Article

How to conduct a mental health and psychosocial support situational analysis in a refugee-based emergency context: a case study example from Cox's Bazar, Bangladesh

Sarah Harrison[1], Alex Ssimbwa[2], Mohamed Elshazly[3], Mahmuda Mahmuda[4] & Olga Alexandra Rebolledo[5]

[1]MA, International Federation of Red Cross and Red Crescent Societies, Reference Centre for Psychosocial Support, [2]MA, Danish Red Cross, [3]MSc, United Nations High Commissioner for Refugees, [4]MSc, United Nations High Commissioner for Refugees, [5]MPhil, International Organisation for Migration

Abstract

Early in 2019, a situational analysis of mental health and psychosocial support services for Rohingya refugees in Cox's Bazar was carried out jointly by International Federation of Red Cross Red Crescent Societies Reference Centre, International Organisation for Migration and United Nations High Commissioner for Refugees. The main objective of this situational analysis was to identify the approaches that were working well within the current response, the gaps within existing mental health and psychosocial support (MHPSS) services for Rohingya refugees in Cox's Bazar and to provide practical options and recommendations for MHPSS service providers working through different sectors. The methodology included: 1) a review of existing knowledge about MHPSS services for Rohingya refugees in Cox's Bazar through desk review methodology; 2) analysis of updated 4Ws (who is where, when and doing what) MHPSS service mapping; 3) strategic priorities mapping which was conducted with members of the MHPSS Working Group in Cox's Bazar; 4) focus group discussions with camp populations; and 5) meetings with service providers. The results from the strategic priorities mapping are shared in another article in the Special Issue of Intervention (Harrison et al., 2019, pp. 206–211). This article draws upon the Cox's Bazar case study to outline the methodological approaches and process used to conduct a situational analysis, with a view to guiding agencies interested in undertaking future situational analyses in other, ongoing, refugee and humanitarian contexts.

Key implications for practice

- An MHPSS situational analysis conducted in an ongoing emergency or refugee setting is a useful programming and advocacy tool for country-level MHPSS working groups and the agencies that co-lead these working groups.
- The process of conducting an inter-agency MHPSS situational analysis supports the functioning, purpose and coordination activities of a country-level MHPSS working group.
- Future MHPSS situational analyses should be conducted with the full involvement of persons with severe mental health conditions, to ensure that the perspectives of service users are included, in addition to persons suffering from psychological distress and persons with transient MHPSS problems.

Keywords: focus group discussions, mental health and psychosocial support, MHPSS working groups, service mapping, situational analysis, strategic priorities

Introduction

During the first quarter of 2019, a consortium of agencies – Danish Red Cross/Bangladesh Red Crescent Society and the International Federation of Red Cross Red Crescent Societies Reference Centre for Psychosocial Support (IFRC PS Centre), the International Organisation for Migration (IOM) and the United Nations High Commissioner for Refugees (UNHCR) – conducted a joint situational analysis on the mental health and psychosocial

Access this article online

Quick Response Code:

Website: www.interventionjournal.org

DOI: 10.4103/INTV.INTV_42_19

Address for correspondence: Sarah Harrison, IFRC Reference Centre for Psychosocial Support, c/o Danish Red Cross, Blegdamsvej 27, 2100 Copenhagen, Denmark.
E-mail: sahar@rodekors.dk

Submitted: 24 June 2019 **Revised:** 28 August 2019
Accepted: 23 September 2019 **Published:** 29 November 2019

How to cite this article: Harrison, S., Ssimbwa, A., Elshazly, M., Mahmuda, M., & Rebolledo, O. A. (2019). How to conduct a mental health and psychosocial support situational analysis in a refugee-based emergency context: a case study example from Cox's Bazar, Bangladesh. *Intervention*, *17*(2), 122-129.

support (MHPSS) response for Rohingya refugees in Cox's Bazar, Bangladesh. The situational analysis was undertaken by these three agencies, on the request of the MHPSS working group (WG) in Cox's Bazar, which is jointly co-chaired by UNHCR and IOM. The IFRC holds the co-chair position (along with the WHO) of the global Inter-Agency Standing Committee Reference Group for Mental Health and Psychosocial Support in Emergency Settings (IASC MHPSS), and was asked to support the situational analysis process, both in the global role. But also to reflect the volume of MHPSS programming conducted by the Bangladeshi Red Crescent Society with the support of the IFRC and Danish Red Cross.

