

MINDFUL SHELTERING



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Recognising and Enhancing the Impact of Humanitarian Shelter and Settlements on Mental Health and Psychosocial Well-Being

Proceedings of the Shelter and Mental Health Learning Event, May 2021



Acknowledgements

The Shelter and Mental Health Learning Event was instigated and organised by the Self-recovery from Humanitarian Crisis research project core team at the Centre for Development and Emergency Practice (CENDEP) at Oxford Brookes University and CARE International, UK.

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Report Structure

Over 80 participants representing more than 30 organisations attended the 2021 Shelter and Mental Health learning event. We hope to reach a wider audience with this report, which loosely follows the sections of the two half-day event, using the three themes shown in **Fig. 1 on page 11** as a scaffold to explore the overall topic of Shelter and Mental Health.

The report chapters consist of a blend of background literature review, contributions from speakers at the learning event, points and questions made in the online event 'chat', Google Jamboards (digital whiteboards) and 'breakout room' discussion groups. Anonymised quotes from event participants are identified in the text by the use of italics and quotation marks. The compilers of the report hope that all participants' opinions have been reflected accurately and that this document acts as a starting point for more detailed discussions of how to integrate humanitarian shelter assistance and mental health, recognising the impacts of existing practice and exploring how to do more and do better. The full 'writing team' is an interdisciplinary group of researchers and practitioners and the compilers gratefully acknowledge the many varied contributions since the initial plans for the learning event were laid in early 2021. Any errors or omissions are the compilers' responsibility. Please get in touch with any comments or corrections.

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Source: Adapted from IFRC, (2013) page 9

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Source: Adapted from IASC, (2007)

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Source: Adapted from CRS

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Source: Adapted from CRS

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Source: Author's own

Contributors

The organising team at CENDEP and CARE International UK would like to thank the many individuals from a wide range of organisations who helped to plan and execute the learning event. The agenda of the two half-day event was built around the case studies and expertise offered by practitioners and researchers in humanitarian shelter, development housing and MHPSS. The agenda of the Learning Event, giving details of the different sessions, speakers and panel facilitators, is available on [page 52](#).

Thank you to all who contributed to the Learning Event, and to this report, particularly the speakers, whose presentations are summarised within Chapters 2-5.

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121 Captions provided a live transcription service to make the online learning event more accessible.



Language and acronyms

The terms 'shelter' and 'housing' are used interchangeably throughout this report. The language used can be confusing. In general, 'shelter' refers to humanitarian response; the provision of physical protection from the elements and ideally a safe, dignified place to live. Humanitarian shelter programmes come in many forms, including provision of toolkits, shelter materials, training, cash, construction of temporary housing and supply of household items. A 'shelter' is typically quite basic but may form the basis for something more long term. An emergency shelter may become permanent housing, depending on the context. 'Housing' generally refers to the development context. 'Shelter' and 'housing' are funded through different means and are frequently addressed by different agencies. 'Shelter' as a noun would rarely be used in reference to a house or home and even has some negative connotations, yet it is embedded in the language of the humanitarian sector. Using an alternative term such as 'Homes and Communities', suggested by some INGOs, helps place people at the centre of the response and recovery and arguably better reflects shelter[ing] as a process, recognising that a house is more than its structure, and community more than a place. Notwithstanding suggestions of a need for changes in common language, throughout the Shelter and Mental Health learning event, participants referred to temporary and permanent homes as shelter and housing in a variety of ways. We have retained these contributions in the report, which records attempts by many humanitarian and development actors to develop a more holistic understanding of the process of recovery.

The term 'mental health and psychosocial support' (MHPSS) is broadly accepted as a composite term used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorders. For a further discussion of this term and also well-being and mental health, see [Chapter 2](#).

CENDEP	Centre for Development and Emergency Practice, Oxford Brookes University
CRS	Catholic Relief Services
DRR	Disaster Risk Reduction
GMH	Global Mental Health
GSC	Global Shelter Cluster
HLP	Housing, land and property rights
IASC	Inter-Agency Standing Committee
IDP	Internally displaced person
IEC	Information, education, communication
IFRC	International Federation of Red Cross and Red Crescent Societies
IOM	International Organization for Migration
MHPSS	Mental health and psychosocial support
MEAL	Monitoring, evaluation, accountability and learning
NRC	Norwegian Refugee Council
SDG	Sustainable Development Goal
UNHCR	The United Nations Refugee Agency
WaSH	Water, sanitation and hygiene
WHO	World Health Organisation

EXECUTIVE SUMMARY

The Shelter and Mental Health Learning Event in May 2021, *Doing More and Doing Better*, explored the connections between living conditions, Shelter and Settlements activities and mental health to better understand how the humanitarian Shelter and Settlements sector can contribute to the mental health and psychosocial well-being of people during and after humanitarian crises. The event was a follow-up to the first Shelter and Health Learning Day in May 2020, which was reported in [Towards Healthier Homes in Humanitarian Settings](#). Participants at the 2020 event expressed a collective lack of confidence in being able to articulate the intersections between their shelter activities and the mental health and well-being of the people they aim to serve. The report recommended that shelter practitioners develop a deeper understanding of the terminology of mental health and how mental health relates to shelter.

The 2021 online event was instigated and hosted by the Centre for Development and Emergency Practice (CENDEP), Oxford Brookes University and CARE International UK, both partners in the [Self-recovery from Humanitarian Crisis](#) research team. It was attended by over 80 Shelter, Health, WaSH, Protection and Mental Health and Psychosocial Support (MHPSS) practitioners and researchers. The event was responding to a need to uncover and better articulate the impacts of existing Shelter and Settlements best practice on mental health and well-being and to plot a path towards more deliberate and documented beneficial impacts.

Experts in MHPSS in emergencies joined the meeting to explain the spectrum of mental health and associated terminology and the fact that MHPSS is a cross-cutting issue, relevant to all sectors of humanitarian support. They stressed that, while humanitarian crises and associated displacement and loss of home can be traumatic and cause or exacerbate mental distress, most people have the capability to recover. A person's mental health and psychosocial well-being is affected as much - or even more - by their living conditions as it is by their experiences of crisis and disaster. Shelter is a determinant of mental health and well-being in all emergencies; inadequate shelter and poor access to water and sanitation facilities are among the 'daily stressors' that contribute to mental distress for individuals and communities and are detrimental to early recovery and eventual development.

The Shelter and Settlements sector can therefore promote good mental health and psychosocial well-being not only through the services it provides, but how it provides those services. The Learning Event helped participants to reflect on the aspects of 'good shelter programming' that already contribute to mental health, such as routine inclusion of people with disabilities, including psychosocial disabilities, in programming. Shelter activities that aim to mitigate gender-based violence also protect and promote mental health, as do programmes that go beyond paying lip service to being participatory in design and implementation. Examples of such activities were shared by shelter practitioners who joined the meeting to present and discuss case studies from Nigeria, the Philippines and elsewhere.

Upgrades to people's living conditions in post-disaster, conflict and protracted displacement settings can do much to promote both physical and mental health. For example, improvements to flooring, ventilation or insulation from heat and cold can reduce physical ill health and also mental distress. Presenters shared case studies from Bangladesh and North-West Syria to illustrate these links, some of which demonstrated unexpected benefits on the well-being of women as a result of housing upgrades designed to improve the physical health of children. Aesthetic improvements to housing, and the opportunity and resources to choose them, were also widely recognised to contribute to recovery from crisis.

From a focus on emergency shelter and housing improvements, the learning event moved on to consider further how the design, implementation and monitoring and evaluation of Shelter and Settlements programmes and projects could adopt an 'MHPSS approach' to humanitarian assistance. Recognition of the existing alignment between MHPSS 'core principles', the characteristics of 'good shelter programming' and the connections with Protection and other sectors is an important step. These points of alignment should be further identified and the opportunities for their expansion disseminated at global, country and local levels. Additional actions by Shelter and Settlement practitioners in the field, such as psychological first aid and making referrals, will require training and capacity building. Stronger connections and future collaborations between MHPSS and Shelter actors will allow useful cross-pollination of tools and indicators to allow evidence of the positive impacts of continued good shelter programming on mental health and psychosocial well-being to be built.

The key recommendations arising from the Shelter and Mental Learning Day

Key recommendations	1	Build capacity within the sector, through collaboration with MHPSS specialists, to enable a confident focus on mental health and psychosocial well-being of affected populations.
		More informed shelter practitioners with knowledge about mental health will create better outcomes.
	2	Clarify the impact of current programming on mental health and psychosocial well-being to a wider audience.
		Articulate to organisation programme leads the connections between shelter activities, protection, recovery and psychosocial well-being.
		Articulate to donors the links between 'good shelter programming' and mental health and psychosocial well-being.
	3	Build more robust evidence of these impacts, using new tools and approaches.
		Modify assessment, implementation, monitoring and evaluation approaches to measure success against these differently articulated objectives.
	4	Connect with MHPSS colleagues to integrate an 'MHPSS approach' with normal good practice.
		Widen Shelter and Settlements programme objectives/targets to include well-being outcomes, through the development of new indicators of well-being.
		Identify easy wins: start building mental health and well-being indicators into current assessment and evaluation frameworks.
	5	Strengthen connections with other clusters and sectors, including Health, WaSH and development actors, in order to work together to improve living conditions and mental health and well-being.

Message from Global Shelter Cluster co-leads

Brett Moore, GSC coordinator on behalf of UNHCR

I recall being in Lebanon more than 10 years ago and seeing graffiti on a wall with a cartoon of a boy and a girl talking to each other saying "I have the right to a cultural life". That image on the wall has stuck with me - the built environment, beyond being an asset and providing protection and security, has intrinsic value in its representation of shared history and culture, as much as a home has for the individual and family. When a home or a city is destroyed, the trauma of individual and collective loss is evident. What people have created, through sometimes centuries of constructing the built environment and the memory and history it captures, can be lost in an instant.

COVID-19 has precipitated some significant changes to how we think about our living conditions and the relationship of dwelling to our safety and security. On an individual level, it has placed new and unfamiliar pressures and stresses on us in unpredictable ways. For those already displaced, coping with the additional stresses and uncertainty of COVID-19 is hard to imagine. The pandemic has made us even more aware of the basics and the essence of what our work in the Global Shelter Cluster is about. Shelter is a process – it's one of protection and security, both physical and psychological. Forcibly displaced people that the cluster and its partners respond to have been subjected to significant disruption in their lives – sometimes protracted disruption. Losing one's home, or being forced to flee, significantly affects individuals, especially children, and the families and wider communities that support their growth, well-being and social development.

*As shelter practitioners, we have a role in preparedness, response and recovery: reducing risk of disaster and displacement, responding to the displaced, and supporting recovery needs through provision of shelter and housing projects. We know that in many cases, the provision of shelter is minimal, meeting only basic protection needs. Even worse, when people are displaced for years, sometimes in collective centres, they face long-term compromised safety and security which has consequences for their mental health. **During 2020**, Global Shelter Cluster partners reached around 15.5 million people with all forms of shelter support, but this was fewer than half of those in need. The gaps are not just financial, it's about how we work, across the whole spectrum of need and response, understanding vulnerability and how people's needs can be better met. The provision of shelter is not purely a technical function, it's really about choice, participation, and who is involved in decision making – real elements of the localization agenda.*

For the billion or so people living in informal settlements and inadequate housing, the relationship between the quality of living conditions and health outcomes, and the limitations created by that, is a significant and complicated issue that is preventing full realization of human potential in all aspects of health and well-being. At the Global Shelter Cluster, we are proud to support and be involved in these discussions and prioritise the work on health, including mental health, and housing – there is a lot to learn, and co-create from both built environment and health practitioners. Academic and practical linkages can not only help identify better and more effective programme approaches, but forge better ways of working with affected people to respond to their individual and collective needs.



Message from Global Shelter Cluster co-leads

Ela Serdaroglu, GSC Coordinator on behalf of IFRC

While reflecting on the title of this Learning Event: 'Doing More and Doing Better', I thought Shelter practitioners are already doing so much, how can we do more? We can always do better, but how can we do more? What does it mean for us? It is about not working harder, but smarter. From my point of view, and from the Cluster, we can work smarter through partnerships and creating enabling environments which bring experts together who previously have not had the connections or a productive environment for discussions to take place.

In the period that I have been involved in the Cluster, the discourse on shelter assistance has moved on from very technical discussions to a much wider variety of topics and interests. This event builds on everything that has taken place on the health topic in recent years. Zooming into mental health aspects opens up a lot of possibilities, so I am hopeful for the future of collaborations with mental health colleagues that we have just made contact with through this event. This will prompt us to start thinking of things in a different way and to identify ways of building new synergies between various humanitarian and development sectors. Mental health does not just 'belong' in the Health sector. There are so many connections between mental health and aspects of shelter, including protection and inclusion.

*We have discussed the shelter itself as a stressor, with inadequacy of shelter creating psychosocial or mental health concerns. It's not just about the home itself, it's also about what happens around the house - the environment. Imagine going out to a place where you don't feel safe on the street, or where there is no green space, or no area provided for the communities to come together; that is also a big stressor. We must continue to consider the settlement point of view. There are many overlaps between different models of well-being presented during the event and the seven principles in the **Right to Adequate Housing**. This right to housing is also a human right, which gives us a lot of credibility to build our work going forward. Providing shelter assistance for people who are already suffering from psychosocial needs also requires more of our attention, as we continue to work towards inclusion of all in our Shelter and Settlement activities.*

The Global Shelter Cluster is committed to provide the platform for discussion, collaboration and partnership and of course to advocate. We will soon have a dedicated capacity for advocacy and we want to highlight the cross-sectoral impacts of shelter, including the impacts of shelter on mental health and psychosocial well-being. There is much potential for collaboration going forward - there was a lot of excitement during the Learning Event as participants with backgrounds in Shelter and MHPSS saw many overlaps in their work, and possibilities to continue working together. As the Global Shelter Cluster, we are happy and committed to facilitate the dialogue going forward and to align our advocacy work with what comes out of this event.



CHAPTER 1

Introduction and context

The Shelter and Mental Health Learning Event

Why?

Within the Shelter and Settlements sector and beyond, there is significant interest in the wider impacts of shelter assistance on physical and mental health. Health has been identified by the Global Shelter Cluster as one of their priority areas for research. Currently, few implementing organisations have the knowledge or capacity to change their practices in such a way that health can be evidenced as one of the wider impacts and outcomes of sheltering processes.

The first Shelter and Mental Health Learning Day was hosted jointly by CARE International UK and The Centre for Development and Emergency Practice (CENDEP), Oxford Brookes University in May 2020. [Towards Healthier Homes in Humanitarian Settings](#) is the report based on this event. One of the recommendations of the learning day was for the humanitarian Shelter and Settlements sector to develop a greater understanding of the spectrum of mental health and how it relates to shelter assistance. Participants at the 2020 event expressed a collective lack of confidence in using mental health terminology and articulating the intersections between their shelter activities and the mental health and well-being of the people they aim to serve.

What?

The many connections between Shelter and Settlements assistance, living conditions, mental and physical health, mental health and psychosocial support (MHPSS) in emergencies have not been clearly articulated before. Nor has the Shelter and Settlements sector yet been included within MHPSS mainstreaming efforts at global level. It is timely for the Shelter and Settlements sector to examine these connections more closely. The Shelter and Mental Health Learning Event in May 2021 was designed to do just that.

