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In spite of the clarity of mental health and psychosocial core principles: the existence of a participation implementation gap

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According to humanitarian minimal standards, humanitarian programmes should maximise participation of affected populations within their response. Participation has been a key point in proposals, evaluators are aware of it and every aid worker has heard of it. In theory, it is a perfectly implemented, well understood and a well respected construct. In the field of mental health and psychosocial support, participation is core principle number two. Based on personal observations, this paper will delve deeper into the concept of participation within mental health and psychosocial support and the importance of its implementation. Further, and perhaps more importantly, it will reflect on the fact that even though this concept is so imbedded into concepts of humanitarian aid, there is a huge implementation gap. As a result, this paper also calls for action to fill this implementation gap and improve humanitarian aid through the principle of participation.

Keywords: participation, psychosocial, wellbeing

Introduction

The term *'psychosocial'*, as described by Williamson and Robinson (2006), acknowledges that social and psychological issues tend to be closely inter-related. Further, both the concept of *'psychosocial'*, reflecting this dynamic inter-relationship, and the term are now widely used among humanitarian agencies. Additionally, the number of programmes addressing psychosocial needs among conflict affected populations has been increasing since the 1980s.

A wide variety of approaches have been used to address the psychosocial impacts of armed conflict. Some of the more common have included: psychiatric and psychological clinical interventions, training local paraprofessional counsellors, community based social support and integration, cultural activities, sports, play opportunities, educational activities (formal and non formal) and support for traditional healing. However, within emergency and development work, physical and biological issues often receive primary emphasis in terms of funding allocations and organisational priorities. Social, psychological or psychosocial issues are, at best, seen as secondary (Williamson & Robinson, 2006).

This concept follows older constructs of wellbeing, which suggest that human wellbeing depends on the fulfilment of a series of needs, starting with the most fundamental physiological needs and progressing upwards through the need for safety, love, self-esteem and self-actualisation (Maslow, 1943). Hence, building a bottom up, hierarchical structure instead of achieving a synergy that is protected by participation, development and safety, the minimal standards to ensure wellbeing. This concept of wellbeing is also described by the Psychosocial Working Group in 2003 (Williamson & Robinson, 2006), as a concept that requires participation to succeed. Enabling a community or individual to engage with their

circumstances and more effectively identify resources can be achieved through participation (Ager & Loughry, 2004), and enhanced effectiveness of wellbeing cannot be achieved without participation of the community or individual. Therefore, participation can also be described as an essential element of psychosocial approaches and wellbeing, with the Inter-Agency Standing Committee (IASC) citing participation as one of their main core principles in the *Mental Health and Psychosocial Support Guidelines* (IASC, 2007).

Participation: meeting real needs

Participation is not only a core principle of the IASC guidelines, it also has been incorporated into numerous other humanitarian standards and guidelines, e.g. *Humanitarian Accountability Partnership* (2010), *International Humanitarian Law, Emergency Capacity Building* (2007), *Good Humanitarian Donorship* (2003), the *European Consensus on Humanitarian Aid* (2008), *Core Humanitarian Standards* (2014) and *Sphere Guidelines* (2011).

The IASC (2007) guidelines define participation within humanitarian assistance as the involvement of the target beneficiaries in the assessment, design, implementation, monitoring and evaluation of humanitarian assistance. According to the IASC, participation enables different groups within a population to retain or resume control over decisions that affect their lives and to build a sense of local ownership. This is important for achieving programme quality, effectiveness, equity and sustainability and should, therefore, be maximised in all interventions. In other words, the intervention should be appropriate and tailored to meet real needs of affected populations.

How interventions can better meet real needs, is also based on the fact that a community provides a physical environment and foundation for safety, living, work, education and health services (Church of Sweden, 2011). Additionally, the community also furnishes a social and psychological foundation for individuals and families. No one knows better what is needed than the communities themselves and responding to emergencies should always begin with the community. In turn, participatory decision making strengthens the community. By working together, a community's ability to support families and individuals is increased and can be guided to include even those who, in the past, may have been marginalised.

