelty, barbarism). The Cambodian term for torture is "tieruna kam" and is associated with the Buddhist concept of Karma. Karma, the idea that the sum of a person's existence, the Samsara or endless cycle of birth and death, including his existence in a prior life, affects the (present) future as well as future lives. Therefore, it is important to conduct all your affairs with that in mind.

(Illustrated from Ochberg, F. M., (1988). Post-traumatic therapy and victims of violence. New York: Brunner/Mazel.)

26 - The Cambodian definition of the term torture: = tieruna kam (tierun = cruel, savage); (Kam, Kammea, Karma = action, dead, act, activity, a work; calamity; fate; Karma; an action or thoughts (often of an evil nature) in prior existence that produce effects in subsequent existence). Cambodians who have been tortured generally feel they are somehow responsible for their suffering, because of their karma.

ACTION 2.4

LEARN ABOUT ORGANIZATIONS AND SERVICE PROVIDERS AND ABOUT THEIR ACTIVITIES

Even if you are familiar with organizations and their work in the setting in which you are undertaking the assessment, it is useful to consolidate and organize this information early on in the assessment process. Above all, you should ensure that any assessment is done as much as possible in coordination with other organizations – you do not want to duplicate information! And there might be information organizations already have that would be useful to your assessment.

In addition to exploring ACF material and input to date (from that setting as available), you should also research other organizations including non-governmental organizations (NGOs), international organizations, community-based organizations, philanthropic initiatives, the health system as well as health workers (including paraprofessionals), religious leaders and traditional healing experts. You should look at what was there and what was functioning prior to the disaster. It is essential that you explore and consult these sources and resources. Even in a disaster setting – there are some types of organizations and healers.

To understand the entire assistance community, it is essential to look outside "mental health" and "psychosocial" providers. Given the diversity of programs to address psychosocial and mental health needs and resources, you should consider not only those programs or actors, which focus explicitly on mental health/psychosocial support but also those organizations/programs that may have a mental health or psychosocial component but which are not explicitly referred to as a mental health and/or psychosocial intervention (e.g. kids clubs, sports activities, women's support groups and cooperatives, etc.). In addition to specialized or focused mental health and psychosocial programs, information on the following other activities and services should be obtained (as possible): centers for persons with physical disabilities; pre-existing social services for vulnerable groups (e.g., refugees, elderly, etc.); and education programs and their link with health and/or psychosocial activities.

YOU SHOULD LEARN ABOUT/MEET, AS NEEDED:

- Ministries of Health, Education and Social Welfare (any ministry of reference for mental health and psychosocial programming as the name may change depending on the country)
- Central district offices, local offices, local UN administration
- Local security authorities
- Central UN administration
- UN agencies
- NGOs – international, regional, local
- Protection/ MHPSS clusters/WG
- Religious groups, spiritual community and religious leaders
- Indigenous/traditional healers
- Cultural anthropologists, sociologists
- Health and mental health professionals and relevant associations
- Women's groups, as well as groups and associations for youth, ethnic minorities, persons with disabilities

Once these types of organizations have been identified, a brief review of their mandates is useful and meetings should be arranged with as many of these organizations as possible in a two- to three-day period. Local staff can provide useful assistance in facilitating contact with individuals within these organizations on your behalf. During these meetings, you can provide information on your assessment (objectives, partners, approaches) and can request information on their work, the problems they have found and are addressing, gaps in assistance, and ask for any information related to monitoring and evaluation, ongoing/planned studies and interventions led by that organization or another organization in the area.

FOR MORE INFORMATION ON ACTIVITIES, ORGANIZATIONS, AND NEEDS AND RESOURCES, ALSO LOOK AT:

- Policy approaches to mental health and health
- Activities supported by NGOs and information on coordination amongst them (documentation)
- General country reports (Development and Relief organizations)
- Consolidated appeals process documentation
- Annual reports of organizations and providers
- Participatory rapid appraisals (PRAs)
- Needs and resources assessments (Current/Past; Rapid/In-depth)
- Existing registries with demographic and/or health information (i.e., Demographic Health Survey)

You should also subscribe to Mental Health and Psychosocial Support Network, where you can find information on organizations, efforts, situation reports, etc.: *http://mhpss.net/*

ACTION 2.5

UNDERTAKE EXPLORATORY RESEARCH BASED ON WHAT YOU HAVE LEARNED UP UNTIL THIS POINT

INPUT FROM STAKEHOLDERS

Essential to understanding any population is the most important resource: people's own perceptions as they are the primary witnesses, survivors and potentially beneficiaries of ACF's work. Before beginning the study, such **exploratory research** can be elicited through meeting with key individuals or through focus group discussions. If time allows, it is useful to meet with a couple of key individuals and one or two focus groups. This exploratory research does not replace or substitute for the larger needs and resources assessment but can provide some useful and firsthand insight into key issues, concerns, coping mechanisms, needs and resources and potential areas where ACF could prioritize its assistance. Findings can then be used in selecting and designing questions for a larger assessment.

KEY INDIVIDUALS = people who may have particular insight into or opinions about the mental health and well-being of the population and pressing issues and needs. They may be ordinary people and not necessarily professional specialists, better educated, etc. In order to best determine who the relevant key persons are, different resources should be consulted. For more information on how to conduct key informant interviews, see Section 3. For some ideas on questions to ask key informants, see Annex 5.

FOCUS GROUPS = people when together are expected to provide information about the mental health and well-being of the population and pressing issues and needs. For example, this group may include mothers receiving nutritional care from ACF. In designing the focus group, careful attention must be paid to any power dynamics and other issues (e.g., gender disparities) to ensure individuals are comfortable contributing to the group. For more information on how to conduct focus group discussions, see Section 2. For some ideas on questions to ask in focus group discussions, see Annex 5.

COMMUNITY ADVISORY GROUPS = one approach to ensure that the entire assessment process is informed by the community, is to establish a community advisory group that can accessed as a guide for the assessment. This group can have between 5 and 20 members and include local stakeholders and members of the assessment team. A local stakeholder is any influential individual or a group with an interest in the process or outcomes of the assessment (community members, religious leaders, teachers and health workers from the assessment population).

You should hold an initial consultation with these health and social work professionals and relevant stakeholders included in the community advisory group.

STAFF INPUT AND YOUR OWN

ACF staff can be a tremendous resource – particularly those who have worked in these settings on various issues. Having spent time in the setting and worked with people and partners, they probably have an idea of some of the major problems and what is needed. Also, you should not underestimate the value of **listening and observation**. Pay attention and try to learn about social issues and norms, behaviors, actions and symbols. It is important to spend as much time as possible with the affected community rather than with other organizations.

You could take notes on activities witnessed and people present (similarities and differences between them, actions and conversations, relationships to each other, risks or risk behaviors taking place), ***remember though it is important not to include any sensitive or confidential information in these notes.***

In the context of mental health and psychosocial support (including child care practices), there are various things you can observe and try to learn about to get a better idea of what normative behaviors are, what problems there might be and how they can be addressed, you could look at/learn about:

CAREGIVING BEHAVIORS

- Care for pregnant/lactating women
- Feeding/breastfeeding (or bottle-feeding)
- Meal time behaviors (who feeds the child, response during illness)
- Psychosocial and cognitive stimulation
- Hygiene behaviors/views
- Health seeking behaviors/views
- Food preparation and storage
- Conditions in home (including hygiene)

CAREGIVING RESOURCES

- Knowledge/beliefs – value of child care
- Health nutrition status
- Mental health status/stress
- Behaviors experienced (e.g. violence)
- Control of resources autonomy (employment, decision making)
- Workload/time constraints
- Social support

SOME POTENTIAL ISSUES OF CONCERN THAT YOU MIGHT NOTE DURING YOUR ASSESSMENT – AND MAY WANT TO EXPLORE FURTHER INCLUDE:

- Mothers with malnourished children may have poorer mental health
- Lack of social interaction with other mothers/not having social support
- Mothers who are overwhelmed with work/limiting time to spend with infant
- Absence of antenatal counseling
- Mothers who eat smaller amounts of food
- Mothers who drink, smoke during pregnancy
- Mothers working late in pregnancy
- When giving birth, other women from their family are not present
- Difficulties/delay in beginning breastfeeding
- Breastfeeding is interrupted before the baby is 6 months old
- Frequency of breastfeeding is dictated by daily work
- Notions that infant should be autonomous very early on
- Mother leaves child with others regardless of training/age
- Limited access to care including family planning
- Religious/cultural practices which do not benefit (and may harm) infant/child

ACTION 2.6

COLLECT, COMPILE AND SUMMARIZE AVAILABLE INFORMATION

Organize and keep information in such a way that it can be easily accessed and reviewed as you move forward. Though, do not include in your notes -any confidential information/any identifiers, which might compromise confidentiality and anonymity. Any information should be kept in a locked cabinet, a laptop, a tablet with identified users in order to keep information and data secure. For more details, see Action 3.3.5.

At this point, you may have additional information and insight on the group you aim to study (if this was specified in the assessment's objectives). If that is the case, continue to complete each step in this manual focusing on that specific group. On the other hand, you may not have much clarity on specific vulnerable groups/those in need of assistance and what they need. If that is the case, continue to complete each step of this manual focusing on assessing the needs and resources of the general population. As time allows, and vulnerable groups are identified through your population assessment, you can explore their needs and resources in further details by returning to the beginning of the manual and following each step.

STEP 3

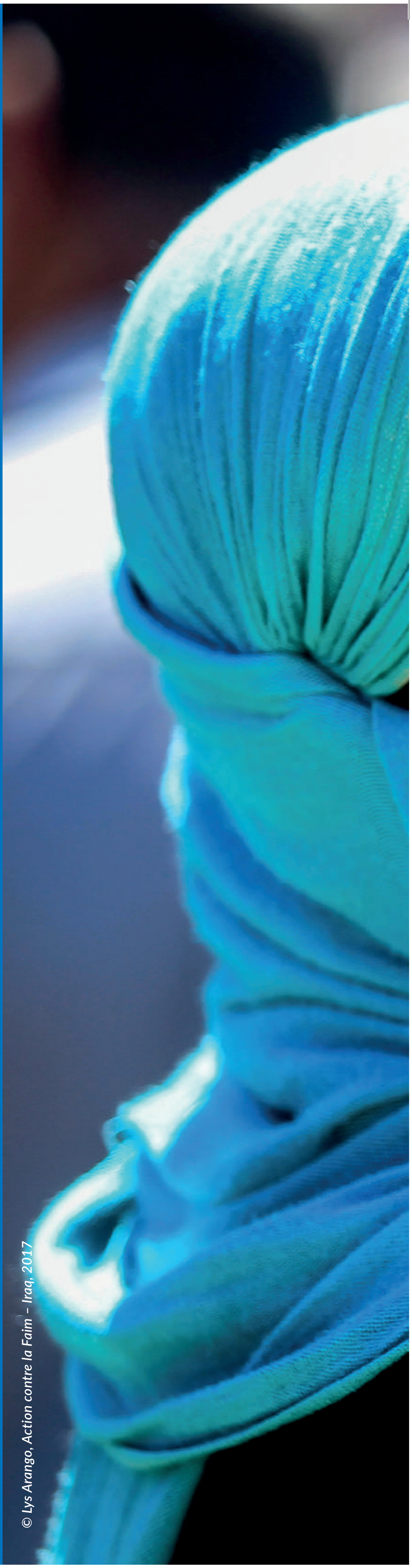
DETERMINE STUDY APPROACH/ METHODS

ACTION 3.1
DETERMINE YOUR TARGET POPULATION

ACTION 3.2
DECIDE WHAT SPECIFIC INFORMATION YOU ARE LOOKING FOR

ACTION 3.3
SELECT DATA COLLECTION METHOD

ACTION 3.4
SELECT ANALYTIC METHODS



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STEP 3 - DETERMINE STUDY APPROACH/METHODS

HAVING COMPLETED STEPS 1 AND 2, YOU NOW SHOULD MOVE TO IDENTIFYING THE STUDY METHODS YOU WILL USE.

THIS SHOULD BE DONE IN COLLABORATION WITH MHCP REGIONAL TECHNICAL ADVISORS AT ACTION CONTRE LA FAIM HEADQUARTER AND LOCAL AND INTERNATIONAL SOCIAL SCIENTISTS (IN TERMS OF SEEKING FEEDBACK, AT THE VERY MINIMUM).

FEEDBACK FROM LOCAL COMMUNITY LEADERS SHOULD BE SOUGHT DURING IN-PERSON MEETINGS.

YOU WILL NEED TO CONSIDER YOUR RESOURCES (TIME, PERSONS WHO WILL BE ABLE TO ASSIST IN STUDY IMPLEMENTATION AND ANALYSIS) WHILE MAKING THESE DECISIONS.

ACTION 3.1
DETERMINE YOUR TARGET POPULATION

The target population is the group of individuals whose needs and resources you are trying to explore and describe in this assessment.

This decision is related to the objectives of the assessment. Think back to your objectives (see Action 1.1) - are you trying to assess the needs and resources of the entire population ***(population needs assessment)*** or needs and resources of mothers in a specific region, for example ***(targeted group needs assessment)*** as well as orphans and vulnerable children living with HIV/AIDS (your assessment can include more than one targeted group). If this is already determined, be sure that it is clear and then move to next action. If you are looking at population-based data to make a determination, you will need to review data you have obtained to decipher who is in need that ACF could help and for which additional information would be helpful to collect.

According to the ACF mandate and policy, **some possible vulnerable groups can include:**

- Refugees and/or internally displaced persons (IDPs)
- Single mothers/fathers
- Female-headed households
- Orphans and vulnerable children
- Children head of households
- Demobilized and/or child soldiers
- Widows/widowers
- Persons with disabilities
- Elderly persons
- Individuals who have chronic mental disorders
- Survivors of sexual and gender-based violence
- Survivors of torture

ACTION 3.2
DECIDE WHAT SPECIFIC INFORMATION YOU ARE LOOKING FOR

This is informed by your established objective (See STEP 1). You may already have some information you need from the information-gathering phase, from existing studies, survey data and/or exploratory research. Capitalize if this is the case, it is still useful to collect primary data to add to existing data or to further interpret previous assessment findings. Review the information you have, and see if the objectives can be made even more specific, for example, **the objectives of the needs and resources assessment may be (one or several of the following)**[27]:

- To understand how the population and/or specific communities or groups have been affected by a disaster
- To determine specific traumatic events and their severity experienced by the population or groups
- To assess level of functioning among a specific group
- To determine priorities of community members and leaders as to which psychosocial and mental health needs require the most urgent response
- To determine what groups are at greater risk for having experienced or for experiencing a traumatic event, psychological and mental health problems
- To assess the need for the provision of community-based mental health services
- To identify community resources useful for collaboration on psychosocial interventions

27 - Good, B., Good M.-J. D., Grayman, J. and Lakoma, M. (2006). Psychosocial Needs Assessment of Communities Affected by the Conflict in the Districts of Pidie, Bireuen, and Aceh Utara. Geneva: International Organization for Migration. Available at: http://www.academia.edu/3399451/A_Psychosocial_Needs_Assessment_of_Communities_in_14_Conflict-Affected_Districts_in_Aceh

Having a solid grasp on what information you're looking for is critical so ensure that it is well-thought out. Once you have collected data, it is difficult and time consuming to collect more data – and you may not have time. Take the time to think of all the types of issues and areas of interest that will be important in understanding needs and resources and in assisting ACF in deciding what intervention is needed that they might implement. You should discuss these ideas and make decisions with other ACF staff, including staff working specifically on mental health, psychosocial and child care practices. You should be able to justify your plan on the basis of existing research, what you have learned during the information-gathering phase, and your professional opinion.

WHILE THERE IS NO REQUIREMENT, AT A MINIMUM THE ASSESSMENT SHOULD FOCUS ON OBTAINING INFORMATION RELATED TO THE THREE DOMAINS OF INTEREST[28]

1. **Mental/Emotional:** symptoms of depression, PTSD, hopelessness, anxiety, substance use/abuse (other high-risk behaviors), general psychological distress, etc.
2. **Social/Functioning:** social/role functioning, coping mechanisms, conflict management skills, access to support (e.g. family, friends), etc.
3. **Skills/Knowledge:** life skills, vocational skills, and care practices.

AN ASSESSMENT CAN ALSO EXPLORE

- **Life events/traumatic events:** major events, with information related to specific experiences, location during disaster, events in aftermath of conflict, recently experienced events.
- **Practices/Behaviors:** positive/negative practices and behaviors, high-risk behaviors and underlying causes.
- **Changes in Practices/Behaviors:** comparing practices, behaviors and views prior to the disaster to those after the disaster.
- **Other key issues:** HIV/AIDS, orphans and vulnerable children.
- **General demographics:** age, gender, ethnicity, marital status, children, employment status, etc.

SOME OTHER QUESTIONS YOU MAY WANT TO INCLUDE OR EXPLORE ARE

- What are current living conditions/what is the physical environment?
- Did they, friends/family members experience injuries?
- Are individuals with special needs or those at-risk being addressed?
- How might normal coping mechanisms be strengthened?
- What are some coping mechanisms that may negatively impact health?
- Are certain groups coping better than others? Why?
- What are major cultural practices and religious beliefs?
- What are major support systems and how are feelings expressed?
- What economic difficulties do they face and how might these be addressed?

28 - These areas will be used for monitoring and evaluation of program outcomes.

ACTION 3.3
SELECT DATA COLLECTION METHOD

ACTION 3.3.1
DECIDE WHAT DATA COLLECTION METHOD IS FEASIBLE

As such assessments will be undertaken immediately after the disaster, there are likely to be some difficulties. For example, physical destruction and devastation may have rendered maps potentially useless, translators may not be available and access to the internet might be limited and other modes of communication unavailable. Local researchers, government and/or organizations may have left the area or be overwhelmed with other tasks.

