

Mainstreaming mental health and psychosocial support in camp coordination and camp management. The experience of the International Organization for Migration in the north east of Nigeria and South Sudan

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This article examines the efforts of the International Organization for Migration to mainstream mental health and psychosocial considerations into camp coordination and camp management, through capacity building and provision of direct psychosocial support. It focusses on the activities carried out by the International Organization for Migration in South Sudan, in the Protection of Civilians Areas, and in the north east of Nigeria, with the aim to identify relevant challenges and best practices.

Keywords: camp coordination, camp management, capacity building, internally displaced persons, mental health, psychosocial mobile teams, psychosocial wellbeing

Introduction: background

Camps are often the last resort for forced internal and international migrants, including internally displaced persons (IDPs), refugees and asylum seekers seeking immediate and short-term shelter and protection escaping from war or disaster. Most camps originate from the spontaneous movements of displaced populations to certain sites and are often not the best settings for people to reside. However, due to the limited available resources and capacities of the humanitarian system and registration of the population, the provision of primary

Key implications for practice

- Provides insights into practical experiences of mainstreaming psychosocial approaches at camp management level
- Offers recommendations and examples of good practice in integrating MHPSS in CCCM activities
- Highlights that living in a camp setting has an impact on the wellbeing of residents and exacerbates vulnerability

and secondary services is often concentrated in camps. As a result, this brings a need to foster the agency of the residents, their sense of being a community and their active participation in the preparation of sustainable alternatives to the life in camps (International Organization for Migration [IOM], Norwegian Refugee Council [NRC], & United Nations High Commissioner for Refugees [UNHCR], 2015).

From the beginning of the new millennium, the increase in populations' displacement and the resulting socio-economic range of displaced populations has brought the emerging phenomenon of urban displacement and so-called 'urban refugees' (Campbell,

2006; Schininá, Bartoloni & Nuri, 2008). However, camps continue to accommodate a [consistently large] part of displaced populations worldwide. The setup and management of camps remain, therefore, a fundamental feature of humanitarian interventions today.

In some instances, a camp's life is protracted over long periods of time, sometimes even decades. This sort of protracted residency limits residents' sense of agency and their integration (Perouse de Montclos & Kagwanja, 2000). Moreover, there is a relation between the setup of camps, their organisation and functioning, and the wellbeing of the residents, including their mental health (Schininá & West, 2014), social relations and supports and their cultural identities (Kenyon-Lischer, 2005).

Overcrowding, lack of rule of law (Ataya, Duigan, Louis, & Schininá, 2010), undignified or culturally inappropriate modalities of service delivery (Kenyon-Lischer, 2005), induced and protracted lack of sense of agency within the population (Crisp, 2000), stigma from host communities (Kenyon-Lischer, 2005; Oh & Van der Stouwe, 2008), the perception of not being represented enough in decision making and the fact of being depersonalised (Giardinelli, Kios, Abubakar, Schininá, & Hammen, 2015) can all provoke distress, anxieties, insecurity, low self-esteem, withdrawal, sadness and anger on an individual level (Schininá & West, 2014). The same factors can provoke divides, social withdrawal, violence and tensions within families and among sub-groups in the community (IOM et al., 2015). Finally, the protracted life of a camp can generate an aid or victim culture that can affect the residents' capacity to reintegrate at a later stage (Inter-Agency Standing Committee [IASC], 2012).

Conversely, stress, tensions, posttraumatic reactions, pre-existing societal divides and cultural misunderstandings among the residents can intuitively have an impact on the management of a camp. Especially if they

remain unaddressed, which can nullify or reduce the effects of good camp management strategies. As a consequence, providing mental health and psychosocial support services in camps is important, but also brings about a series of ethical and technical dilemmas related to the problematic relation between protection and control, and the dynamic between 'vulnerable persons' and 'spaces of vulnerability' (Leatherman, 2005).

According to Leatherman, biocultural relationships like the ones that are established in a camp and between the camp and its surrounding environment, have to be read '*within a political ecology approach that connects issues of power and inequality with human-environment interactions and addresses these relationships at the intersection of the global and the local*' (Leatherman, 2005, p.2).