A situational analysis differs from an MHPSS assessment in that it is a *review of current MHPSS responses within an ongoing emergency*. It provides a snapshot in time with the results used to evaluate and adjust current programming, raise awareness of the importance of MHPSS within a response, provide opportunities for collective advocacy through an existing MHPSS WG and offer a platform for engagement and feedback with affected populations. MHPSS assessments take place at the *early* stages of an emergency, with the information used to inform and *start-up programming* and to seek funding through project proposals. MHPSS assessments often pre-date the formation of an MHPSS WG in a sudden-onset emergency.

The main objectives of this situational analysis were to identify the approaches that were working well within the current response, the gaps within existing MHPSS services for Rohingya refugees in Cox's Bazar, to raise the voice of camp-level service providers (who were often national actors) and to provide practical options and recommendations for MHPSS service providers working through different sectors. Indirectly, the MHPSS situational analysis serves as a useful advocacy tool for the MHPSS WG in Cox's Bazar to inform their discussions with relevant line ministries and with donor agencies.

The process of developing a situational analysis provided the opportunity for reflection and review of the MHPSS situation by the MHPSS WG members in Cox's Bazar. This is the first MHPSS situational analysis after the large movement of Rohingya refugees into Bangladesh which started in August 2017 and remains ongoing. It is also the first collaborative MHPSS situational analysis by multiple agencies who are also members of the Cox's Bazar MHPSS WG. This article draws upon Cox's Bazar as a case study to outline the methodology behind conducting an MHPSS situational analysis in an ongoing refugee emergency context.

Methodology

In this Cox's Bazar case study, a mixed methodology approach was used following a process that was previously developed for a similar situational analysis conducted in Iraq in 2017 (Harrison, 2017). The methodologies used included: 1) a desk review of existing knowledge about MHPSS services for Rohingya refugees in Cox's Bazar through recent publications and studies from implementing agencies and the health, protection and camp management and camp coordination sectors; 2) an analysis of updated 4Ws (who is where, when and doing what) MHPSS service mapping; 3) the development and ranking of strategic MHPSS priorities; 4) focus group discussions (FGDs) with age- and gender-disaggregated camp populations (registered refugees in Kutupalong and unregistered refugees in Kutupalong and Teknaf camp complexes); and 5) individual and group meetings with MHPSS service providers (national NGOs, international NGOs, Bangladesh Red Crescent Society (BDRCS)/IFRC and operational United Nations Agencies), sector leads, government line ministries and counterparts.

Desk review of relevant MHPSS publications related to Rohingya refugees in Cox's Bazar

The co-chairs of the Cox's Bazar MHPSS WG compiled a folder of recently published MHPSS assessments by operational agencies providing services (Action contre La Faim, 2017; International Organisation for Migration, 2018; and the Royal Tropical Institute of Amsterdam (KIT) (KIT, 2018), recent journal articles (Riley, Varner, Ventevogel, Taimur-Hasan & Welton-Mitchell, 2017) and a large publication on the *Culture, Context and Mental Health of Rohingya Refugees* (Tay et al., 2019), in which many agencies in Cox's Bazar had contributed. The rapid desk review primarily enabled the authors to obtain a deeper understanding of the MHPSS needs of the registered and non-registered refugees residing in Ukhiya and Tekknaf camp complexes, and then to compare and analyse these needs with the feedback from camp populations and service providers through FGDs. The desk review also aided the facilitators of the FGDs to use the appropriate terminology or phrases when discussing MHPSS problems and concerns in a manner that was understandable, appropriate, non-stigmatising and respectful of the dignity of the camp's inhabitants. The UNHCR '*primer*' publication on the *Culture, Context and Mental Health of Rohingya Refugees* (Tay et al., 2019) was a useful resource when developing the FGD questions, methodology and in the qualitative analysis of the FGD responses.

Who is where, when and doing what (4Ws) – MHPSS service mapping

The first MHPSS 4Ws service mapping was conducted in early 2018 using the tool, *IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings' Who is Where, When and doing What* (IASC, 2012). In the earlier stages of the response, Action contre La Faim (ACF) initiated the 4Ws MHPSS service mapping process whilst they were the chair of the MHPSS WG in Cox's Bazar in late 2017. The process was finalised by UNHCR and periodically updated during 2018 to reflect the changing number, type and scope of MHPSS service providers. With the end of the 2018 cyclone season, the overall humanitarian response shifted from the acute emergency phase to a more stable, albeit protracted, nature in late 2018 and early 2019. The overall membership of the MHPSS WG remained constant and this shift in response phases provided members with the time to analyse and use

the results to inform the overall MHPSS response for registered and non-registered Rohingya refugees living in the camp complexes located in Teknaf and Ukhiya districts.

