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START NETWORK

Mental Health and Psychosocial Support Manual

Philippines

Kumustahan:
Building Community Resilience through Psychosocial Support

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Mental Health and Psychosocial Support (MHPSS) Manual Philippines

Kumustahan:

Building Community Resilience through Psychosocial Support

Regions Covered:

Cagayan Valley (Region II)
Bicol (Region V)
Eastern Visayas (Region VIII)
BARMM (Bangsamoro Autonomous Region in Muslim Mindanao)
Caraga (Region XIII)

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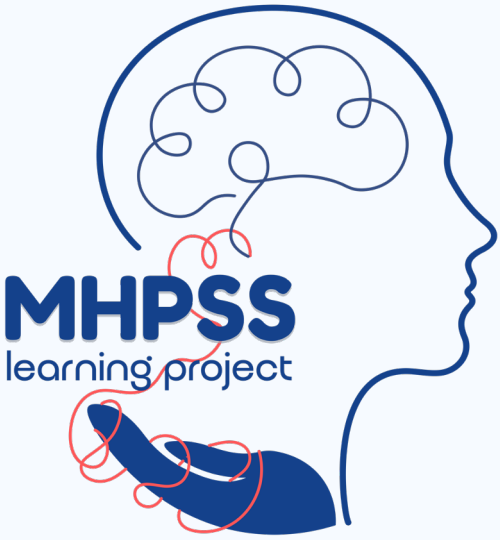


EXECUTIVE SUMMARY

The Philippines is among the most disaster-prone countries in the world, where repeated exposure to typhoons, floods, earthquakes, and conflict has profound impacts not only on physical well-being but also on mental health and psychosocial resilience. While humanitarian systems have strengthened logistics, medical, and shelter capacities, the psychosocial dimensions of crises often remain under-prioritized. Communities experience cumulative distress, and frontline responders themselves face risks of burnout and secondary trauma.

This manual was developed under the People in Need (PIN) MHPSS Learning Project, in close collaboration with the START Network and In Touch Community Services. It combines the results of a landscape assessment in five priority regions—Cagayan Valley, Bicol, Eastern Visayas, BARMM, and Caraga—with global standards, contextualized practices, and community-grounded models. The goal is to provide a structured, practical guide for strengthening MHPSS in humanitarian response, ensuring that psychosocial support is predictable, consistent, and sustainable.

The manual presents:

- **Minimum Standards for MHPSS and PFA** tailored to the Philippine context, grounded in humanitarian principles such as Do No Harm, cultural sensitivity, and accountability to affected populations.
- **Referral Pathways and Protocols** that outline how cases should be identified, triaged, and linked across community, LGU, NGO, and specialized service providers, with feedback mechanisms to ensure continuity of care.
- **Kumustahan Training of Trainers (ToT)** Module, designed to build the capacity of community-level gatekeepers (BHWs, teachers, social workers, faith leaders, and NGO staff) to deliver structured psychosocial support sessions in safe, accessible spaces.
- **Implementation and Monitoring Guidance** that supports LGUs, NGOs, and START partners to integrate MHPSS into DRRM systems, sustain practices beyond immediate emergencies, and track quality through clear indicators.

Findings from the regional assessment highlight both persistent gaps and emerging strengths. Services remain concentrated in urban centers, referral systems are often informal, and stigma limits help-seeking, particularly in rural and conflict-affected settings. Yet innovative community approaches—such as Kumustahan circles, Bicol's Bilog ng Buhay, and faith-based psychosocial supports in BARMM—demonstrate that culturally resonant models are effective entry points for MHPSS delivery.

This manual responds to those realities by offering not just a record of challenges, but a practical set of tools, standards, and frameworks that can be adopted and adapted by humanitarian actors. By institutionalizing these approaches, MHPSS can become a core component of disaster preparedness and response in the Philippines. Importantly, these findings confirm the readiness of START Network partners to adopt standardized manuals and referral systems under the PIN MHPSS Learning Project, ensuring harmonized, accountable, and resilient psychosocial support across regions.