An ideal approach whether you are undertaking a population needs and resources assessment or targeted group needs and resources assessment is to use a survey to assess various aspects of an individual's well-being, as described above. A population-based survey would aim to interview a sample of the population while a targeted group survey would aim to interview a sample of individuals from the targeted group. This should be followed by key informant interviews and/or focus group discussions (see: Decision tree). In some cases, **capitalize this may not be feasible if there is inadequate time and/or limited movement.** In this case, only key informant interviews and focus group discussions should be held. See Action 3.3 for more detailed information on data collection methods and relevant sampling approaches.

ACTION 3.3.2
DECIDE WHAT TYPE OF DATA THAT IS FEASIBLE TO COLLECT WOULD BE MOST USEFUL

Though you have already decided what issues to study (the content you are seeking), you need to decide whether you will collect quantitative or qualitative data. It is ideal to obtain **both quantitative and qualitative data**[29] to illustrate findings. While quantitative data are often viewed as objective, numeric data and qualitative data as subjective and non-numeric – in reality, both types of data are often coded into numeric values and quantitative data may reflect subjective categories. Both types of data can be assembled, summarized, analyzed and used effectively to characterize needs and resources in populations. Quantitative and qualitative data can work together – each with their strengths – supporting each other and adding depth to your understanding of needs and resources. If findings can reflect each other in qualitative and quantitative data, we can have more confidence in our findings. Often research focuses on quantitative alone, while qualitative can provide vivid insight into experience, perceptions and beliefs of study participants. This information can be used to describe aspects of a population's needs and resources that may not be uncovered solely using quantitative methods, for example, by using and analyzing responses to multiple choice or yes/no questions. In the case of child care practices, questions such as number of lactating/pregnant women, number of children under 2 years old, etc. – may not provide enough insight into the area that you are studying – or enough information to help you determine a population's needs and resources.

In tandem with the decision as to "what data you want" – it is important to think through the details as this will guide your approach to analyses – and selection of, for example, qualitative and/or quantitative analyses for specific questions (Consider Action 3.4 in terms of selection of analyses). For example, do you want prevalence information (quantitative) on hopelessness or detailed information as to how it might be experienced (qualitative)? Or both? Are you interested in exploring a specific symptom of depression? Its occurrence? Its severity? How people understand it? Do you want to say with some accuracy the proportion of people that have depression in your sample? How you answer the questions above will determine the "types" of data you will need. For example, if you are interested in knowing about the prevalence of depression you may want to collect quantitative data/use quantitative analysis – if you are interested in describing a common pathway to depression, you may want to collect more qualitative data from focus group discussions and undertake a qualitative analysis.

*29 - **Quantitative information** is usually objective data about individuals/groups in a beneficiary population, and includes the following: basic health care data and mental health statistics, psychosocial questionnaires, symptom checklists, and self-completion questionnaires. Qualitative information is usually subjective data about individuals or groups in a beneficiary population, and include the following: literature reviews, focus group discussions, key informant interviews, structured or checklist observation, diaries, mapping, anthropological tools, workshops and dictionaries. Qualitative evaluation is usually collected in the context of long-term contact with the field, to obtain a holistic overview; to understand perceptions of local actors from the inside; and analysis is most often done in words.*

In sum, on the basis of the study objective, you want to be sure to:

1. define concepts the study will explore,
2. define variables you will need (quantitative/qualitative)
3. identify the approach or develop the instrument to obtain these data.

The data collection method you choose should be well-suited to the data you are trying to collect. And, several methods can be used in the same study to get the information you need. In addition, if you get the information using one method (focus group discussions), it is also useful to ask the same question(s) using another method. This can substantiate your findings and provide additional perspective.

There are many ways to collect data, in addition to qualitative methods of focus group discussions and key informant interviews (list of questions to facilitate discussion and obtain information), you can also use a survey instrument (an existing one or you can create your own survey questionnaire (or a combination of existing and developed measures)).[30]

For example, in studying maternal mental health and child care practices:

IF YOU WANT INFORMATION ON…	YOU SHOULD CONSIDER USING THIS METHOD…
Prevalence of depression or % of mothers having experienced symptoms of depression	**Survey**
Mother's beliefs, motivations and constraints related to child-feeding practices	**In-depth interviews**
Actual feeding behavior (type of food, interaction)	**Observation**
Health care providers' motivation and ability to provide effective counseling on child-feeding	**Focus Group Discussions**
To obtain reactions to recommendations for behavior change	**Focus Group Discussions**
To check/verify interpretation of findings and recommendations of report among influential people, other organizations, etc.	**Key informant interviews**

ACTION 3.3.3

LOOK FOR TOOLS AND/OR STUDIES, WHICH HAVE COLLECTED THIS TYPE OF INFORMATION OR HAVE BEEN USED IN THE SETTING WHERE YOU ARE UNDERTAKING THE NEEDS AND RESOURCES ASSESSMENT

Your approach to data collection (surveys, specific screening instruments, focus group discussions) should be tailored to the focus of your assessment and the population you are assessing. You should still look at the three domains – emotional/mental, social/functioning and skills and knowledge – as possible but the specific focus and/.or questions under each will need to be adapted according to the specific group/issue you are studying.

Depending on your time limitations, you may only be able to use a measure which already exists or to develop a basic local measure rather than adapting an instrument (which is a more lengthy process) – but you can consider for a later time, a more thorough assessment using a culturally adapted tool. Guidance on how to culturally adapt an instrument can be found in the Annex 3. Further, this process can be more effective if there is a high level of collaboration with local actors on this process and the overall assessment activity.

*30 - **Screening Instrument:** A tool administered to an individual to detect the presence of a specific disease (in this case poor mental health or psychosocial problems) by looking at symptoms of that condition. At the time of the administration, it is uncertain whether those individuals being screened have symptoms of poor mental health. Screening instruments are not perfect and are likely to misclassify a certain portion of respondents (sensitivity and specificity varies). They cannot affirm a diagnosis of a condition. Often screening instruments are included in survey instruments. It is ideal that such an instrument, as is the case with many instruments, is administered by trained professionals. However, in some settings – this may not be feasible or practical.*

An existing measure can be used for assessments and this will allow for comparisons to be made with other situations (for example, if you are using a measure, which can identify individuals who probably have depression).[31] However, such instruments should only be used when there is clear evidence of their validity in a given cultural context. This means that they have been used before and that "norms" (or typical scores for individuals in that context) have been established. The selection of instruments should be discussed with and validated by the MHCP Regional Technical Advisors before use. Even so, most instruments do not focus on all of the domains that should be explored in this evaluation (emotional/mental, social/functioning and skills/knowledge). A list of useful instruments and their focus can be found in the Annex 2 as well as a how-to guide (See Annex 3) for culturally adapting instruments. Most of the existing instruments focus on the mental/emotional domain, so it is more likely that a new measure will need to be developed to assess well-being in the other two domains (social/functioning and skills and knowledge).

New measures can also be developed to produce a simple listing of indicators that reflect local understandings of well-being or adjustment. This can be done through free listing.[32] Input from local communities can inform how these indicators are defined, integrating their values and ways of understanding into the assessment process. You should be sure that when using this approach you have considered all of the domains – emotional/mental, social/functioning, and skills and knowledge. Information on how to do "free listing" can be found in Annex 5.

NOTE

Note that any instrument you develop or adapt to a specific cultural context can also be used as a guide in designing the questions you will use in key informant interviews and focus group discussions.

For examples of some instruments frequently used in mental health and psychosocial research, see Annex 2. For information on instruments/mental health research done in various countries/cultures, see Annex 3.

ACTION 3.3.4

DECIDE WHICH OF THE FOLLOWING FOUR METHODS (SURVEY RESEARCH, FOCUS GROUP DISCUSSIONS, KEY INFORMANT INTERVIEWS AND/OR CASE STUDIES (OR ANY COMBINATION OF THESE) WILL BE USED[33]

A mixed-methods approach - using both quantitative and qualitative data is ideal. You can do a survey and then focus group discussions and key informant interviews (see Annex 4 for example) or you can conduct qualitative research (focus group discussions, semi-structured interviews) before conducting quantitative efficacy research.

While this manual focuses on assessments in general – with a specific focus on mental and psychosocial health, and care practices, there is some information on related issues/questions, etc. which can be found in Annex 5. For other vulnerable groups, see Annex 1, which has a list of useful resources for specific populations

Before describing in detail, each of the methods – it is useful to have an understanding of sampling – why it is used, why it is important, which type of sampling to use for your study, and how to do it.

31 - To ensure that an instrument is most effective in correctly identifying persons who are depressed, a mental health professional using his/her judgment must interview an individual and make his/her own determination. That same individual then also takes the survey, the score at which the instrument most accurately captures most of the diagnosis made by the psychiatrist is the cut off that will be used for that population.

32 - This approach is useful in identifying the criteria with which well-being is understood in a particular culture or community. This might be used to identify what members of the community considered to be the characteristics of a "resilient child". Children might develop a long list of those qualities; these were then discussed and grouped under major headings – looking closely at features, which are local indicators of resilience. The same exercise can be conducted with parents, which would reveal some similarities on what signaled children's well-being.

33 - Remember, as per the Decision Tree, as possible, you want to undertake survey research in most cases – in addition to focus group discussion/key informant interviews. If this is not possible, you can just use focus group discussions and key informant interviews for the assessment – but this should be a measure of last resort and should be discussed with Action contre la Faim MHCP Regional Technical Advisors at ACF headquarter.

BRIEF OVERVIEW OF SAMPLING

<u>OBJECTIVE OF SAMPLING:</u> Sampling aims to select a group of people that is representative of the population you are targeting (the group of individuals whose needs and resources you are trying to describe). For example, if in your needs and resources assessment you are trying to provide information on the "general" population – since you do not have time to interview everyone in the general population (the target population), you want to have a representative sample of that population. For example, if you are trying to obtain information on health center members (target population), you want to survey individuals which are representative of health center members themselves. We do this because we expect that the characteristics being studied are distributed amongst the sample in the same way that they are distributed amongst the target population. There will, however, be some error, that is a difference between the sample and the target population.

<u>SAMPLING APPROACH TO USE:</u> Within the same study, you can use different sampling approaches. For example, for a survey portion you could use *simple random sampling*, for the focus group discussion portion of a study you could use *convenience sampling* (described in greater detail below).

TYPES OF SAMPLING

TYPE OF SAMPLING: PROBABILITY (RANDOM): Each member of the population has a known non-zero probability of being selected	
DESCRIPTION	**USED WHEN/DIFFICULTIES WHEN**
SIMPLE RANDOM SAMPLING Member of the population has an equal and known chance of being selected. This is ideal – but difficult. Steps include: 1) identifying the population from which the sample is to be drawn; 2) enumerating and listing each element in the population; and 3) devise a method of selection, which ensures that each element has the same probability of selection and that each combination of the total number of elements has the same probability of selection. For a table of random numbers, see Tool 2 in Annex 6.[33]	Difficulties when - There are very large populations, it is often difficult or impossible to identify every member of the population, so the pool of available subjects becomes biased.
SYSTEMATIC RANDOM SAMPLING is also called an Nth name selection technique. After the required sample size has been calculated, every Nth record is selected from a list of population members. As long as the list does not contain any hidden order, this sampling method is as good as the random sampling method. Systematic sampling is frequently used to select a specified number of records from a computer file.[34]	Used when - Its only advantage over the random sampling technique is simplicity.
STRATIFIED SAMPLING A stratum is a subset of the population that shares at least one common characteristic. Examples of stratums might be males and females, or managers and non-managers. The researcher first identifies the relevant stratums and their actual representation in the population. Random sampling is then used to select a sufficient number of subjects from each stratum. ***"Sufficient"*** refers to a sample size large enough for us to be reasonably confident that the stratum represents the population.	Used when - One or more of the stratums in the population have a low incidence relative to the other stratums.

34 - You can begin a random sample by using a table of random numbers: If you have a list of 250 people, for example, you pick one number (with your pen/without looking) on the table of random numbers. This number, or the first number after the one you choose, whose first three digits are between 1 and 250 will be selected. This continues going up and down the table of random numbers until you have reached your desired sample size.

*35 - **Detailed procedure for systematic random sampling:** 1) Divide the total number of beneficiaries in the listed population by the required sample size to produce a number called the "sampling interval" (e.g. with a population of 800 children receiving a school-based intervention, divide by 100 to get a sampling interval of 8); 2) Choose a random starting point between 1 and the sampling interval (e.g. by writing the numbers 1 through 8 on pieces of paper and picking out one piece of paper by chance, say, the number 5; 3) The first person in the sample is then defined by this number (e.g. in this example, the fifth child on the list); 4) Subsequent members of the sample are selected by picking those that fall according to the sampling interval (e.g. in this example, we select the 13th (5+8), 21st (5+8+8), 29th (5+8+8+8) child, all the way up to the one hundredth member of the sample (who turns out to be the 797th on the list); 5) Make clear rules for how you deal with those who are due to be in your sample, but are not around when you come to meet them. You can afford to lose one or two people from your sample, but if there are many absentees you will need to make "substitutions" (e.g. in the above example, if the child 21st on the list is not available for interview on more than two occasions when you visit the school, you replace them with the next child on your list i.e. the 22nd child listed)*

TYPE OF SAMPLING: NON-PROBABILITY (NON-RANDOM): Sample members are selected from the population in some non-random manner	
DESCRIPTION	**USED WHEN/DIFFICULTIES WHEN**
GEOGRAPHIC[35]/AREA SAMPLING (CLUSTER SAMPLING) In this technique, the total population is divided into groups (or clusters) and a sample of the groups is selected. Then the required information is collected from the elements within each selected group. This may be done for every element in these groups or a subsample of elements may be selected within each of these groups. This is a type of cluster sampling: Elements within a cluster should ideally be as heterogeneous as possible, but there should be homogeneity between cluster means. Each cluster should be a small-scale representation of the total population. The clusters should be mutually exclusive and collectively exhaustive. A random sampling technique is then used on any relevant clusters to choose which clusters to include in the study. In single-stage cluster sampling, all the elements from each of the selected clusters are used. In two-stage cluster sampling, a random sampling technique is applied to the elements from each of the selected clusters.	Used when - The main reason for using cluster sampling is that it usually much cheaper and more convenient to sample the population in clusters rather than randomly. It is also useful when you are assessing a geographically dispersed population. In some cases, constructing a sampling frame that identifies every population element is too expensive or impossible. Cluster sampling can also reduce cost when the population elements are scattered over a wide area. Suppose you want to survey school children of a certain age in a specific area. If you drew a simple random sampling of school children, you might have to visit all schools in the area to interview your sample. With cluster sampling you could first select the schools to be included in your sample, and then select school children within each of the selected schools. That would probably reduce the number of schools you have to visit and therefore reduce the cost of data collection. In this example, the schools are what are sometimes referred to as natural clusters. In other cases, the population may be widely distributed geographically, and then cluster sampling, where the clusters consists of geographical areas, could reduce the number of areas that need to be visited. A smaller number of areas that need to be visited could reduce travel expenses and also make possible more efficient supervision of the fieldwork.
CONVENIENCE/ACCIDENTAL SAMPLING As the name implies, the sample is selected because they are convenient. This non-probability method is often used during preliminary research efforts to get a gross estimate of the results, without incurring the cost or time required to select a random sample.	Used when - In exploratory research the researcher is interested in getting an inexpensive approximation of the truth. This may be necessary but it is not ideal as there are a number of limitations associated with it.
JUDGMENT SAMPLING the sample is selected based on judgment This is usually an extension of convenience sampling. For example, a researcher may decide to draw the entire sample from one "representative" city, even though the population includes all cities.	Used when - The researcher is confident that the chosen sample is truly representative of the entire population.
QUOTA SAMPLING[36] Like stratified sampling, the researcher first identifies the stratums and their proportions as they are represented in the population. For example, ensuring that 50% of participants are male and 50% are female. Then convenience or judgment sampling is used to select the required number of subjects from each stratum. This differs from stratified sampling, where the stratums are filled by random sampling.	
SNOWBALL SAMPLING Snowball sampling relies on referrals from initial subjects to generate additional subjects. While this technique can dramatically lower search costs, it comes at the expense of introducing bias because the technique itself reduces the likelihood that the sample will represent a good cross section from the population.	Used when - The desired sample characteristic is rare. It may be extremely difficult or cost prohibitive to locate respondents in these situations. It is useful in accessing marginalized or hidden groups.
PURPOSIVE SAMPLING This should start with this sampling technique, the assessment team identifies individuals who are service providers who have specific information and are specifically selected by the assessment team. Interviewees should be selected from a broad range of agencies and types of service providers, including health care workers in health centers, hospitals, reproductive health services, managers of NGOs.	

Adapted from: StatPac

36 - Geographic sampling could be considered if you can access accurate maps from many of the organizations providing post-disaster assistance (e.g. UNDP). For example, in a survey assessment in Haiti, a multi-stage approach was used to identify households in Port-au-Prince and in three over-sampled highly populated zones. First, a list of random GPS locations was produced, with interviewers identifying all households within a 20 meter radius at each location before randomly choosing one to interview. Additionally, five large camps were identified using Google Maps and an estimated population figure for each camp was obtained from those agencies servicing the camp. Camp leaders also provided an estimated population figure and granted permission for enumerators to enter the camp. In order to obtain the desired sample size, the population was divided by needed number of respondents and every nth person was selected to participate in survey.

37 - If it is impossible for quantitative research to do either random sampling or cluster sampling, quota sampling can provide a good substitute – particularly if you want to explore sub-groups. An example of quota sampling would be the following: You select your sample to fit in with a "quota" of beneficiaries defined by certain criteria. For example, in a sample of 80 children in a school, you decide to sample 20 young girls, 20 older girls, 20 young boys and 20 older boys. Although less than 5% of children may come from a particular ethnic minority, you may want to set a "quota" of 20 children from this group, as with random or cluster sampling you are likely to recruit only 4 or 5 such children from a sample of 80 to 100.

