Practical Approaches

# Taking a psychosocial approach to epidemic response

A psychosocial worker holds the hands of twin brothers, 8, just released from the Ebola Treatment Unit in the Democratic Republic of the Congo (DRC).
PHOTO: © UNICEF/NAFTALIN

**This Practical Approaches brief highlights key considerations for taking a psychosocial approach to working in the context of an epidemic. Public health emergencies can cultivate fear, anger and grief, and deeply impact the wider social fabric. Exposure to disease is frightening to many. When people are frightened, they may avoid or flee treatment facilities and distrust those responding to the epidemic. They are also more difficult to 'engage' through traditional mechanisms. Furthermore, people in affected areas may misattribute signs of worry (headaches, stomach-ache, etc.) as symptoms of the disease, which can increase suffering and overwhelm health services.**

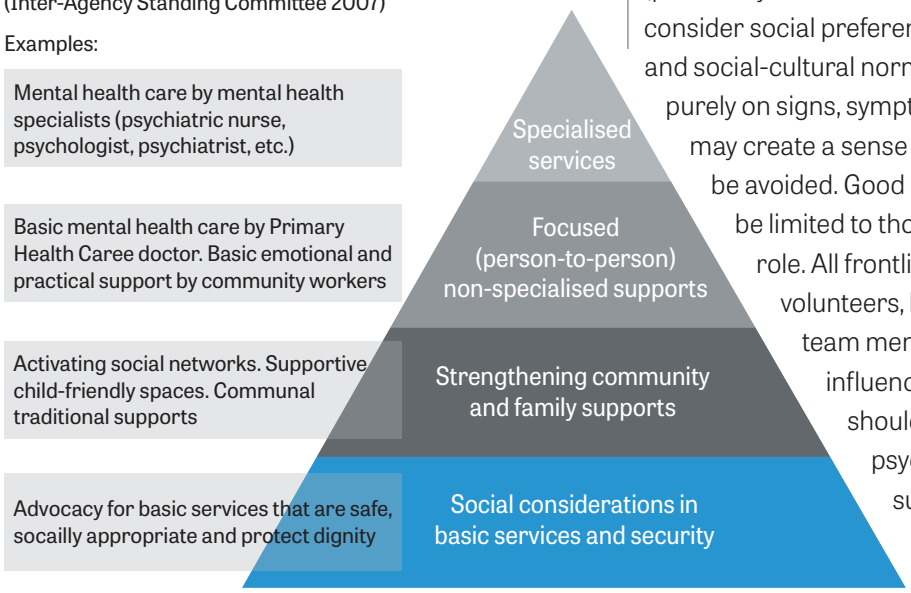
This brief gives guidance on how responders can protect and promote psychosocial wellbeing and 'do no harm' in their actions. This is the responsibility of all responders, not only mental health and psychosocial support professionals. Psychosocial considerations must be adequately integrated into public health assessment, preparation and response and recovery plans. This brief outlines key areas and actions, in line with the *Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC 2007)*, the *Mental Health and Psychosocial Support in Ebola Virus Disease Outbreaks. A Guide for Public Health Programme Planners (IASC 2015)* and recent publications from the Social Science in Humanitarian Action Platform.

## Global definitions and systems

The term 'mental health and psychosocial support' (MHPSS) is used in the Inter-Agency Standing Committee (IASC) Guidelines for MHPSS in Emergency Settings to describe 'any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder'. The global humanitarian system uses the term MHPSS to unite a broad range of actors, including those working with biological approaches and sociocultural approaches, as well as to 'underscore the need for diverse, complementary approaches in providing appropriate support', as described further below.