Acronyms and Abbreviations

AAP	Accountability to Affected Populations
APMC	Amai Pakpak Medical Center
BARMM	Bangsamoro Autonomous Region in Muslim Mindanao
BHW	Barangay Health Worker
BHERT	Barangay Health Emergency Response Team
CSO	Civil Society Organization
CSWDO	City Social Welfare and Development Office
CVCHD	Cagayan Valley Center for Health Development
DepEd	Department of Education
DOH	Department of Health
DRRM	Disaster Risk Reduction and Management
DSWD	Department of Social Welfare and Development
ECT	Electroconvulsive Therapy
FGD	Focus Group Discussion
GIDA	Geographically Isolated and Disadvantaged Areas
ICRC	International Committee of the Red Cross
IASC	Inter-Agency Standing Committee
ITCS	In Touch Community Services
KII	Key Informant Interview
LGU	Local Government Unit
MEAL	Monitoring, Evaluation, Accountability, and Learning
MHPSS	Mental Health and Psychosocial Support
mhGAP	Mental Health Gap Action Programm
MOH	Ministry of Health (BARMM)
MSP	Minimum Service Package
MSWDO	Municipal Social Welfare and Development Office
NCMH	National Center for Mental Health
NGO	Non-Governmental Organization
PAP	Psychological Association of the Philippines
PFA	Psychological First Aid
PGCA	Philippine Guidance and Counseling Association
PIN	People in Need
PSS	Psychosocial Support
RA 11036	Philippine Mental Health Act of 2018
RHU	Rural Health Unit
START Network	Strategic Training and Advocacy for Responders Network
ToT	Training of Trainers

SECTION A
Introduction

SECTION A.
Introduction

Context of MHPSS in Philippine Humanitarian Response

The Philippines is one of the most disaster-prone countries in the world, regularly exposed to typhoons, floods, earthquakes, and conflict-related displacement (National Disaster Risk Reduction and Management Council [NDRRMC], 2020; World Bank, 2022). While humanitarian response systems have become increasingly sophisticated in logistics and physical recovery, the mental health and psychosocial impact of crises often remains under-addressed (Inter-Agency Standing Committee [IASC], 2007). Repeated emergencies produce cumulative psychological distress for affected populations and add strain on first responders, who must cope with trauma and burnout while delivering essential services (Department of Health [DOH], 2019).

Mental Health and Psychosocial Support (MHPSS) is recognized globally as a crucial pillar of humanitarian response (IASC, 2007; World Health Organization [WHO], 2018). Yet in the Philippines, practice remains fragmented. Previous assessments have revealed varying levels of awareness and inconsistent approaches to Psychological First Aid (PFA) and MHPSS integration across agencies (DOH, 2019; Department of Social Welfare and Development [DSWD], 2021). Referral pathways often remain informal, and stigma continues to hinder help-seeking, particularly in rural and underserved areas (Philippine Statistics Authority [PSA], 2021).

Against this backdrop, the MHPSS Learning Project was initiated by People in Need (PIN) and its START Network partners to strengthen local capacity, harmonize approaches, and provide standardized tools that can be cascaded by humanitarian actors.

Rationale for the Manual

This manual consolidates the results of an MHPSS needs assessment and resource mapping conducted in Regions II (Cagayan Valley), V (Bicol), VIII (Eastern Visayas), BARMM, and XIII (Caraga). It aims to inform service providers, policymakers, and community actors about the current MHPSS landscape, existing referral pathways, and areas for strengthening. It also provides guidance on applying minimum standards and showcases regional best practices to inspire replication.

By linking the Philippine Mental Health Act (RA 11036), the Inter-Agency Standing Committee's Minimum Service Package (IASC MSP), and humanitarian standards, the manual situates MHPSS as both a legal and humanitarian imperative. It highlights how community-grounded interventions such as Kumustahan can serve as culturally resonant tools for scaling psychosocial support in emergencies.

