IFRC Monitoring and Evaluation Framework for Psychosocial Support Interventions

Toolbox

Psychosocial Centre
International Federation
of Red Cross and Red Crescent Societies

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Please see the full list of materials available from the PS Centre at www.pscentre.org.

Detailed overview of tools

Introduction to the toolbox

This toolbox presents a wide range of monitoring and evaluation tools designed specifically for use in relation to psychosocial support interventions. Many are drawn from existing PS programme monitoring and evaluation (M&E) tools. This is, of course, not an exhaustive list. You may find local tools used in PS programmes in your own work context and you may also develop additional tools for your programme.

The toolbox features tools which are listed in the means of verification (MoV) column in the indicator tables of the IFRC M&E Framework Indicator Guide. The tools focus mainly on the MoV for the outcome level of evaluation. However, some of the tools can also be used as a MoV on the output level (particularly for the programme management cycle tools and supervision reporting tools).

The tools featured here include templates for specific M&E tasks, sample M&E documents and guidance on aspects of M&E. The tools can all be adapted to your PS programme, depending on your target group, activities and scope, etc.

There are a number of considerations when selecting and adapting tools for M&E, including:

- *What you want to measure:* For example, consider whether you are looking for quantitative information (numbers) or qualitative information (opinions, perspectives) or both.
- *Who will provide the information:* Consider whether you would like information from individuals or groups, their relationship to the programme (e.g., a user of services, stakeholder, family or community member), and any special considerations (e.g., how to appropriately ask questions according to someone's age and gender, consent for child or adolescent respondents, or facilitating participation of respondents with a disability).
- *Where information will be collected:* This may include, for example, community centres, homes, schools, or psychosocial centres where services are delivered. Consider, for example, if the location is accessible for people with disabilities, and if privacy or gender/age segregation is required for respondents to feel comfortable in participating (e.g., women may not speak openly if men are present, or children may not talk honestly if parents are present).
- *Who will be asking for the questions:* Different types of data collection methods require different skills and training. Consider what kinds of training might be necessary for teams who will be collecting data using the various tools and methods described here. It may also be important to consider the age and gender of the person collecting data and who they will be approaching for information (e.g., young men may be more comfortable talking to men than women, but at the same time may not feel comfortable about approaching an older man in the community).

It is also essential to consider **ethical guidelines** in gathering information for M&E. For further information on ethical guidelines in data collection for M&E (including M&E activities with children), please see the IFRC M&E Framework Guidance Note.

1 Programme management cycle tools

The tools in this section relate to the programme management cycle. These tools are fundamental to programme monitoring and evaluation. They can be used for a number of the outcomes and outputs listed in the indicator guide.

The tools are presented as follows:
1.1 Needs assessment tools
1.2 Staff and volunteer activity records
1.3 Programme monitoring templates
1.4 Community and stakeholder survey tools
1.5 A programme evaluation tool
1.6 Guidance on monitoring and evaluation reports
1.7 Guidance on reporting a 'lessons learned' feedback session.

The IFRC M&E Framework Guidance Note features other key documents used in the programme management cycle, including logframes and other M&E planning tools.

1.1 Needs assessment tools

The following information on needs assessment and tools are taken from the publication, Rapid Assessment Guide for Psychosocial Support and Violence Prevention (2015) IFRC and Canadian Red Cross.[1]

The purpose of a needs assessment is to be able to propose interventions based on the overall situation, PSS and VP/protection needs and issues the target population considers important. Needs assessments help to answer questions such as:

- What are the perspectives of beneficiaries of different genders, ages, abilities and backgrounds, on psychosocial and violence issues?
- What is the current situation/context of psychosocial and violence issues in the community including capacities, needs, and the role of other agencies?
- What are the traditional ways of working with psychosocial and violence issues?
- What is the existing interest and capacity of the NS in addressing PSS and VP issues?
- If PSS and VP issues are to be addressed, what approaches are the most suitable?

Needs assessment helps to ensure programmes are in line with beneficiary needs and realistic expectations of the changes the intervention may bring about. In this way, programmes are more likely to meet their objectives. In emergency situations where programmes may be implemented in a state of continuous change, a needs assessment gives a snapshot in time of the situation, and therefore ongoing assessment and flexibility in programme design are important to respond to changing needs.

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[1] *The Rapid Assessment Guide for Psychosocial Support and Violence Prevention in Emergencies and Recovery (2015) IFRC Reference Centre for Psychosocial Support and Canadian Red Cross.*

A high quality needs assessment aims to:

- Link to rapid provision of effective support and services
- Collect information on how local people understand and experience their situation and how they are able to cope with it
- Analyse how psychosocial impacts and access vary according to gender, age, ethnicity and other stratifications
- Realise not only what the programme may bring but the local resources available and how groups (e.g. women's or youth groups) may contribute to programme delivery and support
- Analyse the situation and programme approach on an on-going basis
- Map local power structures and gender relations, and identify the most vulnerable, invisible groups and those not included in regular community discussions.
- Recognise that Western concepts and tools may not apply in the local context and that especially spirituality may be a significant factor to be considered.

To begin a needs assessment, first collect and review existing sources of secondary data about the situation, needs and resources. Next, conduct interviews with groups and individuals using quantitative and/or qualitative methods. The information gathered should be informed by and validated against those of local key informants and humanitarian stakeholders.

1.1.1 Sample: Rapid PSS and VP/protection assessment – seven questions

The following seven questions can be used in interview and focus group discussion guides when time is very limited, for example when conducting rapid assessments for PSS and VP/protection issues following various disasters. The questions can also be used when integrating PSS questions into multi-sector needs assessment. For each of the questions, probe if there are any distinct differences among the experiences of, and responses from, women, girls, boys and men.

Rapid PSS and VP/Protection Assessment – Seven Questions
Stress and coping
1. Since the emergency, what changes have you noticed in yourself and others? 2. What do women, girls, boys and men normally do to overcome difficulties/deal with stress?
Protection/ Violence prevention
3. What are the dangers to women's, girls', boys' and men's sense of safety? 4. Are there any populations at highest risk of violence? 5. What are the specific locations and/or times women, girls, boys and men are most unsafe?
Formal and informal supporting resources
6. What supportive and protective resources are in place in the community (formal and informal)? 7. How do people support each other in the community?

1.1.2 Sample: Detailed PSS and VP/protection assessment questions

If you have more time for assessment, more detailed questions can be used (see the Rapid Assessment Guide[2]). Several of these questions have been selected and adapted below. They can be used to gather greater depth of information on specific topics and/or can be used in follow-up phases of an assessment. For each of the questions, ask if there are any distinct differences among the experiences and responses from women, girls, boys and men.

Detailed PSS and VP/Protection Assessment Questions

Stress and coping

1. How would you describe a normal day before the emergency?
2. Since the emergency what changes have you noticed in yourself and others?
3. What are some of the stressors for women, girls, boys and men in the community?
4. How is stress shown in the community?
5. How is stress handled by the community?
6. How can you tell when women, girls, boys or men in your community are not doing well or are in distress?
7. How do people usually get through difficult times?
8. What are the best solutions to enhance stress relief, mental health, and safety?
9. What happens in families and communities when people die or go missing? What are the traditions and rituals? Are they different for women, girls, boys and men? What are the spiritual beliefs?
10. What do people normally do when they feel sad?
11. What do people normally do when they feel happy?

Protection/Violence prevention

1. Who is most at risk of being unsafe and why?
2. Are there specific locations or times people are most unsafe?
3. Where do people feel safe?
4. Which people are most at risk of violence in the current situation? What makes them especially vulnerable?
5. What types of violence are people facing? Are the types of violence different by age (children/adults/elderly) or by gender (male/female)?
6. Who is inflicting violence in the community/camp? What is motivating them? Where do they get their power from?

Formal and informal supporting resources

1. How do people support each other in the community?
2. What formal or informal support resources are in place in your community to help people cope with the emergency?
3. What protective systems exist to solve problems around unhealthy coping, mental health and violence? How do people access these services?
4. Are the protective systems working (can people access, etc.)? What are the barriers? What can be done to overcome the barriers?
5. Who best could spread awareness of psychosocial well-being and violence prevention in the community?

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[2] Rapid Assessment Guide for Psychosocial Support and Violence Prevention in Emergencies and Recovery. (2015) IFRC Reference Centre for Psychosocial Support and Canadian Red Cross.

The Rapid Assessment Guide[3] also contains more detailed information about how to conduct needs assessment, including:

- setting up the assessment
- focus group discussions/questions for qualitative data collection
- situation/context analysis
- environmental walk-around
- internal questionnaire for leadership of the NS
- analysis checklist.

Please also see section 3 for more information on qualitative data collection and the IFRC M&E Framework Guidance Note for ethical considerations in data collection.

The following links also contain useful tools and information for needs assessment data collection:

Other Useful PSS Needs Assessment Resources
WHO and UNHCR (2012) Assessing Mental Health and Psychosocial Needs and Resources: Toolkit for humanitarian settings. http://apps.who.int/iris/bitstream/10665/76796/1/9789241548533_eng.pdf
UNICEF (2011) Inter-Agency Guide to the Evaluation of Psychosocial Programming in Emergencies. New York: United Nations Children's Fund. http://www.unicef.org/protection/files/Inter-AgencyGuidePSS.pdf
IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings (2012). IASC Reference Group Mental Health and Psychosocial Support Assessment Guide. http://www.who.int/mental_health/publications/IASC_reference_group_psychosocial_support_assessment_guide.pdf

1.1.3 Sample: Needs assessment questionnaire

The sample needs assessment questionnaire below relates to PS needs and vulnerable groups. It features quantitative and qualitative questions. It can be adapted to your particular situation or programme outcomes by adding questions, focusing questions on specific topics, deleting or rephrasing questions, etc.

Place: **Date:**	**Respondent's age:** **Respondent' gender:**
Hello, my name is [name of staff/volunteer] *and I am a Red Cross/Red Crescent volunteer*. *We want to better understand the needs of the* [community or target population]. (Obtain informed consent before conducting the survey.)	
Qualitative Questions: Traditional Views and Systems The following questions can be used in focus group discussions, and formal and informal interviews with the target population. They can be combined with questions below on specific emotional or social problems in the community, as relevant to your specific programme.	

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[3] Rapid Assessment Guide for Psychosocial Support and Violence Prevention in Emergencies and Recovery. (2015) IFRC Reference Centre for Psychosocial Support and Canadian Red Cross.

1. What are the traditional views in the community about mental illness? (e.g., is there stigma or shame?)			
2. What are the traditional/informal systems to help people who have mental illness or psychosocial issues?			
3. What are the referral systems for people who are experiencing mental health or psychosocial issues and acute stress?			
Questions about specific emotional or social problems in the community			
1. What kinds of emotional or social problems do people face in this community?	*Ask the respondent to explain what kind of emotional or social problems they know people are facing in the community. Use the respondent's answer to put in the brackets below for the subsequent questions.*		
2. How big a problem do you think [ ] is in this community?	Not a problem	Small problem	Big problem
3. What would you do if someone you loved suffered from [ ]?			
4. How confident do you feel about your ability to help someone who is suffering from emotional or social problems, like [ ]?	Not at all confident	Somewhat confident	Very confident
5. How easy is it to get help for someone suffering from [ ]?	Not at all easy	Somewhat easy	Very easy
7. Where (or to whom) could you take the person suffering from [ ] for help?			
6. How much do people in this community know about the services available for people suffering from [ ]?	Not at all (know nothing)	Know a little	Know a lot
8. How much do you think the person suffering from [ ] can benefit from receiving the available services/help?	Not at all	A little bit	A lot
9. Is there anything you would like to add about the problems facing people in this community, or the help available to them?			

1.2 Staff and volunteer activity records

Staff and volunteer activity records document activities completed during the course of implementing a project. They help to ensure that all activities related to the programme are recorded. The format for recording staff and volunteer activities can be adapted to your programme and the actual activities that are implemented. For example, activities may include home visits, community meetings, provision of oral or written psycho-educational material, referrals, etc.

1.2.1 Template: Staff and volunteer work plan

Staff and volunteers may benefit from a work plan that provides them with an overview of activities that they will be implementing. Here is a template for a work plan:

My Work plan			
Date & Time	Activity/Event	Place	Participants

1.2.2 Sample: Staff and volunteer activity record

An activity record provides details about activities once they have been implemented. It records outcomes and notes any follow-up that is planned. A sample activity record is provided below.

An activity record can be filled out on a regular basis depending upon the time frame of the project and when and how activities are implemented. For example, it may be useful to compile information on a weekly or monthly basis. Be sure to adapt the format to your specific programme's activities. For example, if you are working with children of different age groups within the programme, consider separating the data recorded for the number of participants/people reached accordingly (e.g., 0-12, 12-18).

Activity record								
Name of staff member or volunteer:				Date:				
Time frame of record (monthly/weekly):				Project details (name, location):				
Are the activities a component of a larger programme or a standalone psychosocial support programme? State which programme(s).								
Sample activities *(examples are shown below - adapt to your programme and add additional activities as needed)*	Number completed (e.g., # of home visits, lay counselling sessions, referrals)	Date completed	Description (e.g. purpose of home visit or group meeting, type of referral, types of psycho-educational materials distributed)	Number of participants/ people reached				Outcomes/ comments/ follow-up plans (if any)
				Men	Women	Boys	Girls	
Home visits								
Community awareness sessions								
Psychological First Aid								
Referrals								
Lay counselling								

<table>
<tr><td>Psycho-educational material distributed</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Other activities [change according to the activity]</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="9">Provide additional information as relevant
<i>(Examples are shown below – but these need to be adapted to your programme)</i>:</td></tr>
<tr><td colspan="9">Topics discussed during [home visit, group meeting, lay counselling session, etc.]:</td></tr>
<tr><td colspan="9">More detailed description of stakeholders or beneficiaries participating in [e.g. group meetings] or reached by the activity [e.g. PFA]:</td></tr>
<tr><td colspan="9">Observations and lessons learned:</td></tr>
<tr><td colspan="9">I need support for [include activity-related and/or personal support]:</td></tr>
<tr><td colspan="9">Follow-up plans:</td></tr>
</table>

1.3 Programme monitoring records

Two templates for programme monitoring reports are provided for programme managers or PS delegates conducting programme monitoring. These include templates for:

- a monitoring visit report
- a monthly activity report.

Monitoring visits include a review of staff and volunteer activity records. Programme managers and PS delegates may also visit the programme and project sites (e.g., CFS in refugee camps); talk with staff and volunteers, beneficiaries and stakeholders; note general observations and generally conduct quality assurance of the programme. Monitoring visits are also used to provide supervision and support to PS staff and volunteers.

The monthly activity report compiles information from various sources, including the staff and volunteer activity records and monitoring visit reports. It provides an overview of activities implemented each month, including lessons learned and future plans.

1.3.1 Template: Monitoring visit report

Visit Details			
Completed by:	Location:		
Date:	Objectives of the visit:		
Agenda The following activities were completed as part of a monitoring visit:			
Date	Time	Activity	Participants
General Observations Record your general observations from the monitoring visit below. This may be a few paragraphs up to a few pages. Include photos, case studies and quotes to illustrate your points.			

Specific Issues and Actions List the specific issues/problems that were identified during the visit. Then identify the actions that need to be taken to solve the problem. This should include the specific individual responsible for taking the action, and when it should be completed by.	
Issue Identified ***Example:*** *During the psychosocial training activity that we observed on 6th January 2014, local trainers had some questions about the IASC MHPSS guidelines and how the guidelines should be implemented*	**Actions to be taken** ***Technical Advisor:*** *Organise a briefing session for local trainers by 30/02/2014 on the IASC MHPSS guidelines. Provide ongoing coaching to help them implement the guidelines.* ***Programme Manager:*** *Ensure all PS trainers understand and follow IASC MHPSS guidelines by 30/03/2014 and verify through supervision visits.*

Next Visit Provide details of the next monitoring visit. The objectives of the next visit should match the issues and actions identified in this visit. For example, if the quality of activities is an issue, then the next visit should observe those same activities to make sure the quality has improved.	
To be completed by:	Location:
Dates:	Objectives:

1.3.2 Template: Monthly activity report

Data is compiled into this monthly activity report from the staff and volunteer activity records and monitoring visit reports, as well as other sources. Below is a template for a monthly activity report.

Thematic templates are provided below the executive summary. Use these to summarise data about the PS activities and programmes being monitored. Use the thematic templates relevant to your current programme and adapt as necessary (add new if necessary and delete the once that are not relevant to your programme).