It should be noted that **qualitative research can use non-probability sampling** as it does not aim to produce a statistically representative sample or draw statistical inference. Sometimes, however, the first order can be non-probability and then random sampling methods can be used to select people from those identified.

If you are studying more than one targeted population in your assessment, for example, women with infants and orphans and vulnerable children, you can use different sampling methods to select the sample for each of these groups. The following box provides one example of how different types of sampling were used in order to obtain a sample of each population being studied:

A study in Haiti had three different target populations:

1) displaced survivors living in camps
2) non-displaced survivors living in community
3) a clinic sample

THE FOLLOWING DESCRIBES THE SAMPLING FRAME FOR EACH:

- **TARGET POPULATION (1) displaced survivors living in camps:**
  4 of the 8 official displacement sites were selected within the catchment area as recognized by the World Food Programme (WFP). The number of respondents sampled from each camp was weighted based on the published camp census. Interviewers chose a central starting point within each camp and approached an individual to interview at each 3rd shelter on their left-hand side. If there was no eligible person at this location, a person was approached at the adjacent shelter. If there was more than one eligible present in a particular dwelling, the closest birthday method was used.
- **TARGET POPULATION (2) non-displaced survivors living within the community:**
  For the community sample not living in camps, a catchment area map was used and divided into 32 zones, each of these being roughly 500 square meters. Of these zones, 16 were randomly selected using ***ProcSurvey*** select in SAS. The sampling proportion was equal across all zones with 32 people sampled from each. From a predetermined starting point, interviewers approached a candidate to interview at each 7th dwelling on their left side. If the dwelling was destroyed or no eligible persons were within, the adjacent dwelling was selected.
- **TARGET POPULATION (3) clinic-going survivors at a local health clinic:**
  The clinic sample was obtained by approaching every third patient to register for care at the clinic. There are three populations in equal proportions with random drop-in visit pattern: general community medicine, dermatology and HIV.

The following section provides detailed information on the advantages of each data collection method as well as the type of sampling approaches often used for each. The next step (STEP 4) provides important guidance on implementation of the study as well as some key requirements (e.g., informed consent, protecting data) and general considerations (e.g., interview techniques).

DATA COLLECTION METHODS

1. SURVEY RESEARCH

Survey research is useful in describing population averages (behaviors, mental health issues, child care practices). It can be used to assess the needs and resources of an entire population or the needs and resources of a targeted group, for example, mothers with infants younger than 2 years old living in a specific region. For survey research, you can use: 1) an existing tool which has already been culturally adapted; 2) an existing tool which has not been adapted which you will need to adapt[38]; and/or 3) another survey instrument – combining existing screens and/or adding your own questions (see examples below). Survey instruments should not take any longer than 40 minutes to administer and should include information related to all of those issues that you want to explore (see Annex 4).

In 2016, a needs assessment was conducted in Kazher camp, near Mosul (Iraq), over a two-day period to assess mental health and psychosocial wellbeing and potential thematic areas of intervention. The assessment team was composed of two male and two female staff. Two of them were psychosocial workers and two were qualified psychologists. The assessment team split and progressed in 4 directions in the camp in order to favor a random methodology. Potential participants were explained the purpose of the assessment, and how data would be used. Confidentiality of responses was assured, and no identifying information was collected. Participation was entirely voluntary.

38 - Remember, adapting an instrument to a local setting requires specific steps and will require more time than using a tool which has already been adapted → however, if you aim to provide information on prevalence of a disorder (that the tool measures), it must be adapted.

During the time of the assessment there were over 1200 tents occupied. Assessments were conducted in the respondents' tent to assist with ensuring privacy. Limitations to privacy existed though, as at times it was difficult to ensure no other family members of the beneficiary entered the tent.

As a result, 64 people were interviewed with 44% of females and 66% of males, (mean age=37,7 years). The visual analog scale was used to measure levels of distress within the community. It ranks from 1-10 and visually depicts the level of distress an individual might experience. Overall, half of the respondent (53%) had a score ranging from 8 to 10. The majority of respondents (92%) reported their distress was due to having lived under ISIS control with persistent fears for their safety (i.e. bombing, fear of being killed, witness people executed, oppression, fear for children, fear of punishment and kidnapping, stay locked in this house without being able to communicate with other families, etc.) and 76% of them mentioned the general effects of displacement, namely having limited food and money, having a part of the family still in Mosul, unknown future.

LEARN MORE

For more information on conducting survey research, see:

- The DIME program research model developed by the *Applied Mental Health Research group*. *Available at: https://www.jhsph.edu/research/centers-and-institutes/global-mental-health/resource-materials/design-implementation-monitoring-and-evaluation-dime/*
- Check, J. & Schutt, R. K. (2011). *Research Methods in Education, Survey Research*. Chapter 8, p 159-185. Sage Publications Inc. *Available at: https://www.sagepub.com/sites/default/files/upm-binaries/43589_8.pdf*
- Kelley K., Clark B., Brown V., Sitzia J., (2003). *Good practice in the conduct and reporting of survey research, International Journal for Quality in Health Care*, Volume 15, Issue 3, 1 May 2003, Pages 261–266. *Available at: https://www.ncbi.nlm.nih.gov/pubmed/12803354*

SAMPLING FOR SURVEY RESEARCH

With survey research, you are more likely trying to get a general idea of a population or targeted group. To achieve this, you want to ensure that everyone in the "target group" has an equal probability of being selected for the sample. If you have a list of all population members, and adequate resources, you can do ***simple random sampling*** or ***systematic random sampling***; if not you can use another method listed (the most commonly used apart from random methods is *cluster sampling*).

The following provides an overview of each of the types of sampling often used for survey research (mentioned just above) and the steps to take for each to select your sample. For this type of research, the required size of your sample (in order to ensure that it is representative of the population you are studying), needs and resources to be calculated. Information on how to calculate the required sample size (number of people in sample), is also provided below.

SIMPLE RANDOM SAMPLING

1. Obtain a list of all members of the target population.
2. Number each respondent on this list.
3. Then select individuals into the study by randomly choosing numbers (for instance by using random number table in Annex 6).
4. Continue until you have reached your required sample size.

SYSTEMATIC RANDOM SAMPLING

1. Obtain a list of all members of the target population.
2. Number each respondent on the list.
3. Calculate a sampling interval by dividing the number of individuals in the target population by the desired sample size.
4. Randomly select a number between 1 and the number of the sampling interval (this is the first selected individual).
5. Select each new individual by adding the number of the sampling interval to the previous number.
6. Continue until you have reached your required sample size.

CLUSTER SAMPLING

1. Divide the target population into clusters (different areas in a country, different towns in villages, etc.).
2. Randomly select a number of clusters.
3. Randomly select a specified number of households within these chosen clusters.
4. Randomly select an individual as a study participant from within the chosen household.

CALCULATING SAMPLE SIZE

The formula to calculate a required sample size is (as long as the target population includes a few thousand people):

$n = (t^2 \times (p \times q)/d^2)$

Where: ***n*** is the required sample size

t is a value related to the risk of error *(where the risk of error is 5% a figure of 1.96 should be used for this)*

p is the expected prevalence *(reported as a fraction of 1, e.g. 0.5)*

q is the expected non-prevalence *(i.e. 1 – p)*

d is the level of precision *(also reported as a fraction of 1, e.g. 0.1)*

You then need to adjust for non-response (and if using cluster sampling, the design effect[39]):

- Calculate the minimum number of people needed for the study by using the formula: $n = (t^2 \times (p \times q)/d^2)$
- If you are using cluster-sampling methods, multiply this number (***n***) by the design effect.
  Skip this step if you are using simple or systematic random sampling.
- Divide the obtained number by the expected response rate to account for non-response.
- **The result is the number of people you need to select into your study.**

THERE ARE SOME COMMON PITFALLS THAT YOU WANT TO AVOID

SURVEY STEP	POSSIBLE PITFALLS AND BIASES	POSSIBLE PRECAUTIONS/REMEDIES
SURVEY PREPARATION	Question not understood as intended	Make the purpose of the survey explicit from the start
	Time period for survey not sufficient	Develop a detailed action plan with timeline and responsibilities upfront
SAMPLING	Relevant people not studied	Clearly define the study population
	Sample not representative of population studied	Use appropriate probability sampling method
	Convenience sampling chosen	Use appropriate probability sampling method
	Sample size insufficient to answer the intended question/s	Calculate sample size, using statistical means, before carrying out the survey
QUESTIONNAIRE DESIGN	Essential information not collected	Consider carefully what data are required
	Long Questions or interviews (from collecting unnecessary information) cause a low response rate	

(Gorgens & Kusek, 2009)

2. FOCUS GROUP DISCUSSIONS

Focus groups discussions are a method of group interviewing in which the interaction between the moderator (facilitator) and the group, as well as the interaction between group members, serves to elicit information and insights in response to carefully designed questions. The dynamic nature of the questions asked by the moderator and the group process produces a level of insight that is rarely derived from "unidirectional" information collection devises such as observation, surveys and less interactional interview techniques.

In focus group discussions, a ***series of questions is explored in a systematic way by a focus group, with the moderator (facilitator) posing the questions and being responsible for recording the responses.*** The facilitator may probe certain key issues or concepts that emerge in the discussion.

*39 - **Design effect** is a survey statistic computed as the quotient of the variability in the parameter estimate of interest resulting from the sampling design and the variability in the estimate that would be obtained from a simple random sample of the same size (Encyclopedia of Survey Research Methods, Sage (2008)). Said in another way, it "is a correction factor that is used to adjust required sample size for cluster sampling. The required sample size is estimated assuming a random sample, and then multiplied by the design effect. This accounts for the loss of information inherent in the clustered design." (Available at: http://influentialpoints.com/Training/design_effect-in-cluster_sampling.htm)*

A key and very valuable feature of focus groups is that group members build on each other's responses by, for example, adding detail or correcting one another, and in this way the information gathered is likely to be more accurate. Methods of recording and analyzing information gathered during focus group discussions, and strategies for collecting unbiased information have helped focus group research to gain credibility as an accurate and useful source of information collection. For example, for focus groups you can consider members of the entire healing community (including psychologists, or mental health professionals as well as traditional healers, religious people) as well as teachers and women who are in good standing in the community. By using various focus groups you can also gain additional perspective and a variety of inputs. It is possible to find different responses between different "types" of focus groups – which may highlight an area for further attention.

The box below provides an example of how focus group discussions were used for an assessment in Afghanistan and the ways in which findings can be drawn from this approach.

EXAMPLE FROM AFGHANISTAN[40]

Designing focus group discussion in order to assess children's psychosocial well-being

One study used the focus group method to assess Afghan children's psychosocial well-being related to intervention outcomes. In focus groups of 8-10 people, in age groups 7-13, 14-18 and over 21 (separate for boys and girls), four main questions were addressed:

- *What are children's main worries?*
- *Which are the most severe worries?*
- *What do children do to cope or to manage their situation?*
- *Which strategies work best to solve their worries?*

Scenarios were included as a means of providing concrete situations for participants to respond to: An Afghan boy is upset. Why? When are Afghan boys upset? An Afghan boy is on his way to school and an older boy stops him and takes his books. What does the younger boy do in this situation?

Focus groups can be used in their own right or in conjunction with another tool to crosscheck information obtained. In the above example given from Afghanistan, differences between adult and children's perspectives were found through convening focus groups with people of various ages. The focus groups identified gaps in some villages between what adults said children worried about and what children themselves said they worried about. For example, none of the men who were interviewed in one village indicated the lack of water and toilets at school as a significant worry for young boys. The young boys themselves, however, ranked this among their top three worries. In another village women said young girls worried about being poor and having no access to a clinic. But, the girls themselves said their main worries were getting sick from sun exposure, being yelled at by teachers and being injured in traffic. The report noted that these differences prompted further program planning around parent-child communication.

STEPS FOR THE FOCUS GROUP INCLUDE

1. Nominating the facilitator and note-taker
2. Choose a private location where the discussion cannot be overheard and the participation cannot be readily seen going to and from the group
3. Decide what questions are to be explored in the group
4. Select six to eight participants of similar age/gender/experience
5. Obtain informed consent
6. Note pre-focus group information (including age/sex and number of participants) on the focus group record sheet
7. Conduct the focus group for up to 1.5 hours, flexibly following the focus group guide with note-takers recording verbal and non-verbal information (how participants interact, layout of the room, seating of participants, etc.)
8. Conclude, noting the finish time
9. Write expanded field notes after saying good-bye to the participants (see example of field notes form in Annex 6)

There are several requirements that must be met in order to hold a focus group/discussion: participants must feel confident and trust that what they say during the conduct of a focus group will be treated with the same confidentiality as the responses made on a survey questionnaire. Thus, no one besides the facilitator will have access to the participants' names; no one besides the facilitator will have access to the participants' comments; no observers are allowed in a focus group; and ground rules are posted and discussed with participants, including: participate fully, respect comments of all participants, and the requirement that "what is said here, stays here".

40 - Assessing Afghan Children's Psychosocial Well-Being: A Multi-Modal study of intervention outcomes. February 11, 2015. Research conducted by Christian Children's Fund, Oxford University and Queen Margaret University College, Edinburgh. Available at: https://www1.essex.ac.uk/armedcon/story_id/afghan_report_ccf_ox_qmuc.pdf

SAMPLING FOR FOCUS GROUPS[41]

Selecting participants who are similar may help them to share ideas more freely (i.e., a group of women talking about dating) and may prevent results from being so mixed that no conclusions may be drawn. It is important that the group membership selection is described and results are not generalized to other groups. Focus groups often employ participants who are strangers to reduce sharing in ways that acquaintances might expect and to increase anonymity for the sake of honest responding. Usually focus groups are comprised of 6 to 10 participants who do not know one another and who have similar associations to the topic being investigated (i.e., elementary teachers discussing a new reading curriculum) and 3 to 5 focus groups are conducted.[42] Having two homogeneous groups that provide different results suggests that more information is necessary. The degree to which these rules of thumb are followed depends on their importance within the context of the project, the stakes of the evaluation project and available resources.

The sampling frame is developed by identifying key population groups whose opinions you are interested in hearing. This may follow a stakeholder analysis exercise, a participatory wealth ranking exercise or some other method of identifying differentiated groups. This may result in the “population” being divided by characteristics such as age, wealth, gender, ethnicity, health status, etc. The research team will need to decide how many ‘‘levels’’ of each characteristic are meaningful for the purposes of the study (e.g., perhaps four income levels, two for gender, three for age) and form a group for each level of each important characteristic. If focus groups are used, they need to be repeated with the same type of participant (for example, women) exploring the same question until no important new information is being provided, at which time focus groups are begun among different types of participants (for example, men).

STEPS TO PREPARE FOR FOCUS GROUP DISCUSSIONS

1. Prepare an invitation
2. Set up date, time and location
3. Contact each participant and ask him/her to attend and explain objective/method
4. Choose facilitator (if not you, then someone else)
5. Arrange for notetaking/taping of discussion
6. Make food/drink arrangements
7. Have them meet informally prior to the discussion

LEARN MORE

For more information on conducting focus group discussions, see:

- Jacobsen M.J. & O’Connor A. (2006). *Population needs assessment: A workbook for assessing patients’ and practitioners’ decision making needs.* University of Ottawa.
  Available at: http://med.dartmouth-hitchcock.org/documents/population_needs.pdf
- Sharma, A., Lanum, M., & Suarez-Balcazar, Y. (2000). *Community Needs Assessment Guide: A Brief Guide on How to Conduct a Needs Assessment.* Center for Urban Research and Learning, Department of Psychology: Loyola University Chicago.
  *Available at: http://loyola*curl.squarespace.com/projects/community-needs-assessment-guide-a-brief-guide-on-how-to-con.html
- World Health Organization & United Nations High Commissioner for Refugees (2012). *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings*. Page 63-77. Geneva: WHO.
  Available at: http://www.who.int/mental_health/resources/toolkit_mh_emergencies/en/

3. KEY INFORMANT INTERVIEWS (IN-DEPTH INTERVIEWS)

Key informant interview is an in-depth interview of an individual and/or select group of individuals who are likely to provide needed information, ideas and insights on a particular subject. Often, in the case of ACF assessments, such interviews will be carried out with mothers, to elicit information about their care practices, for example. Such interviews, unlike surveys, are open-ended and do not have limited options for answering (e.g., Yes/No, or 1 – 5, etc.)

41 - Description – these can either be undertaken concurrently or following a survey – or when survey is not possible – this can provide important information.

42 - Using only one focus group to arrive at conclusions about a particular topic is risky since the opinions expressed may have had more to do with the group dynamics (i.e., persuasive skills of one or two members) than reflective of the opinions of the population that the group represents.

Such an approach is helpful when general descriptive information is insufficient for decision-making; a better understanding underlying motivations and attitudes of a target population is required; and quantitative data collected through other methods need to be interpreted. If the survey provides information on specific behaviors which you want to explore further, this can be done in the context of key informant interviews.[43] Often semi-structured interviews[44] are used- with some survey questions, for example, with the option of probing further to obtain more information.

Two characteristics of key informant interviews to remember include:

1. only a small number of key informants need to be interviewed (e.g. 15 to 35); and
2. these interviews are essentially qualitative interviews. They can provide important insight, flexibility to look at new issues, and it is usually easy to find respondents.

It should be noted that other similar qualitative approaches to elicit information from key informants (but not through a standard interview) can be used:

<u>A) MAPPING.</u> This is a general term used to describe participatory work (creating a map) that can then be used for generating discussion. For example, children may be asked to draw the places where they perceive risks or fears in their community. Once these lists are created by children – a ranking of dangerous places (in order of frequency mentioned) can be made – this might highlight whether it is current environment or past distress which is most severely impacting them. You can also draw a risk and resource map where children can draw a map of their immediate surroundings and then other areas that they frequently visit – this method can identify those things/people/institutions that they see as threatening and as sources of support and protection in their daily lives.