During February and March 2019, national staff from the IOM and UNHCR (in their position as co-chair agencies of the MHPSS WG in Cox's Bazar) took on the responsibility of working with each MHPSS WG member agency to update the service mapping document and to adapt and adjust the tool to be more user friendly for frontline workers. The adaptations involved making each worksheet specific to all the MHPSS activities conducted in one camp, rather than all camps being represented on one large Excel sheet. One '*master*' worksheet (automatically populated by data from the individual camp sheets) provided an overview of all MHPSS activities. These key adaptations help to facilitate referrals of affected individuals and families between frontline workers operating within the camps in addition to meeting the needs of programme officers based in Cox's Bazar. The 4Ws data entry essentially involved IOM and UNHCR meeting directly with individual agencies to review and type their MHPSS data into the Excel spreadsheet, with follow-up comments discussed over email. Whilst this adaptation in the representation of the data was hugely time consuming and human resource intensive, it has made the MHPSS 4Ws tool more accessible and useful as a service mapping document. Consolidating the 4Ws data onto one sheet is perhaps useful for programme officers from a statistical analysis and graphic representation of MHPSS services perspective, but it proves to be a particularly unhelpful format for frontline workers who need to find, quickly, an agency's contact details and service information related to a specific camp. The adapted Excel database has also proved to be a more useful data entry format for MHPSS agencies to periodically fill in as new services become available and others close or move.

An updated 4Ws service mapping was released to the humanitarian community in Cox's Bazar in April 2019; it was also presented by UNHCR and IOM at the March 2019 MHPSS WG meeting, where further discussions and analysis took place. The known gaps in provision of certain services and geographical gaps in service provision within and across certain camps remain agenda points within the ongoing monthly MHPSS WG meetings.

Strategic prioritisation workshop

In late January 2019, a half-day workshop took place in Cox's Bazar with MHPSS WG members. The principal purpose of the workshop was to develop the top ten strategic priorities that the MHPSS WG members believe should be the focus for the next one to two years as part of the overall response to meeting the MHPSS needs of Rohingya registered and non-registered refugee camp populations. MHPSS WG members also began to update the 4Ws MHPSS service mapping database during this workshop, with data entry continuing for two months afterwards. The process and results arising from the strategic prioritisation exercise are part of another journal article in this Special Issue (see Harrison et al., 2019, pp. 206–211) and are included in a report that was shared with MHPSS WG members in Cox's Bazar in March 2019 (Harrison el al., 2019).

Focus group discussions

Seven FGDs were conducted across the Ukhiya and Teknaf camp complexes involving both registered and non-registered Rohingya refugees from ages 7 to 60+ years. The exact age of the oldest FGD participant is unknown. The profile of refugees included registered refugees who arrived many years ago (during the 1990s) and non-registered refugees who arrived from August 2017 and onwards. The FGDs were primarily conducted by national staff from UNHCR and IOM and an international staff member from the IFRC PS Centre, along with a local Rohingya translator. However, the organisation of the FGDs took place in collaboration with MHPSS WG members and thus involved national partners from UNHCR, BDRCS with IFRC and Danish Red Cross support and national partners from IOM. In practice, the FGD participants were persons somehow involved in MHPSS activities or receiving MHPSS services from a national NGO or an international agency. The decision on where to hold the FGD was left to the respective agencies collecting the data in collaboration with their national partners. Some FGDs took place in community centres, in '*shantikhanas*' (places of peace), others in child friendly spaces and others still in the '*front room*' of the shelter of a block leader. The location of the FGDs was based upon the operational presence in the various camps of UNHCR and IOM's national partners and the BDRCS, in addition to the physical availability of locations in which to conduct the discussions.

There were approximately 12–15 persons in each FGD, with age and gender as the main criteria determining the groups' profile. Due to reasons of cultural sensitivity, the group of older persons (persons aged 50+ years) and children (age 7–12 years) were the only groups where males (boys) and females (girls) were interviewed together. The mixing of genders in these age groups is not viewed as problematic by the camp population. There were no FGDs specifically for persons with severe mental health conditions to prevent stigmatisation of an already marginalised group. All FGD participants were engaged in MHPSS activities, so while they may not have a specific mental health condition, they are persons in need of psychosocial support and can thus be classified as persons with lived experience. Table 1 illustrates the breakdown of the groups and their geographical locations.