How?

An initial collaborative process between the research team and humanitarian organisations to create an agenda for the 2021 event produced a long list of topics and ideas. Sorting these ideas identified three themes that required closer examination. These are represented by the three circles in the diagram on the next page:

- Mental health parameters and MHPSS
- Living conditions and their impact on physical and mental health
- Shelter and Settlements approaches and responses

The intersections between the three themes offer opportunities for “doing more and doing better’ with respect to the mental health and well-being of all people living through humanitarian crises, in varied crisis settings and all within the ambition of reaching the Sustainable Development Goals.

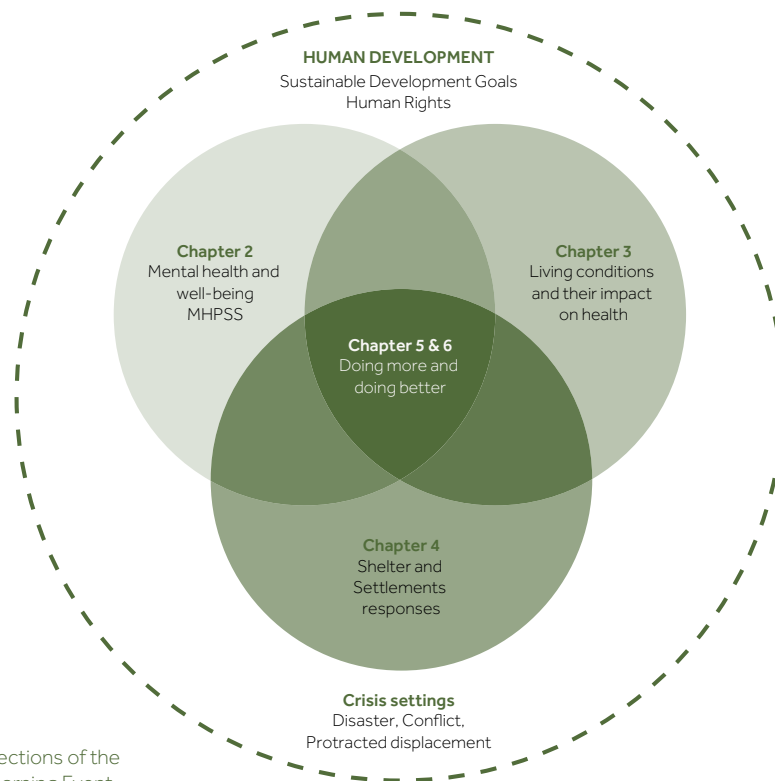


Figure 1: Themes and intersections of the Shelter and Mental Health Learning Event

Global Mental Health

Mental Health goes beyond the absence of problems - it also includes optimal psychological and social functioning (Patel et al., 2018). Until recently, mental health was sidelined, or ignored in discussions of global healthcare and public health. Worse, people living with mental health conditions have been stigmatised and excluded from healthcare, public health and also from wider society and development (see Kleinman, 2009). **Mental Health for Sustainable Development: A Topic Guide for Development Professionals** (Ryan et al., 2019) makes a strong case for the integration of mental health within all areas of international development - not just into health care. It gives guidance for development practitioners to integrate mental health into areas other than health, such as social protection, and also stresses that mental health is an important consideration for humanitarian responses. While humanitarian action is often seen to be 'separate' from development activities and processes, positive impacts of humanitarian action can also be related to long-term development goals.

It is important to frame our exploration into humanitarian shelter assistance and its connections with mental health within the aspiration for Global Mental Health (GMH). GMH is the area of study, research and practice that places a priority on improving mental health for all people worldwide (see, for example, the [Centre for Global Mental Health](#)). This relatively new field supplies strong arguments for mental health to be emphasised within Global Health, which locates health within the Sustainable Development Goals (SDGs). Global Health goes beyond SDG3, Good Health and Well-being, as health is connected with so many of the other SDGs. GMH is no longer purely calling for improved access to treatments and public health services for those in low income settings and fragile contexts: it also calls for the human rights of those with mental health conditions to be observed in all contexts (for example, see Ryan et al., 2019). Scaling up mental health care is increasingly seen not only as a public health and human rights priority, but also as a development priority. An expanded agenda for mental health addresses promotion and prevention as well as treatment of mental health 'problems' and conditions. Patel et al. (2018) reviewed the connections between GMH and sustainable development and pointed out the opportunities for prevention, treatment and recovery interventions at different points in the life course, for people with good mental health, those at risk and those with mental health conditions. Lund et al. (2018) reviewed the ways in which different aspects of people's lives can be determinants of mental health and impact the SDGs. However, the GMH movement has been seen by some development and humanitarian practitioners and researchers to be driven by health actors, rather than those in child protection or gender-based violence mitigation. The humanitarian mental health and psychosocial support (MHPSS) world does not uniformly trace its roots to GMH. For a discussion of the origins, current state and future priorities of MHPSS, see Ager (2021). For more on MHPSS, see [Chapter 2](#).

Humanitarian actors have started to become more aware of the importance of mental health. Humanitarian Shelter and Settlements programming can also strive to contribute to Global Mental Health. Programming must include people with mental health and psychosocial conditions and can also contribute to better mental health and psychosocial well-being of all people affected by humanitarian crises. Within the global humanitarian coordinating institutions, there is recognition of the need for multi-layered and multi-sectoral approaches that target various areas of need and priority (IASC, 2007). The Shelter and Settlements sector has a mandate to support people affected by disasters involving natural hazards and those displaced by conflict with the means to live in safe, dignified, appropriate and adequate shelter (Global Shelter Cluster, 2021). People's shelter, their houses and, ultimately their homes, contribute to their overall well-being.

Shelter and Settlements and Mental Health: what do we know?

The Inter-Agency Standing Committee (IASC) 2007 **Guidelines on Mental Health and Psychosocial Support in Emergency Settings** chapter on Shelter and Site Planning (Action Sheet 10.1, from page 174), sets out how to "include specific social considerations (safe, dignified, culturally and socially appropriate assistance) in site planning and shelter provision, in a coordinated manner":

The organisation of sites and shelters can have a significant impact on well-being, which is reduced by overcrowding and the lack of privacy commonly found in camps and other settings. Mental health and psychosocial problems can arise when people are isolated from their own family/community group or are forced to live surrounded by people they do not know, who speak other languages or who arouse fear and suspicion. Also at risk are people such as the elderly, single women, people with disabilities and child-headed households, who are not in a position to build, rent or secure their own shelter. Conflicts among displaced people or between displaced people and host communities over scarce resources such as space or water can often be a significant problem, and site planning must minimise such potential risks.

These IASC Guidelines refer to the Sphere Handbook for guidance and overall standards, but have not been updated to relate to Sphere's most recent (2018) revision. The Sphere Handbook's Shelter and Settlements chapter gives some guidance on aspects of assistance related to recovery and well-being. For example:

Shelter and settlement assistance should support and draw on the existing strengths of affected households, communities, civil society and government. This increases the chance of developing localised strategies that encourage self-sufficiency and self-management by the affected people. A sense of safety, community and social cohesion are essential to begin the process of recovery (page 240).

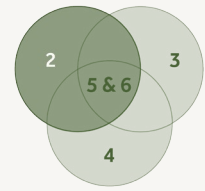
Accommodation layout and design should include open public household living spaces that increase options for socializing (page 256).

Overall though, the Handbook makes limited direct connections between mental health and shelter.

The **MHPSS core principles** (in Chapter 2) are very much in alignment with the 'essentials' of Shelter and Settlements programming, as articulated in the 2021 **Shelter Projects Essentials** publication, which aims to distil the tried and tested elements of 'good shelter programming' from its extensive collection of 250 case studies. Until now, health outcomes have rarely been reported in Shelter Projects case studies. In the **8th Edition of Shelter Projects**, published in 2021, there has been more effort to encourage case study authors to reflect on health outcomes of projects, and health has now been included as a specific theme in conducting the meta-analysis of project strengths and weaknesses. There has not, to date, been a concerted effort to draw out the connections between mental health and humanitarian Shelter and Settlements provision.

CHAPTER 2

Mental Health and Psychosocial Support



What is mental health and psychosocial support?

Mental health and psychosocial support (MHPSS) is a composite term used in reference to “any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental health conditions” (IASC, 2007, page 1). The term ‘psychosocial’ reflects the dynamic relationship between psychological and social issues and has been in use since the 1980s, particularly in contexts of armed conflict (Williamson and Robinson, 2006). IASC defines mental health and psychosocial well-being as follows:

Mental health: *A state of [psychological] well-being (not merely the absence of mental disorder) in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.*

Psychosocial well-being: *The psychosocial dimension of well-being. Although there is no widely agreed definition, practitioners often use the adjective ‘psychosocial’ to describe the interaction between social aspects (such as interpersonal relationships and social connections, social resources, social norms, social values, social roles, community life, spiritual and religious life) and psychological aspects (such as emotions, thoughts, behaviours, knowledge and coping strategies) that contribute to overall well-being.*

Since 2007, MHPSS has been positioned as an interdisciplinary field that requires a collaborative approach between multiple humanitarian sectors (Harrison et al., 2021). UN humanitarian agencies together with civil societies and other organizations have formally committed to treating MHPSS as a crosscutting issue in humanitarian emergencies, relevant within all sectors, including Shelter and Settlements. IASC published its **Guidelines on Mental Health and Psychosocial Support in Emergency Settings** in 2007. Shelter is included as one of the ‘basic services’ that should be provided in emergencies in such a way that they protect and promote mental health and well-being:

The well-being of all people should be protected through the (re)establishment of security, adequate governance and services that address basic physical needs (food, shelter, water, basic health care, control of communicable diseases). In most emergencies, specialists in sectors such as food, health and shelter provide basic services. An MHPSS response to the need for basic services and security may include: advocating that these services are put in place with responsible actors; documenting their impact on mental health and psychosocial well-being; and influencing humanitarian actors to deliver them in a way that promotes mental health and psychosocial well-being. These basic services should be established in participatory, safe and socially appropriate ways that protect local people’s dignity, strengthen local social supports and mobilise community networks (page 11).

The Guidelines define MHPSS 'core principles', to be integrated into programmes in any sector and in themselves serving to strengthen the psychosocial well-being of affected populations and to promote good mental health.

The MHPSS core principles

Human rights and equity:

promoting the human rights of all affected persons, promoting equity and non-discrimination.

Do no harm:

reducing the risk of unintentionally causing harm through humanitarian interventions.

Participation:

maximising the participation of affected populations in the planning, implementation, monitoring and evaluation of programmes which affect them.

Building on available resources and capacities:

based on the belief that all affected groups have assets or resources that support mental health and psychosocial well-being; interventions should build on these, support self-help and strengthen the resources already present.

Integrated support systems:

MHPSS activities are integrated as much as possible into wider systems, rather than being provided as stand-alone services.

Multi-layered supports:

reflecting the fact that people are affected in different ways by crises. A layered system of MHPSS is proposed which meets the needs of different groups. No organisation is expected to meet all the MHPSS needs of a population, but should be able to connect to others who are providing services at different levels.

How are the MHPSS core principles related to Shelter & Settlements programming?

The **IASC Reference Group on Mental Health and Psychosocial Support** was formed in 2007 to support and advocate for the implementation of the Guidelines. The Reference Group fosters collaboration between NGOs, UN and international agencies and academics, promoting best practices in MHPSS. It has two co-chairs: Dr Carmen Valle-Trabadelo from IFRC's Reference Centre for Psychosocial Support and Dr Fahmy Hanna from the World Health Organisation (WHO).

Carmen Valle-Trabadelo led the first session of the learning event to explain the Reference Group's role, and suggest opportunities for integrating MHPSS within Shelter and Settlements activities. She was joined by Dr. Ross White, the associate professor of clinical psychology at Liverpool University, Ben Adams, senior mental health advisor for CBM Global and Dr. Rebecca Horn, an independent psychosocial specialist and senior research fellow at the Institute for Global Health and Development at Queen Margaret University in Edinburgh. Their interventions helped to explain the ways in which living conditions impact on mental health and well-being and how MHPSS principles can enhance Shelter and Settlements activities.

The IASC Reference Group on Mental Health and Psychosocial Support: opportunities for closer collaboration with Shelter and Settlements

Carmen Valle-Trabadelo, IFRC. Co-chair, IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings

*In order to take care of the well-being of those in emergency settings, there is a need to be comprehensive and look at the whole spectrum of mental health, from severe mental health conditions to aspects of daily well-being. All of these can be significantly affected when a crisis hits. The idea that comes to mind when somebody talks about 'mental health' in humanitarian settings is probably the idea of mental illness, and severe impacts such as post-traumatic stress disorder. Supporting people with such conditions, either prior to the crisis or as a consequence of it, is indeed part of what MHPSS professionals do. But our work is very importantly distributed throughout the continuum of mental health and psychosocial needs, and therefore places great importance on prevention and promotion, as well as on the social determinants of mental health that are present very clearly during a crisis. Before 2007, the field of mental health and psychosocial support was dispersed, with different approaches and ways of working, different points of view and disagreements on terminology. In 2007, experts in the field got together to develop **IASC Reference Group on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings**, as a way of bringing together the field around best practices and providing clear guidelines on MHPSS implementation. It was in the development of these guidelines that the important definition of the composite term MHPSS, which incorporates preventing or treating mental health conditions AND protecting or promoting psychosocial well-being, was coined.*

*The **Reference Group** was created not only to promote the Guidelines but to harmonize the work on MHPSS at all levels in emergencies, developing a standard evidence-based way of working. The Reference Group connects with different actors in the Health, Protection and other sectors, with a key role in coordination. MHPSS doesn't sit under any of the clusters or sectors, but rather across all of them - we are happy we have had the opportunity through the Inter-agency Standing Committee to remain as a reference group, as an associated entity, because it allows us to work cross-sectorally. The reference group at the moment is composed of over 60 member organizations, working on MHPSS globally (international and national NGOs, UN Agencies, Red Cross and Red Crescent), plus several observer organizations, academic institutions, donors and individuals.*

At country level, when a crisis happens we try to activate a Technical Working Group, which coordinates MHPSS activities from different organizations and links with the other clusters or sectors. So far, we have been more strongly connecting and integrating our work with the Health sector and with the Protection sector, specifically the child protection Area of Responsibility (AoR), but also Gender and Mine Action AoRs. We have also been working increasingly with the Education sector. Education Cannot Wait, for example, is a funding mechanism that has been focusing on integrating MHPSS within education programmes. We have not, to date, been very integrated with the Shelter and Settlements sector, but we believe this is very important and it presents exciting opportunities for the future. Our vision for the coming months and years is to actually have the opportunity to provide much more close support to sectors other than Health, Protection and Education, so as to have the opportunity to give more technical support to other sectors in different areas, to provide the connections at country-level and more service to the entire humanitarian community. We hope to be able to offer a help desk function soon to support other clusters.

The reason why, for the first time ever, MHPSS outcomes are included in the global humanitarian response for COVID-19 is because this crisis has touched all of our lives. For the first time, people have seen how experiencing a crisis, losing access to freedom, and seeing our communities going through these challenges, impacts their well-being so much. I had a very clear idea before joining this learning event how shelter is so important to mental health and well-being for all of us. Our homes and communities and the cities we live in promote, or not, our well-being. We all are very aware of this at a personal level. But listening to the voices of Shelter and Settlements practitioners and learning about specific projects has reinforced this idea even more. I am keen to continue the conversation because together, we can define the entry points for Mental Health and Psychosocial Support within Shelter and Settlements. From that, we can build tools and resources and collaborate in research. I think this is just the beginning of a positive friendship and collaboration.