<u>B) CREATIVE SELF-EXPRESSION.</u> Drawing, drama and other forms of self-expression can be used to gain insight into needs, resources concerns, ideas and opinions. One example of this would be asking an individual to draw a timeline highlighting the important events and changes that occurred in their community over a certain period of time. These can be discussed when they are completed. Similarly, a **lifeline** can be drawn where individuals can place positive events about the line and negative events below the line. These approaches provide a less invasive and threatening way of gathering potentially sensitive information.

THE STEPS FOR CARRYING OUT KEY INFORMANT INTERVIEWS (INCLUDING THE TWO ADDITIONAL OPTIONS ABOVE) INCLUDE

1. Choose a private/safe location for the interview where the conversation cannot be overheard and the participant cannot be readily seen going to and from the interview
2. Invite the participant to be interviewed, assuring confidentiality will be maintained
3. Obtain informed consent using the consent form
4. Record pre-review information on the interview record sheet
5. Conduct the interview for no more than one hour, flexibly following the interview guide you have developed and making some notes during the interview
6. Conclude the interview, noting the finish time on the interview record sheet
7. Write expanded field notes after saying good-bye to the participant

SAMPLING FOR KEY INFORMANT INTERVIEWS

To ensure the quality of information, it is important to select the right informants. The most important consideration is that informants possess an intimate knowledge of the subject on which they will be interviewed. This knowledge may be a result of their special social position, experience, participation in programs, professional expertise making a key informant very different from a typical respondent in sample surveys. In this context, some of those who might be considered as key informants include: government officials, academic experts, mental health professionals and para-professionals, parents,

43 - Alone, key informant interviews are not ideal. They are not, however, a substitute for a quantitative method and there is some innate bias – as those selected may have some features in common not representative of the larger community (e.g. they speak English or are from an elite class which is non-random selection)

44 - Semi-structured interviews are characterized by topic guides containing major questions that are used in the same way in every interview, although the sequence of the questions might vary as well as the level of probing for information by the interviewer. Semi-structured interviewing is suitable when the researcher already has some grasp of what is happening within the sample in relation to the research topic. However, the researcher should ensure there is no danger of loss of meaning as a consequence of imposing a standard way of asking questions. This could be achieved by conducting pilot interviews (these use broad topic guides with few direct questions) prior to data collection. Even in a semi-structured interview, the questions posed during the interview should be as open-ended as possible, in order to avoid yes/no or rehearsed answers. Further, the questioning techniques should encourage respondents to communicate their underlying attitudes, beliefs and values that are so central to this method. It is important to build a rapport with the interviewee before starting the interview so that both sides can feel more at ease. (Adapted from Crinson & Leontowitsch 2006, revised in 2016 by Dr G. Morgan. The contribution of qualitative methods to public health research and policy. Available at: https://www.healthknowledge.org.uk/public-health-textbook/research-methods/1d-qualitative-methods/section2-theoretical-methodological-issues-research).

teachers, store owners/business owners, members of the healing community (health care workers, traditional healers, etc.), local leaders and representatives of specialized groups.

It is hoped to have both "typical" and "unique" informants. All potential key informants should be identified and be grouped accordingly. You should then select those groups from where key informants will be selected providing justification for including or excluding a group. For example, if you only include refugees from the largest refugee camp with the greatest access to services, your sample will not be representative of all refugees in camps (in the area that you are trying to "speak about" or to assess). Once a few individuals have been sampled from the chosen groups, a list of possible interviewees can be made up. You can select individuals from focus groups to be key informants, as well. The number of these that should be selected is largely related to available resources – with the rule of thumb being anywhere between 15 and 35. Interviews should continue until the team decides that no important new information is being provided (referred to as **data saturation**).

LEARN MORE

For more information on conducting in-depth interviews/key informant interviews, see information in Action 3.3.4 (3) and Action 4.2 and/or consult the following resources:

- Kumar, K. (1989). *Conducting key informant interviews in developing countries*. Agency for International Development.
  Available at: http://pdf.usaid.gov/pdf_docs/PNAAX226.PDF
- Josse, E. (2006). *Guide pour un assessment rapide des besoins psychosociaux et en santé mentale des populations affectées par une catastrophe naturelle*.
  Available at: http://www.resilience-psy.com/IMG/pdf/guide_assessment_net_e.josse.pdf

4. CASE STUDIES

The case study can come from a continued interview with a participant (who agrees to participate) or it can also come from a key informant interview. So, it is not necessarily a separate approach – but it is important to consider the material that is useful in a case study and how to select a case study. Essentially, the case study *"investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used."* (Yin, 1984, p. 23[45]). It answers the question: "What is going on?" It can be exploratory – or it can provide context to data already collected. It is useful in bringing us to an understanding of a complex issue or object and can extend experience or add strength to what is already known through previous research. Case studies emphasize detailed contextual analysis of a limited number of events or conditions and their relationships.

You may want to think about all of the data you have collected and reviewed and describe those stories which illustrate clearly the challenges you faced, or which demonstrate a point you are trying to convey. You can select these now, or when you have undertaken some general analysis on the data and use a case study to add meaning to the story line.

SAMPLING FOR CASE STUDIES

As noted, this information can come from a survey participant, a key informant interview, among others. You may be able to pull this information from data already collected – or you may want to explore in further detail an experience that was briefly described or mentioned to you.

LEARN MORE

For more information on how to do a case study, see:

- Baxter, P. & Jack, S. (2008) Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers. *The Qualitative Report vol. 13* (4) p. 544 – 559.
  Available at: https://nsuworks.nova.edu/tqr/vol13/iss4/2
- Yin, Robert. K. (2017). *Case Study Research and Applications: Design and Methods.* Los Angeles: SAGE Publications, Inc.
  Available at: http://tiny.cc/vv8ysz

45 - Yin, Robert K. (1984). Case Study Research: Design and Methods. Sage Publications Inc.

ACTION 3.3.5
KEEP GOOD AND CONFIDENTIAL RECORDS

For each interview and focus group, the date, start time, type of interviewee, location of interview, name of interviewer, name of interpreter and note-taker (if used) and code (interviewer initials, sequential number) should be recorded on a separate information sheet, and verbal and non-verbal information obtained during the interview should also be recorded. The finish time and any problems that occurred should be noted. Field notes should be expanded by the interviewer and the note-taker(s) following the interview and at the end of each day. Expanded field notes include statements of who said what, important quotes (noting details of the speaker such as age, gender, and ethnic group), observations on interactions and the quality of the interview or focus group and any notes about hypotheses or emerging themes.

All information recorded on paper should be kept in a locked cabinet. For digital data collection, login and passwords should be used and data transfer should be encrypted according to approved data protection procedure.

A back up of data should always be kept and the database should be secured for the long term. It is essential that someone working on data analysis could trace a result or finding back to the original form on which the data was collected. This can be secured by keeping a separate spreadsheet (or database) for logging incoming data.

ACTION 3.4
SELECT ANALYTIC METHODS

This is not a new action and should have been taken into consideration from the earliest phases. When selecting survey questions and approach(es), analytic techniques should be determined at this point to ensure that data will be well-fitted and not require significant adaptation (which is time-intensive). Again, as highlighted before – you should collect both quantitative and qualitative data and use similarly both types of techniques in your analyses of data.[46]

Quantitative analytical methods that you may want to use include: describing proportions, prevalence, incidence of characteristics, outcomes, etc. Relationships can be described through regression analysis (logistic regression, linear regression, multivariate regression); **Qualitative methods include:** direct observation, consensus, content analysis, analysis of texts or documents, case study and interview.

For any further questions, please contact MHCP Regional Technical Advisors at ACF headquarter.

46 - Each have their advantages and can complement each other. For example, Qualitative methods may help define dimensions that a quantitative method such as a self-administered questionnaire would aim to measure (Asadi-Lari and Gray, 2005).

STEP 4

PREPARE AND **IMPLEMENT** STUDY

ACTION 4.1
DETERMINE STUDY SAMPLE SIZE AND SELECT SAMPLE(S)

ACTION 4.2
ORGANIZE RESOURCES, HIRE AND TRAIN STAFF

ACTION 4.3
COLLECT, RECORD AND STORE DATA

STEP 4 - PREPARE AND IMPLEMENT STUDY

FOR THE STUDY TO BE SUCCESSFULLY IMPLEMENTED, IN ADDITION TO UNDERSTANDING TOOLS AND METHODS – YOU NEED TO ENSURE THAT:

- **THOSE ASSISTING YOU ARE ADEQUATELY AND APPROPRIATELY TRAINED,**
- **INFORMATION IS NOT COMPROMISED AND ENTERED INTO THE DATABASE CORRECTLY AND EFFICIENTLY**

IMPLEMENTATION CAN BE MOST SUCCESSFUL IF THE STUDY IS WELL PREPARED, THE PROCESS IS WELL-SUPERVISED AND IF ANY ISSUES/PROBLEMS IDENTIFIED ARE HANDLED QUICKLY.

FURTHER, THE ENTIRE PROCESS, INCLUDING ROLES AND RESPONSIBILITIES, AS WELL AS ANY DECISIONS MADE SHOULD BE WELL-DOCUMENTED.

ACTION 4.1
DETERMINE STUDY SAMPLE SIZE AND SELECT SAMPLE(S)

Having determined study methods you will use and type of sampling approach, you are now ready to implement the selected strategy. Each type of data collection method describes in more detail the sampling methods and provides examples. Sampling size depends on several factors: the purpose of the survey; how common the variables you are studying are among the sample population, the amount of variation of the factor of concern and how precise the results need to be. See Action 3.3.4 and earlier guidance above on calculating sample size.

ACTION 4.2
ORGANIZE RESOURCES, HIRE AND TRAIN STAFF

Consider the various types of assistance you may need and different responsibilities for staff in ensuring that the study is successfully implemented. You may not be able to have each study task be done by different people, so you should recognize where there might be limitations and try to address those or consult an expert. Some areas that you should ensure can be undertaken by the staff include: study management; sampling; design/adaptation of instrument, manuals and codebooks; fieldwork; data management; and data and related policy analysis. Awareness of available resources – and necessary tools to collect information is essential to guaranteeing that the data collection process is well-organized. This requires ensuring that each person within the study is adequately prepared for his/her role both with materials and knowledge. To the extent possible, it is important to use local staff given their experience and knowledge of the setting, culture and language. Moreover, hiring international individuals is more costly (in terms of rate and the need for an interpreter). You can also, as possible, draw on the capacity and availability of other local partners. There should always be an emphasis on capacity-building and sustainability – meaning that you can include new researchers from the local community and they can learn from and/or be mentored by more experienced researchers. At this point, you should inform the local authorities on the progress and output of your evaluation (who already know that you were planning a needs and resources assessment), your precise timeline and any other relevant details.

Training staff should focus on technical issues and more general issues. The team should understand ACF's mandate, guiding principles, as well as the processes, steps and methods that will be used in the assessment. They should have familiarity with the content of the study, and should have an understanding of the study procedures step-by-step. This does not mean every minute detail (e.g., how you arrived at the sample size calculation). But they should be very familiar with the sampling procedure, their role and contingency issues (next steps if say, for example, a household sampled is no longer there or if two people from the household fit the participant criteria). You want to ensure that they are cooperative with each other and, if need be, to strengthen cooperation among them you can conduct team-building activities. They should have a clear understanding of their responsibilities and tasks. This requires being upfront about the timeline, the tasks you expect them to complete and how you want to handle any problems faced.

Two days should be devoted to technical training and providing your team with necessary information. You should provide them with written materials, presentations, as well as adequate role playing - it will be necessary to practice interviewing techniques in front of other team members and to provide guidance and suggest modifications as needed. They should be aware of the importance of demonstrating respect in terms of action and language, security issues, cultural practices/ norms (and familiarity with any actions that may be portrayed as offensive), the importance of informed consent (see below) and to whom they might refer an individual who requests or needs immediate assistance.

Once the training is completed, it is a good idea to pre-test the interview. Like a pilot study – you can identify a local sample (even a sample of convenience) and have interviewers practice their interviewing techniques – and then you can provide feedback on the interview process: were all the questions understood? Which questions were not understood? Did some households refuse to participate? What was their reaction to your description of the study and its objectives? These can then be discussed and revised by the study team.

WHAT ARE KEY INTERVIEW TECHNIQUES?

The approach used in interviews must be adaptable to various types of respondents (different socio-economic backgrounds, gender, ages, etc.). Good practice is for the interviewer to present the study objectives and the proposed process and methods for data collection and analysis. Then, the interviewer should explain to them their right to participate and/or to decline responding to any questions asked *(Principle of Informed consent)*. In the case where a child is being interviewed, consent should be obtained from his/her caregiver(s). Those interviewed must be informed that the information they provide is anonymous, that the interviewer is neutral and is not there to pass judgment, and that any information shared (in case study, descriptive text) would be confidential. Interviews should be conducted in a private location, which is agreed to by the participant, where an individual feels safe and secure physically and psychologically. In focus group discussions, you should require that participants respect the others' confidentiality. Cultural considerations must also be heeded – for example, what are the gender norms of the population? How might this affect an individual's willingness to disclose information? How might the presence of an interpreter affect the interview dynamic? Since you are asking for information from usually a community that has been traumatized, participants should be informed of their right and the availability of support if they should need it.

IN TERMS OF PRIVACY, AN INTERVIEWER SHOULD NEVER:

1. Talk to other participants about another interview
2. Ask intrusive questions
3. Probe for an answer when it is clear that someone is uncomfortable providing it
4. Take pictures or record individuals (audio, video) without their informed consent

It is imperative that each participant give their informed consent willingly – or they cannot participate in the interview (see Annex 6 for example of an informed consent form). See next action for more information on informed consent and the informed consent form.

Be sure that an individual is comfortable with the location of the interview and participating in the interview before beginning the interview.

THE INTERVIEWER MIGHT WANT TO START WITH SOMETHING LIKE THIS:

> *"Before we start, let me tell you about the interview process. You will be asked two kinds of questions. In some cases, I will be asking you to answer questions in your own words. For other questions, you will be given a set of answers and will be asked to choose the one that is closest to your own view. Even though none of the answers may fit your ideas exactly, choosing the response closest to your views will enable us to compare your answers more easily with those of other people…."*

ACTION 4.3
COLLECT, RECORD AND STORE DATA

Data collection requires a high level of organization and coordination – each step must be documented in an operational manual – as well as quality control and confidentiality. For key informants, notes can be taken during an interview.

Notes should include information relevant to: 1) wellness of affected people (and their definition of wellness and knowledge of ways to uphold this); 2) perceptions and life stories, demographics; 3) biases; 4) personal history, emotional condition, mental state and level of coherence, 5) privately held stereotyping/expectations; 6) vested interests of groups or contacts; 7) fact versus opinions (subject to interpretation, understatement or exaggerations); 8) need for cross-checking information gathered from various sources and soliciting comments from the community about the collected data; 9) quality, degree and amount of information available; and 10) reasons for absence of, discrepancies or irregularities in data.

Particular note should be made of the topics covered in the course of the conversation including, for example: their understanding of trauma and mental illness, stories of stress, trauma and mental illness in their community related to the conflict/disaster, local resources and priorities for managing such conditions and opinions about the peace and/or recovery process. In addition, emphasis should be on facts versus opinion, perceptions and life stories, biases, personal history, emotional condition, mental state and level of coherence among contacts, stereotyping, and/or reasons for absence or non-response.

It is imperative that each participant be asked for and to give their consent before they can participate in study - they would need to give or what is called *informed consent*. (See Annex 6 for example of informed consent form). The informed consent form describes the project as well as study procedures, roles and rights (e.g. privacy, to refuse to participate, etc.) This form should be read by or read to the study participant and signed/dated by him or her. An individual has the right to refuse to participate – and they should know that there are no negative consequences for refusing to participate. An individual also has the right to not answer any questions that he/she does not want to answer. If an individual does not give his/her informed consent or does not want to answer specific questions they should be told that this is understood and OK. A participant should be given a copy of this consent and the original should be kept by the interviewer. A numerical code should be tracked on the top of the form. Each participant's responses should be kept on one copy of the questionnaire form. If an individual refuses to respond or to participate – this should be included on the interviewer's notes form.

KEY POINTS TO REMEMBER IN GATHERING DATA

1. Follow formality, restrictions and protocols or courtesies in meeting with local people
2. Remember to inform participants of research findings and how they will be provided with these
3. If there are any questions re: ethical issues, seek advices from MHCP Regional Technical Advisors at ACF headquarter
4. Consider time management and location of meetings or interviews
5. Arrange for accurate and reliable translation
6. Be sensitive towards the community on the use of cameras/recorders
7. Respect rights of children and adults
8. Consider the context (religion, culture, ethnicity, social norms)
9. Cooperate with others

The following are some common pitfalls in collecting, recording and analyzing data to be avoided:

	NOT TO DO	TO DO
COLLECT THE DATA	Invalid measurement of information	Use validated measurement tools to carry out pilot studies Pre-test all questionnaires
	Sloppy field work and inadequate controls	Check and supervise every facet of the survey. Supervisor re-do some surveys to see if similar results are achieved
	Not sufficiently following up on non-respondents (low response rates make survey results questionable)	Ensure proper procedures that are all carried out
	Inability by respondents to recall information that is difficult to recall	Encourage participants to use records to help them remember OR shorten the required recall period
	Biases: Non-consent and non-response bias, Social undesirability bias, or Observer bias	Approach and explain survey carefully and politely Train enumerators well
RECORD AND ANALYZE THE DATA	Inaccurate recording of results	Use optical scanning, computer-assisted questionnaires, validate data as they are being captured
	Wrong analysis	Use statistical packages
	Sampling errors not known	If a probability sample was used, calculate the sampling error in the report
	Imprecise findings	Increase the sample size or choose a stratified sample
	Incomplete survey coverage	Work out the percentage not covered and adjust the findings by this weighting

(Gorgens & Kusek, 2009)

A systematic approach to data entry should be clearly outlined and explained to the staff. The approach used can vary according to type and amount of data, availability of computers, approach to data collection, etc. A database should be seen as a live record. This means that at any given time, someone familiar with the database (and authorized to use it) can assess what data has been entered and what is still pending. For example, this could be completed by looking at simple descriptive analyses (number of participants and gender, number of missing values, etc.).