Each gender-disaggregated age group was asked the same questions, with each FGD following the same format or template. The questions to guide the discussions within the FGDs were initially developed by the IFRC PS Centre and Danish Red Cross, and then reviewed and amended by national colleagues from UNHCR and IOM. The questionnaires started with a broad opening question to learn more about the daily routines and responsibilities of the different genders and ages within the camp. This opening

Table 1: Gender and age breakdown for focus group discussions

Group	Camp
Women (18–50 years)	Camp 13, Teknaf district
Men (18–50 years)	Camp Kutupalong Extension 2W, Ukhiya district
Adolescent girls (13–17 years)	Camp 7, Ukhiya district
Adolescent boys (13–17 years)	Camp 13, Teknaf district (2 groups due to a high number of participants)
Children mixed boys and girls (7–12 years)	Leda camp, Teknaf district
Older persons mixed males and females (50 years+)	Camp Kutupalong Extension 1W, Ukhiya district

question stimulated the discussion on an '*easy topic*' whilst also informing the interviewers of how much '*free*' time the participants had, if they moved outside their shelters for daily tasks and to access services or had knowledge of service providers. For example, through this opening question, the interviewers were able to learn of the disproportionately large amount of time that adolescent females spent inside their shelter conducting daily chores. The adolescent females stated that their chores and responsibilities rarely took them outside of their shelter and they were thus not accessing services within the camp, most of which were unknown to them.

Tools 10, 11 and 12 from the WHO and UNHCR *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings* (WHO & UNHCR, 2012) provided inspiration for some of the questions and for the introductory text to begin an FGD. Whilst these tools are assessment tools, some questions were also applicable in this situational analysis – particularly from the perceptions by community members and persons with in-depth knowledge of tool 10 and Section C (questions 1–5) from tool 11 (WHO & UNHCR, 2012 pp. 63–73). Questions that required adaptation included the decision to use '*unusual behaviour and distress*' when talking about a person with moderate or severe MHPSS problems, rather than using question 1.2c in tool 10 which uses alternative language of '*problems with thinking, emotions and behaviour*' (WHO & UNHCR, 2012, p. 63–73). This decision was informed by feedback from national Bangladeshi MHPSS staff based on their experience of how the Rohingya camp population spoke of their problems and was furthermore supported by evidence from the desk review – particularly the publication from Tay et al. (2018) on the *Culture, Context and Mental Health of Rohingya Refugees.* However, unlike the methodology described in the WHO & UNHCR (2012) toolkit, tool 10, a free-listing and ranking approach did not take place according to MHPSS problems and coping strategies. This was not viewed as a useful approach during an ongoing emergency response where the interviewers wished to track the *applicability* and *access* to MHPSS services and the *community perception of current MHPSS services* offered, based upon gender and age. Section C in tool 11 WHO & UNHCR (2012) provided a useful structure in which to ask how community members supported persons (children, adults, older persons) in distress before the emergency, and now, and how an outsider would recognise them (see questions 2, 3 and 4 in the below questionnaire). Figure 1 illustrates the template for the respective FGDs.

The importance of conducting FGDs with the Rohingya camp-based populations cannot be over stated. Affected populations have the right to participate in decisions that affect their lives and they have the right to enter a dialogue with humanitarian agencies on the services they claim to provide and whether these services meet their needs. The principles of dignity, participation and accountability are highlighted within the IASC MHPSS Guidelines (Inter-Agency Standing Committee, 2007) and the Sphere Handbook (The Sphere Association, 2018) and they should form the bedrock of '*good*' MHPSS programming. The FGDs were time consuming, both to conduct but also in terms of data analysis and the time required for inter-agency logistical coordination, arrangements and permissions. However, the process and results of the FGDs were invaluable to MHPSS WG members and service providers from other sectors, particularly where key protection risks and concerns were highlighted, such as a lack of knowledge of available services by adolescent females, for specific risks faced by boys and girls in certain camps (e.g., Leda camp) and the need to shift towards a community-based or a shelter-based programming approach to reach the most vulnerable, rather than focusing on facilities. The FGDs also informed health partners of the need for greater outreach in their health programmes, to move beyond facility-based care programming modalities and to also explore ways to work with traditional healers who remain influential sources within the community.