Humanitarian crises and mental health

Forced migration, disaster and conflict can be traumatising events. The 'migration journey' can be conceptualised as a series of potentially traumatising episodes. Similarly, displacement and loss of homes due to hazard-related disasters can be traumatic for individuals, families and communities. But people who have experienced these events should not necessarily be seen as victims of trauma. Ongoing everyday stressors of life after disaster or in protracted displacement may be as important, or more so, for people's well-being. Allen et al's. (2014) review of the social determinants of mental health concluded that access to such basic amenities as water, sanitation and waste management improvements, interventions such as energy infrastructure upgrades, new transport infrastructure, mitigation of environmental hazards, and improved housing can improve mental health and functioning. Other researchers have also found that factors such as unequal access to basic resources and opportunities to partake in occupational and recreational activities have negative impacts on mental health and psychosocial well-being (for example Logie et al., 2020).

Both Rebecca Horn and Ross White, speakers at the Learning Event, highlighted the common misconception that the mental health and psychosocial well-being of people affected by humanitarian disasters and conflicts is mostly influenced by their experiences of that conflict or of that disaster and that the majority of people experiencing crisis need professional help to recover (Horn, 2016; White & Van der Boor, 2021). Both speakers emphasised the role of 'daily stressors', such as inadequate housing, on mental health and well-being, relating this to the potential for Shelter practitioners to mitigate these daily stressors. While extreme events do have a significant impact on health and psychosocial needs, equally important are the conditions in which people are living in that humanitarian setting. Horn et al. (2020) found that, in Sierra Leone, daily stressors (including family violence, unemployment, perceived discrimination, food insecurity and poverty) can have at least as much impact on mental health as extreme events such as war experiences. Daily stressors such as lack of access to water and toilets were commonly identified by men and women. Other stressors were lack of electricity, and housing issues, especially the cost of rent and poor condition of housing which led to health issues as well as shortage of communal, social spaces. Horn et al. (2020) found that typically, people were more troubled by social and economic problems than with explicitly psychosocial or mental health issues, but they were aware of the inter-related nature of these issues.

The Capabilities Approach, displacement and well-being

Ross White, Associate Professor of Clinical Psychology, Liverpool University

Working for many years as a clinical psychologist in academia and practice, on the mental health impacts of displacement, has confirmed that mental health and psychosocial well-being is much more than just a health issue. The mental health and psychosocial well-being of displaced people needs to be understood as a human-rights issue, that includes a focus on key principles such as participation in society, non-discrimination, human dignity, and empowerment. Discrimination or prejudice, loss of empowerment or agency can have a profound impact on people's mental health and psychosocial well-being. Research evidence indicates that although varying proportions of displaced people meet criteria for mental disorders, a considerably larger proportion do not. A review by Charlson et al. (2019) found that amongst people who had been displaced from their homes in low- or middle-income countries, 22% had experienced mental disorders (depression, anxiety disorder, post-traumatic stress disorder (PTSD), bipolar disorder, and/or schizophrenia) and 9% had experienced a moderate to severe form of mental disorder. Mental well-being is something that we all aspire to, and we need to promote the mental health and well-being of all people in humanitarian crises, rather than purely planning to enable the treatment of 'disorders'.

The Capabilities Approach (Sen, 1999; Nussbaum, 2000) is relevant when trying to understand factors affecting well-being. This is a human development approach that foregrounds individuals' freedoms to engage in forms of being and doing (or functionings) that are valuable to them. The approach attempts to articulate what constitutes a 'good life'. Qualitative research with Congolese refugees living in two refugee settlements in Uganda and Rwanda used interviews with 60 adult male and female refugees to explore "What does 'having a good life' mean to you?" (Chiumento et al., 2020).

Responses emphasised the importance of basic needs relating to food and shelter. Women's aspirations focused on the well-being of their children and material fabric of their homes. Men foregrounded opportunities for employment, material possessions that demonstrate their status, and opportunities for greater public participation in community life.

I have co-developed a framework which examines the different layers of stressors that can be barriers to the capabilities of forcibly displaced people (White and van der Boor, 2019). It shows that although historical 'displacement related stressors' are important, 'daily stressors', such as shelter, are also significant. Both sets of stressors can impact health and well-being as they limit people's ability to develop their capabilities - to engage in forms of behavior that they have reason to value. Our research found that, in order to try to influence the stressors operating for individuals and communities, interventions are needed at multiple levels, from people's immediate environments to structural governance and policy levels. Humanitarian actors have a part to play in all these, whether by direct programme actions, or by advocacy.

Nonetheless, the mental health consequences of rapid onset emergencies, such as fragility, conflict and violence, often compounded by the cyclical relationship between poverty and mental illness, are pressing challenges. People with pre-existing psychosocial disabilities are also among the most vulnerable in emergency and protracted contexts. Ben Adams, in his presentation ([summarised in Chapter 5](#)), highlighted the importance of including people with all disabilities in all levels of shelter programming, for better individual and community well-being.

Following the presentations from MHPSS experts, it was clear that mental health challenges in humanitarian crises can be divided into three categories: those that are emergency induced, those that are induced by socio-economic circumstances and those that are induced by humanitarian action. Shelter and Settlement practitioners may be in a position to mitigate some of these challenges. How they might do that was addressed in later sessions of the learning event and is summarised in [Chapters 3 and 4](#) below. The summary key points of the interventions in the first main session of the learning event led by the MHPSS experts formed a valuable backdrop to the later sessions:

- MHPSS is complex and cross-cutting across all sectors.
- Inclusion of people with disabilities is central to successful, human rights-based humanitarian response.
- A person's mental health and psychosocial well-being is affected as much, or even more, by their living conditions as it is by their experiences of crisis and disaster.
- Shelter is a determinant of mental health and well-being in all emergencies. The Shelter & Settlements sector can promote good mental health and psychosocial well-being not only through the services it provides, but how those services are provided.
- MHPSS and Shelter can support each other and together contribute to the well-being of communities affected by crises.
- The MHPSS Reference Group and its partners are developing mechanisms to coordinate, support sectors, and ensure inter-agency collaboration.

CHAPTER 3

Links between housing and mental health

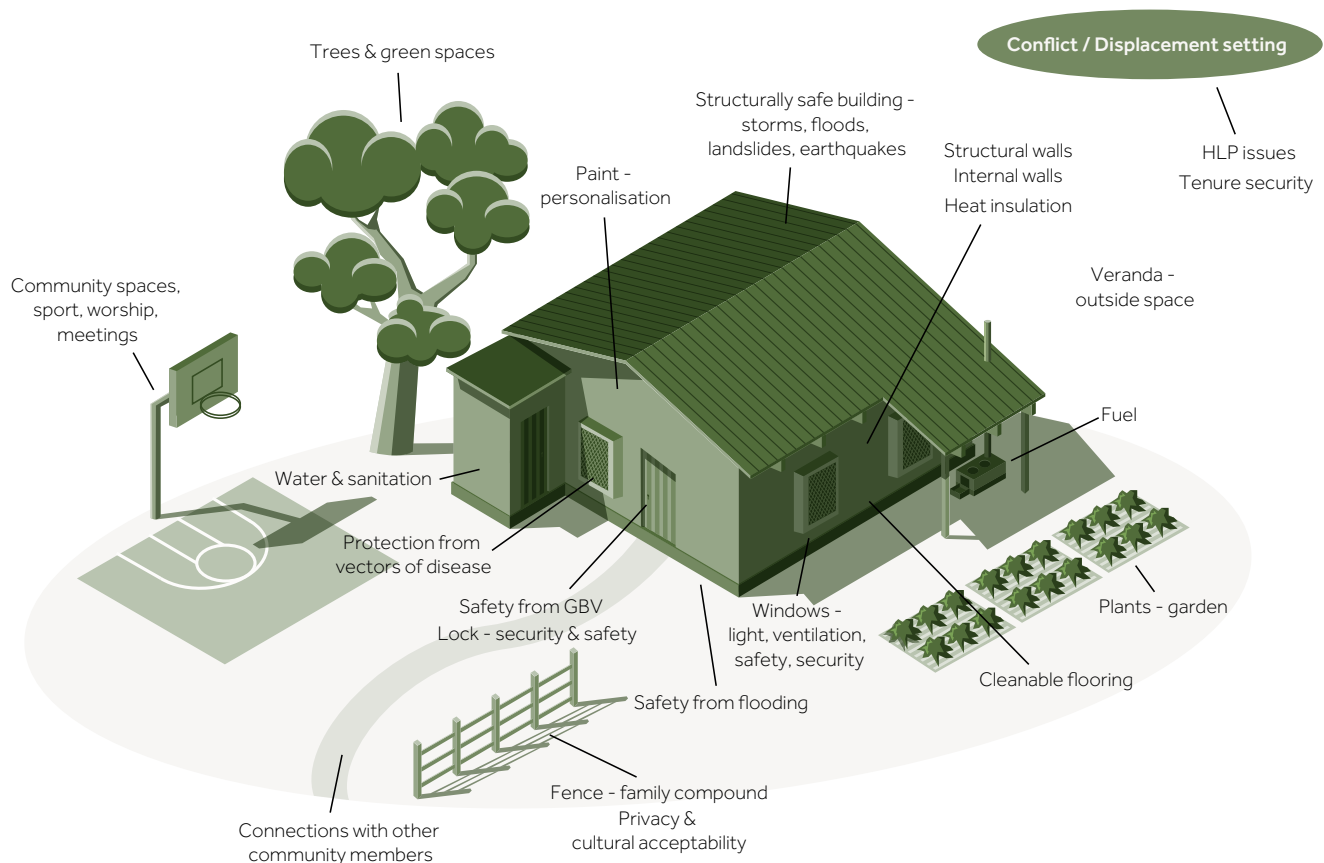
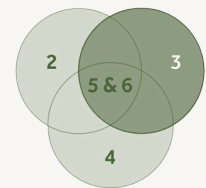


Figure 2: Aspects of the home and surrounding environment linked to physical and mental health.

Interactions between housing, physical health and mental health

Across the case studies and the wider literature, it is clear that having a decent, healthy home supports and maintains mental health (Buck, Simpson and Ross, 2016, page 25).

Children who live in crowded housing may have poorer cognitive and psychomotor development or be more anxious, socially withdrawn, stressed or aggressive (Harker, 2006, page 16).

Many women become homeless because of domestic violence. When women lose their homes and are forced to live in inadequate conditions often without privacy or security they may be exposed to sexual and other forms of violence (CARE International UK, 2016, page 14).

Poor-quality, cold, damp and overcrowded housing can cause psychological distress among both adults and children. There is a substantial body of literature on the connections between poverty, housing and mental health, although much of the available literature comes from studies of deprivation and disadvantage in high income countries. The same is true of literature on the connections between housing and physical health; physical and mental health are themselves often closely related (see also InterAction, 2020; Webb et al., 2020; Webb et al., 2021). Diagrams illustrating the 'vicious cycle' of poverty and poor mental health are commonly reproduced, showing how poor mental health can affect economic and social life chances and how poverty can cause and exacerbate mental health conditions (for example, Lund et al., 2011; Elliott, 2016). Evans, Wells and Moch (2003), in an evidence review, found that there is sufficient evidence that aspects of housing (such as crowding) affects psychological health, especially for low-income families with young children. However, difficulty lies in understanding the causal and the consequential factors of housing and mental health connections and in how to address both. Notwithstanding those gaps, the humanitarian shelter sector should be more aware of and learn from what is widely accepted in other sectors.

Examples of evidence from the UK public health sector of the mental health implications of poor and overcrowded housing.

Mind (a UK mental health charity) makes a clear link between housing and mental health in [The Mind Guide to Housing and Mental Health](#) (Murphy, 2011). Poor mental health can make it harder to cope with housing problems, while being homeless or having problems in your home can make your mental health worse.

Harker (2006) points out the wider-ranging impacts of poor and/or overcrowded housing on well-being beyond physical health in the UK context in [Chance of a Lifetime: The impact of bad housing on children's lives](#).

The UK's [Mental Health Institute](#) agrees that "good-quality, affordable and safe housing is a vital component in good mental health, as well as supporting those with existing mental health conditions".

[Shelter](#) (a UK housing/homeless charity) identified housing as a key issue which had an impact on patients' mental health, particularly on anxiety and depression. Depression of adults was also found to have knock-on effects on children's mood and behaviour.

Overcrowding has multiple social impacts – perhaps particularly for children and their ability to learn. This issue has received attention during the 2020-2021 lockdowns brought about by the COVID-19 pandemic, with school children and university students around the world forced to study at home, in inadequate learning environments with insufficient space and support. The pandemic has generated a great amount of attention on the connections between housing quality, overcrowding, safety within the home from domestic abuse, vulnerability to the virus and mental health (Treiveno and Nielsen, 2020) and has brought to the fore the connections between multiple deprivation, including housing quality and overcrowding, on the transmission of the virus and also the psychological impacts of lockdown and physical/social distancing requirements.

Physical conditions linked to housing characteristics can contribute to mental stresses. For example, tungiasis is a foot condition caused by vectors in earth floors. Sufferers can face both physical incapacities, mental distress and achieve reduced school performance (see BOVA Network, 2021). It is likely that other physical health conditions connected to housing and sanitation inadequacies cause worry and mental stresses. For example, tuberculosis and pneumonia linked to poor indoor air quality, diarrhoeal diseases linked to lack of clean water and sanitation, vector-borne diseases such as malaria linked to inadequate screening and ventilation, all cause stress to sufferers and their carers. Fear of disease, the burden of caring for suffering family members and resultant financial strain inevitably have mental health implications. Women and children are particularly vulnerable to the physical health risks related to housing, and it is reasonable to suggest that much of the mental burden falls on women as well. Caring responsibilities and socio-economic and cultural factors may mean that women's psychosocial well-being is more closely related to living conditions, based on the fact women typically spend more time in the home. Addressing mental health needs is therefore not just about improving access to healthcare and therapeutic interventions, it is also about tackling poverty, multiple deprivation and inadequate living conditions. This is an entry-point for the humanitarian Shelter and Settlements sector.

Impacts of building upgrades on physical and mental health

Improving housing conditions, perhaps initially to improve physical health, can have unintended beneficial mental outcomes. Studies from the development sector have shown the co-benefits of housing interventions on more than just physical health outcomes but on mental health too. Sarah Ruel-Bergeron, the Executive Director of ARCHIVE Global joined the learning event to share updates from their Mud to Mortar project in Bangladesh.

The Unexpected Social Benefits of Concrete Flooring

Sarah Ruel-Bergeron, Executive Director, ARCHIVE Global

ARCHIVE (Architecture for Health in Vulnerable Environments) has worked in low income communities throughout the world since 2006, aiming to improve health through the built environment. Housing design is a key strategy to combating diseases such as tuberculosis, malaria, diarrheal disease and also combating gender-based violence. ARCHIVE's projects are built on pillars of research, design and implementation and education.