It is believed that participation, as such, is not a concept that consists of one action or step, but takes several levels into account. The participation ladder by Arnstein (1969) explains that participation as a concept consists of eight levels: manipulation; therapy; informing; consultation; placation; partnership; delegated power; and citizen control (Figure 1). Each level describes an amount of participation of the target group. Manipulation and therapy have no real objective to enable people to participate, but merely to educate or cure them. Informing and consultation offer people the opportunity to be heard, but people lack the power to ensure their views will have any effect on those who hold power. Placation enables people to advice, but it remains for those who hold power to continue to hold the right to decide. People can enter into a partnership that enables them to negotiate and engage in trade-offs with traditional power holders, and at the highest levels, delegated power and citizen control, people obtain the majority of decision making seats or full managerial power. Hence, the higher you go on the ladder, the more participation of the target group, the more participation evolves. The more participation, the more involvement of the target group in the stages of a project cycle. Hence, as a core principle, participation is not a concept that should be taken as *'black or white'*, but as a concept that has multiple levels, with different levels required for varying forms of interventions.

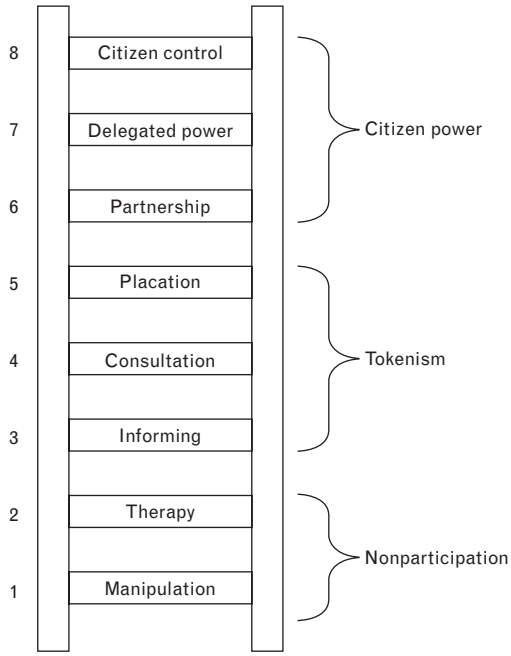

Figure 1: Participation ladder by Arnstein (1969)

For example, a purely medical intervention, cannot have full delegated power, as a surgeon still needs to retain the power to perform as they see fit.

Empirical evidence has also shown that participation creates lower levels of conflicts and hostility within a peace building process, as well as successful reconstruction efforts in the wake of humanitarian interventions (Gizelis & Kosek, 2005). Participation has also been linked to the decrease of a dependency syndrome (Harvey & Lind, 2005), which is generally seen to have negative impact on self-sufficiency, self-reliance and sustainability. Further, participation contributes to a better design of programmes, improved implementation and increased wellbeing for the beneficiaries.

Challenges of implementation

However, effective implementation of participation is not easy to achieve. Facilitating genuine community participation requires understanding of local power structures, patterns of community conflict, working with a variety of population groups and avoiding privileging any particular group (IASC, 2007). In 2005, Gizelis and Kosek concluded that there are no available indicators of participation of local populations within humanitarian interventions. Fortunately, a review of existing practices to ensure participation of disaster affected communities in humanitarian aid operations, published by Barry and Barham (2012), highlights changes that have occurred since. The paper mentioned that, in general, the importance of participation is more recognised and consequently general guidelines have been developed to properly monitor and evaluate the principle.

Although the study did highlight various risks and challenges of proper participation implementation in aid, regrettably, the effect of participation as evaluated by Barry and

Barham (2012) only analysed benefits on issues of do no harm, protection, human rights, inclusion, equity, dignity, effectiveness and efficiency of humanitarian programmes, but did not analyse the direct effect of participation on wellbeing and mental health in particular. Additionally, low levels of participation have been shown to reduce the populations' sense of ownership or personal attachment to a solution that has been externally imposed.

Due to the presence of so many additional challenges and risks related to the proper implementation of participation in humanitarian assistance and, in particular, in relation to mental health and psychosocial support (MHPSS), what can be done practically to assure participation in the field will require further assessment and research.