Once data are received they should be immediately screened for accuracy. When reviewing forms and notes, it is important to ensure that:

1. responses are legible;
2. all important questions are answered (and if not, why not?)
3. responses are complete; and
4. all relevant contextual information is recorded (date, time, place, researcher, etc.).

A random sample of completed survey instruments should be reviewed – to ensure clarity in selecting responses and also detail provided in open-ended questions.

A useful strategy to ensure a high level of data accuracy is a procedure called **double entry**. In this procedure you enter the data once. Then, you use a special program that allows you to enter the data a second time and checks each second entry against the first. If there is a discrepancy, the program notifies the user and allows the user to determine the correct entry. This double entry procedure significantly reduces entry errors. However, these double entry programs are not widely available and require some training. An alternative is to enter the data once and set up a procedure for checking the data for accuracy. For instance, you might spot check records on a random basis. Once the data have been entered, you will use various programs to summarize the data that allow you to check that all the data are within acceptable limits and boundaries. For instance, such summaries will enable you to easily spot whether there are persons whose age is 601 or who have a 7 entered where you expect a 1-to-5 response.

It is essential that a printed **codebook** is maintained which describes the data and indicates where and how it can be accessed. While this is a time-consuming task initially, it will save significant amount of time in the data cleaning and analysis phases and will facilitate the use of these data by others. Some of the information that should be kept in this codebook includes:

- variable name and description
- translation of any terminology
- variable format (number, data, text)
- instrument/method of collection
- date collected
- respondent identifier
- variable location (in database)
- notes

STORING DATA is a critical consideration to ensure the **1) integrity of the data**; and **2) confidentiality of information.** To best ensure this, as few individuals as possible should be able to access the data and/or the database. Further, the computer or system where data are stored should be password-protected and any hard copies should be kept in a locked cabinet (and have no identifiers).

DATA CLEANING TECHNIQUES techniques can be conducted. For example, you can begin by exploring outliers (responses that are not feasible), patterns of missingness, patterns of attrition, etc. Missingness is an important issue – but as it has many causes and/or sources (refusals, don't know, not applicable, data processing errors, design factors, attrition) – these need to be better understood. The reason behind the missing data tells us how we might be able to deal with it.

STEP 5

ANALYZE AND **INTERPRET** DATA

ACTION 5.1
REVIEW OBJECTIVE(S), INITIAL EXPECTATIONS AND HYPOTHESES

ACTION 5.2
IDENTIFY KEY VARIABLES

ACTION 5.3
LOOK AT PATTERNS AND VARIOUS ASPECTS OF YOUR FINDINGS

ACTION 5.4
DESCRIBE AND DISCUSS FINDINGS AND RECOMMENDATIONS WITH OTHERS

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STEP 5 - ANALYZE AND INTERPRET DATA

THERE ARE VARIOUS APPROACHES TO DATA ANALYSIS AND INTERPRETATION.

PUT SIMPLY, HOWEVER, YOU SHOULD NOT OVERLOAD THE AUDIENCE WHO WILL BE RECEIVING THIS INFORMATION.

GENERALLY, IT IS A GOOD IDEA TO:

- **SIFT THROUGH ALL DATA AND FILTER SPECIFIC INFORMATION TO SEE THE ISSUES MORE CLEARLY**
- **MAKE ASSUMPTIONS, MAKE DECISIONS AND ACT ACCORDINGLY**
- **CHECK ASSUMPTIONS AND PROVIDE DATA RELATED TO EACH OBJECTIVE**
- **REFLECT ALONE AND WITH OTHERS AND REVISE THE ASSUMPTIONS**

ACTION 5.1

REVIEW OBJECTIVE(S), INITIAL EXPECTATIONS AND HYPOTHESES

An effective approach to data analysis requires attention to the original and well-defined objectives of the needs and resources assessment. Go back to the initial study objectives that were clarified in the beginning of this manual and have them in the back of your mind. Additionally, the data should be analyzed with consideration for your initial hypotheses. Look also at your initial hypothesis/hypotheses:

EXAMPLE

Original Needs and Resources Assessment Objective

To determine if depressed women have poor care practices and what ACF can do to assist them (or to address their depression).

Original Hypothesis

Depressed women have poorer care practices than non-depressed women.

Approach

A survey was undertaken to determine prevalence of depression (and major symptoms among the population), possible causes and care practices. Quantitative analysis methods were used to compare the care practices of the depressed and non-depressed women (generally and in terms of specific practices). These were supported by case studies and key informant interviews related to these. Additionally, subsequent focus group discussions provided additional information and insight into patterns emerging from the data, expected and unexpected findings.

In the context of the analysis, you will want to provide descriptive statistics and inferential ones. Descriptive statistics is providing information on the data as it is. For example, describing the study population and the data (key variables) as collected – including demographics. This is usually presented in means, modes, frequencies, percentages. These can be represented in tables and in graphs. The importance of quantitative data in this regard is important since they can provide summary statements about needs and resources, which can quickly be grasped, described and used in discussions or in making recommendations. Often quantitative indicators (e.g. prevalence of depression, percentage of women adhering to recommended feeding practices) can allow for comparisons across regions and localities, over time periods and among population sub-groups. Such measures can, for the program phase, be used as part of the monitoring and evaluation mechanism.

Inferential statistics are more in-depth and require more thorough and often technical analyses. Inferential statistics are used to investigate questions, evaluate models and hypotheses. For example, we explore differences among populations that we expect to be different or similar. We might look at the relationship between an exposure (abusive partner) and an outcome (physical injury)– and the pathway by which an exposure leads to an outcome (e.g., mediation[47] or moderation[48]).

47 - A mediation is the relationship that exists between the independent and dependent variables and that explains the reason why this relationship exists.

48 - The moderation allows assessing whether a third variable influences the relationship between an independent and dependent variable.

ACTION 5.2
IDENTIFY KEY VARIABLES

In any analysis, for each of the questions you are trying to answer you should be clear on your independent (**X**) and dependent variables (**Y**). A study's main independent variable is often the exposure being studied (occurrence of an event, specific characteristic, etc.) and your main dependent variable (depression, high-risk behaviors, unhealthy care practices) is the outcome you are looking at.

This diagram may be useful:

EXPOSURE (X) → **OUTCOME (Y)**

Other variables (for example, gender, age, marital status) are also essential – because they allow for you to explore the relationship between independent and dependent variables while controlling for (holding constant) differences between subjects – providing more evidence that **(X)** is associated with **(Y)**, regardless of age, marital status, gender, etc. For qualitative data analysis, you may want to use thematic analysis, in which key themes, which emerge from the data, are identified. Once initial data are collected, a coding system for themes can be developed which can be revised and modified as the analysis progresses. A chart should be created, recording the frequency with which each theme is identified. Patterns that develop should be noted, such as themes that are consistent across groups. Quotes that exemplify themes should be recorded, noting details about the speaker (including age, gender, ethnic group, etc.) but not specific identifying information.

GUIDANCE FOR WORKING WITH DATA (EXPLORING PATTERNS IN DATA AND PRESENTING FINDINGS):

- Consider the relevant ways to sort the information (by age, gender, mental health status, working mothers vs. non-working mothers, etc.) and then explore patterns that you see among these varying groups which are relevant to the objective of the assessment.
- Consider also, when selecting categories, extremes, averages, other patterns, remember the categories should be useful for the research (i.e., distinguishing between possibly depressed/non-depressed persons according to instrument used to determine this).
- Ensure the data you have collected can fit into the categories you would like (e.g., if you have "scores" for an instrument used – you have a relatively simple way of looking at those who have a score higher than cut off point vs. those who have a score lower than the cut off).
- Code data into these categories (use data, which has been entered into the database to fit into categories that you have defined; these can be changed later).
- For qualitative analysis, consider themes and the most relevant method that suits your purpose (case studies, Key Informant Interviews).
- Present data in tables, graphs, charts, etc. in addition to text.

Remember, your data can be triangulated or cross-checked with other sources. Information gathered through primary data collection can be triangulated with information obtained from secondary sources. Data obtained from the community should be analyzed separately and compared with data from policy makers and service providers. It is important to look at data for women and men separately (as well as together). The assessment team should also ensure that a broad range of respondents has been included (according to gender, ethnicity, age, etc.)

In the context of mental health and care practices, you might explore/analyze data to provide information on:

- Breastfeeding patterns by area, nutritional status, illness status, and child care patterns
- Transition to solid food – what food and when introduced – by area, nutritional status, breastfeeding history
- Feeding frequency and style by age, area, child's state of health, mother's work pattern
- Feeding practices by information related to each of the domains (emotional/mental, social/functioning and skills and knowledge)

ACTION 5.3

LOOK AT PATTERNS AND VARIOUS ASPECTS OF YOUR FINDINGS

IN THE ANALYSIS PHASE, YOU SHOULD:

- Explore descriptive statistics first: demographics of the sample (gender, age, marital status, etc.) and consider how your sample compares to that of the target population (if you have this information).
- Develop categories (for variables of interest).
- Explore features of individuals who refused to participate or whose responses were not included in the study (insufficient information, etc.) and look for similarities (to understand how the sample and findings could be biased, i.e., if all chronically ill individuals did not participate though they had been selected for the sample).
- Look at frequency and type of traumatic events experienced, symptoms of mental disorders, and behaviors of interest (see three categories) (mean, median, mode).
- Use instrument scores as a continuous variable and create useful classifications based on literature (e.g., using score ranges .
- Create additional variables to show important phenomena (e.g. social support/negative feeding practices, etc.) to see if you can simplify your message/summarize and look for patterns in summarize open-ended questions.
- Look at relationships between the variables that you are interested in (related to your objective and what you have observed in exploring your data).
- Look at differences between groups (for means, use t-test when comparing 2 groups, ANOVA when comparing more than 2 groups).
- Identify vulnerable groups and describe them as possible.
- Explore the qualitative information you have collected for patterns or to explain quantitative patterns and findings.

ACTION 5.4

DESCRIBE AND DISCUSS FINDINGS AND RECOMMENDATIONS WITH OTHERS

General findings and your understanding of needs and resources should be discussed with other colleagues in ACF, organizations, experts and the community (similar to focus group discussions). Since needs are not absolute, undisputed, unequivocal and unchanging – in order for them to be useful for programming purposes, they must be brought together and discussed openly. Using this approach, some conclusions or inferences you have made will be met with wide unanimity while others will be discarded. This does not mean that you do not include this information in your findings – and describe your inferences - you can include this but also include why those consulted did not think it substantiated findings, or that (**X**) variable did not explaining why the outcome (**Y**) was observed, and include their interpretation of the findings explain why this was the case. Through this discussion, you can gain insight into the community's needs and resources and priority actions. Assessing needs and resources might be more of a scientific process – but determining priorities can be is a political one. For this reason, careful attention should be paid to ensure that all relevant stakeholders are included (stakeholders are those individuals or groups which the needs and resources assessment process will directly or indirectly impact). Stakeholders may include, for example: target population and service recipients, service providers, service funders, policy makers, members of the community in the study's target population and where services might be provided.

Remember, the objective is to inform ACF about needs and resources – so an informed decision can be made by the organization moving forward. Your recommendations should be justified by your data. In thinking about the thrust and scope of your recommendations, you may want to consider:

- Timeline and available resources
- ACF approach/mandate
- Other (providers' experience and lessons learned)
- Community feedback
- Issues of concern and evidence-based responses
- Level of cooperation with other organizations
- Tools and methods identified to monitor and evaluate outputs and outcomes

Interventions can and should be modified on the basis of the context and population you are seeking to assist. When highlighting recommendations for ACF response, you should consider:

- ACF's interventions to date
- ACF's mandate and scope of work
- Current and prior interventions by others and lessons learned from these
- Recommendations from community(ies)
- Your and other experts' knowledge of effective responses to respond to mental health and psychosocial needs and to strengthen resources

Three types of approaches are usually considered as ways to provide assistance[49]:

1. **Curative projects (treatment):** these are projects focused on addressing psychological issues that have been found among the population (e.g., treatment of trauma), this might include counseling and may require referral to other agencies.

49 - National Institute of Mental Health (2002). Mental health and mass violence: Evidence-based early psychological intervention for Victims/Survivors of Mass Violence. A workshop to reach consensus on best practices. NIH Publication No. 02-5138, Washington, DC: U.S. Government Printing Office. Available at: https://eric.ed.gov/?id=ED469199

Saxena S., van Ommeren M., Saraceno B. (2006). Mental health assistance to populations affected by disasters: World Health Organization's role. Int Rev Psychiatry. Jun;18 (3):199-204. Available at: http://www.who.int/mental_health/resources/tsunami/en/index2.html

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Centre for Mental Health and the NSW Institute of Psychiatry (2000). Disaster Mental Health Response Handbook. Available at: http://www.churchdisasterhelp.org/files/manuals/Disaster%20Mental%20Health%20Response%20Handbook.pdf

2. **Preventive projects:** these are projects which prevent further psychosocial deterioration, strengthen individual and community coping mechanisms and rebuild protective social networks. This will include usually targeted work with "at risk" populations (e.g., providing day care for adolescent mothers so that they can continue their education)
3. **Promotion projects:** these projects promote psychosocial well-being and reinforce positive activities within the generally-affected population (e.g. providing children opportunities to engage in educational, social and spiritual activities).

Consider and try to articulate – what improved mental health and psychosocial support would look like and then how might ACF support individuals in getting there from where they currently are. Perhaps some positive practices and outcomes you would want to help the community achieve include:

- Children displaying more (a desired level of) pro-social behavior as considered by the culture
- Infants being provided with a satisfactory level of psychosocial stimulation by caregivers
- Women are more knowledgeable about the importance of play among children
- Depressive symptoms are less common in women than they were

Remember that often those individuals who need assistance most (less educated, poorer, more distressed) are the least likely to ask for assistance – and sometimes the hardest to find for research. In formulating responses, you should think of how best to ensure that the intervention will reach these individuals and provide them with effective and appropriate assistance.

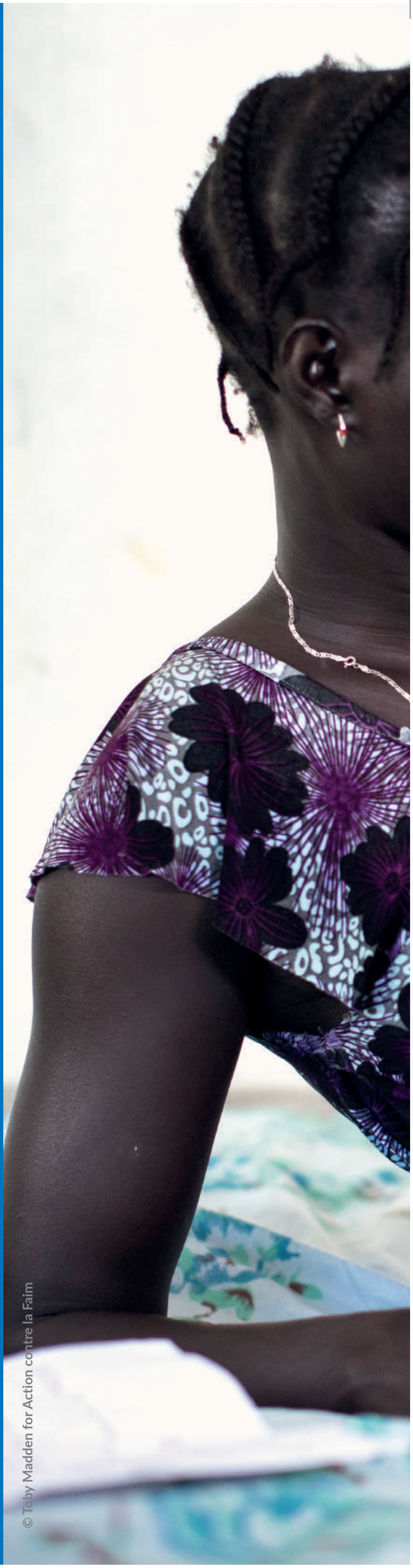
STEP

6

DESCRIBE YOUR FINDINGS

ACTION 6.1
CRAFT AND DRAFT TEXT

ACTION 6.2
VET THE TEXT (FINDINGS AND RECOMMENDATIONS)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STEP 6 - DESCRIBE YOUR FINDINGS

YOUR OBJECTIVE IS TO ORGANIZE AND SUMMARIZE DATA IN A FORMAT THAT CAN FACILITATE AN UNDERSTANDING OF PRIORITIES, WHICH ARE EMERGING FROM THE DATA.

DESCRIPTIONS OF INDICATORS AND THE USE OF FIGURES ARE IMPORTANT IN DESCRIBING YOUR FINDINGS. THIS PROCESS SHOULD TAKE APPROXIMATELY FOUR DAYS AND AN OUTLINE OF A REPORT (AND THE APPROACH OF THE REPORT) CAN BE FOUND IN ANNEX 8.

ACTION 6.1
CRAFT AND DRAFT TEXT

While drafting the assessment report, remember to be clear and succinct. While you want to share information, you want to be sure that the “message” does not get lost (i.e. more is not necessarily better!).

It is important to provide important details on methods as well as findings (so work doesn’t have to be redone and methods/findings are not questioned or unclear over time); while tables and graphs (and figures more generally) are useful, they should not be so complex that they can’t be understood by individuals with varying levels of education. Though the data should be saved and provided to ACF for follow up as needed, the information you present should adequately present the sample population and information and detail in order for informed decisions to be made.

Focus on the assessment objective: you were hired to provide ACF with answers to those questions that were asked in the beginning (objective of assessment) and your assessment (formal document) should not go much past that. If you want to draft something additional, you can – but it should be a stand-alone piece and not included as part of the assessment. You can include a section near the end giving feedback on difficulties, useful future research, etc.