ARCHIVE's *Mud to Mortar* programme in Bangladesh was presented and discussed at the May 2020 Shelter and Health Learning Event, attracting much interest within the humanitarian shelter sector due to the documented positive impact that flooring upgrades from mud to concrete had on diarrhoeal diseases, particularly in children. Since 2014, ARCHIVE has built nearly 300 concrete floors for families living on less than \$100 a month, with its local partner ADESH. [This video](#) shows more information about Mud to Mortar.

ARCHIVE conducts pre-construction baseline surveys and end-line surveys alongside focus group discussions, and in-depth interviews. Education campaigns help community members understand how the built environment can provide a solution to health issues and how they can participate in the design, construction and maintenance of the new flooring. The concrete floor is created both inside the existing house structure and also in outside veranda areas, commonly used in Bangladesh for eating and socialising. The project has reported significant decreases in reported disease problems of children under 5, including:

- 77% decrease in diarrheal episodes in the 2 weeks preceding the survey
- 72% decrease in diarrheal episodes in the last 6 months
- 83% decrease in breathing problems in the 2 weeks preceding the survey
- 53% decrease in coughing in the 2 weeks preceding the survey
- 92% decrease in short and rapid breathing in the 2 weeks preceding the survey



During in-depth conversations with mothers and focus group discussions unexpected changes to their overall quality of life became apparent. Women who have concrete floors reported improved mental well-being; the concrete flooring required less maintenance to keep clean, releasing them from time spent on daily chores and reduced anxiety about their children's health. The concrete flooring also reduced incursion by snakes and rodents and thefts from houses. Women expressed pride in their homes which also boosted their well-being.

“

My son used to get diarrhea, colds, and fevers. After getting the concrete floor, he does not get colds or diarrhea anymore. I used to spend 4 hours cleaning the dirt floor before and now it only takes 10 minutes to clean the new floor on a daily basis. I am feeling very good. I am able to spend more time at the farm now. Before, guests did not sit inside my house and now they sit and stay a bit longer, which makes me feel good.

”



© ADESH, Bangladesh

The multi-phased nature of this project has enabled ARCHIVE to refine its monitoring and evaluation methods. ARCHIVE has developed both quantitative and qualitative survey tools, including evaluation questions that explore these initially unintended consequences of improved flooring. Asking better questions and spending more time with the women is enabling this understanding to be developed. It is becoming clear that the overall social benefits of the upgraded living environment are as significant as the physical health benefits, culminating in better overall well-being.

The World Health Organisation (WHO) published **Housing and Health Guidelines** in 2018 which aim to reduce the health burden due to unsafe and substandard housing through providing practical recommendations for home-owners, builders and governments.

Healthy housing is shelter that supports a state of complete physical, mental and social well-being. Healthy housing provides a feeling of home, including a sense of belonging, security and privacy (WHO, 2018, page 2).

The WHO Guidelines do not focus very much on mental health. In the systematic reviews done as part of the Guidelines development, mental health was associated with overcrowding, tenure insecurity, poor insulation from extreme heat and lack of accessibility for those with functional impairments. Nevertheless, it is reasonable to suggest that housing improvements can be associated with positive benefits to mental health, even if that was not the initial objective. Tusting et al. (2021) emphasise the disadvantages of basing guideline development (for example the WHO Housing and Health Guidelines) on biomedical evidence assessments alone. Expanding the guideline development process to be more inclusive of development interventions is necessary to ensure a sustainable approach. “Rather than narrow evaluations focused on single health outcomes, a better question is ‘How can we harness the health benefits of development interventions?’”. The review referenced by Tusting (Loevinsohn, Mehta, Cuming, et al., 2015), re-examined water, sanitation and hygiene interventions, originally examined solely for their impact on child diarrhoea morbidity, from a joint health and development perspective. Of 27 studies re-examined, 37% were judged to result in substantial additional impacts beyond reducing diarrhoea morbidity. Several interventions had impacts on improved mental health. The approach to assessing housing interventions’ impacts advocated by Tusting et al. (2015) should also be relevant to humanitarian Shelter and Settlements interventions, such as shelter upgrades.

Multiple benefits of shelter upgrades

While there is a wide body of literature about the connections between housing quality, tenure security, socio-economic status and mental health in high income countries (and in informal development settings), it is harder to find specific case studies from the humanitarian Shelter sector that link overcrowding or other living conditions with psychosocial issues for adults or children. There are several potential intersections between living conditions in humanitarian settings (which range from camps, rental properties, many types of emergency and transitional shelters, 'collective centres' in repurposed buildings and many more) and physical and mental health.

Building damage and loss of homes can create serious protection risks, particularly for women and girls, including increased risk of gender-based violence. Indeed, the perceived lack of safety resulting from unrepaired damage to homes, unsafe temporary repairs and subsequent lack of privacy can cause significant emotional stress. In a Rapid Gender Analysis conducted in the aftermath of the Beirut Blast (UN Women, CARE, UN ESCWA, ABAAD, UNFPA, 2020), participants reported that the lack of a solid door meant that their home was easily accessible to intruders and lacked privacy. Improved bathroom facilities also contribute to people's perceived sense of safety, including doors to separate rooms and locks on bathrooms and toilet doors (Rule, 2021). Upgrading living spaces can improve people's sense of safety, improve physical health and hygiene and enhance well-being.

Many Shelter and Settlements programmes attempt to improve living conditions for displaced populations, despite funding and political challenges. The objectives of such programmes are rarely articulated as being related to mental health. A case study shared by Joud Keyyali, WaSH/Shelter project manager from CARE Turkey, highlighted the benefits of shelter upgrades in North-West Syria on physical and mental well-being. Joud's presentation highlighted the potential value for the sector of being able to evidence ways that both improved living conditions, and the opportunity for displaced people's preferences to be incorporated into programming, contribute to their mental health and well-being. Joud raised many questions about the need for shelter practitioners to be in a position to build that evidence, in order to be able to advocate for more durable and dignified shelter solutions in protracted settings such as North-West Syria.

'Dignified shelter solutions' in the protracted conflict setting of North-West Syria

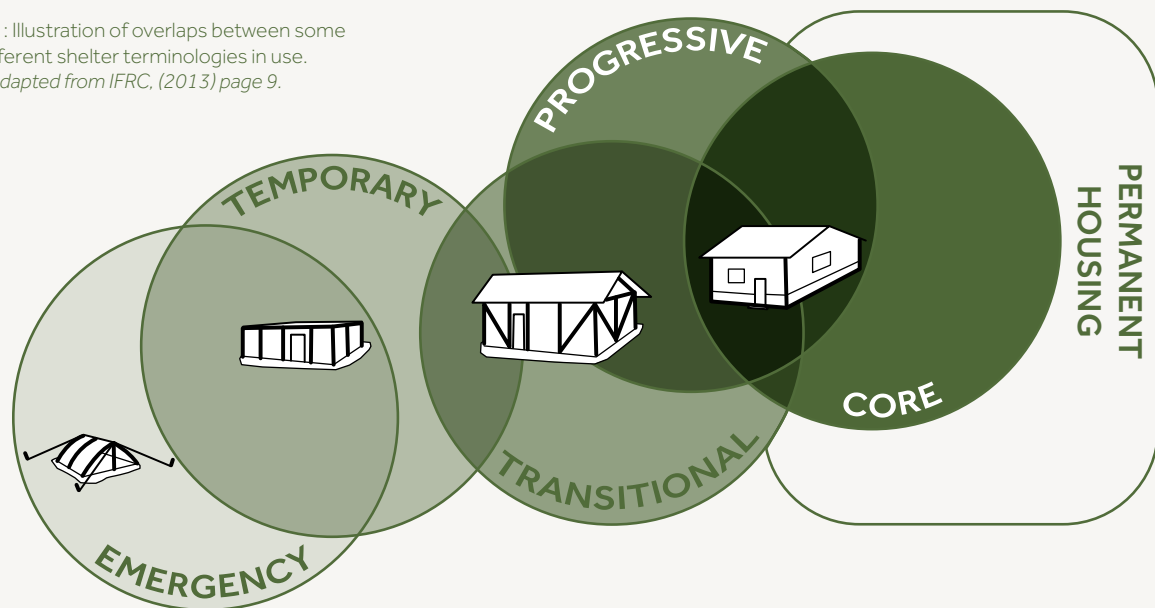
Joud Keyyali, WaSH/Shelter Project Manager, CARE Turkey

After ten years of conflict and forced displacement, North-West Syria (NWS) has a population of 4 million inhabitants; 2.8 million are internally displaced persons (IDPs), the majority of whom (80%) are women and children. The gap between shelter need and provision is tremendous, leaving 67% of IDP households living in hazardous shelters, mostly in IDP settlements. Over a third of IDPs are still living in emergency shelters after many years, reporting a lack of space as their primary concern. Many IDPs live in inadequate, non-durable and unsafe structures, in multi-occupancy buildings, damaged and unfinished residential buildings or collective centres. CARE Turkey's current shelter response involves several activities, aiming to return shelters to habitation by repairing and rehabilitating moderately damaged shelters, rehabilitating and converting collective shelters such as garages and commercial units to improve protection against harsh weather, access to water and sanitation facilities and improving privacy and security of beneficiaries, especially women, by enhancing access, adding walls, doors, windows and repairing WaSH facilities. In IDP settlements, CARE distributes shelter kits, rehabilitates self-built concrete shelter units and upgrades the IDP sites by graveling roads in addition to installing drainage systems when needed. Additionally, CARE Turkey is reacting to two new types of shelter initiated and improvised by the IDPs themselves:

- *a locally made emergency shelter, consisting of a welded metal frame covered with plastic sheeting;*
- *a concrete block shelter (which the Shelter/NFI Cluster (Turkey Hub) has termed a 'dignified shelter solution'). These have created, not a recognisable 'camp', but a self-built concrete environment. IDPs have built inside these concrete block structures to give themselves a more durable solution to their shelter needs.*

This has been a controversial issue in the 'emergency' context for the cluster and for shelter actors, whether to acknowledge these shelters or not. Recently we decided to do so. Several private donors and local NGOs have started to integrate this type of concrete block shelter into their programmes, buying or renting land, planning and building these settlements, then allocating them to IDPs from other locations. This solution has challenged a lot of our predefined understanding of shelters specifically in emergency situations where it is problematic to talk in terms of permanent housing. We had to start from scratch to redefine 'shelter' and understand the role of these concrete block houses and their impact on their inhabitants, as distinct from living in a tent or caravan or other options.

Figure 3: Illustration of overlaps between some of the different shelter terminologies in use.
Source: Adapted from IFRC, (2013) page 9.



Our new definition of shelter consists of two elements:

1. Shelter should be a dwelling where the IDP can accommodate their needs. So the shelter should be expandable and able to be developed to meet future needs of its occupants.
2. Therefore, shelter assistance should be designed after consulting the IDPs and after recognizing their needs.

We consider this to be a process; shelter is not something you can distribute once and forget about. The process needs to be monitored and the impact of the shelters must be continually evaluated. So we now describe these concrete block houses as 'more dignified shelter solutions'. Based on this, CARE has adopted a theory of change:

If communities, particularly women, girls and others at risk, are directly consulted on the design and the setting of these new shelters AND those shelters are more durable and meet Gender Based Violence and Sphere Standards THEN affected IDP populations in NW Syria will be safer and able to live in greater dignity.

Based on that, the Technical Working Group (TWiG), in coordination with the Shelter/NFI Cluster and other shelter cluster actors generated guidelines. We were able to convince the humanitarian committee that this is a solution that we should adopt. It was a big move for everyone, including CARE who later piloted a shelter project, and installed 490 shelter units in Zoghara Camp (shown in the photo on the next page). It was important for CARE and the TWiG to understand the impact of these two different solutions, the new one (the concrete block shelters) and the old one (tents). Focus group discussions (FGDs) with groups of IDPs living in different types of shelter revealed significant improvements in experiences and feelings of privacy, safety, security, health and hygiene for IDPs in the 'durable shelter solution' rather than tents. People living in the concrete block shelters with solid walls, lockable doors and WCs/bathrooms and areas for cooking also found family relationships easier to manage. We therefore suspect that these concrete block houses have a positive impact on overall health and on the mental health and well-being of the IDPs.

Even after learning from these FGDs about the impacts of living conditions on people's lives, there is still a gap in connecting the shelter intervention with mental health. It is hard for Shelter and WaSH practitioners to know how to approach an individual and ask them about their mental state. Many people are unwilling to speak of these things, especially to strangers. We could tell from interviews, and from the FGDs that there is a lot of depression, a lot of anxiety. What are the indications and indicators that I need to use as a shelter actor to identify mental health issues? How can we use this knowledge as shelter practitioners? At the moment, we recognise the contribution that more dignified shelter can have on well-being, yet we need to be able to evidence this more confidently.

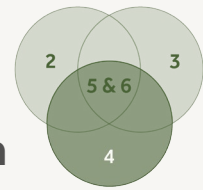


© CARE Turkey Cross Border, Zoghara
Camp, Jarablous, May 2021

The Shelter and Settlements sector does not commonly use mental health outcomes as reportable objectives of their shelter programming. The sector uses the language of safety, privacy and dignity and sometimes health and general well-being, but mental health in programme design and in assessments is not typically or widely used. Well-being itself is also often ill-defined. These issues were discussed further during the learning event and are addressed in [Chapter 5](#).

CHAPTER 4

Shelter and Settlements activities and mental health



The wider impacts of shelter assistance

In addition to the intersections between living conditions and physical and mental health, another aspect of the learning event was to examine ways in which the approach to humanitarian shelter assistance relates to mental health and psychosocial well-being, bearing in mind the very varied contexts in which shelter programmes operate. In conflict settings, protection is a priority. After disasters, rebuilding, or 'building back better' for resilience to future shocks, may be foregrounded. Similarly, within the different phases of humanitarian assistance attention to mental health may be prioritised to varying degrees. Emergency lifesaving assistance, involving distributions of non-food-items (NFIs) like tents, tarpaulins and cooking sets, forms the majority of shelter responses and is very different from recovery and preparedness interventions, which may even have developmental aspirations. One participant at the learning event stressed the time and funding barriers to engaging in any types of assistance beyond emergency distributions:

“

It's not lifesaving, so we don't do it

”

The potential for Shelter assistance to have much wider impacts beyond the provision of basic protection from the elements is well known and widely discussed in the sector (see, for example, InterAction, 2020). The characteristics of an approach to Shelter and Settlements assistance which gives priority to human dignity and well-being was articulated by Miriam Lopez-Villegas, from the Norwegian Refugee Council, during the third main session of the learning event, as she reflected on the relationships between Shelter assistance approaches, recovery and well-being.

Homes, Communities and Mental Health

Miriam Lopez-Villegas, Global Shelter and Settlements Specialist, Norwegian Refugee Council

Being forced to flee means losing one's home; it is more than just losing a building. The immediate impact is the loss of protection against the elements, but also the incremental loss or compromise of privacy and sense of dignity as well as being cut off from employment opportunities, health-care services, schools and other community facilities and social networks; being separated from loved ones, the also incremental loss or compromise of the expression of cultural identity and the loss of the sense of belonging. As humanitarians, our mandate is to provide lifesaving emergency shelter, though often a first-line response is insufficient. Particularly as our assistance often goes beyond the first days or weeks of displacement and becomes a housing solution. Why do we emphasise enabling the functional improvement of the dwelling? We do this because the process contributes to a sense of normalcy; by creating a home, families strengthen their resilience and improve their chances of recovery.