In order to add to this sorely needed knowledge pool, this paper provides personal observations and examples where participation has been difficult to implement within humanitarian interventions. In addition, it will discuss causes, consequences and recommendations to advocate for social action to better respect and implement the MHPSS core principle of participation. Finally, the article includes a framework that reflects the integration of safety, participation and development to protect the various elements of wellbeing: biological, material, social, spiritual, cultural, mental and emotional.

Observations

Based on the model of Williamson and Robinson (2006), participation should be analysed within each of the wellbeing elements: biological; material; social; spiritual; cultural; mental and emotional. Therefore, participation should not only be respected within specific time frames within a humanitarian project cycle, but also within different disciplines of the concept through mainstreaming core principles into other disciplines. Yet, the author has found over several years in the field, organisations and individuals that do not respect MHPSS core principles, nor participation as a key principle.

Quality health care is a good example of why participation is a necessary component in the delivery of aid. Quality of care requires six dimensions to be respected in its implementation. Being patient centred is one of these dimensions, that means delivering health care that takes the preferences and aspirations of individual service users and the cultures of their communities into account (World Health Organization, 2006). The other dimensions show strong links with humanitarian evaluation criteria, such as: effectiveness; efficiency; accessibility; safety; and equity. In turn, all six of these dimensions have strong links with participation (UNICEF, 2011). Additionally, within quality of care, the most effective and sustainable approach for promoting psychosocial wellbeing and recovery is to strengthen the ability of families and communities to support one another. Girls, boys, women and men should all be active partners in decisions that affect their lives (UNICEF, 2011). Furthermore, if the care process has active stakeholder participation, an agreed quality improvement strategy could be produced within a short period of time (World Health Organization, 2006). In other words, for the medical discipline or the biological component of wellbeing, participation is key to make the intervention successful.

The following examples illustrate some of the challenges of proper mainstreaming of participation into humanitarian interventions. They are personal observations from a humanitarian aid worker with a psychosocial background and several years of experience as a coordinator of medical and psychosocial interventions in both conflict and post conflict settings. Case by case they will illustrate the level of participation based on the participation ladder explained above (Arnstein, 1969). All examples are from the period following the publication of the *IASC Guidelines* (2007), so there was consensus

around the importance of participation at the time. Yet, the examples below will show that participation was lacking across a wide variety of contexts. They also illustrate the need for more consistent support at a field level in order to mainstream participation into humanitarian aid.

Liberia 2010: After a major armed conflict along the Ivorian border with Liberia refugees fled into the middle of the jungle, close to the Ivory Coast. Most of the refugees were absorbed by the host community, as they have been for decades. Historically, Liberians crossed to the Ivory Coast as a result of conflict, but in this emergency it is the other way around. They speak the same language, share brothers and sisters, tribal roots and cultural norms and values. As aid is less easy to control over an area comprised of many small villages, aid agencies decided to make three large camps (in the middle of nowhere), where thousands of individuals fleeing violence could seek refuge.

The coordination of the camp used level one of the participation ladder, manipulation, to guide new arrivals to their tents. Refugees were guided through fenced areas to locations where they could wash, eat and be directed to their ten-person tent. This was done without properly informing beneficiaries (level three of the ladder), nor requiring their input (level four). This showed a lack of understanding of cultural norms, (child) protection issues and individual values. This resulted in beneficiary dissatisfaction, refusal of aid and major insecurity for both beneficiaries and the organisation.

Later, of the three camps, only one was calm during food distribution. This was due to the fact that the coordinator had had training in MHPSS core principles and included all (community) leaders in the way they distributed (non) food items. Power was delegated (level seven of the participation ladder) and leaders took on their natural role of leading during the end stage of the distribution. In the other camps, the end stage of the distribution was done through external staff, who lacked understanding of local structures, tribal compositions and power balances, which resulted in refusal of aid and major insecurity.

While most of the 10,000 newly arrived refugees experienced varying levels of severe stress, they did not (at the time of arrival) show challenges in their daily functioning. However, medical interventions decided to focus on the few that clearly needed individual specialised care (counselling), leaving thousands without proper community or family support. This showed little consultation (level four of the participation ladder) or even placation, meaning that communities were not heard and decisions were made by those in power without consulting the communities for advice. This highlights the western ideal of putting individual counselling in place, whereas community and family support would have been more appropriate. Therefore, during camp coordination and camp management, including basic health care and (non) food distributions, participation of the target group is key.