The qualitative data from the FGDs were coded, categorised and thematically analysed. Similarities, differences and contradictions were reviewed across genders and age groups. Key themes included the importance of traditional healers in providing mental health care for the group of older males and females, which contradicted with younger adult males and females (including adolescents) who did not obtain mental health care services from traditional healers. Other themes included the importance of feeling safe within their camp and having a space to play outside for boys and girls (7–12 years), whereas for adolescent females safety was a key concern; they rarely ventured outside of their shelter unless for a specific errand or purpose (e.g., to access medical care). For male youth, safety was not raised as an issue, rather their primary concern was access to formal educational opportunities and books with which to study. Adolescent males and male youth were more aware of, and knowledgeable of, available services and facilities within their camps and neighbouring camps than adolescent females and adult females

MHPSS Working Group- Cox's Bazar - Bangladesh
Rohingya Response- Situational Analysis 2019
MHPSS FGD Guide

1.0 Introduction and Informed Consent:
This focus group discussion (FGD) guide will help data collectors in assessing the current MHPSS situation as represented by a sample of selected MHPSS beneficiary groups supported by three organisations and their national partners: IFRC/ BDRCS, IOM and UNHCR in the camps.

1a. Informed consent (suggested text to read out)
In this discussion, we would like to ask you about various problems people in the community may have, how people deal with these problems and which services or support they access. Our aim is to learn from your knowledge and experience, so that we will better be able to design services and provide support that better meets your needs. We cannot promise to give you support in exchange for this interview. We are here only to ask questions and learn from your experiences. Your participation is voluntary.

If you choose to be interviewed, then I can assure you that your information will remain confidential. You are free not to take part. We cannot give you anything for taking part, but I greatly value your time and responses.

You can stop the discussion at any time.
Do you have any questions? Would you like to take part in this discussion? Yes/ No

2.0 Data collection
This is a basic qualitative assessment. Data will be collected through an FGD methodology conducted by experienced staff from the three above-mentioned organisations. The profile of the FGDs are broken down: organisation/gender/age and area of the camp. Please see the below table (in section 4.0). Data collection will take maximum two days per organisation.

3.0 Focus of the discussions
The discussions will focus on the following themes for each age and gender group;
- Recognition of MHPSS problems
- Coping strategies—past, present and future
- Availability, accessibility and use of services
- Participation

- Each focus group will consist of 8 up to 12 maximum people.
- There will be 2 facilitators: One will lead the conversation guided with the tool; 2. The other one will play the role of the observer and note taker. Translators may be required by some agencies.
- FGDs should take no longer than 90 minutes. Please ensure there are drinks/refreshments available for participants.

Questions for Children (7–12 years) and Adolescents (12–years) boys and girls

1. Tell me about an ordinary day in the camp for a girl or a boy. Your routine, activities, responsibilities?
2. How would an outsider recognize a child who is emotionally upset or distressed?
3. BEFORE you came to Bangladesh, what did your families and community usually do to support upset/distressed children or children living with a disability (e.g., physical disability, developmental problem)?
4. What are your families and community doing NOW to support upset children or children with a disability?
5. What are your favourite activities/services – the ones you most enjoy taking part in? Why do you like these activities so much?
6. Where do you and your friends seek help? Who do you trust? Are there different people/services during the day and at night time?
7. What problems do you or your friends experience when trying to seek help from others?
8. What more could be done to help a friend who is upset or a child with a disability?
9. Are there any children (perhaps one of your friends) who struggle to access services? If yes, why?

Questions for Adults (males/ females) age 18–50 yrs

1. What is an ordinary day in the camp for an adult male/ female? Your routine, activities, responsibilities?
2. How would an outsider recognize a male or female who is emotionally upset or has unusual behaviour?
3. BEFORE you came to Bangladesh, what did your families and community usually do to support upset women/men or women/men with unusual behaviour?
4. What are your families and community doing NOW to support upset women/men or women/men with unusual behaviour?
5. Where do you (as a male/female) and your friends seek help? Who do you trust? Are there different people/services during the day and at night time?
6. Are there any services or organisations that help distressed women/men, or women/men with unusual behaviour? If yes, what are their names? Do you know what services they provide?
7. What problems do you or your friends experience when trying to seek help from others?
8. What more could be done to help upset women/men or for women/men with unusual behaviour?
9. Are there any specific groups of women/men who cannot access services? If yes, why?

Questions for Older persons males and females (aged 50+ yrs)

1. What is an ordinary day in the camp for older males and females? Your routine, responsibilities and activities?
2. How would an outsider recognize an older male/female who is emotionally upset or has unusual behaviour?
3. BEFORE you came to Bangladesh, what did your families and community usually do to support upset older women/men or older women/men with unusual behaviour?
4. What are your families and community doing NOW to support upset older women/men or older women/men with unusual behaviour?
5. Who do you trust? Where do you seek help? Are there different people/services during the day and at night time?
6. Are there any services or organisations that specifically help upset older women/men or elderly women/men with unusual behaviour? If yes, what are their names? Do you know what services they provide?
7. What problems or challenges do you or other older males/females experience when trying to seek help?
8. What more could be done to help upset older women/men or for elderly women/men with unusual behaviour?
9. Are there any older women/men who cannot access services? If yes, why? Where are they located?