People often start homemaking practices (including aesthetic and functional upgrades or modifications) from the very start of displacement. This varies across generations, geographies and cultures and the experience is different for a refugee who is born in a camp to someone who has been displaced as an adult. Yet, the value of home and of belonging is very relatable across cultures. Dignity is intrinsic, and is a constant that all people possess simply by virtue of their humanity. So, we have to ask ourselves, what can we do to increase the sense of belonging and promote respect for people's inherent dignity? We know that we come with bias and our own ideas and understandings and it is very clear that we do not provide dignity. But what we can do is provide assistance with dignity. We can encourage programmes that respectfully address and honour the fact that everyone has dignity. We must acknowledge that the concepts and language we use and the way we design programmes matter and have a direct impact on mental health and well-being. Humans are extremely resilient, and we should define our assistance based on minimum standards of what is needed to recover with dignity, not based on what people can endure.

Not only conflict, disasters and displacement have long-lasting impacts, so does the fear from everyday experiences such as evictions. Being evicted could be a potential death sentence, as emphasised by **Leilani Farha, former Special Rapporteur on Adequate Housing**. The vulnerability of being homeless is now even more clear to us since COVID-19. Evictions can be an individual, family or community issue, can affect anyone, and in this time of pandemic, this is a crucial concern that we can address. Eviction threats have increased across rental price brackets and in varied settings, from among people staying in unfinished buildings or in tented settlements. When we respond to emergencies, are we consistently responding to this vulnerability, fear, the worry of being evicted?

These photos are from Haiti and still today, portray one of my most important professional achievements. Looking around Jacmel and Lamontagne, we could see colour was essential in helping families recover a home like the one they lost in the earthquake. Further, offering only two colours and deciding by ourselves was not enough. There was an initial hesitation as this could become a procurement and warehousing nightmare, but between our community mobilizers and logistics colleagues, we managed. Each family could choose up to three colours among sixteen or so options and the combinations different people selected were at times very surprising! It quickly became apparent how necessary paint was for the well-being of their recovery. Even the very last brush of paint was used to paint one last wooden chair leg. I realised this is what cultural adequacy looks like: paint is not a luxury, it is essential, it is precious.



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This is why we must understand the wider impact that our shelter assistance has on helping families recover, to build connections and to cope together. We know that adequate housing protects our health, we know that there are specific connections with the quality of the floor and the roof with health issues such as diarrheal and respiratory diseases. We know that stress related to the home can affect both children and adults and is connected to privacy, safety, protection, and stability. I cannot imagine something more stressful or anxiety-inducing than being a teenage girl sleeping on the shoulder of a highway in Venezuela or in Herat. Privacy is often gender-related too: in Jalalabad across eight districts about 50% of women said they did not have privacy in their toilets, compared to the male perception of only 4%. A private place for women and girls to manage their menstrual hygiene is essential for well-being and mental health. At this stage, it must be clear to all of us that a shelter without access to water and sanitation, is not a shelter, it is a shed. The connections are clear, but now we need to take the next step. Simply put, when someone leaves their home behind, it means they are constantly fighting against living in fear. We are ready to make a case as humanitarians and partner agencies - through coordinated action, that our assistance can contribute to better mental health and psychosocial well-being.

We know that there are organizations providing support to people experiencing trauma. We are not claiming to have this expertise, but recognise our unique position to be able to contribute to this; adequate housing can provide a personal space to heal, to heal at an individual, household, family and community level. Increasingly, we talk about an inter-agency working group. We know more and more that there is interest to implement a coordinated and effective mental health response. Pulling together the experience of this forum, we can make a strong case for shelter supporting mental health. Our interventions matter and now we have a clearer understanding on the elements we have to work together.

The principles of the **Right to Adequate Housing**: security of tenure, affordability, habitability, availability of services, materials, facilities and infrastructure, accessibility, location and cultural adequacy also offer a framework to articulate what 'adequate shelter' in different phases of humanitarian crisis might look like. This is explored further in the 2019-2020 edition of **Shelter Projects**, in a multi-agency 'opinion piece' entitled *All The Ways Home: A proposition for the Shelter & Settlements sector to embrace Homes & Communities*. Related aspects of Shelter and Settlements programming relevant to mental health and well-being were discussed during the Learning Event.

Housing, home, homemaking and recovery

There are strong connections between crisis, displacement, losing a home and mental health. Housing and feelings of home and identity are closely related. Recovery of housing has a role to play in the overall process of recovery from disaster, and onwards into preparedness and resilience to future shocks. Even in displacement, homemaking practices (see for example Brun, 2012) can be very important for people's mental well-being. Homemaking practices include decoration, planting flowers and vegetables and making spaces to host guests. Hart, Paszkiewicz and Albadra (2018) similarly highlight the actions and aspirations of Syrian refugee camp residents in Jordan to "imbue their dwellings with a sense of home". There can, however, be humanitarian barriers to those homemaking practices, as documented by Verderber (2008) after Hurricane Katrina in the USA. Trailers used by the Federal Emergency Management Agency (FEMA) as emergency shelters were linked to adverse health outcomes including severe chronic depression. However, the 'recipients' of these temporary 'homes' were threatened with legal action if they attempted to personalise their trailers. Humanitarian shelter assistance which recognises the ways in which people's emergency and recovery 'shelters' are, at least temporary, homes, and supports rather than hinders their homemaking practices will also promote mental well-being. The importance of paint, planting, verandas for hosting guests and other aesthetic improvements to even temporary homes was brought up by many participants of the learning event, who expressed frustration at frequently being unable to fund such simple interventions.

Settlement community spaces beyond people's immediate family living spaces are also important to their mental well-being and broader social cohesion. Rahman (2019) explored how women's prayer spaces (Taleem) are a site of identity, home and belonging for Rohingya refugees in Bangladesh. Many participants at the learning day highlighted the importance of green spaces, yet also the barriers for their inclusion in programming. Trees, in particular, can be seen as too permanent for host governments to sanction in some displacement settings, despite their role in flood mitigation and in the well-being of residents.

Housing, land and property

Participants at the learning event added that disasters and particularly conflicts have a longer lasting impact beyond the immediate destruction of homes and infrastructure. Housing, land and property (HLP) issues around equitable access to land, space and housing, are crucial aspects of Shelter and Settlement programmes and a focus of immediate and longer-term stress, often particularly acute for female heads of households. Related to that, tenure insecurity is a particular stressor post-emergency. Rental support programmes and other HLP interventions may also have benefits on mental well-being.

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Access to shelter and tenure security is a foundation for feeling confident to tackle other challenges in your life.

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The refusal or discrimination of affected people also determines mental health throughout displacement and pushes refugees and IDPs to live in substandard conditions. Frequently, displaced people cannot rent, and are pushed to ghettos in the most dangerous neighborhoods or buildings where they face problems with privacy, safety, security and hygiene.

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External organizations can help, accompanying individuals looking for a place to rent and advocating for protection of tenure. With regard to discrimination, it is critical to involve host communities and work with them to overcome fears and reservations against the the displaced or other minorities.

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Protection

One of the Shelter and Settlement sector's primary roles is providing emergency shelter to protect people from the elements and from harm. Yet in many post disaster and conflict settings, people do not feel protected by their housing. Particularly for women and girls, security, privacy and access to safe facilities (toilets, washing facilities) can be inadequate in such settings. These inadequacies cause mental distress as well as physical ill health. Unsafe settlement layout and the necessity of (often women and girls) collecting water and fuel, can add additional fears and harm. Humanitarian action that improves security and privacy can also improve mental well-being and mitigate gender inequities. Joseph Ashmore from the International Organization for Migration (IOM) joined the learning event to explain how gender-based violence risks can be mitigated through thoughtful Shelter and Settlements programming.

Mitigating Gender-Based Violence through Shelter and Settlements Programming

Joseph Ashmore, Shelter and Settlements Specialist, IOM

Gender-based violence is clearly linked with shelter. It can take many forms. One notable example is physical harm, including domestic violence or abuse, which can increase for people living in and sharing inadequate and overcrowded shelters. Another form of gender-based violence is exclusion: people can be excluded from accessing assistance on account of their gender. Another example is fear attributed to threats and coercion related to poor site planning, and also issues related to poorly implemented distributions. Sexual exploitation and abuse must also not be forgotten and can have clear links to humanitarian assistance. It is clear that gender-based violence in all its forms is linked to physical and mental health of individuals, families and communities and therefore shelter practitioners must be more aware of best practices to mitigate gender-based violence. Shelter responses should safeguard the health, security, privacy and dignity of affected people. If gender-based violence is ignored, then responses are not inclusive and agencies will not be fulfilling their mandate. Shelter is life saving, though we struggle to prove it; we need to be better equipped with the language to explain the positive impact shelter has on mental health.

Over recent years IOM, along with other implementing agencies, has been trying to understand what shelter practitioners can do to address gender-based violence issues, looking closely at where the pressure points are in programming. Traditional approaches such as putting locks on doors probably won't make much difference because a lot of gender-based violence is related to domestic violence and people known to the survivors. It requires a further analysis of the processes, particularly the process of accessing assistance and how that assistance is provided. For instance, hiring women on your team, ensuring your team understands the issues and can respond appropriately in challenging contexts. The majority of shelter assistance is based around distribution. Even if housing materials are being provided, shelter practitioners must ensure distributions are planned and carried out using a gender lens and do not inadvertently increase the likelihood of any form of gender-based violence.

The key to being able to have any kind of recovery after trauma is probably having a place to call home. If you live in temporary, unsafe and inadequate shelter, it is very hard to recover from disaster and displacement. IOM are looking at these issues in relation to site planning and density, working as we do in settings where achieving permanent housing is problematic, if not impossible. When we think about gender-based violence and gender-based rights approaches, we may talk about rights, but in fact, we are responding to an identified need on the ground. The common thread between rights- and needs-based approaches is that all seek to safeguard health, security, privacy and dignity, certainly in emergency responses. IOM has developed tools outlining what staff need to know and developed training, particularly focusing on distributions and how people access assistance and how this assistance is being conducted, this being one of the key ways in which shelter practitioners can reduce gender-based violence risks and the subsequent impacts on mental health.

[Online class on responding to gender-based violence disclosures](#)

[Video on distributions of non-food items \(NFIs\) in shelter responses](#)

[Online class on good shelter distributions](#)

Participation - going further

The psychosocial aspects of housing loss (and recovery) can be overlooked by technical shelter and housing experts. Few et al. (2021, page 14) point out that community participation and co-production of humanitarian interventions can be key to effective and inclusive housing-based recovery:

Officials collecting data on disaster impacts, for example, tend to record tangible impacts - loss of housing, damage to hard infrastructure such as roads and power supplies, and measurable economic indicators. Much less monitoring and reporting attention is given to intangible impacts such as trauma, loss of social networks, detachment from a secure sense of home, and loss of local cultural heritage. Partly as a consequence of this, psychosocial dimensions are often overlooked in representations of disaster affected people and their needs.

This is not new. 'Participation' is already a principle of all humanitarian action (Sphere Association, 2018). Indeed the importance of participation for well-being and 'community spirit' was stressed in the 2007 IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, Action Sheet 10.1 (page 95):

The participation of people affected by an emergency in decisions regarding shelter and site planning reduces the helplessness seen in many camps or shelter areas, promotes people's well-being, and helps to ensure that all family members have access to culturally appropriate shelter. The engagement of women in the planning and design of emergency and interim shelters is vital to ensure attention to gender needs, privacy and protection. The participation of displaced people also promotes self reliance, builds community spirit and encourages local management of facilities and infrastructure.

However, participants at the Learning Event repeatedly opined that 'real' participation is still not the norm in Shelter and Settlements activities, citing multiple challenges but also advantages of truly including the people affected by humanitarian crises in all aspects of decision-making.

Asking and listening

Good Shelter and Settlement programming can contribute to mental health and psychosocial well-being, and indeed, programming that has more of a settlement and community focus than the shelters/houses themselves can also respond to community priorities and have a positive impact on social cohesion. Reihaneh Mozaffari and Miriam Lopez-Villegas of the Norwegian Refugee Council (NRC) presented a case study from Nigeria to reflect on some tensions between adhering to minimum standards and incorporating voices of participants in good shelter programming. The benefits of dialogue and taking the time to integrate community priorities in shelter programming were described.

Shelter and Settlement Programming and Mental Health in Practice

Reihaneh Mozaffari, Shelter Specialist, NRC Nigeria with Miriam Lopez-Villegas, Global Shelter and Settlements Specialist, NRC

Two of NRC's shelter projects in North-East Nigeria demonstrate ways in which widening our focus from prioritising protection from the elements to broader measures of success can enhance the impacts of programming. While safe and dignified shelter is our constant objective, we have come to understand that setting standard indicators is a way to ensure we provide services of an acceptable quality. Standards are an expression of our humanitarian principles of humanity and impartiality and that no person should receive less than what is needed, even if the conditions were not conducive to engage in meaningful consultation. We have a role to ensure rights are respected and the provision of sufficient assistance is not compromised by the context (regardless of budgets or politics). We have also come to understand the comparable value of listening, paying attention to local cultural norms, improving privacy and people's sense of safety, which in turn directly contribute to mental health, especially for women and children.



Half of the population in North-East Nigeria in the states of Borno, Adamawa and Yobe are in need of some form of humanitarian assistance. Approximately two million people are displaced and there are more than one million returnees. This is a long-term displacement setting due to 12 years of conflict yet we are responding mainly with what would be considered as an emergency response. Some people live in overcrowded makeshift shelters, others in tents and upgraded timber-frame structures like the ones pictured in a camp for newly displaced people. We design our programmes to intervene following settlement and shelter standards, in terms of site planning and in terms of shelter space. Once we were also asked to help 60 women who had spontaneously settled in a warehouse. Conditions were crowded, dark and there was an almost total lack of privacy - all detrimental to both physical and mental health.

*Tackling these living conditions created a dilemma for NRC colleagues in the field who needed to adhere to the Sphere Standards of 3.5 square metres of space per person. We discussed it with the donor and realised we could still meet our overall target indicator of 80-90% of people with sufficient space, although lower than the almost 100% we usually meet, and still improve the living conditions of these women. We consulted the women with our initial plan to partition the warehouse. They expressed a preference for privacy for family groups over space per person, so we came up with a new layout that enabled spaces for different sized households, overall giving 3 m² per person, a little lower than Sphere Standards. After listening to their priorities, the team got back to the drafting board and returned with a new suggested layout. We showed the women this plan and there were very positive reactions from the beneficiaries; the 60 women were clapping for us and it was very emotional. **They were really touched by the fact that we went twice to discuss the plans with them and we really tried to implement what they wanted. To participate and to be listened to was the key for them.***

We painted the partitioned warehouse inside and out and replaced some of the roof panels with transparent plastic to lighten the space and make it less depressing. While we strive to meet minimum standards, this compromise was acceptable because the solution was designed with the women who were living in this space, they had a choice and the opportunity to have a say in the decisions that impacted their daily life. Even before the partitions were up, they could have a sense of some improvement in their living conditions, they knew this was better for their mental health, and this should be our priority.