Monthly activity report		
Completed by:	Place:	Dates (month):
Executive Summary		

Trainings Facilitated							
Date	Location	Number of Participants			Topics covered	Duration	Facilitators
		M	F	Total			

Psychological First Aid skills used by RCRC staff/volunteer				
Date	Location	Number of People	Topic	Comments

		Men	Women	Boys	Girls		

Community Outreach Activities

Date	Location	Number of Participants				Topics discussed/activities conducted	Comments
		Men	Women	Boys	Girls		

Child Friendly Activities

Date	Location	No. of Children			No. of Sessions	Activities	Comments
		M	F	Total			

Referrals					
	Reason(s) for referral (please list examples)	Gender/ Age of person(s) referred	Date of Referral	Referred by [staff/ volunteer]	Referred to [organisation, community protection committee, clinician, legal service, health clinic, etc.]
1.					
2.					
3.					
4.					
5.					

Community Meetings				
Dates	Location	Agenda	No. of Participants	Outcomes
Challenges				
Lessons learned				
Recommendations				

Plans for following months

1.4 Community and stakeholder survey tools

Community and stakeholder survey tools are used to gather M&E data from beneficiaries of PS programmes. They help to engage the target population (community members and stakeholders) in PS programme areas and gather data for measuring indicators. They are conducted in the communities where the target population lives. They can be used to ask the target population within the community about existing PS programmes, such as their awareness of the programme, understanding of its aims and activities, perceptions of access and use of services.

It is essential to maintain the privacy and confidentiality of all respondents and to adhere to ethical principles when conducting community and stakeholder surveys.

Surveys[4]

Surveys involve "the systematic collection of information from a defined population, usually by means of interviews or questionnaires administered to a sample of the population (e.g. person, beneficiaries and adults). A survey can be administered by someone trained to record responses from respondents (a data collector), or can be self-administered by the respondent (respondents must be literate)."

Community surveys are administered as widely as possible (depending on time and resources) to a sample of the target population within the community. They can be conducted door to door in the homes of community members, at community centres or at schools, depending upon the target group and situation.

Other methods may also be used to understand the viewpoint of community members and stakeholders and to triangulate data. These may include focus groups, case studies and key informant interviews for gathering more in-depth information. (See section 3 for more information on qualitative methodologies.)

A programme evaluation survey is an example of a tool used to monitor and evaluate how direct beneficiaries of PS programmes feel about the services they are receiving. This kind of survey also provides information about how direct beneficiaries have experienced change in various aspects of their wellbeing, for example, as a result of participation in the programme.

The sample programme evaluation survey below includes quantitative questions (4-point scale response) and open-ended questions for qualitative data. Questions relate to:

1. A description of the programme/activities.
2. Respondent's rating of his/her participation in the programme, and questions related to reasons the respondent does or does not participate.
3. Accessibility of the programme to the respondent/target group.
4. Overall quality of the programme.
5. Relevance of the programme.

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[4] IFRC Project/Programme Monitoring and Evaluation Guide. International Federation of Red Cross and Red Crescent Societies. Geneva (2011)

6. Sense of connection to the programme (e.g., feeling of belonging, ownership of the programme, relevant to programme design).
7. Usefulness of the skills and knowledge gained in the programme.

1.4.1 Sample: Programme evaluation survey of direct beneficiaries

Programme evaluation survey of direct beneficiaries ***Instructions to data collectors are given in italics***				
Name of programme: Location: Today's date:	**Basic information about respondent**: Gender: Age:			
1. About the programme				
1a. What programme do you participate in? *(Please ask the respondent to name and/or describe the programme, such as who the intended beneficiaries are, what is its general purpose, and what activities are held.)*				
1b. What activities do you participate in? *(If the programme has more than one activity, please ask the respondent to list the ones they participate in.)*				
2. Participation				
2a. How often do you participate in the programme/activities?	Rarely	Sometimes	Often	Always
2b. What makes it easy or difficult to participate in the programme/activities?				
2c. Please tell me why you participate in the programme/activities.				
2d. Please tell me why you do not participate in the programme/activities.				

3. Accessibility *Explain that you will read each statement below about how easy or difficult it is for [target group] to access the programme. Ask the respondent to tell you how much they disagree or agree with each statement.* *[Target group] can be people 'like the respondent' who attend the programme, such as 'youth like you,' 'women like you', or other people who could benefit from the programme or activities.*				
3a. [Target group] can easily find information about the programme.	Strongly disagree	Disagree	Agree	Strongly agree
3b From what you know, people who need the programme are actually using the services	Strongly disagree	Disagree	Agree	Strongly agree
3c. The programme and/or activities are held somewhere the [target group] can easily attend.	Strongly disagree	Disagree	Agree	Strongly agree
3d. The programme is located in a safe place for the [target group].	Strongly disagree	Disagree	Agree	Strongly agree
3e. All people who could benefit from the programme/activities are able to join/attend, even if they have special needs *(as relevant to the programme, this can be people with disabilities or other special needs or circumstances*).	Strongly disagree	Disagree	Agree	Strongly agree
3f. Please tell me more about what you think of the accessibility of the programme.				
4. Satisfaction with the programme				
4a. The programme/activities are satisfactory.	Strongly disagree	Disagree	Agree	Strongly agree
4b. Please tell me more about what you think in terms of being satisfied or not satisfied with the programme/activities.				
5. Relevance of the programme				
5a. The programme/activities meet(s) my/target group's needs.	Strongly disagree	Disagree	Agree	Strongly agree
5b. The programme/activities is/are appropriate to my/target group's culture and community.	Strongly disagree	Disagree	Agree	Strongly agree

5c. Please tell me more about what you think of the relevance of the programme:				
6. Connection to programme				
6a. I feel connected with the programme (e.g., a sense of belonging to the people involved in the programme).	Strongly disagree	Disagree	Agree	Strongly agree
6b. I have a say (a voice) in what happens in the programme/activities.	Strongly disagree	Disagree	Agree	Strongly agree
6c. This programme belongs to us (e.g., group of participants, target group, or community as appropriate to the programme).	Strongly disagree	Disagree	Agree	Strongly agree
6d. Please tell me more about feeling connected or not connected to the programme.				
7. Skills and knowledge gained *In this section, the word 'useful' means that the respondent feels the knowledge and skills are applicable to and help them in their lives.*				
7a. I gained useful skills and knowledge in the programme.	Strongly disagree	Disagree	Agree	Strongly agree
7b. I am able to apply the skills and knowledge gained in the programme in my daily life.	Strongly disagree	Disagree	Agree	Strongly agree
7c. Please tell me more about the usefulness of the skills and knowledge you have gained in the programme to your daily life.				
8. Other comments				
8a. Please tell me any other thoughts or feelings you have about the programme/activities, including things you like or things you do not like. This will help us to improve the programme.				

1.4.2 Sample: KAP survey – VP/Protection within PS programmes

The tool described below is a KAP (knowledge, attitudes and practices) survey. KAP surveys are used to collect information on what people know, how they feel and how they behave in relation to a certain topic. In most KAP surveys, data is collected orally by interview using a structured questionnaire. The data can then be analysed quantitatively or qualitatively depending upon how you are measuring indicators. A KAP survey can be designed specifically to gather information about MHPSS and VP/protection-related topics, but it may also include questions about other practices and beliefs, such as those related to general health.[5]

KAP survey data are very useful in planning, implementing and evaluating PS programmes and addressing VP/protection issues within PS programmes. A KAP survey can be used to gather information about:[6]

- What community members know about PS and VP/protection problems, what they think about people with those problems or about support responses to those problems.
- What people actually do in seeking support for social and emotional difficulties, or for issues related to VP/protection.
- Knowledge gaps, cultural beliefs, or behavioural patterns that may facilitate understanding and action, as well as pose problems or create barriers for people seeking PSS or protection from violence and abuse.
- Communication processes and sources that are key to defining effective activities and messages in PS and VP/protection needs assessment and response.
- The needs, problems and barriers in PS and VP/protection programme delivery, as well as solutions for improving quality and accessibility of services.
- Ways to involve all stakeholders (community members, families, health personnel, authorities) in PS and VP/protection interventions.

The data collected can help to set priorities for the programme (e.g., identifying the most common PS and VP/protection problems, and understanding those who are vulnerable); to estimate required resources for appropriate interventions; to design effective community outreach messages; and establish baseline and milestone level of change anticipated for PS interventions (including addressing VP/protection issues).

The sample KAP survey below has three parts: 1) a set of qualitative questions for use in focus group discussions or interviews; 2) a series of quantitative questions about attitudes toward violence; and 3) a set of mixed methods questions about beliefs and practices. It has been adapted from IFRC M&E source materials.[7]

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[5] Adapted from Advocacy communications and social mobilization for TB control: a guide to developing knowledge, attitude and practice surveys. WHO/HTM/STB/2008.46
http://whqlibdoc.who.int/publications/2008/9789241596176_eng.pdf

[6] Survey Methodologies: KAP Surveys. Unite for Sight. http://www.uniteforsight.org/global-health-university/survey-methodologies

[7] See *Planning Monitoring Evaluation and Reporting (PMER) Toolkit for Community-based health and first aid.* (2013) IFRC, CBHFA and *The Rapid Assessment Guide for Psychosocial Support and Violence Prevention in Emergencies and Recovery* (2015) IFRC Reference Centre for Psychosocial Support and Canadian Red Cross, p. 32.

KAP Survey – VP/Protection within PS programmes[8]

Instructions to data collectors are given in italics

Qualitative Questions: Traditional Views and Systems
The following questions can be used in focus group discussions, and formal and informal interviews with the target population.

1. What are the traditional views in the community about violence such as interpersonal and self-directed violence? (Is there stigma, shame, is it considered acceptable, etc.?)	
2. What are the traditional/informal systems to help people who have been hurt by violence?	
3. What are the referral systems for people who have been exposed to violence?	

Quantitative Questions: Attitudes about Violence

Important information before administering the survey ***Use the response scale to the right for the first five questions (Please note: 'appropriate'[9] responses are indicated here in the table in italics, but should be removed before collecting data, particularly for self-assessment/reporting).***	Disagree	Neither agree nor disagree	Agree	Don't know
1. To what extent do you agree with the following statement: "Violence against women, men, girls and boys is preventable."			*(agree)*	
2. To what extent do you agree with the following statement: "There are certain situations in a family when it is ok to hit someone else."	*(disagree)*			
3. To what extent do you agree with the following statement: "A woman always has the right to refuse sexual contact."			*(agree)*	

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[8] IFRC CBHFA module on violence prevention and response (2013 version)

[9] Appropriate as aligned with international standards such as the Child Rights Convention, International Declaration of Human Rights as well as IFRC policies and guidelines for violence prevention and protection.

4. To what extent do you agree with the following statement: “Constantly insulting another person is a form of violence.”			*(agree)*	
5. To what extent do you agree with the following statement: “People who see or hear violence occurring have an important role to stop the violence when it is safe to do so.”			*(agree)*	
6. To what extent do you agree with the following statement: “In certain situations it is ok to hit or physically punish children as part of discipline.”	*(disagree)*			

Mixed Methods Questions: Beliefs and Practices

For the following questions, read out only the question and not the possible responses that are listed. Allow respondents to come up with ideas themselves, and then check the box with a next to answers they give. Do not lead or influence the respondent by indicating what the ‘right’ answer should be.
Explain that respondents can provide more than one answer. Record all responses that are mentioned.

1. In your opinion, what are the safest ways to discipline children?

Place a check by any answers given by the respondent:
- ☐ Separate yourself from the child.
- ☐ Reason with the child.
- ☐ Take away a child’s privileges.
- ☐ Model the behaviour you want your child to follow.
- ☐ Other (specify): ____
- ☐ I don’t know

Calculate the % of people that can identify at least two safe ways to discipline a child.

2. What are some of the human impacts of violence?

Place a check by any answers given by the respondent:
- ☐ Physical injuries
- ☐ Emotional injuries (e.g., lower self-esteem, shame, powerlessness, betrayal, guilt)
- ☐ Diseases/illnesses
- ☐ Loss of trust
- ☐ Other (specify):____
- ☐ I don’t know

Calculate % of people who can identify two impacts of violence.

3. If you saw or heard committing sexual violence against another person, what immediate action could you take?

Place a check by any answers given by the respondent:

☐ Get the person being hurt to safety.
☐ Get help immediately.
☐ Speak up to bring attention to the violence.
☐ Make it clear to inflictor that violence is unacceptable and must stop immediately.
☐ Talk to someone else in the hoe or community who can help.
☐ Other (specify): ____
☐ I don't know

Calculate % of people that can list two actions to respond to sexual violence.

4. What practical actions can you take to prevent violence after a disaster? *[Note: this question is specific to communities affected by disaster. Adapt the question as necessary for your context.]*

Place a check by any answers given by the respondent:

☐ Do not act out violently from anger or fear.
☐ Manage your stress levels (by staying busy, meditating, helping others, taking time for yourself).
☐ Do not rely on harmful coping strategies like alcohol or drugs.
☐ Make a plan so you and your family know how and where to go to be safe; plan how your family can communicate and reconnect after a disaster.
☐ Work with your community to build violence prevention into disaster planning.
☐ Other (specify): ____
☐ I don't know

Calculate % of people who can list two practical actions to prevent violence in disasters.

5. If a person tells you they are being hurt by violence, what can you do to help the person?

Place a check by any answers given by the respondent:

☐ Listen to the person and show empathy.
☐ Comfort the person.
☐ Take the person to a safe place.
☐ Know the community resources and support systems.
☐ If it involves a child, report the violence immediately to a helping resource in the community.
☐ Other (specify): ____
☐ I don't know

Calculate % of people that can list two actions to take if a person discloses violence.

1.5 Programme evaluation tool

The following programme evaluation tool can be used to gather qualitative and quantitative data to evaluate PS programme quality against certain standards. It is adapted from the IFRC Project/Programme Monitoring and Evaluation Guide[10] and Development Assistance Committee (DAC) Principles for Evaluation of Development Assistance (OECD, 1991).[11]

1.5.1 Sample: Programme evaluation questions

Programme Evaluation Questions	Response Scale			
Relevance	Not at all	Somewhat	Very much	Completely
• Were the programme's objectives consistent with beneficiaries' needs?				
• Were the programme's objectives consistent with Red Cross Red Crescent policies?				
Additional comments:				
Efficiency	Not at all	Somewhat	Very much	Completely
• Were the PS response activities successfully implemented in the intended time frame?				
• Were activities implemented on schedule and within budget?				
• Were outputs delivered economically (at lowest cost)?				
Additional comments:				

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[10] *IFRC Project/Programme Monitoring and Evaluation Guide.* (2011) International Federation of Red Cross and Red Crescent Societies. Geneva, p. 14.

[11] *The Children's Resilience Programme: Programme Manager's Handbook*, (2012) IFRC Reference Centre for Psychosocial Support and Save the Children: Copenhagen, p. 31.

Effectiveness	Not at all	Somewhat	Very much	Completely
• Have the set objectives been achieved?				
• Did the outputs lead to the intended outcomes?				
• Has the response been implemented in the most effective manner compared to alternatives?				
Additional comments:				

Impact	Not at all	Somewhat	Very much	Completely
• Has the programme had a positive impact on the lives of participants?				
Comments: please explain why you answered the way you did....				

Additional qualitative questions about programme impact: *What changes has the programme brought about?* *Were there any unplanned or unintended changes?*	*Record responses here:*

Sustainability	Not at all	Somewhat	Very much	Completely
• Are the programme benefits likely to be maintained for an extended period after assistance for the programme ends?				
Comments: please explain why you answered the way you did....				

Protection	Not at all	Somewhat	Very much	Completely
- Does the programme contribute to violence prevention/protection by strengthening the protective environment for adults and children?				
Additional comments:				
Coherence	Not at all	Somewhat	Very much	Completely
- Has the work has been consistent with good practice standards and approaches?				
Additional comments:				
Coverage	Not at all	Somewhat	Very much	Completely
- Has programming reached all intended geographic areas targeted?				
- Have the needs and capacities of different age, gender and vulnerable groups been addressed?				
Additional comments:				
Coordination	Not at all	Somewhat	Very much	Completely
- Have organisations worked well together toward the common goal of improving psychosocial well-being				

and violence prevention/protection of programme beneficiaries?				
Additional comments:				

1.6 Guidance on monitoring and evaluation reports

Monitoring and evaluation reports provide crucial data informing programme management for quality performance and accountability. This is the programme's primary reporting mechanism and compiles information from various sources (e.g., activity records, monitoring visit reports). Information from M & E reports is also used for other external reports for accountability and advocacy purposes such as in donor reports. Reports are compiled on a regular basis, such as quarterly or as defined by reporting requirements of the NS or the programme donor.

The following main headings for a monitoring and evaluation report are adapted from the IFRC M&E Guide (2011) and are provided as guidance for topics you may want to include in your reports.