- **Pyramid of support:** The IASC *Guidelines for MHPSS in Emergency Settings* recommends that multiple levels of interventions be integrated within outbreak response activities (see Figure 1). These levels align with a spectrum of mental health and psychosocial needs and are represented in a pyramid of interventions ranging from embedding social and cultural considerations in basic services, to providing specialised services for individuals with more complex conditions. Core principles include: do no harm; promote human rights and equality; use participatory approaches; build on existing resources and capacities; adopt multi-layered interventions; and work with integrated support systems.
- **Humanise the response:** You do not need to be an MHPSS practitioner to take a psychosocial approach. All actors should ensure that all their actions protect and promote wellbeing. Normal epidemic response **must** address the bottom layer of the pyramid by providing basic services that are safe, socially appropriate and protect dignity. Responders are also able to protect and promote wellbeing through the second layer - strengthening community and family support systems. These two layers are the focus of the key actions in this brief.

**Figure 1 IASC MHPSS Intervention pyramid**
(Inter-Agency Standing Committee 2007)




## Key areas and actions

**Protective environments:** Any response to an epidemic must seek to create safe and protected environments for care and support. Key psychosocial principles include promoting a sense of hope, safety, calm, social connectedness and self- and community-efficacy (Hobfall *et al.* 2007). These principles should be embedded across every intervention. Exactly **how** to do this can be a participatory discussion with local staff who know how to best promote these principles in their context. Treatment centres for disease should be protective spaces, by meaningfully integrating these principles and recruiting trained staff dedicated to psychosocial support for patients, relatives and health workers.

**Communication:** Information must be timely and clear. Communication is a powerful psychosocial tool, able to relieve anxiety, build trust and convey respect. When equipped with knowledge, people can become active agents, able to protect themselves and others. Communication strategies should take a solution-focused approach that mitigates fear and promotes a sense of agency and hope. Clear, instructive and encouraging messages should be developed (preferably with affected communities) and should consider social preferences, networks, identities, and social-cultural norms. Rote messages focused purely on signs, symptoms and mortality rates may create a sense of helplessness and should be avoided. Good communication **should not** be limited to those in a communications role. All frontline workers (including volunteers, health workers, burial team members, community leaders, influencers and religious personnel) should be trained on essential psychosocial care principles, supportive communication and Psychological First Aid (WHO *et al.* 2014).

**Community engagement:** Effective community engagement, which carefully maps, understands, and builds upon existing support structures, itself promotes psychosocial wellbeing. It creates a sense of individual and collective understanding, ownership, and agency, and acts as a powerful demonstration that responders are working to help people, recognising that they are more than case numbers and/or data points (IFRC and Anthrologica 2019).

**Community-based supports:** The most important points of contact when first seeking help in any crisis are family and friends. Unfortunately, epidemics can create distance between people for many reasons. All responders can support the normal functioning of families and communities as far as possible, so that they can resume operating as effective, natural sources of support. It is crucial to 'do no harm' in this sense by avoiding activities that can create further social tensions (e.g. by creating conditions for violence around aid distributions, by seemingly prioritising one group over another, without transparency in decision-making). A community-based approach builds on local practices and local care structures, whether these are directly designed for delivering psychosocial support or for any other intervention in an epidemic response.

**Social fractures and stigma:** As noted, epidemics can create, fracture or increase existing social tensions, and risk unintentionally contributing to stigma and discrimination of infected persons and groups they are associated with. If affected communities clearly understand the health concern, its causes and transmission routes, this can help reduce this risk. Responders should be careful to avoid increasing stigma by over-targeting and drawing more attention to certain individuals. Even introducing the term 'stigma' into a vernacular where it does not previously exist can create it as a construct. Responders should therefore not assume this is a problem, without careful understanding (with the support of MHPSS actors, see Technical expertise section).

**A focus on strengths:** A narrative assuming and emphasising vulnerability is often adopted for communities affected by crisis, but this is rarely accurate or fair. Many people in the midst and wake of crisis demonstrate a high level of resilience and resourcefulness. Whilst compassion and sensitivity are important, responders must avoid creating or contributing to perceived vulnerabilities. This includes avoiding: weighted language such as 'victim' or 'traumatised'; over-targeting certain groups that are perceived to be most-affected (e.g. survivors); narrow assessments that only focus on weaknesses rather than also on strengths; and actions that undermine personal agency and self- and community-efficacy. The media should also be involved in highlighting strengths, successes and positive stories.

