

Integrated programme planning and psychosocial concepts in humanitarian response: a response to Williamson and Robinson

Mark van Ommeren, Jodi Morris & Shekhar Saxena

The article by John Williamson and Malia Robinson (*Intervention*, this issue) represents a way of humanitarian thinking and acting that will hopefully increase its influence to dominate humanitarian response across all sectors. The authors argue for an integrated, cross-sector response to biological, material, mental, emotional, social, cultural and spiritual well-being. We agree. Indeed, it would be over-simplistic to think that response by the nutrition sector merely leads to improved biological well-being, or that a response by the educational sector merely leads to improved cognitive well-being, or that a response by the social services sector merely leads to improved social well-being. Indeed, a response by the nutrition sector is likely to affect mental well-being as infant malnutrition affects cognitive development. A response by the educational sector may affect social well-being, as schooling has known protective effects. In the same way, a response by social services may also have an impact on biological well-being as good social services identify and escort isolated, malnourished people to available food services. Humanitarian sector responses thus have outcomes that go well beyond their sector. Such outcomes may occur in a positive direction (as in the examples above) or in negative directions (e.g., when nutrition, shelter, health or protection interventions

are done in such manner that they lead to negative psychological and social outcomes, such as decreases in people's experience of dignity and/or sense of community). Increasingly, humanitarian actors are becoming aware of the need for intersectoral planning and acting to improve aid.

The *Inter-Agency Standing Committee (IASC) Task Force on HIV/AIDS in Emergency Settings* was tasked in 2001 with developing guidance on prevention and to respond to HIV/AIDS in emergencies. This Task Force came up with an integrated, intersectoral approach, with clear specifications on how each sector was advised to contribute (IASC, 2003). Subsequently, the *IASC Task Force on Gender and Humanitarian Assistance* was tasked to develop guidance on prevention of and response to gender-based violence. The latter Task Force used the *IASC Task Force on HIV/AIDS in Emergency Settings'* seminal framework and developed similarly structured, integrated, intersectoral guidance (IASC, 2005). In 2005, an *IASC Task Force on Mental Health and Psychosocial Support in Emergency Settings* was formed. This Task Force – co-chaired by the World Health Organization and the NGO consortium InterAction – is similarly on its way to provide guidance also using an integrated, intersectoral approach, along the lines of the aforementioned *IASC Guidelines for HIV/AIDS Interventions in Emergency Settings*.

The article by Williamson and Robinson (*Intervention*, this issue) is thus in full harmony with recent developments in the area of policy and planning in emergencies, including in the domain of mental health and psychosocial support. The article is rich in arguments and examples showing why integrated approaches are most likely the right way forward.

A potentially controversial point in Williamson and Robinson's (*Intervention*, this issue) article is that 'psychosocial intervention' may be an unhelpful concept. The authors' write that the question is not defining what is a psychosocial intervention, but rather how do humanitarian interventions together promote well-being? Conflict-affected persons would certainly agree that the latter question is more important, as do we. Nevertheless, in the day-to-day proceedings of humanitarian aid, the question 'what is a psychosocial intervention?' is regularly posed. Actors who work in the area of mental health and psychosocial support should be able to answer this question quickly, without having to enter into long explanations why the question itself is not a great question. Indeed, if one spends a short time in the elevator with a Minister of Social Welfare, a Minister of Health, or the executive director of one's agency, or if one has one minute with a village head after a community meeting, and she or he poses the (feared!) question, one should be able to give a clear answer before the time is up. We would suggest quoting the following:

'The term social intervention is used for interventions that primarily aim to have social effects, and the term psychological intervention is used for interventions that primarily aim to have psychological effects. It is acknowledged that social interventions have secondary psychological effects and that psychological interventions have

secondary social effects, as the term psychosocial suggests. (WHO, 2003, p. 2)?

There are two limitations to this conceptualisation. It is too long and may accordingly confuse the audience if one only has one minute to explain the concept. Second, this conceptualisation – similar to conceptualisations referred to in Williamson and Robinson's article - focuses on the outcome of interventions rather than on their nature. However, the idea that a psychosocial intervention should be defined as something that produces social or psychological effects or psychosocial well-being may perhaps have limitations. For example, should one consider psychotropic intervention for agoraphobia a psychosocial intervention simply because psychotropic treatment for agoraphobia addresses social well-being? Most practitioners would not consider this a psychosocial intervention. Perhaps definitions of 'psychosocial interventions' should focus conceptually on the nature of the intervention, rather than on their outcomes? Indeed, as Williamson and Robinson show, there are many complimentary roads to an outcome. The type of outcome one chooses (e.g. whether protected dignity, protected/enhanced well-being, prevented/reduced psychopathology, or improved survival) is perhaps unrelated to what should be defined as 'psychosocial intervention'. We believe that the discourse on what is a psychosocial intervention should continue. If we say we do 'psychosocial interventions', then we owe it to (a) the people we assist (e.g., community members), (b) to humanitarian colleagues in specific sectors (e.g., health, protection, nutrition) with whom we work, and (c) to the people who support our work (e.g., Ministers, agency directors) to provide a crisp and conceptually correct answer to the question 'What is a psychosocial intervention?' Ideally, such

answer will be formulated sooner rather than later.

These observations, hopefully, will not distract from Williamson and Robinson's main message that humanitarian aid needs to focus on the results, to be jointly achieved across sectors, as basic requirements for good outcomes that are also strongly inter-related across sectors. Williamson and Robinson's article provides a strong message to all humanitarian actors to work collaboratively across sector boundaries to protect and improve the mental health and psychosocial well-being of disaster-affected populations.

References

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Mark van Ommeren, Jodi Morris, & Shekhar Saxena are attached to the World Department of Mental Health and Substance Abuse of the World Health Organization, 1211 Geneva 27, Switzerland. Correspondence should be sent to Mark van Ommeren, vannerenm@who.int

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Williamson and Robinson (2006).