Leatherman believes that the concept of vulnerability is not only intrinsic to some individuals or groups, but that social, political, anthropological and economic power dynamics contribute to create spaces that perpetuate vulnerability (Leatherman, 2005). These spaces and vulnerabilities manifest themselves at the local level, but are also often the product of geopolitical inequalities. This concept can be easily applied to camps, especially when they are maintained over protracted periods of time. Camps respond to the necessity to protect individuals, who are made vulnerable by an environmental or geopolitical occurrence often linked to power and global inequalities, such as war or natural disaster. Alternatives to camps, after the initial phases of an emergency, are necessary. Yet, often these are not possible or explored. One of the reasons is logistical: it may be easier to provide aid and perform verification procedures in locations where displaced populations have gathered, as the humanitarian system is not adequately equipped yet to deal with '*urban refugees*'. Another seems to be political: the protracted existence of camps can perpetuate a sense of emergency around situations that are endemic, but politically

difficult, and, in some situations, the lack of alternatives to camps can be related to a sense that camps make it easier to control populations (UNHCR, 2014). As a consequence, protection measures and services to displaced individuals are often provided only if they reside in a camp. From the one side, camp residents are served because of being deemed vulnerable and this remains part of their identity within the humanitarian context, even though their vulnerability is not intrinsic, but rather due to a specific environmental and geopolitical occurrence. On the other side, for all the reasons stated above, the very fact of living in a camp can create new vulnerabilities and reinforce existing ones, disempowering and marginalising the residents. Therefore, a space for protection is often transformed into a space whose residents are identified as vulnerable and that perpetuates vulnerability. Additional ethical challenges are posed by the fact that camps are often funded, managed and secured by entities that are not alien to the geopolitical inequalities that contributed to creating the conditions for the camps residents' vulnerabilities in the first place. Not surprisingly, but ironically, vulnerability in a camp is often measured by the lack of capacity of the individual to adapt to the camp as a *'space of vulnerability'* (Leatherman, 2005), while the various factors that transform the camp into that *'space of vulnerability'* are overlooked. To avoid these ethical dilemmas, agencies should enact policies and strategies that minimise the time people spend in a camp to the bare essential, which are both political and technical challenges. For the lifetime of the camp, using a psychosocial approach to its set up, coordination and management becomes important. This is not only due to the provision of services that help people cope emotionally with the experience of the camp, but regards primarily the consideration of the interrelation of biopsychological, socio-economic, socio-relational and political, and cultural

elements within the organisation of a camp's life (IASC, 2012). A psychosocial approach can help in maintaining the camps as spaces for protection and agency and avoid their transformation into *'spaces of vulnerability'*. Therefore, this paper presents the efforts of the IOM to mainstream mental health and psychosocial considerations into camp coordination and camp management, in South Sudan and in the north east of Nigeria, identifying relevant challenges and best practice.

Policy and guidelines

The IOM, along with the UNHCR, co-leads the Camp Coordination Camp Management (CCCM) Sector, Global Cluster and field Clusters in relevant international humanitarian responses. IOM is the lead in situations of natural disasters and UNHCR in situations of conflict and war. However, both agencies support each other in leading the CCCM sector, whenever this is possible and based on their existing capacity, in each country affected by an emergency. In Nigeria, since 2015, IOM co-leads the CCCM Sector Working Group with the National Emergency Management Agency (NEMA). In South Sudan, UNHCR and IOM co-lead the CCCM Cluster, in coordination with the Agency for Technical Cooperation and Development. IOM also serves as the CCCM State Focal Point in a few states and as camp management agency in Bentiu.

The original Inter-Agency Standing Committee (IASC) *Guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings* (2007) included chapters and specific indications for the mainstreaming of MHPSS into the main sectors of humanitarian assistance, reflecting the humanitarian clusters structure. This document, therefore, contains specific guidance for health, protection, shelter, nutrition, water and sanitation (WASH), and education actors, but not for CCCM.