Similarly, the success of transitional shelter projects in two more relatively secure and stable areas in North-East Nigeria also relied on listening to participants and respecting local housing typologies, cultural norms and women's sense of safety. Local houses built of mud bricks tend to have two rooms, with two doors and windows, either with gable or hip roofs depending on the area. The NRC prototype was designed in a similar fashion, although we wanted to move the position of the windows from the front to the side or rear walls to allow for better ventilation and improved structural safety. In focus group discussions with men and women separately, the men were happy to accept our suggested design. However, the women wanted all the openings to remain on one side which allowed them to sleep feeling secure. Whilst our intention was to provide cross ventilation in such an environment, we needed to listen and take into account the women's priority, even if the actual threat of someone entering into a shelter is the same regardless of the position of the window. We wanted to provide a place they could make their own, where family life and a good rest would be enabled. We have a mandate to do no harm and make sure the structures are resistant - in this case the design was solid enough, so we could accommodate the women's request and recognised how important this design was for their mental health and well-being. What we are learning through these discussions is that promoting good mental health and preventing the deterioration of mental health is to a good extent up to how we deliver assistance. **These two projects in Nigeria confirm that we are in a great position to provide psychosocial support, only by listening.**



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© Norwegian Refugee Council, Nigeria

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Even if concepts such as 'home' and 'well-being' are difficult to define...it is always important to ask and listen and we might find out valuable information in the process of shelter and settlement interventions.

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Empowering communities, diversifying outputs

This Philippines recovery project managed by Cordaid following Typhoon Haiyan, demonstrates the unique pathways communities can steer when they have greater agency over their own context analysis, decision making and project management. Amongst a diversity of project activities this even led organically to community developed project activities that sought to address community identified social cohesion issues in a post-disaster context.

Community prioritised, community-led interventions

James Morgan, Shelter Advisor, CARE International UK (Former Program Manager, Cordaid)

In this post-disaster programme communities were supported to carry out a community-led risk assessment that explored hazards, vulnerabilities and capacities in order to identify capacity gaps that could be addressed through community-identified project proposals. These proposals were then individually budgeted by engineers and then this information was fed into a village-level budgeting exercise empowering the communities to make financially informed choices about which projects to spend their village-level funds on. Communities then managed and implemented their own projects via a structured cash transfer approach. Every community had a different set of priorities reflecting their different contexts and this was echoed in the choice of projects they would each 'green light'.



The community of Buena Vista prioritised rebuilding their boat landing. It was a relatively expensive project that used most of their budget and one that other communities had eschewed for different priorities. However, for the coastal community, the boat landing had always been a vital livelihood platform to facilitate trade with passing fishermen. Other communities would use their budget to fund multiple projects, building resilience and strengthening DRR in different ways: watershed management projects in one remote island context; evacuation bridges in another village that suffered from flash flooding; a community hall in another community that had lost their hall during the typhoon. Each community program took on their own character, reflecting the agency made possible through a community empowering approach.



In another community, Banuan Daan, the community members prioritised a series of social and infrastructure programs aimed at bringing together the disparate migrant and indigenous populations living side-by-side who often found themselves in conflict. This led to the unusual proposal of one particular project looking to renovate a basketball court located midway between the two communities (to Filipinos, basketball courts are an incredibly important social space in every community). At first the humanitarian organisation questioned the eligibility of this particular proposal however the community made a strong case, using their capacity gap mapping exercise and putting together a justification on how a program of basketball social events could bring the communities together and build social capital to help prepare for the next disaster. Ultimately all parties agreed and the communities proceeded to rehabilitate the court (which in the end was a rather low cost intervention) and run a series of tournaments where the two communities both played each other and combined forces to play alongside each other. This is an example of the interesting places Shelter and Settlements programs can lead to if practitioners embrace a truly community-empowering approach.

Supporting self-recovery

The mapping of assets, capacities and strengths of communities should be part of Shelter and Settlements programming from the onset and these should be incorporated in implementation. An approach to shelter assistance that very deliberately puts community priorities and agency at the centre of a response was described by Bill Flinn, using an example of a 'supporting self-recovery' approach by CARE International in the Philippines and Vanuatu.

How supporting self-recovery can turn participation on its head

Bill Flinn, Shelter Advisor, CARE International UK

*The overwhelming majority of houses destroyed by earthquakes, storms and floods, around 90%, are rebuilt by the families and communities themselves. They are the first responders. This process is called shelter self-recovery. Proponents of a 'supporting self-recovery' approach to Shelter and Settlements assistance point to the centrality of the plans and priorities of affected communities in determining their own recovery pathways. This encourages the foundational importance of a home as a cornerstone to recovery of livelihoods, security and safety. At CARE, we would argue that this focus on the agency and priorities of the affected population also contributes to their physical and mental health and well-being - and exploring this is part of the remit of the **Self-recovery from Humanitarian Crisis research project**.*



This approach to humanitarian shelter assistance is also relevant in the aftermath of other crises, although to date the sector has less experience of implementing 'supporting self-recovery' projects in conflict or protracted displacement settings. Indeed, this approach, sometimes considered an ethos, that holds people's priority and agency at the centre, can be appropriate across all Shelter and Settlement response modalities, in a diversity of contexts.

National and international organisations can be effective participants in this process, adding value directly by providing cash, technical information and material support as needed, and also indirectly through support such as infrastructure repair, access to markets and advocacy for secure tenure. It is a process not so much of implementation as facilitation and accompaniment. Rather than asking for a high level of participation from the community, a self-recovery approach turns this on its head: it is the humanitarians who are participating in the community's recovery plans.

CARE Philippines and local partners worked together with communities in the aftermath of Typhoon Haiyan to build 16,000 homes; each unique home was tailored by the family to meet their needs and priorities. Some incorporated a shop or other spaces to support livelihoods. CARE Philippines trained 'roving shelter teams' who provided technical support for local community members. Vulnerable people were given additional practical and financial support. In recognition of this self-recovery approach, CARE Philippines was awarded the **2017 Global South World Habitat Award**.

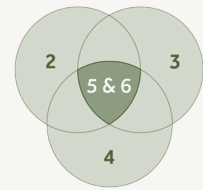
By integrating local traditional knowledge with technical knowledge from the humanitarian sector, communities can build back safer and healthier homes, also improving their resilience to all forms of hazards. Disasters continue to destroy millions of homes due to failures to redress vulnerabilities. In the aftermath of most disasters, materials, labour and funding are in short supply. Small island states have vulnerability and resilience to disasters including those involving tropical cyclones. In Vanuatu, CARE has successfully developed a supporting self-recovery model following three devastating disasters since 2013. Following Tropical Cyclone Harold in 2020, CARE Vanuatu worked with communities on the island of Pentecost to train local leaders on safe shelter reconstruction and delivered chainsaw training so people had the necessary tools to source sustainable building materials.

A video showcases CARE Vanuatu's Cyclone Harold response. Interestingly, Vanuatu includes indicators of well-being and happiness in its national development statistics. See the **Vanuatu National Statistics Office 2019-2020 baseline survey**.



CHAPTER 5

An 'MHPSS approach' for Shelter and Settlements?



Bearing in mind the constraints on aspects of humanitarian, specifically Shelter and Settlements, programming, a wider focus on mental health and well-being can be possible in any phase of response. Adopting an MHPSS approach consists of providing a humanitarian response in ways that are beneficial to mental health and psychosocial well-being. It does not necessarily mean that humanitarian actors should do different things; rather that they do things differently (Horn, 2016). This is distinct from MHPSS interventions, which consist of activities with the explicit goal of improving the mental health and psychosocial well-being of people affected by crisis. MHPSS interventions are usually implemented by Health, Protection and Education actors. Shelter actors can adopt an MHPSS approach without the need for additional expertise or even capacity.

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If mental health and well-being were to become a target of programming, shelter improvements may be the route, the tool to get there.

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Surely that's just 'good shelter programming'?

As noted above in [Chapter 1](#), the Shelter sector already follows recognised principles of good practice, as well as the Sphere standards (Sphere Association, 2018). [Shelter Project Essentials](#), published in 2021 by IOM on behalf of the Global Shelter Cluster, usefully summarises 12 recurring messages distilled from over 250 case studies. Following these messages is a key aspect of 'good shelter programming'. Activities such as ensuring appropriate site planning in camps are already accepted as part of good programming. This is done for many reasons: social cohesion may be one, also access to services, safety (e.g. regarding floods, fire, spread of physical diseases), and the mitigation of gender based violence risks. Possibilities and priorities change over time and, ideally, site planning is revisited after the first emergency phase and communities are consulted and involved in changes. Other examples of good shelter programming are the use of cash or rental support. Such activities are not currently articulated as being relevant to mental health. A point for discussion at the learning event was how much a focus on mental health and psychosocial well-being requires specific interventions by shelter practitioners and how much happens as a by-product of 'normal' good shelter programming.

Rebecca Horn, an MHPSS practitioner and researcher, explained how good shelter programming already contributes to affected populations' mental health and psychosocial well-being and explored what else can be added.

Supporting mental health and well-being through Shelter and Settlements: the how.

Rebecca Horn, independent psychosocial specialist and Senior Research Fellow, Institute for Global Health and Development, Queen Margaret University, Edinburgh

Services that are accessed by the whole population, or by sections of a population, have a key role to play in promoting good mental health and psychosocial well-being, and preventing mental health problems from occurring in populations affected by adversity. This includes services like water and sanitation, shelter, clinics, hospitals, education and food provision. These basic services in themselves promote good mental health and they can do so even more by making some small changes to the ways in which those services are provided.

There are **six core principles of MHPSS programming**, which apply to all sectors. They can help to guide those providing basic services in integrating MHPSS considerations into their programmes. Already, we know that many shelter providers are integrating four of these core principles into their work:

- Participation
- Building on available resources and capacities
- Do no harm
- Human rights and equity

Participation & building on available resources and capacities

Strengthening the participation of affected community members in decisions that affect their lives is something that shelter providers already do in many settings, and this in itself has a positive effect on mental health and psychosocial well-being of those involved, and the wider community. When service providers bring people together and involve them in decision making and implementation, there is not only a positive impact on their psychosocial well-being but it contributes to their recovery from distressing events and potentially prevents some people from going on to develop mental health problems. It is a right, of course, for people to have an input into decisions that affect them, but from a mental health and psychosocial perspective it is also a means of regaining a sense of control in the midst of what might be overwhelming experiences.

Involving the affected communities in decision making and implementation contributes to self-efficacy and community efficacy, which also plays a crucial role in recovery from distressing events. We know that even in the most difficult situations communities do have strengths, resources and capacities that can be identified, engaged and developed. When a sense of self-efficacy of individuals and community efficacy is activated, this facilitates the process of recovery. Participation also contributes to strengthening social connections, which is really key to promoting mental health and psychosocial well-being.

Do no harm

Shelter services already contribute to a sense of safety through providing safe housing and safe environments, but the process by which this is done can also contribute to reducing tensions within a community. This involves being aware of existing tensions or divisions, and making sure that processes and decisions do not unintentionally exacerbate these. Involving the affected community in decision-making will reduce the likelihood of activities having unintentional negative effects.

Human rights & equity

This core principle is about making sure that everyone within a community has a voice, has access and is involved in the decisions that affect their lives. It involves identifying those people who might be marginalised or have different needs to others in the population, and making sure that their voices are heard and they are able to access services. It is also about making sure that services are designed in such a way as to prevent human rights abuses; protection issues are also integrated here. The efforts made by shelter providers to ensure that buildings and environments are suitable for those with different physical, social and psychological needs contributes to the mental health and psychosocial well-being of those groups, and of the community as a whole.

When shelter providers make sure that their programmes have these principles integrated within them, they are already contributing to the mental health and psychosocial well-being of the population they are serving. Integrating MHPSS is about the way in which services are provided, and builds on what is already good practice within the Shelter and Settlements sector. However, if a particular shelter initiative has the capacity to do more, then there are elements that could be added to the standard shelter programme.

Whilst we know that the majority of a population affected by an emergency will recover emotionally and psychologically over time, as long as basic services and security are provided in the ways already described, and they have access to social support networks, there will always be a small proportion of people in a community who experience more severe distress. Of course, it is not within the mandate of shelter actors to offer support to those people, but they are in a good position to identify them because in the course of their work they are in the communities, engaging with a wide range of people. It is relatively rare for people with high levels of distress to seek out mental health support spontaneously, it often takes another person to help them to do so. Staff and volunteers associated with a shelter project are in a great position to do this. It would involve staff and volunteers who work within communities ideally being trained to recognise the signs of distress, to know how to approach them in a helpful way and have a conversation, find out whether the person would like to receive more support, and know how and where to refer them. That is something that everybody working in a humanitarian setting can do, to enable those who are struggling to cope to access the services that they need.

There are resources available to support those with no MHPSS background to acquire these skills: particularly [Psychological First Aid resources](#) and [Basic Psychosocial Skills for COVID-19 Responders](#)

Inclusion of persons with psychosocial disabilities

One specific aspect of good Shelter and Settlements programming is the inclusion of all people, regardless of gender, age, marital status, health, ethnicity, religion, socio-economic status, sexual orientation or disability. One of the working groups of the Global Shelter Cluster is concerned with the [inclusion of persons with disabilities](#). At the time of writing (July 2021), the working group was in the process of reviewing and updating the [‘All Under One Roof: Disability inclusive shelter and settlements in emergencies’ guidelines](#). These guidelines were developed in 2015 to support more inclusive programming. Members of the working group reflected at the learning event that perhaps insufficient consideration has previously been given to those with psychosocial disabilities, as the guidelines focus predominantly on physical and sensory disabilities. The update will try to take into account a wider understanding of disability in general and include links to further support for psychosocial disabilities.

Ben Adams, from CBM Global, joined the learning event to explain how inclusion of people with all disabilities in shelter programmes is important for well-being.

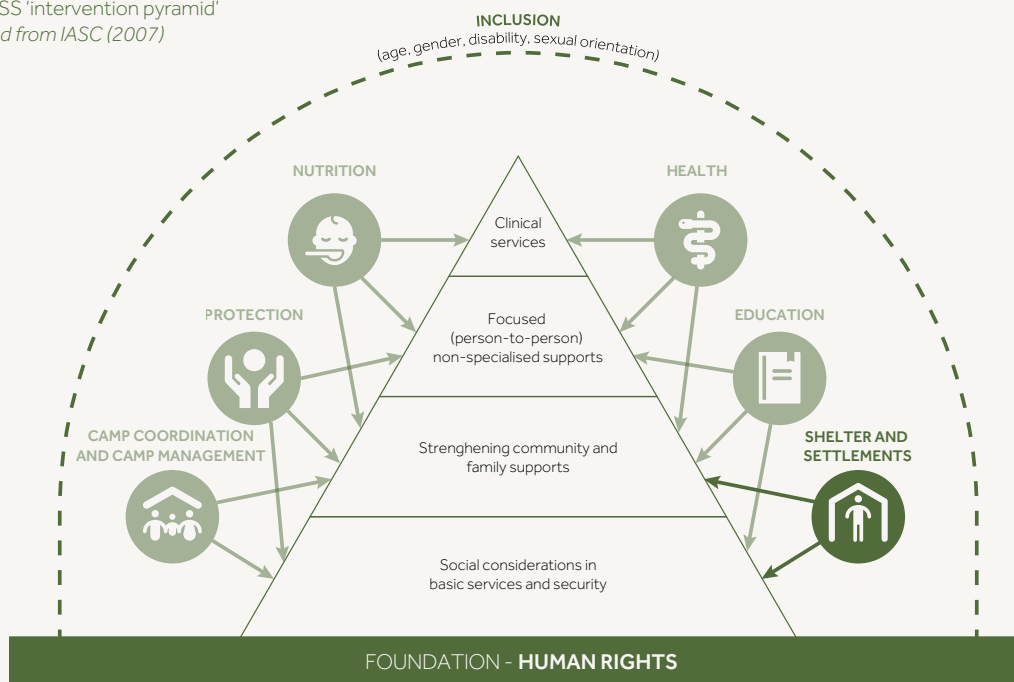
Disability Inclusion, MHPSS and Shelter

Ben Adams, Senior Mental Health Advisor, CBM Global

The MHPSS ‘intervention pyramid’ (see next page), with basic services and security at the bottom and specialized services for people with severe mental health difficulties at the top, allows us to explore what contributes to mental health and psychosocial well-being either positively or negatively. When designing and delivering humanitarian preparedness, response and recovery programmes we must consider the things that impact how people feel and our general well-being on a daily basis - primarily what we are referring to here are social and environmental determinants of mental health. Many of us take things like having a home, a shelter, for granted but we must consider how we would feel and even survive without this safety and security and the impact that would have on our psychological well-being. Here we can see that MHPSS is cross-cutting and that shelter and MHPSS are intrinsically linked.