1. **Identifying information:** Date, name of person compiling report, location, title of programme, etc.
2. **Programme information:** Reporting period dates, programme start and end dates, name of the programme manager, location, etc.
3. **Executive summary**: Summarise key points from the main sections of the report. Provide an overview of the programme's current status – whether the programme is on track, total people reached during the reporting period, key accomplishments and problems or challenges. Include key actions planned to address any ongoing or new issues and to support programme implementation.
4. **Financial status:** A concise overview of the programme's financial status based on the monthly finance reports for the reporting quarter.
5. **Situation/context analysis (positive and negative factors):** Discuss any factors that affect the programme's operating context and implementation (e.g., change in security or a government policy, etc.) as well as actions to be taken.
6. **Analysis of implementation:** Provide an analysis based upon the objectives as stated in the programme's logframe and data recorded in the programme's indicator tracking table. Be sure to:

- Elaborate on what has happened in the programme.
- Relate quarterly performance to overall targets for the year and the life of the programme.
- If no activity was taken for a specific objective during the reporting period, explain why.
- Keep it as simple and short as possible.

7. **Stakeholder participation and complaints:** Describe concisely how key stakeholders, particularly local beneficiaries, have been involved in the programme and summarise any key stakeholder feedback (especially complaints).
8. **Partnership agreements and other key actors:** List any programme partners and types of agreements and status/comments (e.g., roles and responsibilities in an MoV, date the agreement is signed).
9. **Cross-cutting issues:** Discuss activities undertaken or results achieved that relate to any cross-cutting issues, such as gender equality.
10. **Programme staffing – human resources:** List any changes in programme staffing (e.g., new hires) highlighting any implications for the programme implementation and if management support is needed to resolve any issues.
11. **Exit/sustainability strategy summary:** Summarise overall progress towards the exit strategy and eventual continuation of the programme objectives after handover to local stakeholders.
12. **PMER status:** Provide a concise update of the programme's key planning, monitoring, evaluation and reporting (PMER) activities. For example, summarise key activities planned, their timing and status (completed, in process, planned).
13. **Key lessons:** Highlight key lessons and how they can be applied to this or similar programmes in the future.
14. **Report annex:** Attach the programme's indicator tracking table and any other useful supplementary information (e.g., ToR, case studies, relevant reports).

1.7 Guidance on reporting a 'lessons learned' feedback session

Periodically, it is useful for the implementing team to review and compile lessons learned from the design and implementation of a programme in the specific context. Feedback sessions to document lessons learned can gather a range of information about the programme and should foster open dialogue and allow for a broad range of opinions.

It may also be useful to structure the conversation with some guiding questions or topics, such as:

- What went well in implementing this programme (e.g., needs assessment, consultation with beneficiaries, engaging stakeholders, etc.)?
- What were the challenges in implementing the programme?
- What factors in the context influenced how the programme was implemented, its quality, accessibility and reach?
- What was the general impression of beneficiaries who participated in the programme?
- What changes did the programme bring about in terms of PSS for beneficiaries?
- What could we have done differently to improve design or implementation of the programme?
- What did we learn in this programme that we will be sure to carry into other programmes/activities?
- What did we learn in this programme that we should avoid doing in the future?
- What were unexpected or unintended outcomes (positive or negative) of the programme?

The feedback on lessons learned that is gathered in this type of session can be documented in a written report. The report should contain identifying information such as the date, location of the session, names and positions/role of participants in the meeting, title of the programme or activities, and any other important information about the programme itself (e.g., areas where it is implemented, objectives and target population). The reporting format can then be adapted according to the main questions and themes that have been discussed during the lessons learned session. Finally, key conclusions and recommendations for future action can be listed.

2 Well-being measurement tools

Psychosocial well-being does not mean the same for all people.[12] When designing tools to measure change in well-being among a particular target population, it is essential to gain a clear understanding of how individuals experience PS well-being. The IFRC M&E Framework Guidance Note sets out indicators of well-being in terms of three main domains: personal well-being, interpersonal well-being and capacities.

This section describes psychosocial well-being in more detail and presents various tools to identify and incorporate local concepts of well-being for the purpose of monitoring and evaluation.

2.1 Psychosocial well-being concepts

The well-being measurement tools in this toolbox are drawn from many different sources related to well-being concepts, such as life satisfaction, capabilities and resilience. Some of the sources of inspiration for these tools are described below.

Contextual and shared concept of well-being

The way people express feelings of well-being or distress, seek support and offer comfort to others are contextually and culturally grounded. What it means to be 'well' or 'functioning' in emotional, social and capacity terms may vary from place to place, and from person to person. When we measure changes in well-being in M & E, we often try to draw upon what may be considered as shared human values.

A participatory study conducted by Care provides an interesting illustration of women's perceptions of well-being – both unique and shared – in three conflict-affected countries (Burundi, Nepal and Uganda).[13] They aimed to identify, clarify and gain consensus on concepts of psychosocial well-being in each country and in women's own voices. They asked questions such as:

- How do you understand PS well-being?
- What words do you use to speak about being well?
- How would you define well-being for yourself and programme participants?

They then examined how the concepts of well-being interacted and compared them across the country contexts.

In each setting, women defined a series of domains that described the components of psychological and social well-being. Women from all three countries considered these domains as interlinked and interconnected. After combining the results, five common domains emerged across all countries: education; access to resources; love within the family; friendship and support outside the family; and voice at home, in the community and beyond. The domains reflect the importance of both objective well-being (economic and social assets) as well as subjective well-being (positive thoughts, feelings, attitudes and social relationships). The idea of "living a good life, now and in the future"[14] and having the capabilities to make that possible were reinforced by women's responses in the study.

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[12] *Strengthening Resilience: A global selection of psychosocial interventions. (2014) IFRC Reference Centre for Psychosocial Support: Copenhagen, p. 12*

[13] *Bragin, M., Onta, K., Janepher, T., Naeyimana, G. and Eibs, T. To be well at heart: women's perceptions of psychosocial well-being in three conflict-affected countries. Intervention, July 2014, Vol. 12, Issue 2: 187-209.*

[14] *Sen, A. (1999) Development as freedom. New York, NY: Anchor Books.*

2.2 Exploring local concepts of well-being

Well-being surveys are one means of verification for indicators to measure the outcome related to wellbeing. However, first it is important to understand how the target group experiences and describes well-being.

Consider starting with focus group discussions or key informant interviews about the concept to best understand well-being in your local context. The sample questions below (2.2.1) explore the concepts of well-being and distress with beneficiaries and stakeholders from your target population. (See also section 3: Qualitative methods for sample focus group questions related to life skills and well-being.)

Questions should be brief and non-leading, so that respondents are free to respond from their perspective. It may be helpful to word questions in a way that asks respondents to think about a real person that they know (anonymously) for specific examples, but not to describe themselves. For example, "Think of a [woman, girl, boy or man] who has problems because of the war…"[15]

2.2.1 Sample questions: Local concepts of well-being

These sample questions explore local meanings and understandings of well-being and what it means to be well, based on the domains of personal, interpersonal and capacity well-being.

Psychosocial well-being: what does it mean?

Instructions to data collectors are given in italics

1. General well-being

Think of someone [woman, girl, boy, man] in your community.

- How do you know when he/she is doing well? What do you see?
- How do you know when he/she is not doing well? What do you see?

2. Personal well-being

- When someone is "well", what words would you use to describe the way they feel? For example, what might they be experiencing in their body, mind and heart?
- When someone is "not well", what words would you use to describe the way they feel?

Use probes for more information: Ask about local descriptions of sadness, anger, despair, negative or suicidal thoughts, hopefulness, optimism, self-esteem, thinking of the future, physical symptoms (pain the in the body)

3. Interpersonal well-being

- When someone is "well", how can you tell by their relationships with family, friends and others in the community? For example, what are they like (how do they interact and behave) with family, friends and others?
- When someone is "not well", how can you tell by their relationships with family, friends and others in the community?

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[15] *Hubbard J. Manual on Brief Ethnographic Interviewing: Understanding an issue, problem or idea from a local perspective. Center for Victims of Torture.* *http://www.cvt.org/sites/cvt.org/files/attachments/u8/downloads/Brief%20Ethnographic%20Interviewing%20Manual.pdf*

Use probes for more information: Ask about local descriptions of feelings of belonging, feeling connected to family members and others, having one or more close friends, ability to relate to others in positive ways.

4. Capacity to function and cope

- When someone is "well", how do they behave in their daily life (e.g., their school or work inside or outside of the home)?
- When someone is "not well", how do they behave in their daily life (e.g., their school or work inside or outside of the home)?
- What are the "positive" coping strategies that people use during difficult times (e.g., how do they behave)?
- What are the "negative" coping strategies that people use during difficult times?

Use probes for more information:: Ask about local descriptions of ability to make decisions, ability to function in one's role (studies, job, caring for household), capacity to adapt to changes.

5. Other aspects

Please describe any other ways can you tell if someone is "well" or "not well" in this community that we have not discussed.

These questions will enable you to describe local concepts of well-being, once you have analysed the responses. The next step is then to develop or adapt a questionnaire, as described below.

2.3 Developing or adapting well-being surveys based on local concepts of well-being

Developing and validating well-being surveys from qualitative methods is often a long process. Here we offer a suggestion for creating a survey using the qualitative data gathered above from the sample questions to explore local concepts of well-being. The resulting survey would not be "validated" nor would it be a clinical tool to measure mental disorder. Rather, the well-being survey you develop can give you an idea of how your target group experiences PS well-being, and when measured over time (baseline and milestones) can indicate changes in indicators of well-being during the course of implementing your programme.

Steps in Developing or Adapting Well-being Surveys

1) **Explore local concepts of well-being** (see sample questions in 2.2.1)
2) **Compile responses into meaningful categories or domains** ("pile sort"). You can sort responses according to the three well-being domains – personal, interpersonal and capacity – and/or new, alternative domains.
3) **Create a well-being survey questionnaire** from these responses (or adapt the sample well-being questionnaire provided below) for use in monitoring changes in well-being in the target population over time.

The 'pile sort' referred to in the box above is a useful method of identifying common themes in a set of responses:

- Begin by looking for meaningful words and statements describing well-being and distress in the responses from the questions in 2.2.1.
- Now write significant word/s and statements onto separate cards.
- Sort the cards into piles into common themes (such as the three well-being domains – personal, interpersonal and capacity). This sort should be done by a group of people and they should reach a consensus on each pile sorted.
- Define measures and/or specific indicators) related to local concepts of well-being and distress.

During this process, consider domains and themes that are important for measuring your indicators. You can then use the most commonly mentioned words and statements that reflect local well-being descriptions (e.g., local words for grief or depression) in your own well-being survey. Another option is to adapt the sample survey below using local domains and themes.

2.3.1 Sample: Well-being questionnaire (15-20 questions)

This sample well-being questionnaire has questions grouped according to the well-being domains: personal, interpersonal and capacity. You can select questions from each domain, or adapt the questionnaire to local understandings of well-being (delete, change or add questions). Before you use your questionnaire widely, be sure to pilot test it with a small sample of respondents similar to your target group, to be sure they understand and relate well to the questions. Adapt any questions that are unclear or culturally irrelevant or inappropriate.

The questions marked with * in the following sample questionnaire were taken from the WEMWBS (the Warwick-Edinburgh Mental Well-being Scale.[16])

Well-being questionnaire				
Instructions to respondent: *I am going to read a set of statements to you. Please tell me if you agree or disagree with the statement based on how you have been feeling* *over the past month*.	*Put a check mark corresponding to the respondent's answer.*			
Personal Well-being	Rarely	Some-times	Most of the time	Always
I am able to have positive (good) feelings.				
Everyone has difficult feelings sometimes (feeling upset, sad, angry, anxious). I can manage my difficult feelings in healthy ways (without hurting myself or others).				
I've been feeling cheerful.*				
I have energy for the things I want to do.*				
I've been feeling relaxed.*				

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[16] *Tennant, R., Hiller, L., Fishwick, R., Platt, P., Joseph, S., Weich, S., Parkinson, J., Secker, J., Stewart-Brown, S. (2007) The Warwick-Edinburgh Mental Well-being Scale (WEMWBS): development and UK validation, Health and Quality of Life Outcome; 5:63 doi: 101186/1477-7252-5-63*

I’ve been feeling optimistic about the future.*				
I’ve been thinking clearly.*				
I’ve been feeling good about myself.*				
I’ve been feeling interested in things that usually give me pleasure.*				
Interpersonal Well-being				
I have people in my life who love me.				
There are people who will be there for me if I need help.				
I am able to love and care for others.				
I am worthy of love.				
I feel respected for who I am.				
I’ve been feeling interested in other people.*				
I’ve been feeling close to other people.*				
Capacity				
I have the knowledge to take decisions in my life.				
I am able to meet the responsibilities in my life.				
I am able to adapt to challenges that arise in my life.				
I’ve been feeling useful.*				
I’ve been dealing with problems well.*				
I’ve been feeling confident.*				
I’ve been able to make up my own mind about things.*				
I have a voice in decisions that affect me.				
I can express to others the things that are important to me.				

2.3.2 Sample: Pre- and post-interview based analysis questionnaire for the Children's Resilience Programme

The pre-and post-interview based analysis (PIA) questionnaire is a resource specifically developed for the Children's Resilience Programme. A wide range of factors influence children's well-being and how they cope in difficult circumstances, including their family life and circumstances, their sense of belonging and acceptance, and their age and gender. This questionnaire provides quantitative data to compare changes in indicators of child PS well-being directly before and after an intervention. It is usually used to complement other M&E tools (such as focus group discussions). The same fifteen questions in the questionnaire are used in the pre- and post-phases of the programme.

Possible changes in children's PS well-being are measured along five indicators:

1. Troubling thoughts and feelings – relates to levels of anxiety, calmness and sense of security.
2. Home environment – relates to improved relationship with parents, contribution to household activities.
3. School environment – relates to positive learning attitudes and strategies, improved relationship with teachers.
4. Social relations – relates to pro-social values and behaviours with peers and non-family adults, reciprocated social and community support, increased self-expression.
5. Problem solving – relates to increased problem-solving skills, risk reduction behaviours, age appropriate autonomy, initiative, curiosity, exploration and self-regulation.

See the Children's Resilience Programme M&E Guidelines for more detailed information on how best to train staff, to pilot and adapt the questionnaire, to select a sample of children and present the questionnaire to them. Analysis of the PIA is also explained in these guidelines with a link to a data entry template.

The following questions about children's personal well-being refer to the previous two weeks in the children's lives. The child's response to each question is marked in the appropriate box.

"Thinking about the last two weeks…"				
1. Troubling thoughts and feelings	**Never**	**Rarely**	**Usually**	**Always**
1a. Have you felt sad?				
1b. Have you had bad dreams?				
1c. Have you been worried?				
2. Home environment	**Never**	**Rarely**	**Usually**	**Always**
2a. Have you been able to do the things you wanted to do in your free time?				
2b. Have you felt that your parents/caregivers listened to you and respected your opinion?				

2c. Have you felt that your parents/caregivers were able to help you to solve difficult problems?				
3. School environment	**Never**	**Rarely**	**Usually**	**Always**
3a. Have you been able to concentrate/pay attention in the classroom?				
3b. Have you felt that your school is a nice place to be in?				
3c. Have you felt that your teacher listened to you and respected your opinion?				
4. Social relations	**Never**	**Rarely**	**Usually**	**Always**
4a. Have you been picked on or bullied?				
4b. Have you felt you have someone you trust to help you when you need to?				
4c. Have you spent time with your friends (games, activities, talks)?				
5. Problem solving	**Never**	**Rarely**	**Usually**	**Always**
5a. Did you know what to do in difficult or dangerous situations?				
5b. Have you suggested games or activities with friends?				
5c. Have you got angry and lost your temper?				

3 Qualitative methods

Qualitative methods[17] are tools to gain information about human behaviour, relations, perceptions and attitudes, value systems, concerns, aspirations and culture. Qualitative methods help us understand the world in which we live and why things are the way they are. They allow target beneficiaries and communities to respond spontaneously and with more depth and detail than with a quantitative survey. In turn, you can also respond immediately to what beneficiaries say by tailoring subsequent qualitative questions to the information they provide. Qualitative methods use open-ended questions that seek to understand why beneficiaries feel the way they do about the subject. This contrasts with the closed responses of quantitative methods (e.g., surveys with 4-point responses),

Four types of qualitative methods are described in this section:

1. Focus group discussions
2. Key informant interviews
3. Case studies
4. Most significant change methodology.

3.1 Focus group discussions

Focus groups (FGs) are focused discussions with a small group (usually 8-12 people) to get a nuanced sense of participants' opinions, attitudes, perceptions, beliefs and behaviours towards specific issues.[18][19] A moderator uses a prepared interview guide (a list of open-ended questions) to lead the discussion. The conversation, opinions and reactions of participants are recorded in written notes or by tape recording (a note taker can help with this). When done well, FGs create an accepting environment that puts participants at ease and allows them to answer questions thoughtfully and truthfully.