As camps are spaces where all of the above mentioned services are being provided, it was assumed that once these services were properly coordinated and following the MHPSS guidelines, the need for a MHPSS dedicated guideline for CCCM actors would cease to exist.

This motivation did not account for the fact that camps are not just spaces where different forms of assistance are being coordinated, but 'home' to their inhabitants (Papadopoulos, 2002), with all the complexity that this entails in terms of decision making, interactions, prioritisation and service provision, not accounting for the more symbolic elements. Moreover, the lead agencies of the CCCM clusters act as providers of last resort, therefore they should be guided in how to mainstream MHPSS in comprehensive, camp based services delivery.

To cover this gap, in 2012 the IASC Reference Group on MHPSS and the CCCM Global Cluster published the handbook *Mental Health and Psychosocial Support in Emergency Settings: What Camp Coordination and Camp Management Actors Should Know* (IASC, 2012). The publication, compiled by IOM with the support of Action of Churches Together (ACT) was revised by a large number of CCCM and MHPSS actors and organisations and finalised based on their feedback. Based on the *MHPSS Guidelines* (IASC, 2007) and identified best practice, the handbook suggests a series of approaches and activities to camp actors to integrate a psychosocial approach into management and service provision, along the four levels of the pyramid of psychosocial intervention (IASC, 2007), with specific indications on how to mainstream MHPSS in:

- the provision of basic services and security, including in-site planning, with report of abuses during food distribution and information and with the organisation of training for camp actors in basic forms of psychosocial support and 'do no harm' rules;
- the organisation and facilitation of community and family supports, including community mobilisation and ownership: communal, cultural, spiritual and religious practices and child friendly spaces; and cohesion and socialisation initiatives;
- the provision of focused services by technical partners, including basic, low-intensity psychological interventions for people with psychological problems; brief, motivational interventions for people suffering from alcohol or substance use problems; focused support to promote the social integration of vulnerable individuals or marginalised groups; the facilitation of self-help groups and discussion groups, and counselling and referral services for victims of sexual and gender based violence (SGBV);
- and finally, the handbook provides information on how to protect and refer people with severe mental disorders, including basic criteria for evaluating the suitability of partner agencies in providing this service, as well as the organisation of transportation to existing services, and support for families (IASC, 2007).

After the handbook's publication, IOM has trained CCCM actors in the contents of the handbook in various countries, through the CCCM field clusters or coordination mechanisms, including the Philippines, Nigeria, Nepal, Myanmar and South Sudan. The handbook is included among the core resources of CCCM trainings and has been adapted for shelter managers of IDPs residences inside Syria, where training was provided to more than 200 managers (Schininá, Ataya & Hassan, 2015). The handbook is referenced and referred to in most of the chapters of the new *Camp Management Toolkit* (IOM et al., 2015). Different training tools have been produced to cater for the different backgrounds and experiences of camp managers and camp actors worldwide.

Apart from capacity building, IOM has also tried to implement another of the suggestions from the handbook:

'In a camp setting, multidisciplinary psychosocial teams comprised of community workers, social workers, educators, artists and psychologists could be utilized. They can facilitate community and family support at the focused/non-specialized services level, and create a system of internal referral to mental health services for people requiring specialized support' (IASC, 2012, p. 27).

The following sections will first present the country context and analyse the trainings for CCCM actors conducted in Nigeria and South Sudan. Then they will illustrate the utilisation of the psychosocial mobile teams in camp settings in the same situations, thereby providing a full description of IOM's double path strategy for mainstreaming MHPSS in camps.