Figure 1: Focus group discussion guide with camp populations

MHPSS Working Group – Cox's Bazar – Bangladesh
Rohingya Response – Situational Analysis 2019
MHPSS Service Providers FGD Guide

Introduction
This focus group discussion (FGD) guide will help data collectors in assessing the current MHPSS situation as represented by a sample of selected MHPSS service providers supported by three organisations and their partners: BDRCS/Danish RC/IFRC, IOM and UNHCR in the camps.

Informed consent (suggested text to read out)
In this discussion, we would like to ask you about the various MHPSS services/supports your organisation provides. Our aim is to learn from your knowledge and experience, so that we will be able to design services and provide support that better meets the needs of the camp population. We are here only to ask questions and learn from your experience as service providers. Your participation is voluntary.

If you choose to be interviewed, then I can assure you that your information will remain confidential. You are free not to take part. We cannot give you anything for taking part, but I greatly value your time and responses.

You can stop the discussion at any time.
Do you have any questions? Would you like to take part in this discussion? Yes/No

Data collection
This is a basic qualitative assessment with service providers. Data will be collected through an FGD methodology conducted by experienced staff from the three above-mentioned organisations.

Focus of the discussions
The discussions will focus on the following themes:

- Changing dynamics of MHPSS problems over the past eighteen months
- Availability, accessibility and use of services by the camp population (males, females, boys and girls)
- What is working well?
- Challenges in providing services?

Data analysis
Analysed data will be presented in themes, conclusions and recommendations made for future actions by organisations.

- There will be two facilitators: One will lead the conversation guided with the tool; the other one will play the role of the observer and note taker. Service providers all speak English so translation is not required.
- FGDs should take no longer than 90 minutes. Please ensure there are drinks/refreshments available for participants.

1. What are the types of MHPSS problems (thoughts, feelings, behaviours and cognitions) that the camp population (girls, boys, women and men) are suffering from? How are these problems expressed?
2. Has there been a change in the type of MHPSS problems (thoughts, feelings, behaviours and cognitions) presented by the camp population (girls, boys, women and men), from when they first arrived at the camps, and now? (past eighteen months)
3. If yes, what do you think are the reasons for the changes? Have you had to adapt services accordingly? Trends in attendance levels?
4. What MHPSS services are available? (List all types) How are they provided (tent-based, health facility-based, community centre, in mosques/CFS, open-ground e.g., sports activities).
5. What is working well with your MHPSS services? What should we keep on doing?
6. What are the challenges you face in providing MHPSS services?
7. How do people (girls, boys, women and men) register for your activities? (Spontaneous, registration, specific outreach for registration e.g. a new activity, IEC materials promoting services, referrals)
8. Have any of you conducted a referral (sent or received)? How was the process?
9. How are the camp population (girls, boys, women and men) involved in the design, implementation and monitoring of MHPSS services (e.g., leading activities, site location, assessments)?
10. Who are your key interlocutors (intermediaries) in the camp to reach girls, boys, women and men. This can be for psychoeducation messaging purposes, mobilisation, assessments etc. (list all profiles).

Figure 2: Focus group discussion questions for MHPSS service providers

whose environment centred around their shelter and immediate camp block in contrast to their husbands and male family members. Danish Red Cross and the UNHCR presented the coded and analysed results from the FGDs to MHPSS WG members in the March 2019 monthly WG meeting.

Interviews and meetings with MHPSS service providers

A FGD was held with MHPSS service providers in early February 2019. The FGD was organised by UNHCR colleagues at the Kutupalong registered camp field office

with international staff members from the UNHCR and the IFRC PS Centre facilitating the discussions. Fourteen individuals (eight females) from ten organisations, eight of which were national NGOs, one UN agency and one international NGO attended the FGD for MHPSS service providers. All FGD participants were either operational or implementing partners of UNHCR as the discussion took place with service providers supporting registered refugees in Kutupalong camp in Ukihya district. Questions were developed in advance by a staff member from the IFRC PS Centre, which were then reviewed and adapted by a Bangladeshi national staff member from UNHCR. Tool 11 on '*Perceptions by community members with an in-depth knowledge of the community*' from the *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Humanitarian Settings* (WHO & UNHCR, 2012) provided inspiration and structure to the discussion. Overall questions were grouped into categories related to types of MHPSS problems facing the camp populations, types of MHPSS services provided and service delivery approach, how they conduct inter-agency referrals and changes noted within the registered refugee camp population (some of whom have been living there for twenty years). The time period of eighteen months was chosen as the review period to ascertain if the camp population's needs had changed or shifted since the arrival of many Rohingyas in August 2017, which may have impacted on the registered refugee's access to services and the type of services available. The FGD questions and the FGD template used with the MHPSS service providers can be found in Figure 2.