Distributions have been shown to be the most challenging, partly due to insecure and high needs context, but also due to the lack of knowledge of the local context for outsiders in an emergency. Where western designed checklists do not suffice, participation will help identify key people, key community issues and identify the most vulnerable beneficiaries. Through partnership and delegation of power to the community (highest level of participation), the chances that the intervention will be more peaceful and the most vulnerable will get what they need, increases. However, this takes more time, demands diplomatic coordinators, and highly skilled staff able to maintain an open mind in order to adapt the intervention to the context.

Democratic Republic of the Congo, North Kivu 2014: Nord Kivu has been struggling with armed conflict for several

decades and humanitarian medical care is scarce. In a clinic, a woman who had survived sexual violence, needed surgery. She was not provided a surgical gown and had to walk into the operation room naked. This was while five men were looking at her, only their eyes visible. Neither she, nor a woman in labour in the next room, had anything explained by the anaesthesiologist before surgery. No information was provided, not even when he decided to put both of them under full anaesthesia. No one comforted either woman when they were scared, and no one translated what the expat doctor said in a foreign language. Quality of care is not merely the provision of treatment, it goes well beyond that. Support on all levels of wellbeing, including spiritual, will benefit the outcome of an intervention. Informing and consultation levels of the ladder are part of participation. They are easily feasible and would, in this case, have offered further support to a survivor of sexual violence and a woman in labour.

Triage is another aspect of a medical intervention. The fact that whole communities have no understanding of how triage works and why, if you shout the loudest, you are not always helped first, is a sign of lack of information (i.e. participation). In such a situation, it should not be surprising if a community attacks the hospital, perceiving it to be a place that does not offer the help they need.

Lack of information sharing is listed as frustration number one with most individuals receiving care. Participation is not only getting input from communities, it is also the process of feeding back this same information, including the principle of active listening and acting on what is heard. Quality of care will benefit from this level of community participation, medical interventions will be better understood and outcome of treatments will be more efficient and effective. As international organisations, understanding traditional medical seeking behaviour is key. This can only be properly understood through participation of the target group and aid workers maintaining an open mind.

Haiti 2010: The country has seen armed violence, natural disasters and livelihood insecurity for years. It is claimed that security and access are some of the main limitations of the effectiveness of participation in humanitarian aid. However, even though gangs rule large parts of Port-au-Prince, this does not mean that these areas are so insecure that participation is impossible. It is important to remember to follow traditional power lines and hold discussions with the gang leader before implementing any interventions in his neighbourhood. Organisations who implement interventions decide who to hire, where to build and who to treat. However, the local custom has worked differently for many years and won't accept quick (often Western) changes. Acceptance and perception are key in protection of interventions and staff implementing them, and participation is one way to build it. There is often no need to fully adapt interventions, but listening to local norms and values in order to change the approach will usually reach the same goal. Through participation, in the forms of partnerships and consultation, we increase acceptance and thereby safer interventions.

Uganda 2015: Northern Uganda is struggling with high livelihood insecurity and low levels of employment. Vocational training is one intervention to train youth and prepare them for the labour market. Before starting the intervention, an assessment needs to be carried out. Assessments should be the foundation for any intervention, and proper assessments use a participatory approach. Consultation with local communities is a great way to gather information for such an assessment. Unfortunately, in this example, no participatory assessment was carried out, which led to vocational training for tiling, plumbing and electricity in villages

that consisted of only mud huts and straw. No consultation with local communities occurred in terms of selection criteria, content of the training nor community selection. No participation with local communities and/or implementation partners resulted in major fraud, theft and ineffective interventions. Not only were the most vulnerable not identified nor selected, the beneficiaries that were trained never found a job, which greatly decreased the impact of the intervention. Looking back, deadline time pressure imposed by the aid organisation could be considered as major factor. Organisations driven by donor money sometimes need to design the programme off location, as money for proper assessment is only made available after the proposal has been approved. Proper participatory assessments cost time, money and staff, which might not always be possible in emergencies.