Nigeria and South Sudan

Context

In Nigeria a seven-year armed conflict between Jama'atu Ahlis Sunna Lidda'awati wal-Jihad (JAS), commonly known as Boko Haram, and the Nigerian Security Forces (NSF) in the north east of the Country has created a protection crisis, with endemic violations of human rights and humanitarian standards, exacerbating the plight of vulnerable civilians and triggering waves of forced displacement. An estimated 2.24 million people are internally displaced as a consequence of the conflict, and 220,000 people have found refuge in Cameroon, Chad and Niger since 2013 (IOM, 2016b). Within the country, only the 10% of the displaced population is living in camps, which include official camps run by the government and informal camps and settlements. The crisis in the north east of Nigeria is unique in that it comprises emergent and endemic needs, the conflict is still dynamically ongoing,

and the crisis receives little humanitarian attention with few international actors involved in camps (Giardinelli et al., 2015). South Sudan has been grappling with active and protracted conflict for decades, both formerly as part of Sudan, and specifically since 2013 as the newest country in the world. On 26 August 2015, a peace agreement was signed, but continued conflict, food insecurity and the dilapidated state of services and vital community infrastructure has led to further waves of IDPs seeking protection and services within the Protection of Civilian (PoC) sites (Office for the Coordination of Humanitarian Affairs [OCHA], 2016). PoC sites are located within pre-existing United Nations Mission in South Sudan (UNMISS) bases and were established to protect and shelter populations fleeing insurgents' and army violence, as an immediate lifesaving measure. Yet, by February 2016, the majority of the 200,000 resident IDPs have lived in the PoC sites for more than two years, as safe returns are not possible (IOM, 2016a). By the same date, more than 1.64 million people were sheltering in IDPs sites, rural areas and within host communities (OCHA, 2016). IDPs face serious protection, psychosocial and security risks as the experience of violence, displacement and widespread tensions have contributed to communitywide instability (OCHA, 2016). In addition, IDPs are facing high levels of stress due to day-to-day life in the PoC sites, characterised by fear of attack, overcrowding, little or no opportunities for livelihood, feelings of being *'in prison'*, uncertainty for the future, family separation and isolation (Schininá & West, 2014). Although tensions have been building since 2014, a significant increase in gang activity and violence is emerging as a result of the breakdown of social structures (South Sudan Protection Cluster, 2015). PoC sites were established in an emergency fashion, following the spontaneous movement of populations seeking protection in places such as the UNMISS bases that were perceived as

neutral and safe. Sites were improved and camps structures established when those who had been displaced were already on site, which did not allow humanitarian standards to be met due to lack of space and the novelty of the situation. Some sites were later improved and some residents relocated to redeveloped areas, but others have accommodated populations for more than two years, remaining entrenched in the dynamic between a *'space of protection'* and a *'space of vulnerability'*.

Trainings

In Nigeria, in 2015 when the CCCM working group was being formed, two trainings were organised for 60 camp management actors in mainstreaming MHPSS considerations into camp management. The three-day trainings focused on specific key recommendations from the IASC dedicated handbook (IASC, 2012), which were adapted to the specific context of north east Nigeria.

Trainees included governmental actors, camp facilitators and religious, women and youth leaders from displaced groups, in both camps and host communities. The trainings included presentations, discussions on key issues faced by the trainees in their work in camps, simulations and case studies. Additionally, a module on Psychological First Aid (PFA) (World Health Organization [WHO], War Trauma Foundation [WTF] & World Vision, 2011) was included following the indication of the *IASC MHPSS handbook for CCCM actors*, to enhance the camp actors' ability to communicate with camp residents, including people facing severe distress.

In South Sudan, since 2014, IOM has been providing two training curricula for the CCCM cluster: one on PFA (WHO et al., 2011), and another on mainstreaming MHPSS in CCCM. The PFA training was designed for a duration of one to two days, depending on the availability of the 175 participants selected among CCCM field

workers, key community members and volunteers from the camps. The training used experiential learning principles, role play and simulations.

The training curriculum on mainstreaming MHPSS in CCCM usually lasted two or three days and targeted 78 actors from different sectors (CCCM, health, WASH, protection, shelter and non food items [NFI]), all operating in camps. The trainings were based on the *IASC Guidelines* (IASC, 2007) and the *MHPSS handbook for CCCM actors* (IASC, 2012). The workshops included different kind of presentations, group work organised per sector, key messaging and focused on how to foster effective participation from the community.