FOLLOW THIS OUTLINE SUGGESTED

MAIN TEXT

EXECUTIVE SUMMARY

BACKGROUND

a. Context of conflict/natural disaster (description including timeline)
b. Work of ACF and other organizations
c. ACF objectives for this assessment (details including identified group, planning, etc.)
d. Overview of report

METHODS

a. Data collection method(s) (describe and include justification)
b. Sampling approach, sample size (power calculation) and any difficulties (or limitations]
c. Analytic approach used
d. Instrument information (and adaptation)/questionnaire, etc.
e. Key informant interviews of individuals who are part of vulnerable groups
f. Implementation (all details on type of instrument, workers/interviewers, problems faced, individuals not interviewed)

RESULTS

a. Demographics of sample (how different from target population): age, gender, location, ethnicity, marital status, level of education, number of children, etc.)
b. Findings related to each objective 1 by 1 with substantiating data[50]
    i. *General survey information*
        1. *Traumatic events (summary figures, variations by region, types, prevalence, etc.)*
        2. *Mental health issues (depression, PTSD symptoms)*
        3. *Mental health and care practices*
        4. *Functioning (social functioning, quality of life)*
        5. *Available resources (including roles of organizations and services provided)*
        6. *Help-seeking behaviors/coping*
        7. *Opinions about needs and services*
    ii. *Comparison to other regions, different populations, so audience understands what these figures mean (relative to others)*
c. Describe how different or similar to initial hypotheses/what was found in other settings
d. Limitations of study (could not access specific groups, etc.) and what could be explored further

>>>

50 - All of this information would be necessary. In case the full survey cannot be undertaken, please explain this and provide some recommendations on further data collection that could be conducted. Also, whenever it is possible, you should cite the source of the secondary data

TABLES AND GRAPHS SHOULD COMPLEMENT TEXT (for example)[51]

a. Demographics of respondents
b. Responses to specific questions (traumatic events) by region, gender
c. Prevalence of symptoms (or level of depression) by region, gender, age
d. Traumatic events by specific demographics
e. Perceptions of mental health needs and resources by specific group, characteristic, etc.
f. Regression analysis: adjusted odds ratios of outcome given selected exposure
    i. *e.g. depression given traumatic event*
    ii. *e.g., poor functioning given depression*

RECOMMENDATIONS/CONCLUSIONS

On the basis of study data → what 5 to 10 recommendations for action would you make related to:

a. Needs, resources, capacities of individuals and communities
b. Activities to be conducted
c. Specific issues to be addressed
d. Stakeholders to be involved
e. Human resources to be contacted for the project
f. Approximate budget to be allocated for conducting the assessment

ANNEXES MAY INCLUDE

a. Any tools developed for this study and related justification
b. Relevant tables
c. National Policy
d. Other mental health reports/assessments
e. List of organizations/contact persons at field and HQ
f. References for information-gathering phase
g. Other information that would be useful to the reader

LEARN MORE

For some examples of well-written assessments, see:

- Adaku A., Okello J., Lowry B., Kane J.C., Alderman S., Musisi S., Tol W.A. (2016). *Mental health and psychosocial support for South Sudanese refugees in northern Uganda: a needs and resource assessment. Confl Health.* 10(1):18. Available at: *https://conflictandhealth.biomedcentral.com/articles/10.1186/s13031-016-0085-6#Bib1*
- Good B., Delvecchio Good M.J., Grayman J., and Lakoma M. (2006). *Psychosocial needs assessment of communities affected by the conflict in the districts of Pidie, Bireuen and Aceh Utara.* Geneva: IOM. Available at: *http://scholar.harvard.edu/files/maryjo_good/files/good_m_pna1.pdf*
- HealthNet TPO (2010). *Situation and needs assessment of mental health and psychosocial support in refugee camps in Tanzania, Rwanda, and Burundi.* Available at: *http://mhpss.net/?get=67/Report-UNHCR-from-HNTPO-May-2010.pdf*
- Plan & UNICEF (2010). *Anticipating the Future: Children and young people's voices in Haiti's post-disaster needs assessment (PDNA). Plan International.* Available at: *http://tiny.cc/129ysz*

51 - See Annex 6 for ideas on graphs/tables

ACTION 6.2
VET THE TEXT (FINDINGS AND RECOMMENDATIONS)

Once the findings are ready and you have initially vetted them (see previous step) you should conduct numerous feedback sessions and invite participants of any activity conducted, significant people in community (leaders, representatives), any partner organization and members of the assessment team. Any gaps in the evaluation should be addressed through meetings with community members/focus groups. In addition to discussing the findings, you should also discuss the study's approach, specifically, and if desired, consider adding the following annexes:

- The process and methods used (including their cultural and gender appropriateness, etc.)
- Partnerships with organizations
- Interaction of team with community members
- Information on venues where interviews took place
- Community's feedback about their situation
- Difficulties faced in the study and information that was not obtained (or was insufficient for answering important questions)
- Lessons learned by the team, the organizations they worked with and the community

Just as you conducted exploratory research in the first step, you can use exploratory research methods at this stage to discuss findings and their interpretation through key informant interviews and focus group discussions.

ANNEXES

ANNEX 1
REFERENCES ON MENTAL HEALTH & PSYCHOSOCIAL APPROACHES

ANNEX 2
INSTRUMENTS TO STUDY ISSUES RELATED TO 3 DOMAINS & OTHER AREAS OF INTEREST

ANNEX 3
OPTIONS FOR DEVELOPING/ADAPTING AN INSTRUMENT

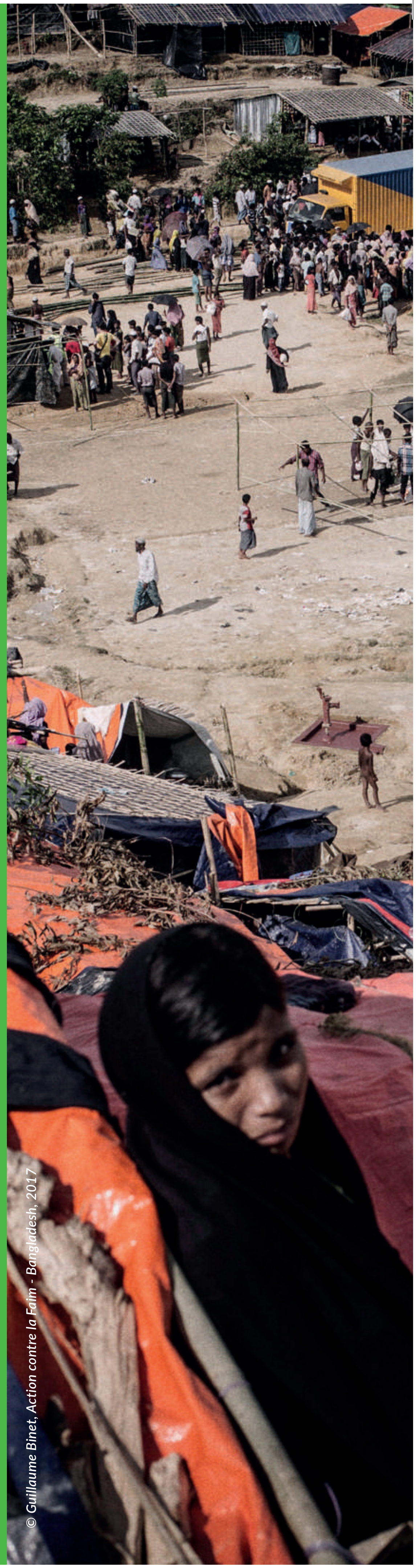
ANNEX 4
KEY ISSUES IN DESIGNING & SELECTING QUESTIONS

ANNEX 5
TO BUILD YOUR OWN QUESTIONNAIRE: A LIST OF QUESTIONS

ANNEX 6
6 USEFUL TOOLS

ANNEX 7
INSTRUMENTS: WHO5 & EPDS

ANNEX 8
EXAMPLES



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ANNEXES

ANNEX 1.
REFERENCES ABOUT MENTAL HEALTH & PSYCHOSOCIAL APPROACHES

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Available at: http://www.actioncontrelafaim.org/fr/content/lutter-contre-le-cholera-le-role-des-secteurs-eah-et-smps-dans-la-lutte-contre-le-cholera-20

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MORE RESOURCES AVAILABLE AT

Action contre la Faim. The supports necessary for the Link NCA method.
Available at: https://www.linknca.org/methode.htm?lng=en

UN Women. Rapid assessments on gender-based violence.
Available at: http://www.endvawnow.org/en/articles/1541-rapid-assessments.html

UPCOMING REFERENCES

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Action contre la Faim. *Toolbox clinic adult.*

Action contre la Faim. *Manual for Measurement of Mental Health and Care Practices Indicators.*

ANNEX 2.
INSTRUMENTS TO STUDY ISSUES RELATED TO 3 DOMAINS & OTHER AREAS OF INTEREST

The questionnaires listed below that contains * are also described in the "Manual for Measurement of Mental Health and Care Practices Indicators".

The following questionnaires have been translated in various languages and validated in some contexts. For more details, please seek advices from with the MHCP Regional Technical Advisors at ACF headquarter.

MENTAL AND EMOTIONAL WELL-BEING	Can use this instrument (if listed) or can find more information on questions to ask in Annex 5 which includes lists of questions related to each of these areas
ADULTS	
Depression	Edinburgh Postnatal Depression Scale (EPDS)* Patient Health Questionnaire 2 (PHQ-2)[52] Distress Scale (K-6)[53] Hospital Anxiety and Depression Scale (HADS)*
Post-Traumatic Stress Disorder (PTSD)	Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)[54]
Anxiety	Hospital Anxiety and Depression Scale (HADS)*
Well-being & mental health	Well-Being Index WHO5* WHO Self-Report Questionnaire 20 (SRQ-20)*
Visual analogue scale	With glasses* With faces*
Resilience	Connor-Davidson Resilience Scale (CD-RISC)*[55]
ADOLESCENTS	
Well-being	Short Warwick–Edinburgh Mental Well-being Scale (SCWBS)[56]
Behavior	Strengths & Difficulties Questionnaire (SDQ)[57]*
Coping	Children's Hope Scale (CHS)[58]
CHILDREN	
Development/behavior (infants, children)	Strengths & Difficulties Questionnaire (SDQ)*
Well-being	Stirling Well-being Scale (SWS)[59] Children's Hope Scale (CHS)[58]

52 - Fore more information, please visit: https://www.hiv.uw.edu/page/mental-health-screening/phq-2

53 - Kessler, R. C., Barker, P. R, Colpe, L. J., Epstein, J. F., Gfroerer, J. C., Hiripi, E., Howes, M.J., Normand, S.L., Manderscheid, R. W., Walters, E. E., Zaslavsky, A. M. (2003). Screening for serious mental illness in the general population. Arch Gen Psychiatry, 60(2), 184-9. Available at: https://www.midss.org/content/k-6-distress-scale-self-administered

54 - For more information, please visit: https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp

55 - For more information, please visit: http://www.connordavidson-resiliencescale.com/user-guide.php

56 - For more information, please visit: https://www.corc.uk.net/outcome-experience-measures/short-warwick-edinburgh-mental-wellbeing-scale/

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59 - Liddle, I., & Carter, G.F.A. (2015). Emotional and psychological well-being in children: The development and validation of the Stirling Children's Well-being Scale. Educational Psychology in Practice, 31(2), 174–185. doi:10.1080/02667363.2015.1008409

SOCIAL & FUNCTIONING	Can use this instrument (if listed) or can find more information on questions to ask in Annex 5
Social Support, relationships, agency and empowerment	Multidimensional Scale of Perceived Social Support (MSPSS)* Social stigma*
Disability, Functioning & Quality of Life	Disability Assessment Schedule (WHO DAS)[60] Unexplained somatic complaints checklist[61] WHOQOL-BREF [62]

SKILLS & KNOWLEDGE	Can use this instrument (if listed) or can find more information on questions to ask in Annex 5
Knowledge of care practices	ACF Knowledge, Attitude and Practice*
Life Skills	Life Skills Inventory / Independent Living Skills Assessment Tool[63]
Vocational Skills	Questions should be included depending on the context[64]

OTHER IMPORTANT AREAS OF INTEREST	Can use this instrument (if listed) or can find more information on questions to ask in Annex 5
Events/Context	
Life Events/Traumatic Events	Impact of Event Scale – Revised (IES-R)[65]
Care Practices	
Breastfeeding practices	WHO BREAST-feed observation form*
Feeding practices	Responsive feeding*
Child development	Gross motor milestones (walking figures)* UNICEF MICS 6 Tools (Questionnaire for children under five)[66]
Mother-child interactions	UNICEF MICS 6 Tools (Questionnaire for children under five)
Changes (before/after)	
Changes in behavior	Behavior change*
Other	
Access to and quality of services* Health status/health system* Physical needs (housing, avail of food)* Separation from family/friends* Child education/activities* Service needs Poverty Displacement HIV/AIDS Gender-based violence Child protection Gender	No specific questionnaires recommended Questions should be included depending on the context For selection of questions please refer to this manual* or other manuals
Demographics	
Individuals* Household* Aid provision* Economic status*	No specific questionnaires recommended Questions should be included depending on the context For selection of questions please refer to this manual* or other manuals

60 - For more information, please visit: http://www.who.int/classifications/icf/whodasii/en/

61 - Kroenke K(1), Spitzer R.L., deGruy F.V. 3rd, Hahn S.R., Linzer M., Williams J.B., Brody D., Davies M. (1997). Kroenke, K., Spitzer, R. L., deGruy, F. V., 3rd, Hahn, S. R., Linzer, M., Williams, J. B., Brody, D., & Davies, M. (1997). Multisomatoform disorder. An alternative to undifferentiated somatoform disorder for the somatizing patient in primary care. Archives of general psychiatry, 54(4), 352–358. https://doi.org/10.1001/archpsyc.1997.01830160080011

62 - Development of the World Health Organization WHOQOL-BREF quality of life assessment. The WHOQOL Group. (1998). Psychol Med, 28(3), 551-558. doi:10.1017/s0033291798006667. Available at: https://www.who.int/substance_abuse/research_tools/whoqolbref/en/

63 - Life Skills Inventory (2000). Department of Social and Health Services. Washington State (USA). Available at: https://washtenawisd.org/life-skills-inventory-independent-living-skills-assessment-tool

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65 - Weiss D.S., Marmar C.R. (1997). The impact of event scale – revised. In: Wilson JP, Keane TM, editors. Assessing psychological trauma and PTSD. New York: Guilford Press; pp. 399–411. Available at: https://www.ptsd.va.gov/professional/assessment/adult-sr/ies-r.asp

66 - For more information, please visit: https://mics.unicef.org/tools

ANNEX 3.
OPTIONS FOR DEVELOPING/ADAPTING AN INSTRUMENT

Betancourt, T., Bass, J., Borisova, I., Neugebauer, R., Speelman, L., Onyango, G., & Bolton, P. (2009). *Assessing local instrument reliability and validity: A field-based example from northern Uganda. Social Psychiatry and Psychiatric Epidemiology*, 44(8), 685–692.
Available at: *https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2716434/*

Horn, R. (2009). An evaluation of the Kakuma Emotional Wellbeing Interview (KEWI). Intervention, 7(3), 223-238.
Available at: *https://www.researchgate.net/publication/228887449_An_evaluation_of_the_Kakuma_Emotional_Wellbeing_Interview_KEWI*

Kohrt B.A., Jordans M.J., Tol W.A., Luitel N.P., Maharjan S.M., Upadhaya N. (2011). *Validation of cross-cultural child mental health and psychosocial research instruments: adapting the Depression Self-Rating Scale and Child PTSD Symptom Scale in Nepal.* BMC Psychiatry. Aug 4;11(1):127.
Available at: *https://www.ncbi.nlm.nih.gov/pubmed/21816045*

Miller K.E., Omidian P., Quraishy A.S., Quraishy N., Nasiry M.N., Nasiry S., Karyar N.M., Yaqubi A.A. (2006). *The Afghan symptom checklist: a culturally grounded approach to mental health assessment in a conflict zone.* Am J Orthopsychiatry. Oct;76(4):423-33.
Available at: *https://www.ncbi.nlm.nih.gov/pubmed/17209710*

ANNEX 4.

KEY ISSUES IN DESIGNING & SELECTING QUESTIONS

Remember, the objective of a question is to have differences in answers that reflect differences in where people stand on the issues rather than differences on their interpretations of the question.

SURVEY QUESTIONS

Designing a survey requires high quality methods – including robust sampling methods and carefully worded questions. In order to select useful questions, it is critical to have questions, which elicit the "type" of answers you are looking for. It is ideal to avoid using jargon (for example, do you feel "blue"?)

The options for answering should also be carefully considered and weighed. Some types of questions include:

1. Yes/No (Binary)
2. Multiple Choice (select as many)
3. Multiple Choice (select one to reflect "degree" of experience, etc.) e.g. Likert Scale

Before drafting questions, it is good if possible to meet with focus groups to allow for free flowing exchange of ideas and opinions among group members. It is useful to hold several focus groups to ensure individuals feel comfortable in sharing their views and ideas. Directions on holding focus groups discussions can be found in the next section and to draft questions see section on *designing questions to be good measures.*

IT IS EASY TO ASK THE WRONG QUESTION!