Democratic Republic of the Congo, North Kivu 2014: Every day trucks with material, staff and funds pass through one village to support another village down the road that is more affected. This does not mean this village is not affected, perhaps just less. The fact that the convoy has never stopped to inform the first village, let alone let them participate in finding a solution, makes the community so angry that they decided to block the aid and beat the aid workers. Access is granted by the communities and the state, so by not properly explaining or interacting with the communities, access might be limited. For managers in the field working on negotiating access, this is often forgotten. Aid organisations should not only negotiate with communities they want to access, they also need to negotiate with the community who want access from them. Participation often goes beyond the target group of any specific intervention.

Discussion

There are so many more examples and discussions of situations where we, as aid organisations, fail to mainstream basic core principles determined in humanitarian standards and guidelines. As illustrated in the observations above, participation has an impact on so many levels of interventions and disciplines. Not only do the interventions benefit, also security, access, staff care and assessments can all benefit from a proper participatory approach. Although each level of participation in the participation ladder has a different outcome, need and benefit the overall impact seems clear.

What does remain unclear, are the causes and consequences of a minimal participatory approach. This discussion will give several examples of causes and possible consequences, but furthermore, it will provide several recommendations of what might be improved, and includes a call for action.

Based on the observations, the following causes are defined as the lack of participation in interventions:

- Skills and knowledge of implementing staff are lacking in regard to the core principles and standards.
- Implementing staff does not accept norms and values other than their own, thereby avoiding participation.
- Misunderstanding of the participation ladder and implementing the wrong level of participation, thereby losing autonomy.
- Donors are pushing organisations to reach unrealistic outputs and puts little emphasis on how actions are implemented.
- Participation requires too many resources and these are not available and/or donors do not want to invest.
- Priorities of community and agencies may differ, thus true participation will affect the objectives of the agencies.
- Timeframes are unrealistic, real participation involves a long-term commitment in terms of time and funding.
- Beneficiaries are often vulnerable groups and might even be marginalised groups. Aid organisations will not always include them in interventions.

- Due to decreased world wide funding, organisations are more focused on securing their funds and organisational growth, than quality.
- Some areas are considered too insecure to have staff present to have a proper participatory approach, yet interventions are still needed there.

Most of these causes have an impact on the effectiveness of the programme and a direct consequence for the beneficiaries themselves. Furthermore, as well as the beneficiaries, organisations can also suffer from the negative impact of insufficient participation. The following are possible consequences for both:

- Lack of participation will not provide the needed safeguard for all the elements of wellbeing. Therefore, wellbeing will be affected.
- In fact, actual harm may be done, in terms of beneficiaries, if participation is not guaranteed. Humanity, dignity, equality, equity and respect are all affected.
- Effectiveness, sustainability, efficiency, impact and other evaluation criteria will be affected if the target group cannot sufficiently participate in each stage of the intervention.
- Acceptance and security for the staff and organisation will be affected, and thereby the activities. This again impacts the outcome for the beneficiaries.
- By choosing funds over quality, low levels of quality will impact the credibility and reputation of the organisation, thereby endangering future funds.

In the introduction, this paper clarifies the essential part of participation in humanitarian interventions and the minimal humanitarian standards that share this claim. The observations above in the mainstreaming of the core principle participation attempt to draw a tangible overview of the importance of participation in a humanitarian intervention. Subsequently, it poses several possible causes and consequences of the still existing challenge of a proper participatory approach. While some of the causes and consequences are still unclear, some recommendation can already be brought forward.

- This paper calls for action for each organisation to emphasize even more the need and focus on participation in their interventions
- At the same time each aid worker that reads this paper, should try and fully engage with the mainstreaming of the core principles
- Donors and organisations should push each other for the need of participation in the phases of an intervention and give it the proper weight
- External evaluators reading this paper should include the mainstreaming of participation into their evaluation criteria and pay more attention to it
- Each organisation should open up debate, funding and capacity building in regard to the mainstreaming of participation. Acknowledge the importance and act accordingly

When we pay due respect to the mainstreaming dimensions of the MHPSS core principles, aid will be doing less harm and more good.

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