In South Sudan, where there are many humanitarian actors, it was difficult to target managers and project developers who have the power to influence design and implementation of activities. This could be linked to a feeling of *'mainstreaming overload'*. The same problem was not encountered in Nigeria, probably because actors are few and coordination reduced to a minimum.

Evaluations of the training

In South Sudan, pre and post questionnaires were administered to participants of the trainings in mainstreaming MHPSS in CCCM. Findings show that the majority of the participants were not familiar with the MHPSS guidelines (IASC, 2007), nor the relevant handbook for CCCM actors (IASC, 2012) before the training (IOM, 2015a).

This result is consistent with the findings of the global review of the implementation of the *IASC Guidelines on MHPSS* (IASC, 2014) that was conducted by a group of independent researchers on behalf of the global IASC MHPSS reference group. Its aim was to evaluate how the 2007 guidelines had been institutionalised by all reference group members and mainstreamed in emergency responses. As part of the review, a survey

was conducted with relevant MHPSS and humanitarian practitioners. Participants were asked which supplementary tools to the guidelines they were using in their work in the field. Only 15.3% of the respondents stated that they used the *IASC MHPSS handbook for CCCM actors*, as opposed to the 36.1% that made use of the relevant *MHPSS handbook for protection actors* (IASC, 2012). The survey did not target CCCM actors in particular, and the *IASC MHPSS handbook for CCCM actors* came out three years later than the other tools. Nevertheless, the results suggest that the handbook needs to be further disseminated.

According to the evaluations, the trainings helped participants to see the intersectionality of the MHPSS approach and emphasised how enhancing and protecting psychosocial wellbeing is a priority of all sectors. This was seen in the practical application of the trainings in the PoCs. For instance, in one camp, the design of the distribution points was reorganised to enhance protection and avoid conflict and other negative effects. In another camp, thanks to the workshop, CCCM, nutrition and protection actors realised the correlation between an increase of domestic violence and the distribution of *Plumpy Nut*, a nutritional supplement aimed at children. As women would wait for hours in line for distribution, they would not be able to do household chores in time. This created conflict in the household and as a result the *Plumpy Nut* would then be used as a meal for the whole family to quickly produce a meal and appease tensions (IOM, 2016b).

In Nigeria, participants could evaluate the impact of the training through an anonymous evaluation form distributed soon after the workshops. Participants stressed the importance of conducting regular training on basic communication, active listening skills and PFA. Moreover, the trainees found it difficult to understand some of the theoretical concepts and preferred real case scenarios and group discussions. This

stresses the necessity to adapt the handbook to local understanding and language.

Apart from passing information and skills, the trainings provide an observation point on some of the shortcomings that could affect the management of the camps. In both countries, issues around gender relations, aid culture, lack of participatory approaches and turnover were identified thanks to the trainings.

In Nigeria, participants were reluctant to work in mixed gender groups, but it was noted during the discussions that women were participating less than men, especially in the presence of men. In response, different groups were formed according to gender to facilitate participation, with separate trainings exclusively for women and girls planned by IOM.

Also, in both countries, a strong aid culture was shown by all participants. In Nigeria, the concurrent presence of IDPs and government officials in the training clarified how this aid culture (Collinson & Duffield, 2013) permeates the narratives of all actors. All participants believed that it is the responsibility of the government, or other humanitarian actors, to provide appropriate responses to any need of the displaced populations. As a consequence, a lack of participatory approach by high level management was highlighted during the trainings. For instance, in Nigeria, when the crisis escalated and the number of IDPs increased in the official camps, men and women were separated as a measure to protect women from SGBV risk. However, this also meant that families were separated, without prior consultation with the displaced population and this resulted in general dissatisfaction. This issue was discussed during the training to promote participatory approaches in camp management decisions and effective protection measures, that support and not further undermine the mental health and psychosocial wellbeing of IDPs. More generally, the psychosocial mobile teams (see below) have

subsequently undertaken activities to promote the agency of the population. Finally, in Nigeria and South Sudan, those who offer services within the CCCM sector are subject to a system of rotation that does not allow the maintaining of an ideal sense of trust between IDP communities and national actors. Furthermore, this rotation has decreased the impact of all trainings. While an evaluation of PFA trainings is not the subject of this article, it must be noted that these trainings were highly appreciated in all evaluations and results suggest that a differential approach should be used. While the trainings on PFA should be offered to all camp actors, the training on mainstreaming MHPSS in CCCM should be offered more to managers of the camps and of other relevant sectors, who have the power to influence such mainstreaming.