BRING YOUR ATTENTION TO THE FOLLOWING POINTS:

1. Question wording
2. Brevity
3. Objectivity (no leading questions...)
4. Be wary of built-in assumptions
5. Simple wording (no technical jargon, familiar wording)
6. Avoid negative or double negative expressions
7. Be specific
8. Avoid sensitive questions

WHEN DECIDING BETWEEN OPEN-ENDED AND CLOSED QUESTIONS, CONSIDER THESE:

ADVANTAGES	
OPEN-ENDED QUESTIONS	**CLOSED QUESTIONS**
Allows exploration of the range of possible themes	Easy and quick to fill in
Can be used even if a comprehensive range of alternative choices cannot be compiled	Minimize discrimination against less literate or less articulate people
Data can be qualitatively coded and frequency of themes displayed in a histogram	Easy to code, record and analyze results Easy to report results

WHEN ASKING QUESTIONS IN FOCUS GROUP DISCUSSIONS

Points to keep in mind when considering questions:

- Questions should be “open-ended” to provide a wide variety and depth of responses. Simple “yes/no” questions can provide very specific information but, generally, do not help stimulate discussion or exchange of ideas;
- Questions should be clearly stated so that participants are not confused or misled; Questions should be neutral to avoid influencing the responses of participant; and
- Questions should be ordered from easy, general questions to more difficult ones, to help participants develop their ease in answering them.
- Note that questions should be appropriate to the group you are meeting with. For example, you may ask youth to describe scenarios (e.g. an Afghan boy is upset. Why? When are Afghan boys upset? Rather than what do you think are the most upsetting events experienced by Afghan boys which might be more appropriate when questioning an adult).

WHEN ASKING QUESTIONS TO KEY INFORMANTS

Include one or several ice breaker questions (some examples):

- Tell me about your agency and who you serve
- Tell me about your neighborhood and who lives there

As well as content questions:

- Adapted to focus of interview/these questions can be taken from surveys/instruments

ANNEX 5.
TO BUILD YOUR OWN QUESTIONNAIRE: A LIST OF QUESTIONS

It is required that questions related to *demographic information* and *information related to each of the three core domains (mental/emotional, social/functioning and skills/knowledge)* are included.

In addition to the questions below, you should use as possible the instruments/resources listed in Annex 2

QUESTIONS RELATED TO MENTAL/EMOTIONAL WELL-BEING[67]

- Do you have important events during the last six months?
- What type of difficulties are you facing?
- Do you consume any substances? If so, which ones?
- Do you consume alcohol?
- Do others' in your household consume alcohol?
- If so, how frequently is alcohol consumed?
- Do you participate in X behavior (high-risk behavior)?
- Do you feel settled here?
- Do you feel sad? Tired? Depressed? (what do you call this?)
- Why do you feel the way you feel – what events made you sad?
- When talking about a specific type of suffering:
  - *How can you treat this suffering?*
  - *Who have you gone to treat your suffering?*
  - *How do you know when someone is suffering/not feeling well?*
  - *What are the causes?*
  - *How do you know when someone isn't feeling well?*
  - *What do you do when you feel sad?*
  - *What type of activities make you feel better?*
  - *When you do not feel well, do you have someone to talk to? Who do you talk to?*
  - *What support services do you know about?*
  - *What support services do you receive (if any)?*
  - *If you know of services but do not receive them. Why not?*
  - *When you experience loss how do you feel?*
  - *Who do you ask for help?*
  - *Is this help effective?*

QUESTIONS RELATED TO SOCIAL/FUNCTIONING ISSUES[68]

- Is there any one around you to help you if you need?
- Do you feel you need some social support?
- From whom do you get the social support you need?
- Would you need support from other people you do not get today? From whom?
- Do you feel you have difficulties to seek for/accept social support?
- Do you see that your child(ren) has/have social issues?
- Do you feel your daily life functioning is lower or better than before?
- In which area of your life you function less or better (home/work/social in general)?

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67 - Specifically for focus group discussions (emotional/mental) Are there people with problems or mental problems? (probe: persons who walk around naked by themselves, people who talk to themselves, who are very sad, who have problems related to drugs/alcohol, who have epilepsy, who are mentally disabled?) Who helps these individuals in the community? What do these individuals do to treat these problems?

68 - For focus group discussions: can you describe some of the problems or difficulties in the relationships that you see in your community? When these relationships are not good who do people talk to? What do people do to get help?

QUESTIONS RELATED TO SKILLS/KNOWLEDGE[69]

SKILLS

- How long a child should be breastfed exclusively?
- When did you start introducing complementary food along with breast milk?
- What type of homemade toys you made for your child (Name)?
- When you are experiencing difficulties concerning your children, who do you usually approach?

KNOWLEDGE

- What can play important role in proper development and growth of your child?
- Do you think it is important to play with the young children?
- What are the factors you think important for your young child's optimum growth & development?
- What should you do to ensure safe environment around your child?
- How will you keep your home safe for the child?

QUESTIONS RELATED TO EVENTS

- Has any stressful event happened to you recently?
- How did you react when it happened?
- What are the consequences today on your physical health? On your psychological (emotional) life?
- Are there any areas in your life you have more difficulties to deal with? (give examples: sleeping, daily functioning, relationship, etc.)
- Has it changed the way you perceived life now?
- Has it also affected other member of your family? How do they deal with the situation today?

QUESTIONS RELATED TO CARE PRACTICES

CHILD DEVELOPMENT

- Can your child stand up? Sit down? Walk?
- Has your child engaged in the following activities?
- Has your child stopped some behaviors (walking, standing up) he used to have before?

LEVEL OF FUNCTIONING

- Do you or your child have mobility difficulties?
- Are you able to care for your child (e.g. complete daily tasks)?
- Has your ability to care for your child changed since the disaster? If so, how?
- Do you notice some people with strange behavior, unable to do anything?

CARE FOR PREGNANT/LACTATING WOMEN AND CHILD BIRTH

- Are you pregnant today?
- During this pregnancy/last pregnancy did you attend antenatal consultations?
- Did you eat less during pregnancy? Or differently?
- Did you receive prenatal consultations? If not, why not?
- If you did not receive antenatal and/or prenatal consultations, why didn't you?
- Where was your last child born?
- If the baby was not born in a health facility, why is this?
- Did you have enough rest after birth? How much?
- If you did not have enough rest after giving birth, why not?
- What types of problems did you have during birth? Health problems?
- Did you see anyone for these problems? Who?
- Who is the main caregiver of the children?
- What is the father supposed to do during pregnancy? After delivery?

FEEDING/BREASTFEEDING

- Timeline for breastfeeding (when did it stop completely?)
- Timeline for using prelacteal foods – precise age of the baby
- How is weaning usually done?

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69 - For focus group discussions: explore reasons why people do not practice adequate feeding/care practices, do not access available services, general motivations/beliefs, etc.

- Until what age do you breastfeed exclusively? Has it changed since disaster/event? Why?
- At what age do you introduce additional food? What do you give? Do you give the same since the event? If no, why not and what did you give yesterday?
- What was your timeline for providing water, sugar-based liquids, infant formula, cow's milk, solid foods?
- Do you use bottle-feeding?
- Complementary feeding
- Diversity of diet (over first 36 months)
- Frequency of feeding (over first 36 months)
- Timeline for first providing food to child in general
- Helping the child to eat
- Encouraging child to eat/Caregiver response to child refusing to eat
- Providing additional foods/second helpings
- What other food is the child consuming?
- How do you care for a malnourished (or ill) child?

PSYCHOSOCIAL AND COGNITIVE STIMULATION

- Do you play with the child?
- Does the child play with other children?
- How do you respond to child if he does something wrong (intentionally or unintentionally)?
- Are boys given more time to play than girls?
- Have you changed the time/quality of interaction with your child? How and why?
- What activities do you do with your children? Games, massage, read, tell stories, and sing?
- When your child is crying how do you respond?
- Do family members understand the different types of play and recognize their importance?[70]
- Do they create play opportunities that are appropriate for children of different ages?

HYGIENE BEHAVIORS/ACCESS AND VIEWS

- What is your main source of water?
- How far is your house from main water source?
- What is the quality of the water?
- How much water is used per day in the household?
- How much time do you spend fetching water?
- Do you boil water?
- Do you recycle waste water?
- Do you have a latrine?
- If you have a latrine - how many people are using it?
- Do you wash your hands before/after eating?
- Do you wash your hands after using the latrine?
- Do you wash your hands with soap?
- How do you bathe the child (hot/cold water? soap? Seasonal differences?)
- How much would you need hygiene kits for menstruations?

KNOWLEDGE/BELIEFS RELATED TO CARE

- What are general beliefs regarding breastfeeding?
- What are some traditional beliefs regarding breastfeeding?
- Until what age do you usually breastfeed exclusively – has this changed since the conflict/disaster?
- How are babies fed if the mother dies in childbirth or soon after birth?
- Do you children under five have special foods?
- What types of meals should children under five have in the family?
- At what age do you introduce additional food? What do you usually give? Has this changed since the conflict/disaster?
- Do you give the first yellow milk to the children?
- Is the child breastfed on demand?
- Has there been distribution of powder milk? By whom? What quantities?
- Do you give powdered milk to children?
- How many times is the child breast fed?
- Was the child always fed at night?

70 - On the importance of play and psychosocial stimulation, see: ACF Manual for the integration of child care practices and mental health into nutrition programs. Available at: https://www.actioncontrelafaim.org/en/publication/manual-for-the-integration-of-child-care-practices-and-mental-health-into-nutrition-programs/

- Who gave you advice on how to take care of your child?
- Who is responsible for the health, hygiene, etc. of a child?
- Are girls treated differently than boys? Why?
- What is malnutrition and how would you recognize it?
- What about question related to sleep? Health?

KNOWLEDGE/BELIEFS RELATED TO PREGNANCY

- What types of problems can women have when pregnant?
- Who should a pregnant woman go and see if she has these problems?
- Who gave you advice for your pregnancy?
- Are there foods you should not eat during pregnancy? And special food you should eat?
- Should you gain weight during pregnancy?
- Should you get more or less sleep when you are pregnant?

TIME/AUTONOMY

- Do you have enough time to adequately take care of your child? If not, why not?
- Are you able to complete daily activities?
- Are you working?
- Who helps you with taking care of your child?
- Do you spend enough time with your children?
- If you do not spend enough time with your child, what might be a potential solution to this?
- Do you have too much work at home?
- Do you have enough time to complete your chores?

SOCIAL SUPPORT

- What are the inter-family relations?
- Who makes decisions? Are you able to make decisions?
- Do children feel secure at home?
- Do mothers spend time listening to their children and show an interest in how they feel, what they do, how they think?
- How does the family respond to a child's mistake?
- Are children involved in social activities?
- Has the mother or child experienced inter-family violence?
- Do men support women during pregnancy? How?
- Do men support women after delivery? How?
- Do others support women during and after pregnancy?
- Could you describe your relationship with your family?
- Do you have any conflicts within your family?
- Have you experienced any physical violence in your family?

ACCESS TO CARE/USE OF CARE

- Do you visit the health center when necessary?
- Do all members of household (infants, children) have access to care?
- Does family know what symptoms may indicate a psychological problem? Do they know what to do if they see such symptoms?
- What possibilities exist in the community for individuals with psychological problems?
- Do you have access to community health volunteers?
- Have you seen a community health volunteer? Why or why not?
- Do you participate in Growth monitoring?
- Has your child been immunized (DPT, Measles)? When? If not, why not?
- If you do not visit the health center when necessary, why not?
- What type of care do you need?
- What type of care does the community need?
- If you have experienced violence, did you seek care? If so, what type?
- If you did not seek care after having experienced violence, why not?
- Would you say that access to health facility is good or bad?

ACCESS TO AND CONSUMPTION OF FOOD

- Where do you get food?
- How many meals per day do you eat?

- In the last 7 days, how much of (type of food) has your family eaten?
- Is this amount above, adequate?
- What foods do you usually eat? (provide list) If any specific and available foods are not consumed, why or why not?

FOR MOTHERS/MOTHER-IN-LAWS

- What advice have you given to your daughter/daughter-in-law?
- What activities do you help with?
- What activities does she undertake by herself?
- Do you spend time with your grandchildren during the day?
- Are you responsible for their feeding? Hygiene?
- Who cooks in the family?
- Who decides on the food to be served?
- Who eats first?
- Are there any foods that women cannot have? Why or why not?
- Does the husband take care of the children too?

FOR FATHERS

- What tasks do you assist with during the day?
- What aspects of the child's day-to-day life are you responsible for?
- Do you think there is a difference between the treatment of girls and boys?
- Have you ever been trained in child care?
- Do you ever read, sing, massage, play a game with your child?
- Who makes decisions in terms of food, hygiene practices, household purchases?

COMMUNITY SUPPORT FOR FAMILIES

- What practical challenges do they face?
- Are their basic material needs being met?
- What special vulnerabilities do they have?
- What resources do they have access to/use?
- How could you ensure that they are using them?
- What qualities do families need to support children?

COMMUNITY LEADERS

- What are the main difficulties faced by mothers and their children?
- What are the main resources you identify for families with children?

TRADITIONAL HEALERS

- What are the main treatments you provide to children?
- Do mothers or other caregivers bring their children when they do not eat properly?
- What are the main requests from mothers?

HEALTH PERSONNEL (DOCTORS, NURSES, HEALTH WORKERS, ETC.)

- What are the difficulties faced by women?
- What are the difficulties faced by children to access the health care center?

QUESTIONS RELATED TO CHANGES – BEFORE AND AFTER DISASTER

- In the week before the event, were you married, separated, divorced, or living with someone?
- In the week before the event, how many people lived with you, not counting yourself?
- In the week before the event, were you employed, self-employed, looking for work, disabled, a student, a homemaker, retired, or something else?
- Who was the main breadwinner in your household before the event: you, someone else, or both you and someone else? Which one of those people made the most money?
- In the week before the event, was main breadwinner employed, self-employed, looking for work, disabled, a student, a homemaker, retired, or something else?
- What's (his/her) job situation now: employed, self-employed, looking for work, or what?
- And what's your job situation now? Are you employed, self-employed, looking for work, or what?
- Where did you live the week before the event?

OTHER ISSUES QUESTIONS

ACCESS TO/QUALITY OF SERVICES

- Do you have access to health care?
- Do you know where health care is offered?
- Do you use health care services? Regularly?
- During the past year, have you had difficulty getting medical treatment?
- How long does it take you to travel to your healthcare provider?
- During the past year, were you prescribed a medicine but were unable to get it?
- Have you received written information about your health from your health provider or other sources in the language you prefer?
- In the past year, have you had difficulty understanding what your doctor or other healthcare professional was telling you?
- Overall, how satisfied are you with the communication you have with your doctor or other health care staff related to your health?

HEALTH STATUS

- Was anyone in your family sick last month?
- If someone in your family was sick last month, which illness did they have?
- What is the MUAC of each child?
- Do you have health insurance?
- Are medicines available in the health center?
- Do you have to pay for consultation?
- Is there any chronic illness in the family?

PHYSICAL NEEDS (LIVING CONDITION, LACK OF FOOD)

- Have you been able to go back to your home?
- Have you been able to find a shelter/safe place to stay since the event?
- Have you been able to find a safe place to stay with your family since the event?
- If separated, have your family found a safe place to stay?

SEPARATION FROM FAMILY/FRIENDS

- Have you been separated from other family members/friends?
- Are some of your family members/friends missing?

CHILD EDUCATION/ACTIVITIES

- Were your children going to school before the event?
- Have your children been back to school since the event?
- Have your children been attending any psychosocial activities?
- Have your children been left unattended during the day?

DEMOGRAPHIC QUESTIONS

1. Name
2. Date
3. Questionnaire Number
4. Sub District
5. Village
6. Sub-village
7. Age
8. Gender
9. Marital status
10. Highest level of Education
11. Type of House
12. Head of Household
13. How many people are living in household?
14. How many children under five?
15. What are the ages of the children?
16. How many people older than age 60?
17. How many are females? Males?
18. What is the mother's age?
19. What is the source of income?
20. What are your current expenditures?
21. Have you borrowed money recently?
22. Why did you borrow money?
23. Have you received aid from the government or an NGO?
24. How much have you received (and type)?

ANNEX 6.

SIX USEFUL TOOLS

TOOL 1. EXAMPLES ON HOW TO PRESENT DATA

FIGURE 1.
BAR GRAPH FOR PYRAMID AGE

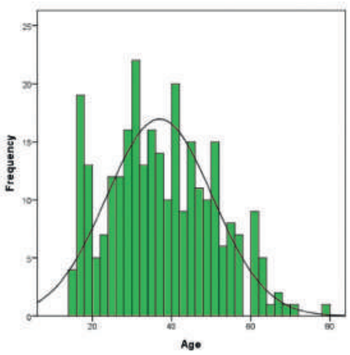


FIGURE 3.
GRAPH FOR PROPORTION OF RESPONSES

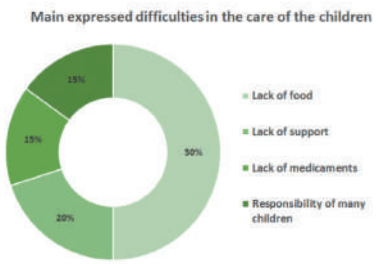


FIGURE 2.
BAR GRAPH FOR PROPORTION OF RESPONSES

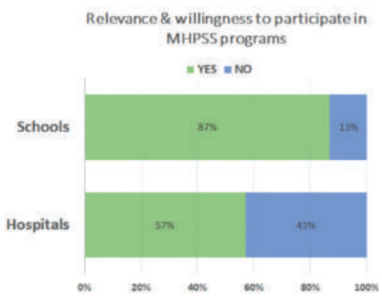
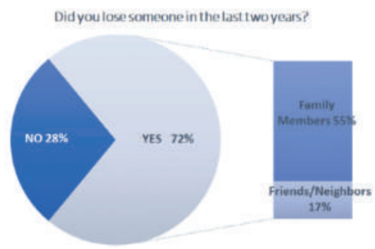


FIGURE 4.
GRAPH FOR PROPORTION OF RESPONSES



TOOL 2. TABLE OF RANDOM NUMBERS

Select a row from 1 to 40 and a column from 1 to 12. Use the number at the intersection of the selected row and column.