Further semi-structured, in-depth interviews were arranged with five staff members (two Rohingya and three Bangladeshi nationals) from different service providers with knowledge of the Rohingya camp community. Key informants were selected based upon the type of services they provided (e.g., primary healthcare, facilitating community activities and classes or counselling outreach), length of time providing services in the camp, interaction with the Rohingya camp community and knowledge of MHPSS. Interview questions were similar to those used in the service providers FGDs (questions 1–8), but they followed a more iterative process and had additional probing questions related to the professional background of the interviewee, her/his learning opportunities and personal motivations to work with the Rohingya camp populations.

Interviews were also held with an MHPSS staff member from UNHCR and two MHPSS staff members from the BDRCS. All three interviewees were Bangladeshi nationals who had relocated from Dhaka or Chiattagong to help respond to the MHPSS needs of Rohingya refugees in Ukhiya and Teknaf districts. Their responses were invaluable in learning about the perspectives of Bangladeshi humanitarian workers in this response, their professional training to help them conduct this work, in addition to the MHPSS services available for the general Bangladeshi population (host community) residing in Ukhiya, Teknaf and Cox's Bazar districts. The results from these discussions were useful in operationalising some of the strategic priorities identified in the February MHPSS WG workshop – for example, human resources, capacity-building initiatives and effective MHPSS approaches, such as community-based interventions provided within shelters as opposed to facilities.

The mixed methodological approaches used in this situational analysis place a strong emphasis on the participation of frontline humanitarian workers who are based in the 34 camps in the Ukhiya and Teknaf camp complexes (including the registered and non-registered refugees) along with national NGOs and the Bangladeshi Red Crescent Society who are providing the bulk of MHPSS services. The wish to travel to the camps to conduct FGDs and to hold interviews and meetings with frontline humanitarian workers and service providers arose from the desire to bridge the disconnect between the services being provided in the camps and the coordination meetings and strategic discussions happening in Cox's Bazar city, approximately a two-hour drive from the camp complexes. Similarly, whilst camp level coordination meetings for MHPSS actors are just beginning to emerge through the support of IOM and UNHCR, very rarely are frontline service providers' voices directly represented in the sectoral and strategic discussions occurring in the '*humanitarian hub*' of Cox's Bazar.

Limitations and lessons learned

This article uses the response to the MHPSS needs of Rohingya refugees in Cox's Bazar as one case example of how to conduct an MHPSS situational analysis of a large scale, ongoing refugee-based emergency. The authors do acknowledge, however, that there were limitations in our approach, mainly related to the two-week time constraint for the collection of raw data from the FGDs, key informant interviews and strategic prioritisation workshop. This two-week timeframe was selected as additional (international) resources were required to support the in-country agencies (BDRCS/IFRC, UNHCR and IOM) with their wish to conduct a situational analysis before the disaster preparedness season and subsequent cyclone/monsoon season. External capacity was required to conduct the desk review, draft the questions for the FGD questionnaires, to facilitate some of the in-depth interviews and discussions, to conduct thematic analysis and coding of the qualitative data arising from the FGDs and to write the first draft of the report. It was impossible for in-country staff involved in the daily emergency operations to also lead the situational analysis process. However, at the same time, the seven frontline staff and volunteers who were involved were indispensable as organisers of the MHPSS WG meetings, collection of 4Ws data from agencies, organising the FGDs, physically sourcing locations for discussions, obtaining consent of all participants, indicating key informants to be interviewed and feeding back the results to the wider MHPSS WG membership and humanitarian community in Cox's Bazar. External (headquarter-level) capacity was required for one month to augment the work conducted by the MHPSS WG co-lead agencies of UNHCR and IOM. The international staff member spent sixteen days in Cox's Bazar, with the

remaining work taking place remotely, but in close collaboration with the seven in-country staff from the three agencies. Costs were covered internally by the three agencies from their operational budgets, with no specific additional nor external funding sought. A similar time frame and human resource capacity are recommended for future situational analyses.

Invitations were sent to the health, protection, child protection and gender-based violence (GBV) sector/Area of Responsibility (AoR) leads in Cox's Bazaar to take part in the strategic prioritisation workshop and the MHPSS WG meetings related to the situational analysis, but they were unfortunately unable to attend. The limited time prevented the authors from arranging separate bilateral meetings with each sector lead, although they were present for the discussion of the results during the February and March MHPSS WG meetings and received copies of the final report.