Psychosocial mobile teams

Psychosocial mobile teams have been deployed by IOM since the Haiti earthquake in 2010 to provide multi-tiered psychosocial support activities in camps and host communities, aiming at bridging service delivery with trainings provided to CCCM actors. The teams are usually comprised of a social worker, a psychologist or counsellor, community resource or an artist, an educator and a team leader. According to varying situations and needs, the teams can also include a health worker (usually a nurse) or a conflict mediator. The teams are selected following an interview among those IDPs and host communities' members with relevant or relatable backgrounds that are referred by community leaders, local universities and relevant authorities. The teams receive daily supervision by IOM experts, weekly technical supervision sessions with IOM and relevant national experts, and are further trained once per month, in dedicated three to four day workshops, based on identified training needs. They start by

assessing the needs of specific sites and/or groups and then provide a set of educational, recreational, ritual, counselling, mediation and referral activities, based on those needs identified during assessment. This model has found different applications and adaptations within different contexts.

In Nigeria, the teams use a service oriented approach, where they provide services to the population that are designed and implemented involving the clients. In South Sudan, the teams are less service oriented and more mobilisation oriented, where members of the community are mobilised by teams to provide support to their peers. In South Sudan, the psychosocial mobile teams consist of selected IDPs from the camps, provided with intensive and in-depth training on basic MHPSS. The team members were selected for: their professional backgrounds, i.e. social workers, teachers, and counsellors; their role in the community, i.e. religious counsellors or women leaders; or their contribution to the community, or specific ability, i.e. musicians, athletes and painters. Continuous on-the-job training and supervision provided by international experts has reinforced their technical capacity and self-reliance. The activities have been mainly organised around interest groups, including cultural groups, sport groups, women's groups, widower's groups, youth groups, different art groups, as well as individual and group counselling, and referrals.

In Nigeria nine teams were established in 2014. Unlike in South Sudan, the teams in Nigeria include IDPs living in camps, IDPs living in the community and members of the host community. Due to the difficulty of accessing health care, a nurse was added to each team. As psychologists are not available in the northeast of Nigeria, or among the affected populations, people with prior experience of health, SGBV or HIV/AIDS counselling were engaged instead. Finally, given the severe difficulty encountered in

referring people with mental disorders to what are usually faraway services, and to encourage families and the community to accept people with mental problems, one dedicated team attend to this endeavour in each state, organising the referral, following up care, and instructing and supporting families.

In Nigeria, each one of the team members has his or her own function, but they all collaborated in the needs assessment and the design of the intervention. They referred clients to each other and when they think their internal support is not sufficient, they seek help and supervision from international experts within the programme, a professional counsellor or a clinical psychologist. Each of them is able to provide PFA.

The health workers produce and disseminate messages related to psychosocial wellbeing, hygiene, health promotion and organise referrals for medical and psychological care. The social workers attend to vulnerable cases and make referrals to service providers that are previously mapped and mobilised. Moreover, they support the rejuvenation of community support and safety networks. The teachers provide informal education to the children, most of whom are not attending school, and organise child friendly clubs. They additionally organise adult education classes and support the educational and awareness activities organised by other members of the teams. The traditional resource person, sometimes an artist, engages the community in some of their traditional, cultural and religious activities, which helps them maintaining a sense of identity. This includes traditional arts and crafts workshops that are used as income generating activities as well as a form of psychosocial support (Babcock et al., 2016). The counsellors in the team offer (lay) individual or group counselling to people they directly identify, who seek assistance or who are referred by other members of the teams.