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[17] *Adapted from: Tool C Example of general guidelines for focus group discussions. M&E package for Health Emergency Response Unit, psychosocial component. IFRC (pending publication)*

[18] *Monitoring and evaluation guidelines for The Children's Resilience Programme. (2012) IFRC Reference Centre for Psychosocial Support and Save the Children: Copenhagen.*

[19] *IFRC Project/Programme Monitoring and Evaluation Guide. (2011) International Federation of Red Cross and Red Crescent Societies. Geneva.*

3.1.1 Guidance: Basic questions about using focus groups

This section provides guidance on focus groups.

Question	Answer
When should I use a FG?	FG are useful when: • designing a PS programme, to understand context and needs, and at the end of a programme to document any changes. • 'how and why' (e.g., people's motivations, range of opinions) are more important than 'how many' or 'how much.' • working with groups who may be resistant to written surveys or are not able to read or write.
How many FGs do I need?	Depending upon time and resources, try to conduct at least two focus groups per target group. For example, for FGs with youth separated by gender, have at least two groups with boys and two groups with girls. When you hear the same things from new groups as from previous groups, you are likely reaching a saturation point for new information.
How long do FGs last?	FGs are ideally about 1.5 hours (between 60 and 120 minutes). If conducting FGs with children, shorten the time for younger participants. [20] Also be sure to limit the number of main questions (no more than about 8) so that participants can explore each question adequately, without going over time. You can use probing questions as needed to explore a topic in more depth.
Who should participate?	Define the characteristics of your group (e.g., certain age groups, common interest). Then, select members who can provide the best information for the topic, will participate and be reflective. Ensure participants are similar in nature (e.g., gender, power relationships) to help them feel comfortable to join freely in the discussion. If a large number of people come along and you judge that it's not possible to go through with a FG discussion, you can convert the session into a community meeting to discuss the topics more generally. You can then reschedule the FG discussion in a more controlled environment with less people, in order to go into the issues in more depth.
What kinds of questions should I ask?	Develop a discussion guide (set of questions) based on the key objectives of your M&E plan. Develop about eight questions that are: • open-ended (cannot be answered by "yes" or "no") and conversational • short, clear and to the point • non-leading, non-judgmental, non-threatening and not embarrassing • focused on ONE idea per question (avoid "and" or "or" in each question).
What types of questions are useful?	• One or two general warm-up questions at the start. These may be specific to the purpose of your FG or the programme, just be sure they are neutral and easily answered by all participants. For example, in a FG to evaluate a PS programme, a warm-up question

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[20] *See Annex 10 of M&E Guidelines for The Children's Resilience Programme (2012) for a more comprehensive guide to conducting focus group discussions with children.*

	could be: "What activities have you been involved in?" • Reflective questions that ask participants to think back to a to certain point in time when reflecting on personal experiences. • Questions of influence such as "What influenced you…" or attributes "What features do you…" (rather than "why" questions that may make some people feel defensive). • Probe questions – these are follow-up questions used AFTER participants have given their insights to clarify responses or reveal more depth: "Can you talk more about that?" or "Can you give me an example?"
What should I remember as the moderator? [21]	• Ensure everyone is seated at the same level to encourage equal rapport, and that participants can all see each other (a circle is best). • Use a natural conversational style to put participants at ease. • Listen actively, respond and probe for more information so that participants know their opinions are important and you want to hear them. • Go from general to specific questions. Summarize and repeat answers to be sure you understood. • Remain neutral: Don't agree/disagree or offer your opinion. Participants are the experts in the discussion, and there are no right or wrong answers. Do not correct or make any judgment (bad or good) on what participants say. • Acknowledge and respect all contributions to the discussion. • Try to hear from all participants, including boys and girls, women and men of all ages (particularly important for mixed gender and/or age groups). • Don't push for consensus; rather seek a variety of views. • Ensure even participation – if one or two people dominate, call on others. Consider using a round-table approach, going in one direction around the group giving each person a minute to answer the question. Ensure everyone gets heard, and, if necessary, moderate the time for each person to respond. • Keep your eye on the time and keep the discussion moving. Remember to keep focused, maintain momentum and get closure on the main questions. • Set ground rules. For example, do not allow for side conversations – rather, keep all discussions within the group. • Use the guide questions in a flexible way, moving out of the question order if participants spontaneously begin to talk about a certain topic. Try to cover each question but do so naturally with the flow of the discussion.
What are some limitations and pitfalls of FGs?	Some pitfalls and limitations are[22]: • Results from FGs cannot usually be used to make statements about the wider community; in other words, they can indicate a range of views and opinions, but not their distribution. • Participants often agree with responses from fellow group members (for many different reasons) and so caution is required when

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[21] *Snider L. and Dawes A. (2006) Psychosocial Vulnerability and Resilience Measures for National-Level Monitoring of Orphans and Vulnerable Children: Recommendations for the UNICEF Psychological Indicator. UNICEF: New York.*

[22] *Adapted from: M&E package for Health Emergency Response Unit, Tool C. IFRC (pending publication)*

	interpreting the results. • The moderator who is not well trained can easily force the members into answering question in a certain way. In addition, participants may try to answer questions in the way they feel the moderator wants to hear, particularly if the setting is formal and the moderator is seen as a learned authority. • FGs may not be the best method for discussing very sensitive topics or exploring complex beliefs of individuals. Other in-depth methods, such as key informant interviews, may be a more appropriate method for this purpose. If sensitive questions are included in the FG, be sure to ask them in a general, non-personal way. • FG discussions can paint a picture of what is socially acceptable in a community rather than what is really occurring or believed – called "social desirability bias". • Even though this is stressed in the FG discussion with participants, remember that FGs lack anonymity and confidentiality cannot be guaranteed for FG participants. Some of the limitations and pitfalls of FGs can be addressed through careful participant selection, good moderating skills and attention to the setting, and ground rules (see box above).

3.1.2 Guidance: Conducting a focus group[23]

Focus groups can be arranged as follows:

Welcome and aim
- Welcome participants, introduce yourself (and note-taker)
- Explain the aim of the meeting (why we are here) and set ground rules (e.g., confidentiality).
- Present participants to each other or let them introduce themselves.
- Explain how notes are taken or about any recording devices.
- Explain the focus group will take about 1.5 hours.

Question and answer session
- Ask one question at a time and facilitate a discussion.
- Repeat answers to make sure you heard correctly.
- Ask the same question in different ways to check consistency of answers.
- Be curious about what meanings and interpretations the participants give to behaviour, events or objects in their experience.
- Probe to better understand participants' underlying thinking.
- Be patient, listen carefully and try to remember what each person says.
- After each question is answered and discussed, summarise what you heard.
- Take comprehensive notes (if you are the note taker) including verbal and non-verbal messages (e.g., body language).

Closing the focus group
- When time is up find an appropriate point to pose the closing questions.
- Thank respondents for their time and willingness to participate.
- Repeat the purpose of the focus group and explain how the data will be used.

After the focus group

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[23] *http://managementhelp.org/businessresearch/focus-groups.htm*

- Immediately after the focus group, moderator and note taker sit down together and expand the notes from the discussion(s).

3.1.3 Guidance: Analysing focus group data

Analysing focus group data is about searching for meanings and understandings in the sea of information you have gathered from notes, transcripts and recordings. Analyse the data from each FG and then compile the analysis from all of the FG you conducted by asking:

- What are respondents saying?
- What did you learn?
- What's new? What's surprising?
- What's confirmed?
- What's the big take away?

Make the text manageable by filtering according to what is relevant to you, i.e., the purpose of the FG. Try to relate the information gathered to the indicators of interest, but also allow for unexpected conclusions to emerge. Code and organise the data into themes:

- Look for repeating ideas or similar words/phrases used by different participants.
- Based on repeating ideas, organise the data by common themes (keeping in mind the indicators you wish to measure).
- Present your findings in a narrative with people's own words, using your themes to organise people's experiences into a coherent story.

Two sample sets of FG questions are provided below that you can adapt to the needs of your programme and context.

3.1.4 Sample: Focus group questions – life skills and well-being

These life skills and well-being questions are taken from Ungar and Liebenberg at the Resilience Research Centre, and relate to child, youth and adult CYRM manuals. The questions could be used in focus groups to assess life skills and well-being among adults (and children and youth through the alternative questions shown).

Sample Focus Group Questions – Life Skills and Well-being

1. What do I need to know to live comfortably here and be safe? (Child/youth alternative: What do I need to grow up well here?)

2. How do you describe people who are able to overcome a lot of adversity here, despite the many problems they face? (Child/youth alternative: How do you describe people who grow up well here despite the main problems they face?)

3. What does it mean to you, your family and your community when bad things happen?

4. What kinds of things are most challenging for you living here? (Child/youth alternative: What kinds of things are most challenging for you growing up here?)

5. What do you do when you face difficulties in your life?

6. What does being healthy mean to you and others in your family and community?

7. What do you and others you know do to keep healthy (mentally, physically, emotionally, spiritually)

3.1.5 Sample: Focus group discussion questions from the Children's Resilience Programme

These questions for focus group discussions with children are taken from the Children's Resilience Programme. These questions could be used to monitor and evaluate PS programme activities.

Focus Group Discussion Questions from the Children's Resilience Programme

FG Questions

1. Which activities do you remember?
2. Which activities did you like/dislike?
3. What was the best/worst about participating in this programme?
4. Have you felt any difference/change in yourself, how you relate to others since going through the workshops?
    a. How do you feel going to school now? For example, how do you feel about your teachers, about homework, about the lessons?
    b. How do feel in relation to your friends and classmates?
    c. How do you feel in relation to your parents and how things are at home?
    d. Have you gotten help from friends, teachers and/or parents when needed and how?
5. Do you think other children should go through such and programme – and why?
6. Do you have any good advice for the programme?
7. Anything else you want to add?

Closing questions

8. Summary: Is this an adequate summary?
9. All things considered: Reflect on the discussion and offer any new positions.
10. Final: Have we missed anything?

3.2 Key informant interviews

Key informant interviews are in-depth interviews with people who have special information about a particular topic. The purpose of key informant interviews is to collect information from a range of people—including community leaders, professionals, or residents—who have first-hand knowledge about the community. These community experts, with their particular knowledge and understanding, can provide insight on the nature of problems and give recommendations for solutions.

Key informant interviews are useful for understanding the motivation and beliefs of the community on a particular issue. It also provides the opportunity to probe for in-depth information from people with diverse backgrounds and opinions. Focus group dynamics may prevent some people from openly discussing sensitive topics. However, key informant interviews (individual or small groups of two or three people) create a comfortable environment for frank and open discussions.

3.2.1 Guidance: Planning key informant interviews

There are several key steps involved in planning and implementing key informant interviews as a means for data collection:

Steps for planning key informant interviews
1. Gather and review existing data – look for information that already exists on the topic from different sources.
2. Determine what information is needed – prepare and formulate the primary questions you would like to answer and determine what type of data is needed (e.g., data on community practice, opinions, existing services and service utilization).
3. Define the target population and brainstorm about possible key informants – choose key informants who are knowledgeable about the target population of interest.
4. Choose key informants – choose key informants who have first-hand knowledge about the community and issues or problems of interest. Diversity is important - try to include a wide range of key informants with different backgrounds and from different groups or sectors to get a variety of perspectives.
5. Choose the type of interview – interviews can be face-to-face or by telephone, depending upon the key informant’s availability and preference, as well as your available time, resources and logistical feasibility.
6. Develop an interview tool – this is an outlined script and list of open-ended questions relevant to your topic. Begin with factual and easy-to-answer questions, followed with questions about opinions and beliefs. Use probing questions to help clarify informant’s comments and get detailed information. End with questions asking for general recommendations.
7. Determine the documentation method – compile interview information to ensure data collection efficiency, quality, and consistency across interviews. Take notes both during the interview, but be careful that your note taking does not disrupt the flow of conversation. Also take notes directly after the interview and review

and fill in details. You may also want to tape record the interview, with the informed consent of the informant.

8. Select designated interviewer(s) – select interviewers who are good listeners, have strong communication skills, can take detailed notes, are detail oriented, and comfortable meeting and talking to new people.
9. Conduct key informant interviews – welcome and thank the informant. Make sure to explain how the information will be used and issues of confidentiality, and gain informed consent. Then conduct the interview based upon the interview tool, listening carefully for recurring and new opinions or beliefs. In order to compare the data collected, be sure to get answers to certain key questions from every person interviewed. At the end of the interview, ask the informant if they have any questions or final comments. Let them know what will happen with the information and conclude by thanking them for their time.
10. Compile and organise key informant interview data – Consider at the outset how to manage the data collected, including notes, comments and impressions of the interviewer. Notes should be typed up quickly after the interviews (supplementing with audio tape information, if used). It may be helpful to organise the data from different key informant interviews into categories based, for example, upon the interview questions themselves. Ensure the confidentiality and anonymity of informants in the informed consent procedures, by keeping identifying information in the data in a locked place during analysis and by removing identifying information once the data is compiled.

3.3 Case studies

A case study[24] is a detailed description of individuals, communities, organisations, events, programmes, time periods or a story (such as a success or learning story as described in the text box below). These studies are particularly useful in evaluating complex situations and exploring qualitative impact. A case study helps to illustrate a situation or findings, and allows for unexpected results to emerge. However, it provides an example from one perspective and only when combined (triangulated) with other case studies or M&E methods is it possible to draw conclusions about key results.

3.3.1 Examples of stories for case studies

***Success story*: A story detailing a person's positive experience resulting from a programme in his or her own words.**
***Learning story*: A story focused upon the lessons learned from a person's positive and/or negative experiences with a programme.**

A case study can provide powerful and interesting in-depth information about the results of a programme. When you begin writing up a case study, begin by making a short list of four or five bullet points to help focus the case study on relevant information. Use examples from the field to capture unique opinions, insights and information to bring the case study to life.

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[24] *IFRC Project/Programme Monitoring and Evaluation Guide. (2011) International Federation of Red Cross and Red Crescent Societies. Geneva.*

3.4 Most significant change methodology

Storytelling is an ancient, cross-cultural process of making sense of the world in which we live, and is familiar to all peoples. Collecting stories from beneficiaries, volunteers and staff of PS programmes can be useful in better understanding perceptions, reflections and unexpected or personally important changes during M&E. One model of collecting stories for M&E is the 'Most Significant Change' (MSC) approach.

MSC is a participatory approach that involves collecting stories about change at regular intervals. It involves the participation of stakeholders at different levels in deciding on the sorts of change to be recorded and in analysing the data collected. It can help in monitoring throughout the programme cycle or in evaluating the impact of the programme as a whole. In evaluations, stories are an ideal way for people to make sense of all the different results of a programme. They also help in understanding the values of key stakeholders – those who participate in or benefit from PS programmes.[25]

The MSC process involves collecting stories from beneficiaries at the field level of 'significant change' resulting from a programme. Panels of designated stakeholders or staff then systematically select the stories they feel are the most significant of all. They read the stories aloud and discuss the value of the reported changes. In large programmes, stories may be pooled and selected at multiple levels. This may span the field level (beneficiaries) to staff and stakeholders, to managers and donors, allowing various people involved to reflect upon and analyse the programme's significant results in relation to the key objectives. Discussing the value of those changes also helps to determine the benefits and/or disadvantages of programmes in order to improve them.[26]

Benefits of most significant change:

- Beneficiaries/stakeholders can share and reflect upon their personal change stories.
- It captures the values among stakeholders regarding the main benefits of the programme. The values become apparent when the different stories are described and discussed. This will clarify why the story is important and what value the story represents.
- It can identify unexpected changes (positive or negative).
- It encourages analysis because participants must explain why they believe one change is more significant than another.
- It builds capacity of staff and beneficiaries in analysing data and conceptualising results.
- It delivers a rich picture of what is happening with a programme.
- It can be creatively documented and disseminated as part of participant-led advocacy.

The MSC method can be used every 3-6 months with both adults and children. The process of helping people to reflect upon and create their stories of most significant change is likely to take 1-2 hours. First, individual stories are developed, followed by a collective (group) sharing and analysis. Stories may be recorded through writing or by other creative means – such as drawings or poems. Stories of most significant change can also be creatively documented after the process with involvement of the stakeholders/storytellers themselves. This can include, for example, the production of a book (perhaps with illustrations), an exhibition or even radio broadcasts of the stories.