Row number	Column number 1	2	3	4	5	6	7	8	9	10	11	12
1	20	288	215	98	44	202	323	226	162	262	248	276
2	331	171	204	131	185	39	183	338	209	352	285	333
3	250	142	85	145	348	55	327	137	289	135	146	282
4	259	226	225	215	219	306	267	181	29	328	247	280
5	143	103	64	332	199	215	159	145	84	87	135	250
6	234	261	211	152	181	198	59	179	99	29	106	342
7	360	61	177	310	265	150	23	8	83	122	303	112
8	86	103	313	117	254	284	17	347	296	196	153	251
9	120	191	52	93	297	209	290	251	155	210	47	357
10	6	105	155	77	191	147	356	245	262	36	268	32
11	37	2	259	115	3	24	105	115	130	246	256	61
12	357	180	52	190	311	20	48	348	12	322	223	355
13	326	227	40	93	217	100	336	262	272	83	179	48
14	336	322	174	335	94	358	303	337	253	253	42	163
15	240	213	217	8	184	72	219	136	211	64	154	217
16	289	327	291	216	112	106	147	181	33	311	7	111
17	140	32	297	319	342	15	30	53	54	55	10	139
18	125	81	128	59	121	236	307	264	328	120	247	127
19	351	21	132	172	148	91	93	334	74	126	223	62
20	80	91	98	280	41	146	219	271	248	246	185	179
21	198	255	26	201	330	134	100	19	41	50	192	349
22	80	225	321	260	161	330	260	333	195	145	42	169
23	66	54	140	179	179	46	311	87	340	341	287	98
24	19	185	137	346	163	224	13	72	208	48	124	288
25	281	321	20	16	5	48	70	91	122	305	240	75
26	126	61	317	336	188	184	23	31	174	280	115	88
27	355	267	117	253	186	72	1	221	345	86	89	355
28	321	327	358	78	320	261	187	325	100	91	179	184
29	201	341	29	14	341	63	253	249	226	170	311	127
30	308	233	229	344	215	341	318	334	144	326	70	148
31	195	42	88	337	122	97	84	215	298	168	300	312
32	22	115	136	100	110	73	219	290	133	70	23	55
33	48	190	121	352	200	249	135	55	336	17	263	269
34	175	225	341	307	283	280	359	348	143	230	102	283
35	133	17	293	356	45	151	49	69	334	340	151	251
36	188	43	324	343	104	302	168	92	97	43	321	268
37	133	103	334	241	207	12	208	168	16	153	121	268
38	351	360	102	5	85	226	246	16	155	323	113	260
39	80	354	191	267	197	169	172	348	271	231	40	164
40	299	311	165	41	211	64	281	91	95	186	283	299

Select a row from 1 to 40 and a column from 1 to 12. Use the number at the intersection of the selected row and column.

TOOL 3. INFORMED CONSENT FORM

We are inviting you to take part in an assessment by Action contre la Faim. We are conducting an assessment to find out about the serious problems that people have when they have experienced a conflict or another disaster. We hope that by better understanding what people, like you, see as their serious problems, more people will get the help they really want.

We want to assure you that participation in this assessment is voluntary. If you do decide to take part, we invite you to meet with the interviewer on one occasion. The interview would take about 15 to 30 minutes of your time and we would ask you questions about the serious problems you may currently be experiencing.

If you do decide to take part in this assessment, you have the right to refuse to answer any question the interviewer asks you. Please let him/her know and he/she will move to the next question. You may also stop the interview at any time if you wish and without having to give a reason. We assure you that all the information we receive will be completely confidential, so it will not be possible for anybody outside our team to link any of the information we collect to you.

If you have any questions now or in the future you can contact Action contre la Faim (address, telephone number) for further advice and information. If you feel discomfort from answering these questions and you would like to speak to someone, please contact (organization name, address)

Thank you for your time.

Do you have any questions?

Do you agree to be in this assessment? ◻ Yes ◻ No

_________________________________ ___________________

Signature Date

Either to be signed by participant (where written consent is taken) or by interviewer as witness to participants' consent (where verbal consent is taken)

TOOL 4. FIELD NOTES FORM

Date: ___________

Recorder: ....

Activities: ....

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Notes: ....

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Supervisor review: ....

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TOOL 5. DECISION FORM

ASSESSMENT PREPARATION		
Background review		
Specify objective of the assessment (on basis of review and ACF guidance)		
Identify research team, resources and partners		
Discuss research with local authorities		
ASSESSMENT DESIGN		
Identify population to study (defined by region, demographics, etc.)		
Determine if feasible to undertake quantitative and qualitative research (w/ consideration for analytic approach)		
Develop study plan and timeline		
Specify qualitative methods (including tools) and sampling		
Specify quantitative methods (including tools) and sampling		
Determine interviewer training, data collection, entry and supervision roles and procedure		
Submit proposal with above details to Action contre la Faim for clearance		
ASSESSMENT IMPLEMENTATION		
Identify sample		
Conduct interviews/focus groups, etc.		

TOOL 6. TIMELINE

STEP	NUMBER OF DAYS
Background review	
Literature	
Organizations, activities and community	
Research design and analysis plan (submit to Action contre la Faim HQ)	
Feedback on Design from HQ and revise	
Permission/establish cooperation with local partners	
Train interviewers/staff	
Identify and set up data collection/entry procedure and equipment	
Collect data	
Method 1	
Method 2	
Method 3	
Data cleaning and Review	
Analysis	
Draft report	
Review findings	
Finalize report	

ANNEX 7.

INSTRUMENTS: WHO5 & EPDS

WHO (FIVE) WELL-BEING INDEX (1998)[71]

The WHO-5 is a self-reported measure of individual mental well-being; it can be administered to a population aged 9 and above.

INSTRUCTION

Please indicate for each of the five statements, which is closest to how you have been feeling over the last two weeks. Then, put a tick in the selected boxes.

OVER THE LAST TWO WEEKS	All of the time	Most of the time	More than half of the time	Less than half of the time	Some of the time	At no time
I have felt cheerful and in good spirits	5	4	3	2	1	0
I have felt calm and relaxed	5	4	3	2	1	0
I have felt active and vigorous	5	4	3	2	1	0
I woke up feeling fresh and rested	5	4	3	2	1	0
My daily life has been filled with things that interest me	5	4	3	2	1	0
TOTAL *(calculate immediately by summing up all answers)*						

SCORING AND INTERPRETATION

The total raw score is the sum of all the five answers, ranging from 0 to 25. This score is multiplied by 4 to obtain the final score ranging from 0 to 100 where a score of 100 represents the best possible well-being.

For additional information and references, please visit the WHO-5 website:
https://www.psykiatri-regionh.dk/who-5/who-5-questionnaires/Pages/default.aspx

References:

Topp C.W., Østergaard S.D., Søndergaard S., & Bech P. (2015). *The WHO-5 Well-Being Index: A Systematic Review of the Literature.* Psychotherapy and Psychosomatics, 84, 167-176.

WHO. (1998). *Wellbeing Measures in Primary Health Care/The Depcare Project*. WHO Regional Office for Europe: Copenhagen.

71 - © Psychiatric Research Unit, WHO Collaborating Center for Mental Health, Frederiksborg General Hospital, DK-3400 Hillerød

EDINBURGH POSTNATAL DEPRESSION SCALE (EPDS)[72]

Administered/Reviewed by ___________________ Date _________________________________

Your Date of Birth: ___________________________ Baby's Date of Birth: _________________

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt ***IN THE PAST 7 DAYS,*** *not just how you feel today[73].*

1. You have been able to laugh and see the funny side of things
   a. As much as you always could ☐
   b. Not quite so much now ☐
   c. Definitely not so much now ☐
   d. Not al all ☐

2. You have looked forward with enjoyment to things
   a. As much as you ever did ☐
   b. Rather less than you used to ☐
   c. Definitely less than you used to ☐
   d. Hardly at all ☐

3. You have blamed yourself unnecessarily when things went wrong
   a. Yes, most of the time ☐
   b. Yes, some of the time ☐
   c. Not very often ☐
   d. No, never ☐

4. You have been very anxious or worried for no good reason
   a. No, not at all ☐
   b. Hardly ever ☐
   c. Yes, sometimes ☐
   d. Yes, very often ☐

5. You have felt scared or panicky for no very good reason
   a. Yes, quite a lot ☐
   b. Yes, sometimes ☐
   c. No, not much ☐
   d. No, not at all ☐

6. Things have been getting on top of you
   a. Yes, most of the time you haven't been able to cope at all ☐
   b. Yes, sometimes you haven't been coping as well as usual ☐
   c. No, most of the time you have coped quite well ☐
   d. No, you have been coping as well as ever ☐

7. You have been so unhappy that you have had difficulty sleeping
   a. Yes, most of the time ☐
   b. Yes, sometimes ☐
   c. Not very often ☐
   d. No, not at all ☐

8. You have felt sad or miserable
   a. Yes, most of the time ☐
   b. Yes, quite often ☐
   c. Not very often ☐
   d. No, not at all ☐

9. You have been so unhappy that you have been crying
   a. Yes, most of the time ☐
   b. Yes, quite often ☐
   c. Only occasionally ☐
   d. No, never ☐

10. The thought of harming yourself has occurred to you
   a. Yes, quite often ☐
   b. Sometimes ☐
   c. Hardly ever ☐
   d. Never ☐

SCORING[74, 75]

*Questions 1, 2, & 4 (without an *)* are scored 0, 1, 2 or 3 with top box scored as 0 and the bottom box scored as 3.
*Questions 3, 5-10 (marked with an *)* are reverse scored, with the top box scored as a 3 and the bottom box scored as 0.
Maximum score: 30
Possible Depression: 10 or greater
Always look at item 10 (suicidal thoughts)
Mothers who score above 13 are likely to be suffering from a depressive illness of varying severity. The EPDS score should not override clinical judgment. A careful clinical assessment should be carried out to confirm the diagnosis. The scale indicates how the mother has felt *during the previous week*. In doubtful cases it may be useful to repeat the tool after 2 weeks. The scale will not detect mothers with anxiety neuroses, phobias or personality disorders.

72 - Users may reproduce the scale without further permission providing they respect copyright by quoting the names of the authors, the title and the source of the paper in all reproduced copies.

73 - Instructions for using the Edinburgh Postnatal Depression Scale: 1) The mother is asked to check the response that comes closest to how she has been feeling in the previous 7 days; 2) All the items must be completed; 3) Care should be taken to avoid the possibility of the mother discussing her answers with others. (Answers come from the mother or pregnant woman. 4) The mother should complete the scale herself, unless she has limited English or has difficulty with reading.

74 - Cox, J.L., Holden, J.M., and Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. British Journal of Psychiatry 150:782-786.

75 - Wisner, K. L., Parry B. L., Piontek C. M. (2002). Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 194-199.

ANNEX 8.
EXAMPLES

EXAMPLE 1
THE PSYCHOSOCIAL NEEDS ASSESSMENT IN 14 DISTRICTS IN ACEH

This needs assessment used both key informant interviews and a survey of randomly selected adults – making their study both quantitative and qualitative.

Key informant interviews were qualitative -- designed to explore the historical context of the conflict in specific regions and to discuss how the conflict affected communities and if there were certain segments of the population that were more vulnerable than others. Community leaders were asked to assess their communities' priorities for psychosocial and mental health services and to describe their views on the best ways to respond to the effects of the conflict.

Sampling: each village was visited and 18 randomly selected key informant interviews. Additional key informant interviews focused on health workers, etc.

Formal survey of randomly selected adults – included open-ended questions and widely used validated scales. The objective was to measure levels of past experiences of traumatic events, assess experience of current stressor events and to identify levels of psychological distress associated with these experiences. The survey was organized in the following way: 1) Open-ended questions; 2) Quantitative measures from validated screening instruments (adapted for culture); and 3) self-assessment questions to assess levels of emotional and psychological distress; 4) HSCL-25; 5) HTQ; 6) items designed to capture popular discourses about post-conflict experiences were integrated into the quantitative measures; 7) additional questions related to head trauma and beating from the HTQ were asked; and 8) closed and open questions regarding respondent's perceptions of what community mental health services are most needed, opinions about who suffered most or at greatest mental health risk, who provides care and who people can turn to overcome current bad experiences, attitudes about public health care services and comments/suggestions about the post-conflict peace process. Additionally, a social functioning scale (adapted to culture) was included as was a section of questions devoted entirely to conflict-related displacement.

Sampling: The objective was to describe the population living in high conflict areas (target population). Once these areas were determined, 50% were randomly selected from the short list of high-conflict villages. Upon arrival in selected village – teams would report to the village head and explain why they were there. The team leaders would work with these community leaders to generate a random sample of 18 households (most villages keep a record of the households so this was an easy process). Upon arrival at a household, surveyors would select a random respondent from the residents aged 17 and older.

EXAMPLE 2
MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT ASSESSMENT IN MOSUL CITY

In June 2017, Action contre la Faim conducted a MHPSS assessment in Mosul city, to gather information on the impact of ISIS occupation on the population. **The methods used to collect information** for this assessment were Focus Groups Discussions (FGDs) and individual interviews. During the FGDs, the main topics discussed were factors causing distress during and after ISIS occupation, distress symptoms after occupation, main coping mechanisms and the perceived relevance of assistance in mental health, and willingness to use the MHPSS services. For individual interviews, a semi-structured questionnaire was used addressing main MHPSS needs, coping mechanisms, and relevance of MHPSS program and care practices. Individual interviews were carried out in the halls and waiting rooms of Al Khansa hospital l. Focus Group discussions were carried out in six locations: one hospital and 5 schools. The key informant participants included teachers from the schools, director of Al Khansa hospital, the MSF psychologist in Al Moharabin, the director of Al Shefa Mental Health Centre and mental health staff and the director of mental health in Ibn Al Ather Hospital.

Sample criteria. Random sampling was used of the selection of participants in this assessment. To ensure a larger participation and include as many participants as possible in the assessment, school with higher number of IDPs population were selected. In addition, Khansa Hospital was selected for its high number of population attending medical services per day; PHCs were on the contrary excluded due to low attendance of patients and lack of space to carry out the assessment activities. The two health facilities in Mosul including psychologists and psychiatrics among the staff were also included in the assessment. In total, 302 people participated in the assessment, with age ranging from 15 to 79 years. The average age of the participants was 36 years with a standard deviation of 13.34 years. Participation in the assessment took place on a voluntary basis (without provision of incentive). A strict protocol of confidentiality was developed, explained to participants and its implementation was ensured during the whole process.

EXAMPLE 3

TEN EXAMPLES OF STUDIES USING VARIOUS APPROACHES (QUANTITATIVE, QUALITATIVE, BOTH) PRESENTED IN:

Poudyal B., Bass J., Subyantoro T., Jonathan A., Erni T.,. *Assessment of the psychosocial and mental health needs, dysfunction and coping mechanisms of violence affected populations in Bireuen, Aceh. A qualitative study. Torture, 19(3), 218-226.* Available at: *https://www.ncbi.nlm.nih.gov/pubmed/20065540*

The study aimed to understand how local people affected by violence perceive their current psychosocial and mental health problems resulting from these experiences, including the variety, importance and severity of these problems, the nature and terminology used to describe these problems, their perceived causes, and what people do to help themselves when they have these problems. Data were also gathered to identify what constitutes the most important aspects of daily functioning in order to design locally-appropriate measures of functional impairment. Also, data were collected to understand the various coping skills used by the local population to minimize their negative emotions and deal with daily life stress. Methods: free listing techniques were used with 71 community members (male and female). Respondents were asked "what are some of the problems that people affected by violence in your community face?" and interviewers probed each respondent for as many problems they could think of. They recorded the exact description in the local language. At the end of each interview, each response was categorized as a problem relating to thinking, feeling or relationships. For each of these problems, they asked respondents the names and contact information of local people who are knowledgeable about these.

All lists from the interviews were combined into one list. The most frequent problems were noted. Four additional lists were also made in each interview on day-to-day activities and tasks that men and women do to care for themselves, their families and their communities, and on the coping strategies that they use to deal with their problems.

From the list of people knowledgeable about the problems from the first interviews and from snowball method (referral by one key informant of another key informant) and some of those interviewed for the free listing were also considered key informants. In total, 21 key informants were interviewed. These key informants were interviewed multiple times. They were asked to tell all they knew about each of the two major problems (nature of the problem, causes and effects, what people do to address each problem, and what could be done by others to help). After this, the interviews were compiled together to see how many of the key informants mentioned the same signs and symptoms – interviewers were asked to come to a consensus as to one of the terms which could be used to capture the overall meaning of the group of terms. The end product were two lists one for each of the main problems identified in the first free listing technique – with all of the different signs and symptoms and the frequency with which each was reported. The interviewers also reviewed the key informant interviewers to identify local ways that people coped with the problems they had.

To further explore functioning among the local population, one focus group was convened of key informant interviews. During the focus group, the participants were provided with a summary of the results of the task lists from the earlier free list interviews. The focus group participants were asked to confirm if these were the activities and tasks that men and women regularly do across all domains (care of self, family and community) and if there were other important activities not listed. To complete the discussion, the group was asked to identify the most important tasks for each gender, understanding that all of the identified tasks were activities that both men and women do regularly.

This provided information on mental health and psychosocial problems identified from the free listing interviews, signs and symptoms of fear and thinking too much (the two major problems identified), coping strategies identified during the key informant interviews and female and male task and activity list.

Once these were identified, questionnaires were then developed which focused on determining:

a. Difficulty individuals were having doing each activity compared to what level of difficulties others (of same age and gender) normally have
b. Difficulty individuals were having in the past two weeks, doing an activity
c. Degree of symptoms (of those associated with the two major problems identified) experienced in the past two weeks
d. Frequency of practicing coping mechanisms (identified in interviews)
e. Changes in ability to cope
f. Life events
g. Changes in activities

NOTES

FOR FOOD.
FOR WATER.
FOR HEALTH.
FOR NUTRITION.
FOR KNOWLEDGE.
FOR CHILDREN.
FOR COMMUNITIES.
FOR EVERYONE.
FOR GOOD.
FOR ACTION.
AGAINST HUNGER.

ACTION AGAINST HUNGER

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