Evaluation of psychosocial mobile teams

Psychosocial (PSS) mobile teams in both countries have proved useful in reaching out to affected individuals, who have isolated themselves and would not seek out services in static centres. Moreover, the teams are able to serve populations both in the camps and within host communities, and follow their movements.

PSS mobile teams have proven to be beneficial to the CCCM sector. An important part of CCCM is to provide a space where people are enabled to live as a functioning community. This is particularly relevant within the context of PoC sites in South Sudan, where traditional community support mechanisms have broken down. For instance, women who used to form cooperatives in their communities are unable to do so in the PoC sites because they have to dedicate all of their time and energy to collecting firewood as a means of income and livelihood (IOM, 2016). Mothers complain that they are left alone with the burden of raising children, including those of relatives who have passed away, without the support they used to receive from other family and community members (IOM, 2016c). Not surprisingly, assessments conducted by the PSS teams pointed out a seemingly paradoxical situation: although there is a desperate condition of overcrowding, IDPs reported feelings of loneliness and social isolation. Social supports are additionally hampered by the aid culture. For decades the country has experienced an influx of humanitarian aid, which has created a culture of relying on humanitarian aid before turning to community support, which in turn hampers social solidarity systems (IOM, 2016c). Humanitarians are quick to point out the aid culture among beneficiaries, but the experiences of the PSS mobile teams have demonstrated that IDPs are eager to play a role. Individuals who participated in PSS activities implemented by the teams viewed

themselves not as ‘beneficiaries,’ but as ‘carers’. They joined activities because they felt that, although needing support, they could also provide support.

‘The comparison between my old life and my life in the PoC is the most difficult thing for me. I used to be a successful woman. I ran three businesses on behalf of the government. I was able to live a good life. I was self-reliant. Here, I am forced to live from the hand of others as if I were a child. My greatest achievement has been working with a young widow who lost her husband. She was wracked with grief and every struggle with her children reminds her of that loss. I spoke with the lady and helped her change her situation, helped her to work through her grief. This work also helps me to cope with the difficulties of my life inside the PoC. I have grown in strength and resolve. I believe that if we come together as a group, we can use our experience of suffering to offer comfort and support to others. The suffering that people are facing is not new. We can help those that endure pain to cope, as we have coped.’ (Member of IOM PSS mobile team, IOMb, 2015, p. 8).

PSS mobile teams have been instrumental in reactivating or strengthening community solidarity, by facilitating discussion groups, setting up recreational clubs and working through existing community structures. Participants socialise and interact with fellow community members and develop positive social bonds. For instance, the members of a sport group facilitated by the PSS mobile team in the Bor PoC site in South Sudan noticed that one of their football team members stopped attending games and meetings. They also heard that he had been spotted engaging in negative behaviour. Some group members decided to visit him and found out that his mother had left the PoC in search of better opportunities in the capital. While still an adolescent, he was suddenly left to care for his many younger siblings and felt overwhelmed by the situation.

The PSS mobile team, with the agreement of the youth, alerted the women’s group for support. The women group ensured that his family had access to basic necessities, such as food, and organised the neighbours to care for the younger siblings. The youth was then able to resume his participation in the sport group (IOM, 2016c). This example shows how PSS mobile teams can promote community ownership in providing support.

In addition, PSS mobile teams can link the community to humanitarian actors. For example, drama clubs and local artist groups established by the teams are regularly contacted to develop plays and songs on specific topics, or for specific occasions, including awareness campaigns. Moreover, the teams have promoted two way communication. For example, drama clubs have been used to elicit feedback from the audience on their fears and perceptions about potential return or relocation, or how to solve certain problems, including how to address conflicts at water points. All groups offered a safe space where participants could talk about their fears, concerns and hopes (for more information on the possible use of participatory drama activities for decision making in camps, see Schininá, Voltaire, Ataya & Salem (2011)).