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[25] *Dart J. and Davies R. (2003) A Dialogical, Story-Based Evaluation Tool: The Most Significant Change Technique. American Journal of Evaluation, 24(2): 137-155.*

[26] *Monitoring and Evaluation News,* http://mande.co.uk/special-issues/most-significant-change-msc/

3.4.1 Guidance: Most significant change – key steps

Key steps include

- Stakeholders are selected and engaged in the process.
- The time frame for collecting and reporting on stories is defined.
- Participants are individually given paper, pencils, crayons or paints/paintbrushes. They are asked to think about stories/examples that illustrate the most significant changes (either positive/successes or negative/challenges) that have occurred as a result of the programme. *"In your opinion, during the last month, what was the most significant change that took place for participants in the programme?"*
- Each participant decides on the most significant change story they would like to share and creatively records the story in writing or drawing.
- In small groups, each person presents and explains their story/picture of significant changes. They explain why they chose this story, why it is most significant for them.
- Notes from the sharing of stories are recorded by facilitators or by the group themselves (on separate paper or flip chart). Basic information on the background of participants is also recorded, but not their names to protect confidentiality.
- After individual storytelling, a facilitator helps the group to discuss similar and/or different experiences, and to analyse the changes and values expressed in the stories.
- The analysis may be done by having participants discuss the different stories and group them into domains. For example, the group may identify 3-5 broad *domains* or types of change upon which the stories can be grouped, such as *'changes in people's lives' or 'nature of people's participation'* or more specific domains like *'changes in cooperation', 'changes in confidence' or 'changes in social networks".* Using domains of change has immediate practical value. It helps organisations to group a large number of SC stories into more manageable lots, which can each be analysed in turn. The domains are used to help describe the nature of most significant change in reporting.
  - Analysis using pre-determined domains: You can determine domains in advance. A benefit of pre-determined domains is that they can provide some guidance to the people collecting stories concerning the kind of changes they need to be searching for without being too prescriptive. *However when using pre-determined domains it is important to also include a domain of "any other type of changes"* that allows participants to report significant changes that don't fit into the named domains.
  - Analysis without specifying domains: At the field level, especially where program participants are involved in identifying and selecting MSC stories, it may be useful to start without specifying domains. Instead, see what sort of stories are generated and valued by the beneficiaries, and then divide these into appropriate domains or have the beneficiaries do so. The choice depends on the extent to which the organisation using MSC wants to be led by its participants rather than its own objectives.
  - Analysis not using domains: Domains are not essential. MSC stories can be

collected and analysed as a group without first being categorised into domains. Participants can be asked to go out and look for significant changes without being given guidance in the form of specific domains of concern. With smaller organisations where there are likely to be fewer SC stories to examine, the MSC approach will probably be easier without domains.

- The group can then choose 1-3 stories which best illustrate the most significant changes they feel have been achieved by the programme that they would like to share with others.
- When documenting the stories that best illustrate most significant changes, include the following information: 1. Information about who collected the story and when the events occurred (remember to keep confidentiality as appropriate) 2. Description of the story itself – what happened 3. Significance/value (to the storyteller) of events described in the story.
- If stories are shared at multiple levels of staff or stakeholders, the process of reading and selecting stories continues, with selected stories filtering up through the typical levels of authority in an organisation or programme. Participants at each level review the series of stories sent to them from the level below and select the single most significant account of change (within each domain/heading, if using domains). This involves a process of reading, discussing, deciding and documenting the reasons for the selection so that the criteria are clear and can be fed back in a transparent process to all stakeholders.

4 Quality standards tools

The following tools can be used by programme managers and staff to measure quality standards forMHPSS programmes VP/protection approaches. They are informed by existing international standards and guidelines for assessment, implementation and monitoring and evaluation of programmes, as described for each tool.

4.1 International programme standards for MHPSS

A major international framework for MHPSS is the Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings (IASC MHPSS Guidelines).[27] The guidelines describe six core principles for humanitarian settings (but also applicable in a variety of PS programme situations):

- Human rights and equity: Promote human rights of all affected persons, protect individuals and groups at heightened risk of human rights violations, and promote equity and non-discrimination.
- Participation: Maximize participation of local affected populations in the response, building upon their resilience. Enable people to retain or resume control over decisions that affect their lives and promote local ownership for programme quality, equity and sustainability.
- Do no harm: Recognize that MHPSS interventions have the potential to help and to cause harm, particularly as they deal with sensitive issues. Reduce harm by coordinating with other sectors; design interventions on the basis of sufficient information; commit to open evaluation and external review; ensure cultural sensitivity and competence and evidence-based practice in interventions; and continually reflect on human rights, power relations and participatory approaches.
- Build on available resources and capacity: Recognize that all affected people have resources and capacity for PS well-being, and build on and strengthen capacities of individuals, families, communities and society to support self-help and strengthen existing resources.
- Integrated support systems: Avoid stand-alone services (e.g., sole services for survivors of SGBV, or people with PTSD) in favour of activities that are integrated into wider systems (e.g., health services, existing community supports) in order to reach more people, ensure sustainability and reduce stigma.
- Multi-layered supports: Develop a layered system of complementary supports to meet needs of different groups. All layers of the MHPSS intervention pyramid are important and should be implemented concurrently (in coordination with other actors providing specialised services).

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

4.1.1 Sample: Survey of programme standards for MHPSS programmes

The survey below relates to programme standards for MHPSS programmes. You can have the respondents to rate the level of achievement for each statement and you can also ask respondents to discuss each theme in the survey in more depth, and to add additional comments and thoughts about programme quality that may not be captured by the survey statements. There is a space under each theme and at the end of the survey to record respondents' perspectives for qualitative data gathering.

Some survey statements relate to staff and volunteer selection, role, training and supervision. These standards are based upon the IFRC PS Reference Centre publication *Caring for Volunteers: A Psychosocial Support Toolkit*. (See also section 10 for more information on staff and volunteer measurement tools).

Programme quality statements	**Scaled Responses**			
Staff/volunteer selection and role	Completely	Partially	Not at all	Don't know
1. Staff and volunteers are screened and selected according to set criteria.				
2. Staff and volunteers are trained on code of conduct and VP/protection policies.				
3. Staff and volunteers have signed the code of conduct.				
5. Staff and volunteers have written job descriptions with clear lines of authority.				
6. Staff and volunteers are briefed and trained on volunteer care policies and procedures.[28]				
Discussion and comments on staff/volunteer selection and role:				
Staff/volunteer training and supervision	Completely	Partially	Not at all	Don't know
5. Staff and volunteers receive regular opportunities for training and continuing skills development.				

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[28] *Caring for Volunteers: A psychosocial support toolkit*. (2012) IFRC Reference Centre for Psychosocial Support: Copenhagen.

6. Staff and volunteers receive regular supervision, mentoring and on the job coaching.				
Discussion and comments on staff/volunteer training and supervision:				
Programme design and planning	Completely	Partially	Not at all	Don't know
7. PS programme is based upon a participatory needs assessment inclusive of target population's voices.				
8. Action(s) has been taken to ensure the PS programme is inclusive of all people regardless of gender, age, ethnicity, disability or other vulnerability (as appropriate to the programme design and objectives). *(Specify what action(s) below in comments.)*				
9. PS programme is based upon and promotes personal, family and community strengths (resilience).				
10. PS programme avoids pathologising common reactions to severe stressors.				
11. PS programme contributes to protection and violence prevention.				
Discussion and comments on programme design and planning:				
Referral and coordination	Completely	Partially	Not at all	Don't know
12. Where relevant, a functioning referral system is in place for the PS programme.				
13. PS programme staff/volunteers are aware of referral resources and procedures.				

14. PS programme is coordinated with other PS actors, governmental ministries and sectoral responses.				
Discussion and comments on referral and coordination:				
Creating a safe environment *If PS activities take place in a specific area or structure, such as a community centre, safe place or school, make sure the programme environment meets the criteria below (as appropriate to programme design and objectives).*	Completely	Partially	Not at all	Don't know
15. Programme participants are safe coming and going to the area/structure.				
16. The passage to the programme area/structure is restricted.				
17. There are locks on latrines and appropriate lighting, as well as separate washrooms for women/girls and men/boys.				
18. There is enough room for all of the participants.				
19. Equipment is available and appropriate.				
20. First aid kits are available and facilitators are trained in using them.				
Discussion and comments on creating a safe environment:				
Is there anything you would like to add that we haven't touched upon related to programme quality?				

4.1.2 Sample: Capacity assessment questionnaire for psychosocial support in National Societies

This questionnaire can help clarify existing capacities and gaps for National Societies in terms of implementing quality PS interventions.

The questionnaire should be administered to a range of people in the organisation, such as PS focal points, branch managers, head of the department responsible for psychosocial support, human resources department, volunteer management department etc. It can be collected for each respondent individually (self-completion) or it can be used as a basis for a more qualitative discussion in workshops with relevant respondents. You would then discuss the different themes in the survey but converting it to a qualitative discussion guide as you do with FGD (see section 3).

Capacity assessment questionnaire				
Psychological First Aid	**Completely**	**Partially**	**Not at all**	**Don't know**
Are all volunteers trained in psychological first aid?				
Is PFA part of the first aid training course?				
Which volunteer groups have been trained in PFA?				
How many PFA instructors/trainers do you have? (write number):				
Technical capacity	**Completely**	**Partially**	**Not at all**	**Don't know**
Do all staff members have a basic understanding of psychosocial support?				
Is there access to volunteers?				
Which volunteer groups are trained in psychosocial support?				
Are the volunteers trained and supervised adequately?				
Is there a need to increase				

the number of volunteers trained in psychosocial support?				
If you answered 'completely' or 'partially' in the question above, please indicate the areas where volunteers need training?				
How many psychosocial support trainers do you have?				
Is there a need to increase the number of psychosocial support trainers?				
Programmatic and organisational focus areas	**Completely**	**Partially**	**Not at all**	**Don't know**
Are the programmes/activities based on a needs assessment?				
Are the programmes based on international principles and guidelines?				
Is there a need to include more and better equipment and tools to carry our psychosocial support activities?				
If you answered 'completely' or 'partially' in the question above: Which tools and equipment are needed?				
Are the beneficiaries involved in planning, implementing and evaluating psychosocial				

support activities?				
Is violence prevention and protection integrated into psychosocial support programmes?				
Is psychosocial support promoted in other programme sectors?				
Are there identified referral pathways and mapping of services?				
Does your National Society have a psychosocial support policy?				
Does your National Society have a caring for volunteers policy?				
Is there a supportive and caring working environment for volunteers?				
Is there a monitoring and evaluation system in place for psychosocial support programmes?				
Does your National Society cooperate and coordinate with other key organisations in the PS Field?				
Which stand-alone psychosocial support programmes do you have?				
Where is psychosocial support integrated into other programmes? Please name the programmes.				

Needs and gaps	**Completely**	**Partially**	**Not at all**	**Don't know**
Is there an interest to include more psychosocial support?				

If you answered 'completely' or 'partially:'
Which areas need more focus on psychosocial support:

If you answered 'not at all,' what are the barriers to including psychosocial support?

	Completely	**Partially**	**Not at all**	**Don't know**
Is there access to volunteers?				
Are the volunteers trained and supervised adequately?				
Is there a need to increase the number of volunteers trained in psychosocial support?				

If you answered 'completely' or 'partially' in the question above: Which areas do the volunteers need training in?

Importance of psychosocial support: How important do you find the following aspects regarding psychosocial support?	**Very important**	**Important**	**Of little importance**	**Not important**
Building resilience and increasing psychosocial well-being in the general				

population				
Inclusion of psychosocial support in the emergency system				
Psychological first aid and supportive communications skills integrated into all activities and programmes				
Management engaged in implementing caring for volunteers systems and activities				

4.2 Violence prevention and protection quality standards

Three sample tools are provided below for measuring VP/protection assessments and programmes according to quality standards:

- Minimum standards in assessment and response for child protection
- Quality standards for safe spaces
- Quality monitoring of child friendly spaces

4.2.1 Sample: Minimum standards in assessment and response for child protection

The minimum standards listed here are based on Child Protection: Briefing notes for IFRC response (Nepal Earthquake 2015 report). They can be used to determine if a NS response meets child protection minimum standards. The categories in the table are a summary of the Inter-Agency Minimum Standards for Child Protection in Humanitarian Action. IFRC is a core member of this group.

SUMMARY OF MINIMUM STANDARDS	STATUS
1. Brief all personnel on child protection requirements (responsibilities, reporting, mainstreaming)	Examples include: Child protection policy in place and shared widely, clear lines for reporting any concerns are available, referral systems for supporting children and families to access local health/psychosocial/legal systems, training of volunteers and staff on child protection, etc.
2. Reach the most vulnerable children	Examples include: Specific efforts to reach and work with unaccompanied or separated children, orphans, children living on the street, children with disabilities, LGBTI children, children of ‘lower castes,’ specific

	interventions for girls or boys, etc.
3. Include child participation	Examples include: Focus group discussions with children, assessments particular to the perspectives of girls and boys, feedback mechanisms that are child friendly, satisfaction surveys that capture children's perspectives, children included in planning and monitoring of projects that are designed for their benefit, children help implement projects (where appropriate) like peer education, etc.
4. Integrate child protection into operations	Examples include: Inclusion within Health, Psychosocial, Disaster Risk Reduction, Migration, Livelihoods, Community Engagement and Accountability, Youth, National Society Capacity Building, etc. Approaches such as safe spaces (e.g. child friendly spaces or transit centres), psychosocial support, restoring family links, humanitarian education, detention monitoring, supporting access to health and WASH services, livelihood projects (for youth), cash transfers, advocacy for increased/improved protection systems, etc.
5. Add child protection into appeals and planning	Examples include: Child protection specific activities included in appeals and plans, and part of monitoring and evaluations.
6. Collaborate with partner agencies, as appropriate, on child protection	Examples include: Local government (Ministry of Health, Ministry of Education, social services/social welfare, Ministry for Children and Women, etc.), local NGOs (e.g. child rights groups, youth agencies, women's empowerment organisations, shelters, etc.), international NGOs (e.g. Save the Children, PLAN International, etc.), UN agencies (e.g. UNICEF, UNHCR, UNFPA, UNWOMEN, etc.).
7. Include child protection within communications and humanitarian diplomacy	Examples include: Part of outreach to communities, advocacy efforts with government, part of communication with the public and donors, etc.

For more information also see:

Minimum standards for child protection in humanitarian action:
http://cpwg.net/minimum-standards/

IFRC briefing note for child protection in emergencies:
http://www.ifrc.org/Global/Publications/principles/IFRC-CPiE-Briefing_EN.pdf

IFRC online child protection briefing:
http://www.ifrc.org/Global/Publications/principles/IFRC-CPiE-Briefing_EN.pdf

4.2.2 Sample: Safe spaces quality standards checklist

The information and sample tools here have been adapted from the Minimum Standards for Child Protection in Humanitarian Action, Standard 17.[29]

Safe spaces are areas where psychosocial activities are offered to children and adults in a safe and protected environment. They aim to help restore a sense of normality and continuity in the lives of adults and children affected by crisis events. They are designed and operated in a participatory manner, often using existing spaces in the community.

One example is child-friendly spaces (CFSs) where communities create nurturing environments in which children can access free and structured play, recreation, leisure and learning activities. They may target children of a specific age group or of a variety of age ranges. They also will often provide education and psychosocial support for children's caregivers.

The following checklist may be useful in designing and implementing safe spaces according to quality protection standards (including child protection standards).

Safe Spaces Quality Standards Checklist	
Location	**Comments**
☐ A needs assessment has been carried out together with the community to decide whether safe spaces are needed. ☐ Existing facilities and infrastructure (schools, community centres, tents, huts) are mapped to determine if a new safe space structure is needed. ☐ The location has been identified that meets safety and accessibility criteria (defined in country). ☐ Safety elements (fences, first aid, toilets, etc.) have been assessed and brought to standard. ☐ WASH facilities, including drinking water, are properly maintained and hygienic.	
Planning and Coordination	**Comments**
☐ Planning, development and support to safe spaces fully involves women, girls, boys and men and vulnerable groups. ☐ Dialogue has occurred with the community to ensure safe spaces are safe and accessible for all target beneficiaries, including children and adults with disabilities. ☐ Programme activities are contextually appropriate and relevant to needs of children, adults and communities. ☐ Dialogue about how to create community safe spaces linked to larger protection systems has taken place.	

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[29] *Minimum standards for child protection in humanitarian action. Child Protection Working Group (CPWG) (2012), pages 149-154.*

☐ Programme activities are coordinated with other agencies and sectors (e.g., health, hygiene, breastfeeding, information on humanitarian help). ☐ A phase-out or transition plan has been developed early on, in consultation with the community and other interested parties, to hand over the activities and link with broader recovery planning.	
Staff and Volunteers	Comments
☐ Resources (both material and human) are identified to run the safe space. ☐ Staff and volunteers working in safe spaces receive initial and ongoing training and follow-up support, including coaching. ☐ Numbers of staff and volunteers are sufficient to ensure safe and quality programmes for adults and children (e.g., 2 adult animators per fifteen 2-4 year olds). ☐ Protection and other relevant sector staff (including government counterparts, community volunteers) are trained in protection standards and safe spaces. ☐ Volunteers are recruited from the community and linked with other community-based initiatives	
Psychosocial Activities and Monitoring	Comments
☐ Age-appropriate activities are implemented in the safe space (including age-appropriate activities for children) on needs identified by women, girls, men and boys. ☐ Clear guidelines, programmes and schedules for adult and child activities (appropriate to the programme objectives) have been ☐ Ongoing monitoring with feedback mechanisms is conducted (e.g., monthly discussion sessions with target beneficiaries), and involves families, adults and children (as appropriate to programme objectives).	