Furthermore, except for the district health departments, there was limited opportunity during the two-week data collection period to consult in person with relevant government line ministries coordinating the refugee response at national and district levels. Remote dialogue, correspondence and consultations are ongoing with these authorities regarding the situational analysis, but these interactions have had to take place outside of the formal data collection period.

Finally, it would have been beneficial to have held direct key informant interviews or possibly FGDs with persons living with a severe mental health condition. FGDs did include '*persons with lived experience*' as participants had mental health and psychosocial needs and were in receipt of services. There may have also been participants with moderate or severe mental health conditions included in the FGDs, but specific interviews were not pre-arranged for this group of people. The authors acknowledge that this limits the voice and participation of persons living with severe mental health conditions, and it is recommended that future situational analysis should proactively reach out and include persons with severe mental health conditions and their caregivers in any key informant interviews.

Conclusion

This article sought to use the case study of the Rohingya refugee response in Cox's Bazar to describe the *methodology* and *process* used in conducting an MHPSS situational analysis in an ongoing refugee-based emergency context. The results arising from the situational analysis are not reported here as they are the subject of a separate journal article within this special issue (Harrison et al., 2019). This is the first, inter-agency MHPSS situational analysis after the large movement of Rohingya refugees into the Cox's Bazaar area of Bangladesh, which started in August 2017 and remains ongoing. It is hoped that the outlined process and methodology can be replicated in other ongoing refugee and humanitarian contexts, and that the lessons derived from this approach can be applied in future situational analyses, where there is a need to raise the profile of MHPSS within the overall humanitarian response and with government authorities, and to aid with the functioning, activities and purpose of a country-level MHPSS working group.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

References

Action contre La Faim. (2017). *Mental health and psychosocial support rapid needs assessment in undocumented Myanmar refugee settlements, Cox's Bazar, Bangladesh: Executive Summary*. Cox's Bazar, Bangladesh: ACF.

Harrison, S. (2017). *MHPSS situational analysis of the IDP and refugee crisis in Northern Iraq and Mosul-response in Iraq. Inter-Agency Standing Committee Reference Group for Mental Health and Psychosocial Support in Emergency Settings' Support Mission Report*. Geneva: IASC.

Harrison, S., Ssimbwa, A., Elshazly, M., Mahmuda, M., Zahidul Islam, M., Akter Sumi, H., & Rebolledo, O. A. (2019) Strategic priorities for mental health and psychosocial support services for Rohingya refugees in Bangladesh: a field report. *Intervention*, *17*(2), 206-211.

IASC Reference Group for Mental Health and Psychosocial Support in Emergency Settings. (2012). *Who is where, when, and doing what (4Ws) in mental health and psychosocial support: Manual with activity codes (field test-version)*. Geneva: IASC.

Inter-Agency Standing Committee. (2007). *Inter-Agency Standing Committee guidelines on mental health and psychosocial support in emergency settings*. Geneva: IASC. Available at https://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf

International Organisation for Migration. (2018). *Rapid mental health and psychosocial needs assessment*. Cox's Bazar: IOM.

Riley, A., Varner, A., Ventevogel, P., Taimur-Hasan, M. M., & Welton-Mitchell, C. (2017). Daily stressors, trauma exposure, and mental health among stateless Rohingya refugees in Bangladesh. *Transcultural Psychiatry*, *54*(3), 304-331.

Royal Tropical Institute (KIT). (2018). *External review of MHPSS services, gaps and response for Rohingya refugees in Cox's Bazar*. Commissioned by the Swedish Development Corporation (SIDA).

Tay, A. K., Islam, R., Riley, A., Welton-Mitchell, C., Duchesne, B., Waters, V., & Ventevogel, P. (2018). *Culture, context and mental health of Rohingya refugees: A review for staff in mental health and psychosocial support programmes for Rohingya refugees*. Geneva: United Nations High Commissioner for Refugees (UNHCR).

The Sphere Association. (2018). *The Sphere Handbook: Humanitariancharter and minimum standards in humanitarian response*, Fourth Edition. Sphere, Geneva. Available at www.spherestandards.org/handbook

World Health Organization & United Nations High Commissioner for Refugees. (2012). *Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for Major Humanitarian Settings*. Geneva: WHO.

World Health Organization (WHO). (2013). *Building back better: Sustainable mental health care after emergencies*. Geneva: WHO. Available at https://www.who.int/mental_health/emergencies/building_back_better/en/