Conclusions

The experiences of IOM in mainstreaming MHPSS considerations in the coordination and management of camps in Nigeria and South Sudan have been an attempt to reduce the likelihood that camps meant to serve as spaces of protection would turn into spaces of vulnerability, and would promote the agency of the population. From one side, this was pursued through instructing the camp management and other relevant actors on how to take into account emotions, dignity and the agency of the residents in the provision and coordination of services, through dedicated trainings. On the others side, PSS mobile teams provided direct MHPSS

with a multidisciplinary and client centred approach aimed at reinforcing the existing expertise and practices found within the communities of the camps. While activities are still being piloted, some conclusions could already be drawn and some recommendations brought forward.

The need for mainstreaming MHPSS among camp actors still exists. The existing tools have proven effective for this mainstreaming, but they are not yet well enough known and they still require constant contextualisation.

Additionally, trainings should have a differential approach. Interpersonal and communication skills should be built for all camp actors, while decision makers should be instructed more precisely on how to mainstream a psychosocial approach into the management of camps and the provision of other essential services. Not doing so may result in adding additional burdens or be counterproductive.

The trainings better serve the needs of CCCM actors if they are practical in nature and rely on the actors' experiences on the job. Rather than using formats, it can be more beneficial to implement a global training of trainers (ToT) for experts that, once deployed in the field, can put their knowledge to serve any context.

Also, the trainings need to be opened to IDPs, refugees and key representatives of the camps' populations. Whenever this was done, the trainings were more effective as they created trust and enabled burning issues and cultural misunderstanding to emerge within a safe space, facilitating their acknowledgment and resolution.

Combining training with the deployment of PSS mobile teams that can follow-up on the recommendations of the training and cover identified gaps in services provision at multiple levels of an intervention has proven useful, providing both training and deployment of PSS teams occur. Further, PSS mobile teams should be selected from camp populations, or come from both IDP and

the host populations. This enables them to engage and validate community resources, to give cultural context to the trainings that they receive and to be able to follow the camp populations in their movements, up to their return. Moreover, PSS mobile teams need to receive constant supervision and ongoing training.

The authors of this article believe that the combination of training for all CCCM actors and deployment of multidisciplinary PSS mobile teams is efficient and efficacious in mainstreaming a psychosocial approach into the camps' life. There are, however, conditions that risk nullifying the positive effects of such activities, and contingencies that ought to be explored further. Moreover, to date, the evidence is quite anecdotal and needs to be validated with more scientific methods.

The conditions that can hamper this method include the prolonged life of the camps beyond the pure emergency phase and the existence of camps that do not respect minimum humanitarian standards. In those situations, the adopted methods can reduce harm, but will be ultimately made inefficacious by external conditions. Contingencies that need to be explored further include: costs, coverage and the typology of the camps. So far, the combination of training for actors and deployment of PSS mobile teams has been tested in newly established camps, but has never covered the totality of the camps within any emergency situation. It remains to be evaluated if the method can still work in long standing camps, where certain dynamics have been crystallised. Moreover, it needs to be further understood if covering all camps within an emergency would become unsustainable. The mobile teams are not any more costly than other interventions, but do require constant supervision and ongoing training, in a moment when all agencies are suffering to find qualified MHPSS experts to cover the increasing demands on multiple fronts.

The evaluation of the results of the combined action of training and deploying mobile teams on populations' wellbeing has been so far quite anecdotal. The evaluation of a method that aims at respecting and enhancing the agency and self-worth of the camp residents could not be successfully conducted using indicators for vulnerability and wellbeing designed and validated in other communities and cultural systems. In fact, the identification of population specific indicators of wellbeing requires lengthy ethnographic processes that hardly fit the timing and conditions of a humanitarian emergency, nor the evaluation culture of the humanitarian system. Most recently, Bragin and colleagues piloted a quick and efficacious method that enables groups to identify their own concepts of psychosocial wellbeing and the concrete operational indicators that can substantiate those concepts (Bragin, Takka, Adolphs, Gray, & Eibs, 2014). This process includes a short series of workshops with representative members of the population. It results in the identification of indicators that the programme management and the camp population can use to identify the baseline and progress in their perceived wellbeing. IOM plans to implement an evaluation approach for the work of the teams that involves working with community members to identify relevant indicators of wellbeing for that specific community, following Bragin's model.

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