This means that humanitarian actors must take a cross-sectoral holistic approach that considers the myriad of factors that contribute to people’s well-being and psychological health. Such an approach needs to have human rights at its foundation and it must be inclusive, leaving no one behind. All people with any type of disability must be included in all humanitarian action. As we know, disability arises when someone interacts with a social environment that presents barriers to their equality with others. It encompasses all persons, regardless of their own identification or diagnosis of a specific condition, who face barriers in exercising their rights to equality with others and to full and equal participation on the basis of an actual or perceived impairment.

Figure 4: MHPSS 'intervention pyramid'
 Source: Adapted from IASC (2007)



Psychosocial disability is not about a diagnosis but it is about the functional impacts and barriers which might be faced by someone with lived experience of mental health or psychosocial difficulty. Psychosocial disability can restrict a person's ability to be in certain environments, to concentrate, to complete tasks and activities of daily living, to interact with others or to manage stress. Here you can really see the impact that shelter and settlement can and do have on people with mental health difficulties and/or psychosocial disabilities, hence the importance of an inclusive cross-sectoral humanitarian response.

The interplay between mental health and disability is multifaceted; people with mental health difficulties may identify as having a psychosocial disability. People with other types of disabilities are more likely to develop mental health or psychosocial difficulties, especially in humanitarian contexts, than the rest of the population. This relationship between mental health and disability should be a key consideration in the design and delivery of inclusive humanitarian responses such as MHPSS and Shelter. To facilitate an inclusive response, we must ensure the participation of people with disabilities at all stages, remembering that accessibility and participation are precursors for inclusion. People with all disabilities must be included in designing, delivering and evaluating all humanitarian preparedness, response and recovery programmes across all sectors.

Doing more and doing better: the first steps towards an MHPSS approach

Recognising and addressing the connections between good shelter programming and mental health and well-being is an important stage of implementing an MHPSS approach. Melissa Tucker and Jamie Richardson of Catholic Relief Services (CRS) led the participants in the learning event to reflect on what integrating MHPSS and Shelter and Settlements activities might look like in practice.

Integrating MHPSS and Shelter and Settlements - what does that look like in practice? Reflections from CRS

Jamie Richardson, Shelter and Settlements Technical Advisor, CRS
Melissa Tucker, Psychosocial Support Technical Advisor, CRS

The familiar **'intervention pyramid'** shows the multi-layered support that we hope to see in MHPSS responses. The foundation layer of the pyramid indicates the basic services and security which can underpin or undermine people's mental health and well-being. Humanitarian sectors that deliver those basic services, such as Shelter and Settlements, have a responsibility to do that in a way that promotes mental health and well-being. The 2007 IASC Guidelines suggest that humanitarian actors should document the impact they have on mental health and psychosocial well-being. What might that look like in practice?

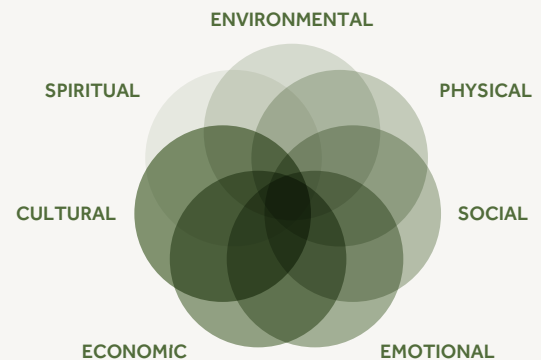


Figure 5: Overlapping aspects and dimensions of well-being
 Source: Adapted from CRS

There are many aspects, or domains, that contribute to well-being, including spiritual, environmental, physical, cultural, social, economic and emotional well-being at individual and community levels. Domains of well-being may also vary from culture to culture, and documenting impacts of Shelter and Settlement activities is not necessarily easy. The **MHPSS framework** addresses some of these domains. The same IASC Guidelines that define this framework also define mental health as a state where individuals realise their own potential and can cope with normal stresses of life and work productively and are able to contribute to their own community. The psychosocial side of MHPSS brings the social community and the interpersonal aspects of life together with the psychological, emotional and behavioural aspects. This can sound like a lot to potentially look at if we are going to try to understand, and document, how we are impacting mental health and psychosocial well-being through shelter programming. To tease this out, the example of a joint CRS, Caritas and UNHCR project to deliver site and shelter upgrades in Kutupalong Refugee Camp, Bangladesh in 2018 is instructive. **This project** piloted a rapid participatory approach in the response within the emergency phase of the Rohingya crisis. The project was designed to test the hypothesis that participatory approaches to improve settlement and shelter conditions, that utilize the skills and capacity within the community, would contribute to greater community cohesion and resilience to future shocks.

Inadvertently, we started looking at mental health and well-being as indicators of the impact of this shelter project, which had two core ideas; to improve living conditions and reduce risk from flooding and landslides and to enhance social cohesion and community capacity. Key informant interviews, focus group discussions, household surveys and individual interviews were conducted with project participants and also with a control group outside the project in an adjacent area of the camp. When we thought through the indicators for social cohesion and community strengthening, we realised that they depended on dialogue with people, asking questions about their community connections and social support mechanisms. We also asked whether people felt anxious and whether they felt safe. The data analysis showed that, perhaps unsurprisingly, the participatory approach to the process of site and shelter upgrades was associated with greater community cohesion and social well-being. Participants reported feeling safer and less anxious compared with the control group. If we were to repeat this study, we would more purposefully draw out the mental health and psychosocial aspects, right from the start.

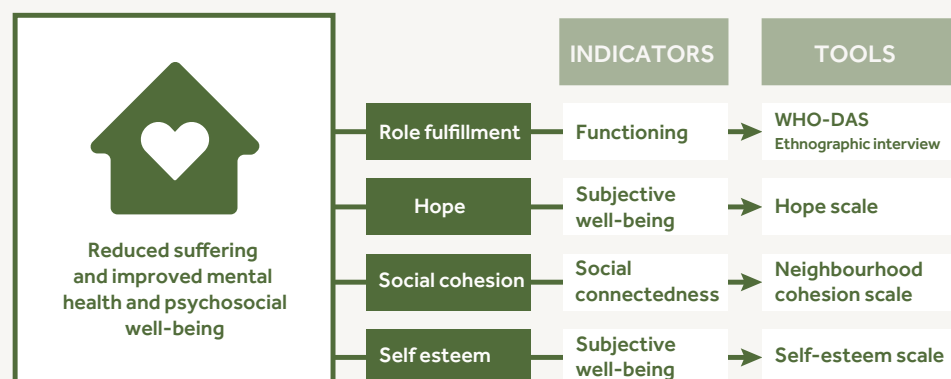


Figure 6: How do we evidence the impacts of S&S activities on mental health and well-being?
 Source: Adapted from CRS

Looking forward, we can be more intentional about how we document the social impacts and hopefully the long-term impacts of applying a real participatory approach to emergency shelter and its role in recovery from displacement and from the daily stressors of inadequate shelter. We can continue to consider how else we might measure impacts and outcomes if one goal of a shelter project is to reduce suffering and improve mental health and psychosocial well-being. There are widely available MHPSS tools to examine outcomes related to a variety of aspects of objective and subjective well-being, such as social cohesion, self-esteem and hope, using a variety of indicators. A key reference point to use is the **Common Monitoring and Evaluation Framework for Mental Health and PsychoSocial Support in Emergency Settings**.

For example, if we want to measure social cohesion, we could look at social connectedness as an indicator using a neighbour cohesion scale.

Tools and indicators already exist that are applicable and can be helpful for Shelter actors who are exploring how to evidence the impacts of their activities on mental health and well-being. MHPSS specialists can help to adapt these or find more fitting tools, for the context and project. MHPSS and Shelter practitioners can also inform each other of the challenges people are facing in their daily lives, as well as how crisis events have impacted their ability to function and participate in the sheltering process. These conversations can help contextualize our approaches and tools. When Shelter practitioners sit down with a community, they might ask questions aimed at deeper cultural and practical understandings that will help determine what the actual needs are, as well as how meaningful those needs are, and how to measure how impactful we are in helping to meet them. We can deepen our engagement by asking:

What does home mean to you?

What does well-being mean to you?

Simply asking these questions can tell us a story of what home used to look like. Asking may provide opportunities for communities to come together around these ideas, and to express themselves in transformative ways.

Breakout group discussions

Participants in the learning event joined two rounds of virtual 'breakout room' discussions to consider the challenges, opportunities and practicalities of adopting an approach which is more mindful of mental health and well-being.

Perceived Challenges

Participants raised several challenges in providing/enabling more adequate shelter interventions which support mental health and well-being. These included:

- Changing perspectives and priorities in different phases of response, from emergency to recovery and also between conflict, protracted and disaster settings
- Concerns about engaging with mental health; another cross-cutting issue for shelter practitioners to worry about
 - How to manage without functioning referral pathways?
 - Limited capacity to collaborate with MHPSS colleagues
 - Mental health and well-being of humanitarian actors operating in stressful environments
 - How to reach MHPSS outcomes, alongside overwhelming unmet basic needs?
 - Concerns about different types of mental health issues and how to recognise and respond

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Focusing on inclusion [of persons with psychosocial disabilities] is hard enough. It's harder still to focus on what a lack of shelter means for mental health.

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- Concerns about adding to assessments and evaluations
 - 'Assessment fatigue' on both sides and fears of doing harm by inappropriate questions/use of language
 - Reaching the most at risk without putting additional burdens on them
 - Potential need for culturally appropriate adaptations in different contexts
- Host governments' and local authorities' fears of permanence, limiting options of shelter upgrades.

Many of these concerns were addressed during the learning event. Making the first steps towards an MHPSS approach to shelter activities does not need to involve significant additional burdens on practitioners or affected populations. Collaboration between sectors and practitioners at global and country level and in the field can mitigate practitioners' anxieties. In addition, being conscious of how different aspects of interventions (like poor project planning and lack of communication) can create stress for project participants is a first step to their avoidance.

An MHPSS approach in practice

Pieter Ventevogel, the Senior Mental Health and Psychosocial Support Officer at UNHCR, could not join the learning event, due to being deployed in Sudan. Instead, he took part in a panel discussion in the **Thematic Session on Shelter and Health** at the Global Shelter Cluster (GSC) annual meeting in June 2021. This Thematic session was in part a follow-up to the mental health learning event, organised by the same team at the invitation of the GSC due to the connections between shelter and health being a priority area for further research. Reflecting on his recent visit to refugee camps for Tigrayans in Eastern Sudan, Pieter offered a valuable perspective on the connections between MHPSS and Shelter and Settlements and ways forward for both sectors, summarised on the next page.

How can Shelter and Settlements activities support community mental health and psychosocial well-being in refugee settings?

Pieter Ventevogel, Senior Mental Health & Psychosocial Support Officer, UNHCR

Siloed sectors can be barriers to a holistic humanitarian response and it is the case that, until now, the links between Shelter and Settlements and MHPSS have been relatively underdeveloped. A visit to two camps in Gedaref State in Eastern Sudan hosting Tigrayan refugees May 2021 emphasised the ways that displacement camp layouts can have a bearing on community well-being. The uniform and seemingly regimented layout of Tunaydba refugee camp (see first image on the next page) was regarded as good by the camp managers. Yet it appears not to be an easy environment for community cohesion and well-being. In contrast, Um Rakuba camp (see second image on the next page) is longer established and had been largely self-settled before a coordinated humanitarian response, although it is also coping with new arrivals. Shelter colleagues regarded it as more problematic from a site safety point of view, but it appeared to offer conditions more conducive to social cohesion with a social infrastructure, including communal spaces, reminiscent more of a spontaneously settled village than a refugee camp. These contrasts are also related to the evolution of displacement settlements at different stages of an emergency. Levels of distress also change over time throughout an emergency as shown on the graph below. Acute settings can create massive levels of distress, which generally reduce over time unless the situation becomes protracted.

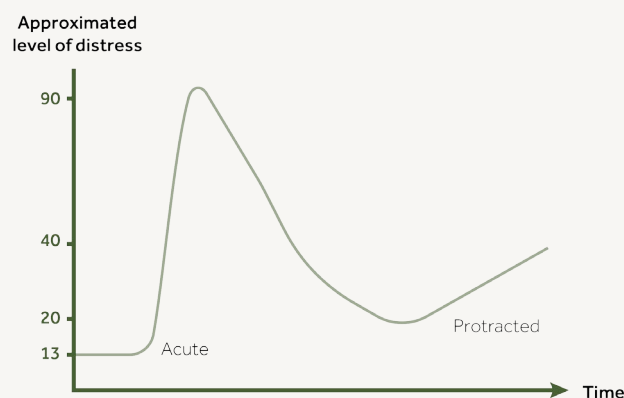


Figure 7: Levels of distress throughout an emergency over time.
Source: Author's own (adapted)

In an immediate crisis, people are worried about their basic needs: shelter, food, water. Later, when those basic protection and survival needs are met and people are out of 'survival mode', the developmental task of people in displacement is to become a community again, which may be hard in an 'artificial' place such as a refugee camp. In more protracted settings, often decisions by host governments mean that housing conditions remain cramped and deliberately non-permanent. People are often unable to go home but are unable to thrive in these settings - we know that poor housing conditions are not good for mental health. In addition to opportunities to enable shelter upgrades, appropriate support from Shelter and Settlements actors includes planning community spaces so people can come together to help themselves and achieve more developmental priorities.