4.2.3 Sample: Quality Monitoring of CFSs

The sample monitoring tool below is for use in relation to CFSs. The monitoring information can be collected through observations, interviews or discussions (formal and informal) with staff and volunteers and beneficiaries. There are ten themes and each theme has things to consider in setting up and implementing a CFS. These can be used as discussion points with respondents to gather qualitative data about whether the CFS is meeting quality standards. A scale is provided for quantitative data collection and there is space to record respondent comments and reflections.

Quality Monitoring of CFSs

1. APPROPRIATENESS

Things to consider

CFSs may not be needed or appropriate in some circumstances, such as:

- When children have access to other means of meeting their needs for PS support, protection and formal and non-formal education.
- In places where children may be attacked or recruited by armed forces.
- In areas where girls or boys could be sexually harassed on the way to and from the CFS.

If CFSs are needed, an assessment should indicate how best to set them up to be effective, safe and secure. Include safety concerns that could be caused by children themselves, such as bullying or threatening each other.

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
The CFSs are **appropriate** to the needs, resources and security situation.				

Respondent comments and reflections:

2. PROTECTION

Things to consider:

All staff and volunteers working in the CFS should be familiar with key protection standards and policies as well as being trained on child protection. The staff and volunteers should be screened to reduce the risk of violence including exploitation.

Adults and children should be provided with child protection messages including referral pathways.

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
The CFS is a safe space where children are				

protected				

Respondent comments and reflections:

3. SPECIFIC GROUPS

Things to consider:
CFSs provide an opportunity to support all children and promote equality and inclusion. Be sure to take steps to identify the most at-risk children, but in ways that do not stigmatise them or single them out. CFSs and the services they provide should also be designed to meet the distinct needs of girls and boys of different age groups, ethnic backgrounds, living situations, disability, etc.

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
The CFSs can support all children and promote **equality and inclusion**.				

Respondent comments and reflections:

4. AGE AND GENDER SENSITIVITY

Things to consider:
Boys and girls of different age groups should be given fair ways to take part in designing, managing and reviewing programmes such as CFSs. The activities should be designed to be comfortable and engaging for them – for example, adolescent girls may prefer peer talking groups over play activities.
For peers of the same sex, discussion groups can allow a forum for sharing on sensitive issues (such as love, sexual health, peer protection strategies), particularly with a gender-matched group animator. In some emergency situations, some groups may require greater attention (e.g., infants and young children in need of PS stimulation).

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
Have diverse boys and girls of different ages been given fair ways of participating in designing, managing and reviewing CFSs?				

Respondent comments and reflections:

5. DISABILITY AWARENESS

Things to consider:
Because of social stigmatisation, parents may not feel at ease to send their children to a CFS. Others may be unaware that CFSs are also intended for children with disabilities, so this should be made clear when designing and implementing a CFS.
Be sure to organise training for volunteers and staff on how to adapt activities for all children, with special emphasis on the needs of children with various types of impairments. Adapt the ratio of CFS volunteers and staff to children accordingly.

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
Children with disabilities have easy access to CFSs, without physical, environmental and social barriers.				

Respondent comments and reflections:

6. PLAY

Things to consider:
CFS activities must be well thought out and have an educational or psychosocial aim to be effective for improving children's well-being. It may be useful to focus initially on basic play and recreation activities within the CFS, adding more advanced activities later (e.g., setting up referral mechanisms, organising activities for individual or small groups of children who need extra support).
Children should have a say on which play activities they want to have at the CFS, and traditional games should be included. Encourage community members to become involved, such as inviting grandmothers and elders to teach songs and tell stories to young children. Use games, songs and drawing activities that are appropriate for children of all ages and for those with disabilities, and that improve children's personal and social skills.

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
CFSs are fun and promote the **right to play**.				

Respondent comments and reflections:

7. SCHOOLS

Things to consider:
As schools reopen, ensure there are time slots for children of different age groups. For example, have activities for younger children during the day and hold after-school programmes. Be sure to have a clear and reliable schedule of activities.

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
CFSs coordinate with formal **schools**, complement them and do not compete with them.				

Respondent comments and reflections:

8. PARENTS

Things to consider:
Parents' psychosocial well-being is important for children's care and protection. Consider scheduling parent support group sessions in CFSs, such as information sessions on childcare with local service providers, and ensure sessions are accessible for everyone including parents with disabilities.

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
The psychosocial well-being of **parents** is considered in children's care and protection.				

Respondent comments and reflections:

9. CAPACITY BUILDING

Things to consider:
Employ men and women in the CFSs fairly to match the intended composition of target groups. Everyone who works in a CFS should receive initial and ongoing training and coaching. It is important to train CFS volunteers and staff in facilitating play for all as well as protecting children. As CFS workers develop more skills, they can enrich the work of CSs.

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
CFS volunteers and staff are highly motivated and skilled.				

Respondent comments and reflections:

10. MONITORING

Things to consider:
CFSs may serve as an entry point to monitoring the well-being of children on a regular basis. People with M&E experience should evaluate CFSs to see whether the activities produce meaningful improvements in the lives of boys and girls, that they are inclusive and achieving goals.

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
CFSs are **monitored** on an ongoing basis to track the development of the CFS and identify gaps in levels of community awareness, quality of activities, safety, logistical support and etc.				

Respondent comments and reflections:

5 Supervision reporting tools

This section contains tools and guidance for the supervision of staff and volunteers involved in PS programmes. Supervision involves ongoing support to PS programme staff and volunteers in continually developing their skills and knowledge, confidence in fulfilling their role in the PS programme, and for performance evaluation reports. This section includes:

- A sample staff/volunteer progress report
- Two sample field supervision checklists
- PS team meeting report guidance.

Other tools may provide useful data for supervision reporting. Staff and volunteer activity records (see section 1, Programme management cycle tools) provide useful documentation of the activities staff and volunteers conduct for the programme. The records also include notes about their achievements and challenges that may need to be addressed in supervision and/or ongoing training or continuing education opportunities. Time sheets (often available from your NS human resource department) may also be useful for monitoring staff and volunteer activities and performance.

Supervision is usually provided by PS programme managers or PS delegates and occurs in various ways, for example:

- on-the-job coaching and feedback
- mentorship in PSS and VP/protection interventions
- commenting on a report or guidance in using data management tools
- regular team meetings and case study meetings
- individual supportive supervision.

Supervision is also closely linked with caring for the well-being of staff and volunteers. Effective PS programmes depend upon the well-being of staff and volunteers. Informal and formal supervision sessions provide the opportunity to check in with staff and volunteers to determine their support needs, ensure a supportive working environment, address any team conflicts or issues and address the need to shift roles or work tasks to best support staff and volunteers and ensure safe and effective programme implementation. (Specific tools for caring for staff and volunteers can be found in section 10 of this toolbox.)

5.1 General supervision template

Individual staff and volunteer progress evaluation and general supervision occur at regular intervals to monitor staff performance, achievements, challenges and well-being. Depending upon the needs of your programme and team members, you may choose to conduct these yearly or more often.

The following sample report can be used to document progress with the staff member or volunteer. The headings prompt discussion about progress in work performance on the programme, note key achievements and identify areas for improvement. There are also prompts about support needs in terms of personal well-being or in relation to further training or supervision to meet work objectives. The PS manager can work through this report together with the staff or volunteer.

5.1.1 Sample: Staff/volunteer progress report

Staff/volunteer progress report	
Name of staff/volunteer:	Date:
Programme:	Programme manager:
Programme location:	Staff/volunteer role or title:
Notes from previous progress report:	

Staff/volunteer programme progress update				
Staff/Volunteer Work Objectives	Progress update (include dates)	Key findings/ issues	Next steps	Date due

Staff/volunteer progress evaluation questions:	**Needs improvement**	**On track**	**Exceeds expectations**
1. Is the staff/volunteer able to perform the tasks expected in their role in the programme?			
Comments:			
2. Is the staff/volunteer achieving programme milestones on time?			
Comments:			
3. Does the staff/volunteer demonstrate confidence and competence in their PS and VP/protection skills and knowledge?			
Comments:			
4. Does the staff/volunteer demonstrate a good			

working relationship with team members?			
Comments:			

Summary and next steps
Key achievements:
Areas for improvement and goals:
Next steps for improvement and to realise goals (e.g., professional development or training activities to increase PS skills and knowledge, PS programme implementation plans):
Support and referral needs:

5.2 Field supervision checklists

The following two checklists are for use by PS managers or supervisors to record field visits. They include:

- an activity/field visit supervision checklist (adapted from CBHFA M&E toolkit)
- a field coordinator visit checklist for children's resilience activities.

5.2.1 Sample: Field visit supervision checklist

This checklist can be adapted to your particular programme and the type of supervision visit undertaken (field visit, general supervision of PS activities, etc.)

Activity/field visit supervision checklist				
Name of staff/volunteer	Name of PS manager:			
Date of visit:	Time: from______ to ______			
Community or programme visited:				
Activity/event observed:				
Objective of activity/event:				
Key Observations and Comments	**Strongly disagree**	**Disagree**	**Agree**	**Strongly Agree**

1. Activity organised as planned Comment:				
2. Participants (beneficiaries) attend the activity as per expected level Comment:				
3. Key messages delivered appropriate to the context Comment:				
4. Level of participation of beneficiaries Comment:				
5. Volunteer/staff ability to convey enthusiasm and motivate participants Comment:				
6. Volunteer/staff ability to relate well with participants (e.g., good communication skills, warmth, empathy) Comment:				
7. Volunteer/staff demonstrated ability to carry out tasks according to their role (e.g., direct PS support to beneficiaries, PFA, psycho-education, group or meeting facilitation) Comment:				
8. Volunteer/staff ability to work effectively with others in the team Comment:				
Volunteer/staff strengths:				
Volunteer/staff areas for improvement:				
Supervision/support provided:				
Recommendations and next steps (e.g., further training, supervision):				

5.2.2 Sample: Field coordinator visit checklist for children's resilience activities[30]

This checklist can be adapted to other child-focused activities.

Field coordinator visit checklist for children's resilience activities	
Date:	Location:
Field Coordinator:	Facilitator(s):
Please observe following aspects during the workshop sessions:	
1. Is the facilitator sufficiently prepared? Please describe how this is reflected in the activities (e.g. does the facilitator give clear instructions that the children understand, is she/he able to motivate the children?).	Yes /No
Comment:	
2. Does the facilitator manage the time well for the activities?	Yes/No
Comment:	
3. Does he/she have all the material needed?	Yes/No
If missing, what is the solution:	
4. Do the children engage in the activities? (E.g. do they have fun/are they bored, enthusiastic, reluctant?)	Yes/No
Comment:	
5. Are some children not participating in the activities?	Yes/No
If so, how is this handled by the facilitator? Comment:	
6. Is the workshop held in a child-friendly environment and manner?	Yes/No

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[30] *"The Children's Resilience Programme (2012) IFRC PS Centre and Save the Children Denmark*

Comment:	
7. Is there any change since the last time you came here? If yes, please describe this change.	Yes/No
Comment:	

5.3 PS team meeting guidance

Team meetings are useful times to provide supervision and support to staff and volunteers involved in the programme. This is in addition to updating programme progress, troubleshooting and planning. Regular team meetings provide structure for staff and volunteers and an opportunity to discuss challenges and achievements in their work in the programme. They give team leaders the opportunity to gauge gaps in skills and knowledge among PS programme staff and volunteers, provide guidance to overcome challenges, appreciate individual and team efforts, and emphasise good self and team care strategies.

Team meetings are most effective when held at a consistent day/time, and when they follow a clear agenda and time limit. How often, where and when you hold team meetings will depend upon the needs of your particular programme. In emergency situations, team meetings may be held on a daily basis. The situation may be rapidly changing and staff and volunteers may require extra support and attention to their well-being. In other situations, team meetings may be held weekly or bi-weekly, for example. The length of team meetings also depends upon programme needs, but is often between 30 minutes to 1 hour.

Team meeting reports should be concise and provide an overview of programme implementation, staff and volunteer achievements and challenges, team issues (including issues relating to team dynamics, roles and responsibilities) and next steps.

Here is a suggested team meeting agenda and reporting format:

- **General information:** Record the date, programme title, name of manager or other person completing the report, team members present (numbers, names).
- **'Old business:'** Review the issues and next steps outlined in the previous meeting report to monitor if they have been resolved or are ongoing.
- **'New business:'** List any topics for the agenda that need to be covered in the meeting. Before the team meeting, the manager outlines a basic agenda of topics, and then team members are invited to add other items that they would like to discuss. Topics should relate to the implementation of the programme, including achievements toward targets, challenges and troubleshooting.
- **Review:** Discuss each topic in turn, and take notes on the discussion, questions or challenges encountered by team members, support and supervision provided, decisions taken and follow-up planned.
- **Next steps:** Outline a list of next steps for follow-up, including who is responsible for each task and a time frame for their completion.
- **Support and encouragement:** During the team meeting, the manager supports, encourages and acknowledges team members' efforts.

6 Training reporting tools

The success of PS programmes depends upon the capacity of those involved directly or indirectly in the day-to-day activities (e.g., programme staff, field coordinators, facilitators, volunteers and community members). Training is therefore a key activity in building capacity of staff, volunteers and community members in PS programme design and implementation. For staff and volunteers directly implementing PS support, it is important that training builds capacity of their interpersonal and social skills, as well as their ability to convey enthusiasm for project activities and positive experiences for adults and children participating in the programme. Training is provided at the onset of a programme, as well as at intervals during programme implementation to enable staff, volunteers and community members to refresh their knowledge and skills on the subject, and learn new things.

Training reports provide valuable data for monitoring and evaluating training, including who and how many participants attended; the impact of the training upon the knowledge and confidence of participants in the subject area; the topics covered and methods used; and trainers' observations of the participants' skills and understanding. The following tools are provided and can be adapted to your specific training:

- training attendance sheets
- participant training evaluation
- training report format (compiling information from the tools above in narrative format)

6.1.1 Template: Training attendance sheets

Training attendance sheets provide a record of who attended the training. They should be disaggregated for gender and in terms of other relevant information. For example, the age of participants might be of interest if the training is for youth in life skills. Depending upon the training and type of participants, you may want to record their role (e.g., manager, staff member, volunteer), their affiliation (e.g., their department within the NS, the organisation they work for, or the community in which they live) and contact details as appropriate for follow-up.

You may want to have participants sign in to the training by filling in their details on the training attendance sheet when they arrive for the training. If the training is more than one day long, provide an attendance sheet for each day of the training with the date marked at the top, or create columns on the attendance sheet where participants can place a check mark corresponding the days they attend.

Training date(s):	**Name of training:**				Mark each training day attended (if training is longer than one day)	
Name	**Affiliation (e.g., department, organisation, staff or volunteer, etc.)**	**Gender and/or age or other**	**Email**	**Phone**	**Day 1**	**Day 2**
1.						
2.						
3.						
4.						

6.1.2 Sample: Participant training evaluation

This is a sample training evaluation that can be given to participants at the end of training. It can be used together with an oral evaluation discussion, asking participants to comment on, for example:

- one thing (or the most important thing) they will take away from the training.
- what went well in the training; then, what could have been better.
- improvements to the training for the future.
- other topics that would be useful for future training.

The sample here has examples of session topics or activities for community-based psychosocial support training. The content should obviously be adapted to your specific training topics and methods. Note that question 1 (“Overall, how would you rate the content of the training?”) can be interpreted in your analysis as a 5-point scale measure as follows: Responses to ‘very poor’ are assigned 1 point; ‘poor’ responses are given 2 points; ‘average’ responses are equal to 3 points; ‘good’ are given 4 points and ‘excellent’ responses are given 5 points. The result of the sum of all answers divided by the number of answers would give a rating (over 5 points) of the entire training which could then be compared to other trainings using the same questions on their evaluation.

Training evaluation					
	Excellent	**Good**	**Average**	**Poor**	**Very poor**
1. Overall, how would you rate the content of the training?					
Comments:					

2. Please indicate how much you agree with the following statements.	**Strongly disagree**	**Disagree**	**Agree**	**Strongly agree**
2.1 The content was interesting and engaging				
2.2 The training met the training objectives				
3. I feel confident to use the skills and knowledge I have gained to conduct the following activities:	**Strongly disagree**	**Disagree**	**Agree**	**Strongly agree**
3.1 Identify common signs of stress				
3.2 Provide people in crisis with psychological first aid				
3.3 Use assisted coping when supporting people in distress				
3.4 Assess psychosocial needs and plan for activities that can meet the psychosocial needs				
3.5 React responsibly if I find out that a child is being abused				
3.6 Use self-care strategies				
3.7 Support my peers if they show signs of distress				
4. The following helped my understanding	**Strongly disagree**	**Disagree**	**Agree**	**Strongly agree**
4.1 Plenary discussions				
4.2 Power points				
4.3 Group exercises				
5. The facilitator	**Strongly disagree**	**Disagree**	**Agree**	**Strongly agree**
5.1 The facilitator was knowledgeable about the topic				
5.2 The facilitator presented the content in clear and logic manner				
5.3 The facilitator had good facilitation skills				
6. Thinking about the training overall	**Strongly disagree**	**Disagree**	**Agree**	**Strongly agree**
6.1 I have gained a better understanding of community-based psychosocial support.				