**Death and burial:** Facilitating a dignified and meaningful death and burial (or cremation) is a powerful psychosocial intervention (see SSHAP Practical Approaches brief *Assessing Key Considerations for Burial Practices, Death and Mourning in Epidemics*). Alongside the normal epidemic practice of modifying 'safe burials' in line with culturally appropriate local practices and allowing relatives to be involved as much as possible, burial teams should be well trained in supportive communication, and activities should be directly linked to formal MHPSS actors (see section on Technical expertise). Community-led and contextually appropriate grief and memorialisation efforts are also important initiatives (Jones, Kasali and Tulloch, 2020).

**Support to frontline response workers:** The well-being of responders is of critical concern – particularly for those who operate for a long time in 'emergency mode'. The risk and reality of infection can leave many frightened, exhausted and/or demoralised, and this high-stress environment can pose a barrier to good communication and positive relationships with affected communities. Response workers often experience additional tensions in their home environments. Critical to wellbeing is that the physical safety of front-line is protected through adequate knowledge and equipment. Also critical is a supportive Human Resources system, with reasonable working hours, adequate holidays, mandatory scheduled respite (especially for national/local staff), and a working environment that facilitates open communication and supportive peer relationships. Additional psychosocial support may be offered if and when appropriate.

**Technical expertise and coordination:** Specific technical expertise and dedicated resources are required to integrate psychosocial considerations into public health responses and preparedness and recovery in accordance with the MHPSS guidelines (IASC, 2007). MHPSS actors should prioritise participatory assessment of the context, including culturally specific MHPSS issues, needs and available resources, training needs and capacity gaps across the spectrum of care. Secondary and primary data should also have a special focus on the sociocultural context that underpins how suffering is both experienced and eased. A cross-sectoral coordinating body (ideally government-led) should be established and maintained, and involve health, protection and other relevant sectors. Relevant partners should be well-connected to these mechanisms, in order to draw on resources and expertise, and refer individuals and communities who need focused/specialised support.

**Longer-term perspectives:** Mental health services for those with more serious needs tend to be under-resourced in areas vulnerable to health emergencies. Therefore, the influx of resources that occur with an epidemic should also be used to strengthen the wider system. Actors involved in MHPSS should take a long-term perspective focused on establishing sustainable access to mental health and other services and mitigating the structural causes of suffering for the whole community, not restricted to sub-populations identified on the basis of exposure to a disease.

## Further reading


Hobfoll S.E. *et al.* (2007) 'Five Essential Elements of Immediate and Mid-Term Mass Trauma Intervention: Empirical Evidence', *Psychiatry: Interpersonal and Biological Processes* 70.4: 283-315

Inter-Agency Standing Committee (2007) *Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, Geneva: IASC

International Federation of Red Cross and Red Crescent Societies and Anthrologica (2019) *From Words to Action: Towards a Community-Centred Approach to Preparedness and Response in Health Emergencies*, Switzerland: IFRC

Jones T.E., Kasali N. & Tulloch O. (2020) *Grief and memorialisation: making meaning with Ebola-affected families. Humanitarian Exchange*, Humanitarian Practice Network, London: ODI

World Health Organization, CBM, World Vision International and UNICEF (2014) *Psychological First Aid for Ebola Virus Disease Outbreak (provisional version)*, Geneva: WHO


## About

The Social Science in Humanitarian Action Platform (SSHAP) aims to establish networks of social scientists with regional and subject expertise to rapidly provide insight, analysis and advice, tailored to demand and in accessible forms, to better design and implement emergency responses. SSHAP is a partnership between the Institute of Development Studies (IDS), the London School of Hygiene and Tropical Medicine (LSHTM), Anthrologica and UNICEF Communication for Development (C4D).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## Credits


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