Post disaster, around 1 in 10 people may have moderate to severe mental health issues such as more severe forms of depression, post-traumatic stress or psychosis. They may need focussed MHPSS help; Shelter and Settlements practitioners can help by referring people to appropriate services. The Shelter and Settlements chapter in the Sphere handbook already emphasises the importance of safety, and social cohesion. There are potential benefits of further collaboration between Shelter and Settlements and MHPSS actors. In some cases, it may be that MHPSS action consists of Shelter development. The list below gives some ideas of jointly developed interventions to improve the mental health and welfare of people in displacement settings:

- *Use participatory and inclusive approaches. Whilst well known, these are not routinely used in emergencies and colleagues must sit down together and work out how to do it.*
- *Train first responders in basic psychosocial skills, including Psychological First Aid. Shelter actors are often among the humanitarian first responders and interact with people so they can be trained in how to deal with people in distress.*
- *Enable the establishment of communal spaces (places of worship/recreation/sport) in between household spaces.*
- *Provide appropriate shelter for people with severe mental health conditions and their families. Currently MHPSS colleagues need to campaign for extra spaces/tents.*
- *Provide private consultation spaces and beds in general health facilities for people in distress.*



Adapting objectives, target outcomes and indicators

There were many ideas around how baseline assessments and monitoring, evaluation, accountability and learning (MEAL) approaches and tools can be tweaked to be more relevant to mental health and well-being aspects of shelter. Using qualitative baselines and narratives from affected communities to measure impacts of shelter programmes and talking about mental health right from the start of projects were proposed as ways forward. MEAL tools such as '**most significant change**' and community-led MEAL practices are not yet widely used in Shelter and Settlements programmes. For further discussion of more participatory MEAL tools, see this 2021 report on **MEAL in shelter self-recovery projects** by GSC's Promoting Safer Building working group. Participants at the learning event expressed a desire to work with MHPSS specialists to develop new approaches, in order to be in a position to share evidence of what works and what does not.

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What we hope would be the outcome of this conference going forward would be a collaboration with MHPSS colleagues to come up with good tools to be able to measure our impact on mental health and well-being. We need this technical capacity to advocate for better shelter solutions.

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If we want a community-driven approach, we need flexibility. Put objectives into a resilience framework (instead of having a rigid logframe from the start).

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Indicators can include more intangible metrics such as privacy and social cohesion.

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Gendered Shelter Assessment

The 'Gendered Shelter Assessment' is a methodology developed by CARE International and used during the context analysis phase of a shelter programme. It focuses on capturing nuanced community data related to homes and communities through qualitative assessment tools such as focus group discussions and key informant interviews. This focus on capturing qualitative narratives helps undertake analysis that can unpack more nuanced aspects of homes and communities not usually captured through other more quantitative, technically focused, household assessments. The gendered shelter assessments are also organised to disaggregate the data based on sex and age as well as capturing the perspectives of other relevant groups such as from people living with disabilities. This way important gendered perspectives (especially women's perspectives) are not lost and instead can become baselines through repeated consultation with these groups throughout the timeline of a project. The assessment is designed to capture pertinent gendered information that can inform and contextualise shelter interventions and the highly participatory nature of its consultations leads well into community-led programming.

Further resources

The WHO Well-Being Index (WHO-5) is a questionnaire that measures current mental well-being

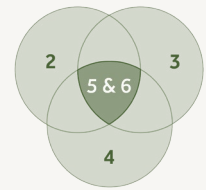
CARE Emergency Toolkit

Participatory Approach for Safe Shelter Awareness (PASSA) is a participatory method of disaster risk reduction (DRR) related to shelter safety.

The IASC **Common Monitoring and Evaluation Framework for Mental Health and Psychosocial Support in Emergency Settings** provides guidance in the assessment, research, design, implementation and monitoring and evaluation of mental health and psychosocial support (MHPSS) programmes in emergency settings.

CHAPTER 6

Moving forward



Making connections, capacity building and training

It is important that the Shelter and Settlements sector continues to forge connections with other sectors, such as Protection, Health, WaSH and MHPSS. Connections with other sectors, areas of expertise (such as MEAL) and programme leads, even within the same organisations, will be helpful. The make-up of 'shelter' teams would also benefit from a mix of technical and social skill sets, should be gender-balanced and ideally include those with MHPSS as well as Protection training. One learning event participant suggested re-envisioning building capacity and resources as strengthening networks and collaboration across sectors rather than a more technical focus on skilled workers/materials. Training needs identified by the learning event participants include:

- Training for assessment teams in how to incorporate MHPSS principles, including guidance on indicators commonly used in MHPSS
- Protection mainstreaming training
- Psychological First Aid training

Advocacy opportunities

“

Shelter in itself is MHPSS.”

Key principles of Shelter and Settlements assistance, such as privacy and dignity, safety and security, health and hygiene and climate protection, all support mental health and well-being. Yet the shelter sector has not defined people's well-being as part of those principles. It is a challenge for the sector to articulate that it is working towards well-being outcomes. While it may be clear that lack of shelter is bad for mental health, the sector is not consistently able to articulate how. Similarly, the role of shelter in recovery is hard to explain: a focus on mental health and well-being may be a useful route. Aspects of living environments that are not 'lifesaving', yet still important for well-being, should be advocated for. For example:

- natural lighting
- plants and green spaces
- space around the house for growing crops and other livelihood activities
- paint and other tools to personalise homes

Exploring the definitions of 'home' and 'well-being' from a mental health perspective could potentially help shelter practitioners to explain such sensitive concepts to donors and especially to government authorities that, in some situations, do not consider discussions about 'home' in refugee contexts appropriate. 'Home' has connotations of permanence and is therefore a difficult concept in displacement settings. (For further discussion of the 'constellation' of meanings of home see Brun and Fabos, 2015). Equally, evidence on the impact of inadequate housing on mental health and gender-based violence may be a good way to argue for more funding to understand mental health and shelter better. Shelter can be seen as part of a public health approach. Good quality shelter can be seen as cost-saving in terms of later need for clinical intervention. Perhaps the co-benefits of better shelter provision, including mental health outcomes, can help guide decision-making when prioritising interventions.



Building evidence

One aspect of the discussions at the learning event related to the need to build evidence around the impact of shelter activities on mental health and well-being. It is a new challenge to measure non-shelter outcomes of shelter, addressed below by Fiona Kelling, who was the author of the much-cited 2020 InterAction publication exploring the [Wider Impacts of Shelter](#).

Measuring outcomes and increasing evidence for improved mental health

Fiona Kelling, independent humanitarian shelter consultant

*Measuring impacts and increasing evidence has been a recurrent topic in recent sector events, which has stimulated questions about how best to accomplish this. Despite research that has captured examples of some of the potential **wider impacts of Shelter and Settlements assistance**, it has also highlighted how current limitations in methodological practices can result in weak findings and the ongoing need to improve the evidence base.*

*It is therefore encouraging to see the **Global Shelter Cluster** investment in a Global Focal Point for Research, as well as a Global Focal Point for Advocacy, that can begin to make the links between what evidence may be required and for what purposes, which audiences and at what level of certainty. This is the starting point for making progress and improvements in gathering evidence.*

At a more pragmatic level, organisations are interested in being able to measure better, starting with metrics that recognise and capture the wide range of sectors that Shelter and Settlements assistance can influence. Mental health is intrinsic to this, as it directly links to notions of recovery and well-being. Although 'well-being' has sometimes been considered too vague to be a goal of programming, articulating the constituent elements that shelter can contribute towards this – such as climate protection, privacy and dignity, feelings of safety and security, improved health and hygiene and space for family life – could be a good basis for making this a more achievable and aspired to aim. This in turn would increase the necessity for these elements to be measured and contribute towards increased evidence of the outcomes of shelter assistance.

*What this highlights is that thinking about what we are aiming to achieve is the starting point for any measurement of outcomes. This begins with good programming and engagement in the design of assessments and evaluations, as much as the design of any built structure or activities in between. It includes clearly articulating the theory of change, identifying relevant questions and thinking holistically, recognising that sometimes this requires input from others with a broader frame of reference. In particular, monitoring and evaluation (M&E) teams have the advantage of being non/multi-sectoral and if well integrated into programming can be well placed to make some of these links. However, this will rely on strong critical thinking skills and **breaking down the separation** that can exist between M&E and technical teams (Kelling, 2021).*

*The real challenge of course is to increase our measuring in a smart way that does not result in unnecessary wasting of people's time or 'indicator overload'. Building on recent explorations into the linkages between shelter and other sectors, there is also an opportunity to use improved collaboration and cross-pollination to learn how other sectors are measuring and applying data, for example, World Food Programme's comparative analysis of assistance methods in the food security sector presented during **Humanitarian Networks Partnerships Weeks 2021**. Examples like this demonstrate that it is not only about getting more or better information – although that would still be progress – but about getting data that can actually inform decisions or improve programming.*

The Shelter and Mental Health event highlighted that we do not need to be mental health experts to have an impact on people's mental health – no one is expecting or asking shelter practitioners to provide psychological interventions. Rather we need to appreciate how people's long term living conditions have a profound impact on their well-being and recognise our own role in addressing – and measuring the impact of – this through our interventions.

Participants at the learning event had more ideas and questions about building evidence related to mental health and well-being, including suggestions for further study. Participants also stressed the need to include affected people not just in the research but as researchers themselves wherever possible. Suggestions captured below:

- How the reconstruction of shelters that match the original setup (e.g. courtyard) makes a difference to recovery.
- How people's ability to host and to beautify and personalise their spaces contribute to recovery and well-being.
- Comparison of communities with spaces for community networks and activities at settlement level compared to communities where there is no space for community activities.
- How to measure the cost savings of preventing the need for specialised MHPSS interventions.
- Individual vs collective well-being. Do we need to consider these separately? Is what works for one household inevitably going to work for the community as a whole?
- How to prioritise other (non-academic) knowledge systems and look at case studies of how communities are successfully supporting psychosocial considerations?
- How can we build a matrix, or checklist, to better understand how to prioritise, where can you get multiple co-benefits for both health and well-being to try and understand where best to support interventions?

The Shelter and Settlements sector is already working towards greater collaboration with Health, WaSH and other humanitarian sectors. It is hoped that this report will help encourage this collaboration, so that it is more possible to use holistic approaches in humanitarian crises that can improve individual and community mental health and psychosocial well-being. There is also a value in partnerships between practitioners and academic researchers to make progress in these research areas to enhance humanitarian action and outcomes. Ilan Kelman, of University College London, expands on these opportunities below.

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We need to learn from the people and include them as researchers. We can learn from their lived experience and consider what it means to have a home.

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Further resource

[Elrha learning paper, From knowing to doing: evidence use in the humanitarian sector](#)

Researcher-practitioner collaborations

Ilan Kelman, Professor of Disasters and Health at University College London, UK

For shelter and mental health, researchers and practitioners have plenty to offer to and gain from each other. One important research component is useability and usefulness. Science gains from practitioners to ensure that research questions and answers are applicable. Simultaneously, scientists are adept at identifying limitations and gaps in knowledge, data, and practices - and then providing what is missing.

Mental health is often stigmatised or deprioritised, yet is inherent within the justification for needing Shelter and Settlement specialists. Health, privacy, dignity, security, and livelihoods are key components of the humanitarian Shelter and Settlement process and they support and are supported by mental health and well-being. Research evidences these statements and explains remaining theoretical and information gaps, while shelter practice grounds communication, improvements, and documentation.

Unfortunately, little knowledge can be gained or applied, and few significant collaborations can happen, without project funding. A pragmatic element of this collaboration is that researchers and practitioners can tap into different sources of funding in order to help each other. Practitioners can be funded partners on research grant applications, while researchers can be consultants or collaborators on bids to agencies, organisations, and the private sector.

One strong advantage of joint, funded projects is covering people's time to listen to each other. Practitioners can then put up with researchers' propensity to detail reference lists, to develop theoretical frameworks by querying every term's definition, and to accept a timeframe of months from a manuscript's submission to publication. Meanwhile, researchers must take cues from practitioners about ensuring that the work has immediacy to support policy and action, while learning how to publish practitioners' ideas and advice in academic venues. Most importantly, people are not necessarily only researchers or only practitioners. Many straddle and succeed in both realms, bringing the best of each world to assist people in humanitarian situations.

Some disaster research institutes for practitioners to contact:

[ACDS, North-West University, South Africa](#)

[CENDEP, Oxford Brookes, United Kingdom](#)

[CIGIDEN, university consortium, Chile](#)

[IRDR, UCL, United Kingdom](#)

[IRIDeS, Tohoku University, Japan](#)

[JCDR, Massey University, New Zealand](#)

[Natural Hazards Centre, University of Colorado - Boulder, USA](#)

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AGENDA OF THE LEARNING EVENT

Day 1, Thursday 20th May 1400-1700 BST	
Session	Item
1.1	<p>Welcome and Introduction</p> <ul style="list-style-type: none"> Susannah Webb, Centre for Development and Emergency Practice (CENDEP), Oxford Brookes University
1.2	<p>Message from Global Shelter Cluster lead</p> <ul style="list-style-type: none"> Brett Moore, GSC lead on behalf of UNHCR
1.3	<p>Mental health – developing a common understanding</p> <ul style="list-style-type: none"> Dr Carmen Valle-Trabadelo, IFRC. Co-chair, IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings Dr Ross White, Associate Professor of Clinical Psychology, Liverpool University Ben Adams, Senior Mental Health Adviser, CBM Global Dr Rebecca Horn, independent psychosocial specialist
1.4	<p>Living conditions, physical and mental health</p> <ul style="list-style-type: none"> Amelia Rule, Emergency Shelter Adviser, CARE International UK Joud Keyyali, WASH/Shelter Project Manager, CARE Turkey Sarah Ruel-Bergeron, Executive Director, ARCHIVE Global Joseph Ashmore, Shelter and Settlements Specialist, International Organization for Migration (IOM)
Break	
1.5	<p>Shelter, Recovery and Wellbeing: approaches to S&S that can make wellbeing central</p> <ul style="list-style-type: none"> Miriam Lopez-Villegas, Global Shelter and Settlements Specialist, Norwegian Refugee Council Bill Flinn, Senior Shelter Advisor, CARE International UK Professor Cathrine Brun, Director of the Centre for Development and Emergency Practice (CENDEP), Oxford Brookes University
1.6	<p>Conclusions of Day 1 and looking forward to Day 2</p>
Day 2, Friday 28th May 1000-1300 BST	
Session	Item
2.1	<p>Welcome and Day 1 recap</p> <ul style="list-style-type: none"> Susannah Webb, Centre for Development and Emergency Practice (CENDEP), Oxford Brookes University
2.2	<p>Positioning and Practicalities</p> <p>If shelter practitioners were to use a 'mental health/MHPSS lens' when developing and evaluating shelter projects, what would that look like?</p> <ul style="list-style-type: none"> Dr Rebecca Horn, independent psychosocial specialist Jamie Richardson, Shelter and Settlements Technical Advisor, Catholic Relief Services
2.3	<p>Learnings for future programming</p> <p>Case study example:</p> <ul style="list-style-type: none"> Reihaneh Mozaffari and Miriam Lopez-Villegas, Norwegian Refugee Council <p>Breakout groups:</p> <ul style="list-style-type: none"> Interactive whiteboards in each breakout room captured participants' priorities, ideas and examples. Breakout room discussions were moderated by experienced Shelter and MHPSS practitioners.
Break	
2.4	<p>What constitutes 'more & better'?</p> <p>Reflections on Shelter and MHPSS:</p> <ul style="list-style-type: none"> Melissa Tucker, Catholic Relief Services <p>Breakout groups:</p> <ul style="list-style-type: none"> Interactive whiteboards in each breakout room will capture participants' priorities, ideas and examples. Breakout room discussions will be moderated by experienced Shelter and MHPSS practitioners.
2.5	<p>Conclusion and next steps</p> <ul style="list-style-type: none"> Ela Serdaroglu, GSC lead on behalf of IFRC





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