6.2 The learning environment was safe and inclusive				
6.3 The overall length of the course was appropriate				
7. What went well in the training?				
8. What did not go well in the training?				

6.1.3 Template: Training report

This template[31] can be used as a basis for documenting a narrative report of your training. The text in italics shows examples of what could be included in the report.

Training Report **Author of training report:**	**Date:**
Title of training	
Type of training and materials used	*Basic / Training of trainers*
Date	
City and country	
Facilitator(s)	*Include the NS focal points*
Background	*Rationale:* *Origin of the request* *Context related to PSS in the country / region* *Relevant information linked to the preparation of the training (specific agreement with NS, challenges around preparation, etc.)*
Partners	*NS, regional IFRC offices, donors and others.*
Project	*Name of project or programme if the training was part of a such*
Demographic indicators	*Number of participants: XXX* *Females: XXX* *Males: XXX* *Affiliation to NS: XX participants from XX Red Crescent Red Cross* *Volunteers: XXX NS Staff: XXX* *Other participants from:*
Objectives and related indicators	*Learning objectives as in the announcement about the training or from the concept note*

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[31] *M&E package for Health Emergency Response Unit, psychosocial component. IFRC (pending publication), tool F.*

Contents	*Main modules covered (see training announcement programme or concept note)*
Methods	*Types of training methods and techniques used, including how any material was adapted to fit target audience.*
Outcomes	*Outcomes related to the training objectives*
Training evaluation	*Results of pre and post-test (if any)* *Summary of participants' evaluation of the training (such as were learning objectives met, facilitators skills, training meeting participants expectations, was the training safe, inclusive and participatory etc.)*
Follow up	*Any information regarding agreed upon for follow-up, when, how and by whom.*
Key lessons learnt	*Any information regarding training content, facilitators' skills, time management, venue, food and others from the facilitator and participants' points of view.* *For this section include responses and comments from the training evaluation and add relevant quotes from participants.*
Other reference documents, materials and their location	*Refer to the location of scanned or hard copies of the evaluation documents and comment on new elements added to this training (such as job descriptions, action plans or M&E templates)*
Other comments	

7 Referral tools

A functioning referral system is an essential component of good practice when implementing PS programmes. Careful documentation of referrals ensures beneficiaries receive the specialised support they need for optimal psychosocial well-being. Referrals may be made for specialised mental health services, as well as other types of services: general health care, protection, social services, legal services, economic support, etc.

The two tools presented here are:

1. Referral resource list (including contact details and procedures); and
2. Referral documentation forms

It may be useful to include referral documentation forms as part of staff and volunteer activity records (see section 1. Programme management cycle reports).

In developing your referral resource list, it is important to ensure the services and service providers you are referring to operate in accordance with good practice standards for PS interventions. Evaluate potential service providers according to 'do no harm' principles such as trustworthiness, solid track record, official status (e.g., governmental or recognized and well-known NGO providers), cultural appropriateness, etc.

It is also crucial to understand official systems and regulations in your area and country regarding reporting and referrals. For example, it is important to understand the rules and methods governing official response to mental health issues and violence by the police, courts, health and other institutions under whose jurisdiction your target community falls. Consider the following questions as you develop your referral resources list and referral documentation form:[32]

1. Reporting process
    - What is the process for reporting a case of violence?
    - What is the process for referring mental health cases?
2. Legal protections
    - What is the age of majority or the age children are legally deemed adults? Is the age the same for males and females?
    - Who needs to give permission for care of children and those who are incapable of giving their own permission?
3. Mandatory reporting laws on violence
    - Is it mandatory to report any specific forms of violence? (e.g., sexual, physical, emotional abuse, any forms of violence against children, etc.).
    - Is there a law on consent? What does it say?
    - Are there special circumstances for which reporting is not mandatory?
    - Who, if anyone, is required by law to report incidents of violence to police, or other, authorities?
    - What are the penalties for non-reporting?

7.1 Referral resource list (contact details and procedures)

A referral resource list should include the names of potential service providers and their contact details – preferably the name of a specific contact and their contact details. It should also

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[32] *The Rapid Assessment Guide for Psychosocial Support and Violence Prevention in Emergencies and Recovery (2015) IFRC Reference Centre for Psychosocial Support and Canadian Red Cross, p. 31.*

include details on the referral procedure for each service provider; for example, if a specific form needs to be filled out, how to make appointments, etc.

7.1.1 Template: Referral resource list

Referral resource list			
Service Provider or Agency	**Services provided** (e.g., counselling, health, legal, housing, etc.)	**Name and contact details** (email, phone and physical address)	**Notes on procedures** (e.g., forms, etc.)
1.			
2.			
3.			
4.			

7.2 Inter-Agency Referral Guidance Note for MHPSS[33]

What is an inter-agency referral?
A referral is the process of directing a client to another service provider because s/he requires help that is beyond the expertise or scope of work of your service provider. A referral can be made to a variety of services, for example health, psychosocial activities, protection services, nutrition, education, shelter, material or financial assistance, physical rehabilitation, community centre and/ or a social service agency.

The minimum requirements for facilitating an interagency referral are a clear definition of a successful referral understood by the client or their caregiver, and by staff/ volunteers at all levels; clearly defined roles of the referring agency and the receiving agency; confidentiality of information; informed consent from the client/ caregiver; an established timeframe; and the provision of information that is only necessary and relevant for the referral.

Who can use the referral form?
The referral form is intended to be used by humanitarian organisations working with persons with MHPSS problems. The referral form and guidance note are tools to facilitate inter-agency referrals, referral pathways, trainings and workshops, and as a means to document referrals in accordance with minimum standards. The referral form and guide can be used by any service provider for example, by a doctor working in a primary healthcare centre referring a child to a child friendly space or a nutrition feeding programme, or a case manager referring a client for physical rehabilitation. It can also be used by persons providing PFA after a distressing event.

The referral form is designed to facilitate referrals between and within all four levels of the IASC MHPSS Intervention pyramid[34]. It is **not** a tool to detect persons with mental, neurological and/ or substance use (MNS) disorders, although it can be used to refer persons to mental

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[33] *Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings, Inter-Agency Referral Form and Guidance Note, IASC, Geneva, 2017.*

[34] *Inter-Agency Standing Committee (IASC) (2007). IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. Geneva: IASC, p. 11-13.*

health care services for assessment and further management. Case managers and community workers may find the tool of particular use in their work with individual clients and their families.

How can I make a referral?
At its most basic, the steps required to make a successful referral are:

1. **Identify the problem- what does the client need?** Identify and/or assess the client's problems, needs, and strengths with her/ him and/ or their caregiver (e.g. if the client is a minor or with severely impaired functioning requiring caregiver help).
2. **Identify which organisation or agency can meet this need**. Identify and map other service providers who may be able to assist the client and/ or the caregiver with her/ his needs. Information about other services in your geographical areas can be obtained from service guides, 4Ws mapping reports or coordination meetings.[35]
3. **Contact the service provider to confirm eligibility**. Contact the other service providers in advance to find out more about their services and eligibility criteria, what their referral protocol entails and whether or not they will be able to assist the client.
4. **Explain referral to the client**. Provide information about available services and explain the referral to the client and/ or caregivers (e.g., what services are provided? Where is the service provider located? How can the client get there and receive services? Why do you recommend the referral?). Keep in mind that the client can choose to not be referred.
5. **Document consent**: If the client agrees to the referral, obtain consent before the client's information is shared with others. Parental/ caregiver consent should be obtained if the client is a minor.
6. **Make the referral**: Fill out the inter-agency referral form in triplicate (x1 copy with referring agency, x1 copy with client/ caregiver, x1 copy to receiving agency). Provide the referral agency's contact information to the client and accompany them to the referral agency if needed. Referrals can also be made over the phone (if in an emergency), via e-mail or through an App or a database.
7. **Follow-up** with the client and the receiving agency to ensure the referral was successful and exchange information (if applicable). Did the client receive the planned services? What was the outcome?

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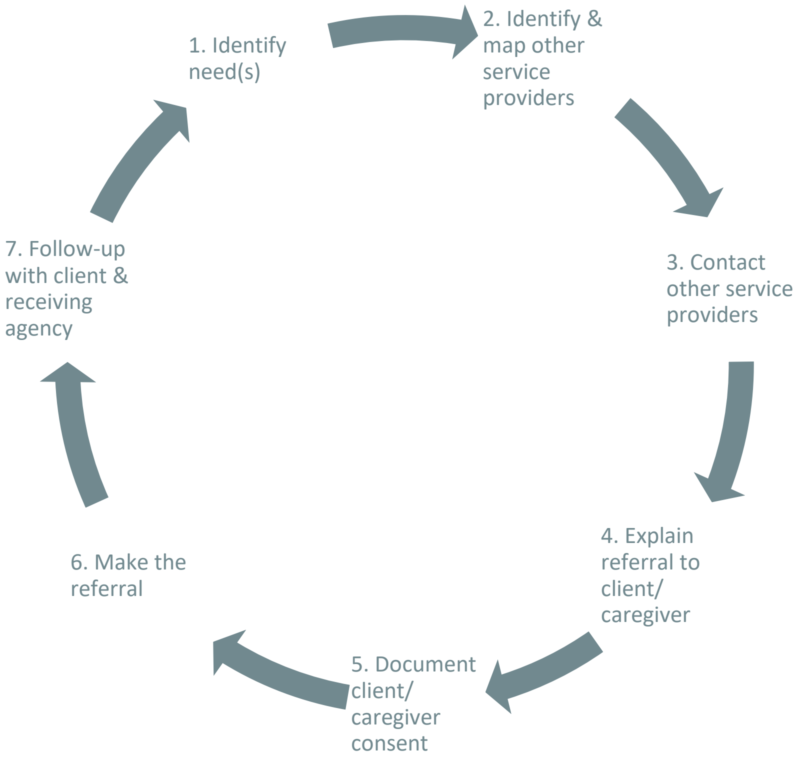
[35] *The IASC 4Ws: Who is Doing What, Where and When in Mental Health and Psychosocial Support Emergency Settings maybe a useful guide when sourcing service providers.*



How can I work together with different agencies to coordinate referrals?
The successful implementation of an inter-agency referral system includes participating agencies to (1) endorse uniform referral documentation (2) agree on specific referral pathways, procedures and standards for making referrals (e.g., which organisation will be best suited to serve which kind of clients), (3) train relevant staff on the use of documentation, standards and procedures, and (4) participate in coordination activities such as a 4Ws MHPSS service mapping (Who is doing What, Where and When), coordination meetings and referral workshops.

These steps should be coordinated through existing mechanisms, such as inter-agency MHPSS coordination groups or through relevant clusters/ working groups. It is recommended that this effort be cross-sectoral, including actors from sectors such as nutrition, camp coordination and camp management, education, protection, MHPSS, and health.

Monitoring and evaluating referrals and functioning referral systems
The success of an inter-agency referral system could be tracked using a variety of indicators, depending on the agencies' data and reporting needs. For example, at a basic level, agencies could report an increase in inter-agency collaboration through agreeing on a referral form to be used by all coordinating agencies, citing the number of agencies who have endorsed the form and committed to training their staff on its use. At a higher level, agencies could track an increase in their staff capacity to make successful referrals via pre-, post-, and delayed-post tests or the number of successful referrals documented through inter-agency quality and tracking measurements. Where relevant, all indicators should be sex and age disaggregated.

Key to filling in the referral form

Section on the referral form	Explanation and examples[36]
Location	Examples include the name of a specific displaced person (IDP) or refugee camp, or a physical street address. The client/ caregiver should be able to physically locate the receiving agency from this information.
Client has been informed of referral (Y/N)	Please explain why the client or caregiver has not been informed of a referral. The consent signature appears towards the end of the form.
Has client been referred to any other organisations (Y/N)	It is helpful for agencies to know about previous referrals to prevent one individual or family being referred several times by multiple agencies for the same service. It also helps guide any future referrals.
Physical health services	Refers to physical health care by doctors, nurses, midwives and community health workers, etc. Please specify in the narrative box whether inpatient or outpatient services are requested.
Mental health services	Category refers to: psychological interventions; clinical management of mental, neurological and substance use (MNS) disorders by specialised and non-specialised health care providers; and support to the caregivers of persons with MNS disorders. Please specify in the narrative box whether inpatient or outpatient services are requested.
Psychosocial activities	This includes community, group and family support activities; child, women and youth friendly spaces; assistance to vulnerable individuals and families; and psycho-education for individuals and families.
Nutrition	Mother-baby groups, promotion of breastfeeding practices, therapeutic-feeding for severe and/ or acute malnutrition.
Protection support/ services	Protection includes mine action and mine risk education, child protection and sexual and gender based violence. Protection support/ services covers protection monitoring, specific services for persons with disabilities, survivors of sexual and gender based violence, survivors of torture,

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[36] 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.

	targeted programmes for children associated with armed groups/ forces, child labour and case management services for children and SGBV survivors.
Family tracing services	Restoring family links; reunification services; best interest assessment (BIA) and alternative care for unaccompanied and separated children.
Any contact or other restrictions (Y/N)	This question relates to the protection of the client being referred and the principle of 'Do No Harm.' In some cases, (such as persons with mental health disorders, survivors of sexual and gender based violence, or in cases of child protection), there may be certain restrictions on how to contact the client and how to provide services/ support to ensure that you are not causing additional harm. This is important in protection-related cases when the perpetrator maybe a family or a community member, and when working with persons with mental health problems to minimise any related stigma and to ensure confidentiality. In such situations, the client may request that she/ he be contacted through a close friend, another relative or a trusted community member, or through another medium such as via e-mail, rather than through the telephone. Please write any such concerns or restrictions in the space provided on the form.
Information agencies agree to exchange in follow up	In functioning referral systems, there is often a need for an exchange of information between the referring agency and the receiving agency. In most situations this is just a confirmation receipt for a referral, but in other situations additional information exchange maybe required, whilst respecting the client's wishes for confidentiality (e.g., if one agency is providing case management services and is responsible for coordinating a client's referrals).

7.2.1 REFERRING AGENCY COPY

☐ Routine ☐ Urgent Date of Referral (DD/MM/YY): ___________________

Referring Agency	Receiving Agency
Agency/ Org: ____	Agency/ Org ____
Contact: ____	Contact (if known): _______________________________________
Phone: ____	Phone: ____
E-mail: ____	E-mail: ____
Location:____	Location: ____

Client Information

Name: ____	DOB: ________________	Nationality: _____________________
Address: ____	Sex: _________________	Language: _______________________
Phone: ____		ID Number: _____________________

If Client Is a Minor (under 18 years)

Name of primary caregiver:_____________________________ Contact information for caregiver: _________________________

Relationship to child: __________________________________

Caregiver is informed of referral? ☐ Yes ☐ No (If no, explain)____

Background Information/Reason for Referral: (problem description, duration, frequency, etc.) and Services Already Provided

Has the client been informed of the referral? ☐ Yes ☐ No (If no, explain below)	Has the client been referred to any other organizations? ☐ Yes ☐ No (If yes, explain below)

Services Requested:

☐ Physical Health care
☐ Mental Health services
☐ Psychosocial activities
☐ Physical Rehabilitation
☐ Education
☐ Shelter
☐ Material Assistance
☐ Nutrition
☐ Financial Assistance
☐ Protection support/ services
☐ Community Centre/ Social Services
☐ Family Tracing services
☐ Legal Assistance

Please explain any requested services**:**

Consent to Release Information (Read with client/ caregiver and answer any questions before s/he signs below)

I, ____________________(client name), understand that the purpose of the referral and of disclosing this information to ____________________(receiving agency) is to ensure the safety and continuity of care among service providers seeking to serve the client. The service provider, ____________________(referring agency), has clearly explained the procedure of the referral to me and has listed the exact information that is to be disclosed. By signing this form, I authorize this exchange of information.

Signature of Responsible Party: _________________________(Client or Caregiver if a minor) Date (DD/MM/YY): _______________

Details of Referral

Any contact or other restrictions? ☐ Yes ☐ No (If yes, explain)____

Referral delivered via: ☐ Phone (emergency only) ☐ E-mail ☐ Electronically (e.g., App or database) ☐ In Person

Follow-up expected via: ☐ Phone ☐ E-mail ☐ In Person By date (DD/MM/YY): _________________

Information agencies agree to exchange in follow up: ____

Name and signature of recipient: _____________________________________ Date received (DD/MM/YY):_________________

7.2.2 CLIENT/CAREGIVER COPY

☐ Routine ☐ Urgent Date of Referral (DD/MM/YY): __________________

Referring Agency	Receiving Agency
Agency/ Org: ____	Agency/ Org ____
Contact: ____	Contact (if known): _______________________________
Phone: ____	Phone: ____
E-mail: ____	E-mail: ____
Location:____	Location: ____

Client Information		
Name: ____	DOB: _______________	Nationality: _____________________
Address: ____	Sex: ________________	Language: _______________________
Phone: ____		ID Number: ______________________

If Client Is a Minor (under 18 years)

Name of primary caregiver:_____________________________ Contact information for caregiver: _________________________

Relationship to child: _________________________________

Caregiver is informed of referral? ☐ Yes ☐ No (If no, explain)____

Background Information/Reason for Referral: (problem description, duration, frequency, etc.) and Services Already Provided	
Has the client been informed of the referral? ☐ Yes ☐ No (If no, explain below)	Has the client been referred to any other organizations? ☐ Yes ☐ No (If yes, explain below)

Services Requested:

☐ Physical Health care ☐ Mental Health services ☐ Psychosocial activities ☐ Physical Rehabilitation	☐ Education ☐ Shelter ☐ Material Assistance ☐ Nutrition ☐ Financial Assistance	☐ Protection support/ services ☐ Community Centre/ Social Services ☐ Family Tracing services ☐ Legal Assistance

Please explain any requested services**:**

Consent to Release Information (Read with client/ caregiver and answer any questions before s/he signs below)

I, ___________________(client name), understand that the purpose of the referral and of disclosing this information to ___________________(receiving agency) is to ensure the safety and continuity of care among service providers seeking to serve the client. The service provider, ___________________(referring agency), has clearly explained the procedure of the referral to me and has listed the exact information that is to be disclosed. By signing this form, I authorize this exchange of information.

Signature of Responsible Party: ________________________(Client or Caregiver if a minor) Date (DD/MM/YY): _______________

Details of Referral

Any contact or other restrictions? ☐ Yes ☐ No (If yes, explain)____

Referral delivered via: ☐ Phone (emergency only) ☐ E-mail ☐ Electronically (e.g., App or database) ☐ In Person

Follow-up expected via: ☐ Phone ☐ E-mail ☐ In Person By date (DD/MM/YY): ________________

Information agencies agree to exchange in follow up: ____

Name and signature of recipient: ___________________________________ Date received (DD/MM/YY):________________

7.2.3 RECEIVING AGENCY COPY

☐ Routine ☐ Urgent Date of Referral (DD/MM/YY): ___________________

Referring Agency	Receiving Agency
Agency/ Org: ___________	Agency/ Org ___________
Contact: ___________	Contact (if known): ___________
Phone: ___________	Phone: ___________
E-mail: ___________	E-mail: ___________
Location: ___________	Location: ___________

Client Information

Name: ___________ DOB: ___________ Nationality: ___________

Address: ___________ Sex: ___________ Language: ___________

Phone: ___________ ID Number: ___________

If Client Is a Minor (under 18 years)

Name of primary caregiver: ___________ Contact information for caregiver: ___________

Relationship to child: ___________

Caregiver is informed of referral? ☐ Yes ☐ No (If no, explain) ___________

Background Information/Reason for Referral: (problem description, duration, frequency, etc.) and Services Already Provided

Has the client been informed of the referral? ☐ Yes ☐ No (If no, explain below)	Has the client been referred to any other organizations? ☐ Yes ☐ No (If yes, explain below)

Services Requested:

☐ Physical Health care
☐ Mental Health services
☐ Psychosocial activities
☐ Physical Rehabilitation
☐ Education
☐ Shelter
☐ Material Assistance
☐ Nutrition
☐ Financial Assistance
☐ Protection support/ services
☐ Community Centre/ Social Services
☐ Family Tracing services
☐ Legal Assistance

Please explain any requested services**:**

Consent to Release Information (Read with client/ caregiver and answer any questions before s/he signs below)

I, ___________(client name), understand that the purpose of the referral and of disclosing this information to ___________(receiving agency) is to ensure the safety and continuity of care among service providers seeking to serve the client. The service provider, ___________(referring agency), has clearly explained the procedure of the referral to me and has listed the exact information that is to be disclosed. By signing this form, I authorize this exchange of information.

Signature of Responsible Party: ___________(Client or Caregiver if a minor) Date (DD/MM/YY): ___________

Details of Referral

Any contact or other restrictions? ☐ Yes ☐ No (If yes, explain) ___________

Referral delivered via: ☐ Phone (emergency only) ☐ E-mail ☐ Electronically (e.g., App or database) ☐ In Person

Follow-up expected via: ☐ Phone ☐ E-mail ☐ In Person By date (DD/MM/YY): ___________

Information agencies agree to exchange in follow up: ___________

Name and signature of recipient: ___________ Date received (DD/MM/YY): ___________

8 Caring for volunteers tools

Caring for volunteers and staff is essential to ensuring effective, quality PS programmes. The tools in this section are drawn from *Caring for Volunteers: A Psychosocial Support Toolkit,* published by the IFRC Reference Centre for Psychosocial Support. See the following for more information about the toolkit which is available in several languages and has accompanying training materials: http://pscentre.org/library/training-materials/caring/

NSs can create conditions that foster resilience for volunteers and staff by:[37]

- encouraging reasonable working conditions through policies and strategies.
- providing accessible guidance and support from managers and peers.
- creating an organisational culture where people can talk openly and share problems, and respect the principle of confidentiality.
- arranging regular meetings that bring volunteers and staff together and foster a feeling of belonging to a team.
- creating a work culture where getting together after a critical event is the norm such as through a peer support system.
- showing appreciation for the work of volunteers and staff.

The tools in this section are from IO 1.2 (Caring for Volunteers). They are relevant for setting up a support system for individual staff and volunteers as well as response teams. They include:

- a sample volunteer psychosocial support survey (see tool 26 *Caring for Volunteers*)
- set-up questions for M&E (see tool 25 *Caring for Volunteers*)
- worksheets (see worksheets A-K *Caring for Volunteers*).

8.1 Volunteer psychosocial support survey

This sample psychosocial survey for volunteers is designed to elicit what volunteers currently know and do in terms of stress and coping, their knowledge of available support from the NS, and their perceptions of the adequacy of that support. It contains both quantitative and qualitative questions.

8.1.1 Sample: Volunteer psychosocial support survey

Volunteer psychosocial support survey					
Volunteers are an important part of the work of our National Society in emergencies. In an effort to better provide support to our volunteers, we kindly request your input on this survey. This will help us to better understand how we can support your well-being. This is an anonymous survey – PLEASE DO NOT WRITE YOUR NAME ON THIS PAPER					
Please circle the number that best fits how you feel about the question being asked: 1=strongly disagree, 2=disagree, 3=agree, 4=strongly agree					
1.	I have a good understanding about the kinds of stress I may encounter volunteering in emergencies	1	2	3	4
2.	I know how to recognize signs of serious stress in myself.	1	2	3	4
3.	I have effective strategies for managing my stress.	1	2	3	4
4.	I know how to recognize signs of serious stress in my team mates.	1	2	3	4

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[37] As described in *Tool 1: Fostering Resilience* in the *Caring for Volunteers Toolkit,*

5.	I know how to support members of my team during stressful times.	1	2	3	4
6.	My manager/supervisor cares about my well-being.	1	2	3	4
7.	My manager/supervisor is available if I need to talk with him/her.	1	2	3	4
8.	My manager/supervisor will reach out to me if I am in distress.	1	2	3	4
9.	I know how to get extra help with stress from the organisation, if I need it.	1	2	3	4
10	I have received information about stress and coping from the National Society.	1	2	3	4
11.	This National Society provides useful support to volunteers in coping with emergency work.	1	2	3	4
12.	My work has been acknowledged by my manager/supervisor and the local branch.	1	2	3	4
Please tell us …					
What is the National Society currently doing that is helpful for you in coping with stress?					
What is the National Society currently doing that is harmful for you in coping with stress?					
What suggestions do you have for us to better support our volunteers?					
Thank you for your time in responding to this survey!					

8.2 Set-up questions for M&E

The following questions can be used in setting up or evaluating your staff and volunteer care system, and for monitoring the system over time. The questions relate to 'what's in place,' 'how it is used,' and 'how well it's working' across specific domains of caring for staff and volunteers.

8.2.1 Sample: Set-up questions for M&E (Caring for volunteers)

Domain	Needs & Resources
Knowledge & skills	• What do volunteers already do to care for themselves and team members? • What do staff and volunteers know about individual and team stress, and how to manage it? • How many volunteers and staff are already trained in peer support, psychological first aid or stress management? • How do managers understand volunteer stress?
Understanding well-being	• How well do volunteers currently feel supported by the organisation? • What kinds of existing support do volunteers find helpful?

	• What other kinds of support do volunteers feel they need? • What are the main stresses volunteers feel they are facing, e.g., heavy workload, not understanding their role, confronting trauma in the field? • How well do staff and volunteers feel their teams function together? • How do managers and supervisors understand their role and responsibility in supporting volunteers?
Materials	• Are there materials on stress and stress management? • Are there training materials for peer support and psychological first aid? • Are there written protocols for supervising volunteers, and referring staff or volunteers who need additional support? • Are the available materials being used and distributed, e.g., do managers and supervisors know about protocols and existing resources?
Human resources	• How many staff and volunteers act as peer supporters? • Who has psychosocial support capacities within or outside of the organisation, e.g., in-house counsellor, local professionals for referral? • Are there experienced staff or volunteers willing to share their perspective during orientation or training of volunteers, or act as a buddy? • How many managers are trained in supportive supervision and PFA?
Financial resources	• What kinds of things are we doing that are cost-free, e.g., talking with volunteers about well-being during their orientation to the organisation? • What other strategies would we like to develop and what might they cost? • What funds are available to develop other needed strategies?

8.3 Caring for volunteers worksheets

Worksheets A-K in the *Caring or Volunteers Toolkit* (see below) can be used to see what your NS currently has in place in terms of basic and additional care strategies. There are worksheets for each phase of a response cycle (before, during and after). The worksheets can also be used to identify aspects of care for staff and volunteers that could be developed further.

8.3.1 Sample: Caring for volunteers worksheets

Caring for volunteers worksheet	
BEFORE: Inform and Prepare	
Before a crisis happens or before the volunteer is sent to help, consider strategies to prepare and equip volunteers for risks they may face as well as preparing the organisation and line managers to be aware of psychosocial well-being of volunteers and how best to support them.	
Worksheet A	**Recruitment and Selection** This worksheet relates to recruiting and screening volunteers for work in the NS. Many volunteers are members of communities in which they will be helping, and in emergency situations, may themselves be directly impacted. In screening volunteers, it is important to assess how they understand and have dealt with their previous experiences, whether or not they have emotional distance from their own experiences, and to help identify volunteers who may become overwhelmed, for example, working in a crisis setting.
Worksheet B	**Orientation** This worksheet relates to how information about self and team care is included when orienting volunteers to the organisation and their work/role.

Worksheet C	**Briefing and Training** This worksheet relates to briefing and training volunteers in self and team care, as well as training line managers in how to monitor and support staff and volunteers.
Worksheet D	**Contingency Planning** This worksheet relates to developing contingency plans in advance within the NS in order to be prepared for volunteer and staff care, if and when an emergency situation occurs.
DURING: Monitor and Support	
During active response to a single event or prolonged crisis, consider strategies to create a supportive and open atmosphere for volunteers and staff, encourage good self and team care strategies, give special attention to volunteers and staff who are exposed to critical events, and ensure there is a functioning peer support and referral system available.	
Worksheet E	**Team Meetings** This worksheet relates to how individual and team well-being is addressed through regular team meetings.
Worksheet F	**Monitoring Individual and Team Stress** This worksheet relates to how line managers can monitor individual and team stress, and strategies to support individuals and teams working in stressful situations.
Worksheet G	**Supervision and Additional Training** This worksheet relates to providing supportive supervision to volunteers and staff particularly related to their well-being (not only supervision of their work performance), supervision for line managers providing care for volunteers and staff, and additional training useful for strengthening staff and volunteer care.
Worksheet H	**Peer Support and Referral** This worksheet relates to peer support strategies (such as buddy systems) within teams and developing and implementing a functional referral system for volunteers and staff in need of a higher level of care for their well-being.
AFTER: Reflect and Refer	
After working in a crisis situation, consider strategies to ensure volunteers and staff have time to rest, re-connect with loved ones, reflect on and recover from their experiences, and access extra support when needed, including peer support, supervision and professional or semi-professional consultation.	
Worksheet I	**Peer Support and Referral after a Crisis Event** This worksheet relates to facilitating individual and team reflection of experiences helping in crisis events, reminders of self and team care, and provision of psychosocial support and/or referral to volunteers and staff.
Worksheet J	**Appreciation of Volunteers** This worksheet relates to acknowledging the work of volunteers and staff in an emergency through informal means and formal rituals or events.
Worksheet K	**Strategies for Formalising Peer Support** This worksheet relates to formalising peer support strategies through training and supervision.

9 Resources

9.1 IFRC Reference Centre for Psychosocial Support resources

Caring for Volunteers: A Psychosocial Support Toolkit (2012) IFRC Reference Centre for Psychosocial Support: Copenhagen.

Strengthening Resilience: A global selection of psychosocial interventions. (2014) IFRC Reference Centre for Psychosocial Support: Copenhagen.

9.2 IFRC M&E resources

IFRC Project/Programme Monitoring and Evaluation Guide. (2011) International Federation of Red Cross and Red Crescent Societies. Geneva.

Monitoring and evaluation guidelines for The Children's Resilience Programme. (2012) IFRC Reference Centre for Psychosocial Support and Save the Children: Copenhagen.

Planning Monitoring Evaluation and Reporting (PMER) Toolkit for Community-based health and first aid. (2013) IFRC, CBHFA.

The Rapid Assessment Guide for Psychosocial Support and Violence Prevention in Emergencies and Recovery (2015) IFRC Reference Centre for Psychosocial Support and Canadian Red Cross. http://pscentre.org/wp-content/uploads/PSS-and-VP-Rapid-Assessment-Tool-Emergencies-and-Recovery-2015.pdf

9.3 Articles, reports and books

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Dart, J. and Davies, R. (2003) A Dialogical, Story-Based Evaluation Tool: The Most Significant Change Technique. *American Journal of Evaluation*, 24(2): 137-155.

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Sen, A. (1999) *Development as freedom*. New York, NY: Anchor Books.

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9.4 Guides, manuals and web resources

Advocacy, communication and social mobilization for TB control: a guide to developing knowledge, attitude and practice surveys. WHO/HTM/STB/2008.46 http://whqlibdoc.who.int/publications/2008/9789241596176_eng.pdf

A Kit of Tools for participatory research and evaluation with children, young people and adults. Save the Children Norway (2008) http://www.hapinternational.org/pool/files/kit-of-tools.pdf

Davies R. and Dart J. (2005) *The 'Most Significant Change' (MSC) Technique: A guide to its use*. CARE International.

Hubbard J. *Manual on Brief Ethnographic Interviewing: Understanding an issue, problem or idea from a local perspective*. Center for Victims of Torture. http://www.cvt.org/sites/cvt.org/files/attachments/u8/downloads/Brief%20Ethnographic%20Interviewing%20Manual.pdf

IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings (2012). IASC Reference Group Mental Health and Psychosocial Support Assessment Guide. http://www.who.int/mental_health/publications/IASC_reference_group_psychosocial_support_assessment_guide.pdf

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

Inter-Agency Standing Committee (IASC) (2017) Reference Group for Mental Health and Psychosocial Support in Emergency Settings, *Inter-Agency Referral Form and Guidance Note*, Geneva: IASC..

INTRAC, *Handout: Most Significant Change Approach*. http://managementhelp.org/businessresearch/focus-groups.htm

Monitoring and Evaluation News, http://mande.co.uk/special-issues/most-significant-change-msc/

Minimum Standards For Child Protection In Humanitarian Action (CPWG) http://cpwg.net/minimum-standards/

Psychological First Aid: Guide for Field Workers. (2011) World Health Organisation, War Trauma Foundation and World Vision International. WHO: Geneva.

Survey Methodologies: KAP Surveys. Unite for Sight. http://www.uniteforsight.org/global-health-university/survey-methodologies

UNICEF (2011) Inter-Agency Guide to the Evaluation of Psychosocial Programming in Emergencies. New York: United Nations Children's Fund. http://www.unicef.org/protection/files/Inter-AgencyGuidePSS.pdf

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