Objectives of the Manual

The manual seeks to:

1. Provide clear minimum standards for delivering MHPSS and PFA in emergencies, tailored to the Philippine setting.
2. Map and strengthen referral pathways, ensuring that individuals in distress are linked to appropriate levels of care through consistent protocols.
3. Equip frontline gatekeepers—including Barangay Health Workers, teachers, social workers, faith leaders, and NGO staff—with structured tools to deliver community-based psychosocial support.
4. Build sustainability by embedding MHPSS into DRRM systems, LGU plans, and organizational protocols, moving beyond ad hoc or project-based interventions.
5. Establish mechanisms for monitoring, evaluation, and continuous learning within the START Network and partner agencies.

Scope and Audience

The manual targets local government units (LGUs), national agencies (DOH, DSWD, DepEd), NGOs, schools, and community-based organizations. It also serves mental health professionals, humanitarian actors, and advocates working to integrate psychosocial support into health, education, and disaster risk reduction systems. START Network partners are a key audience, as they are tasked with applying, adapting, and sustaining these practices at the community level.

How to Use This Manual

This manual is designed as both a reference and a practical toolkit for practitioners working in humanitarian contexts in the Philippines. It is intended for a wide audience, including:

1. LGUs seeking to integrate MHPSS into DRRM and social welfare programs.
2. NGOs and CSOs delivering community-based psychosocial interventions.
3. START Network partners coordinating training, referral, and case management across regions.
4. Frontline gatekeepers such as BHWs, teachers, social workers, and faith leaders who provide initial support during crises.

The manual can be adapted for diverse contexts—from rural barangays to urban evacuation centers—and is meant to complement existing national policies and humanitarian frameworks. Users are encouraged to treat the manual not as a prescriptive text but as a flexible guide that can be contextualized to local realities. Training modules, referral tools, and session plans may be adjusted to reflect cultural practices, resource availability, and the specific needs of populations affected by disaster or conflict.

Methodology

The manual draws from a mixed-methods assessment combining desk reviews, surveys, focus group discussions (FGDs), and key informant interviews (KIIs).

- Desk Review: Official documents from DOH, DSWD, PAP, PGCA, WHO Philippines, and humanitarian partners.
- Survey: Purposive sampling of 5 respondents per region (mental health professionals, health officers, social workers).
- Focus Group Discussions (FGDs): With selected community-based service providers and local leaders.
  Key Informant Interviews (KIIs): Conducted with regional DOH officers, NGO representatives, and guidance counselors.

This triangulated approach ensured that findings combined quantitative data, community narratives, and system-level insights. Importantly, it grounded the manual in both evidence and practice, making it relevant for policymakers and frontline workers alike.

Note on Updates

This manual is designed as a living document and will be periodically reviewed, updated, and expanded to reflect emerging evidence, field experience, policy developments, and contextual changes in MHPSS practice in the Philippines. Maintaining the manual as an online resource allows for timely updates and continued relevance across diverse humanitarian and development settings. People in Need (PIN) welcomes relevant inputs, corrections, and additional resources that may strengthen the manual. Suggestions or important information for consideration may be submitted via **philippines.mail@eopleinneed.net** and will inform future revisions.

SECTION B
MHPSS in the Philippines

SECTION B
MHPSS in the Philippines

Concept of MHPSS in Emergencies

Definition

Mental Health and Psychosocial Support (MHPSS) refers to any form of local or external support that seeks to protect or promote psychosocial well-being and to prevent or address mental health conditions (Inter-Agency Standing Committee [IASC], 2007). In emergency contexts, MHPSS is understood as a layered system of care, ranging from basic psychosocial support at the community level to specialized clinical interventions for individuals experiencing severe mental health conditions (IASC, 2007; World Health Organization [WHO], 2018).

Philippine Context

The Philippines is among the most disaster-prone countries in the world, with communities repeatedly affected by typhoons, floods, earthquakes, volcanic eruptions, armed conflict, and health crises such as COVID-19 (National Disaster Risk Reduction and Management Council [NDRRMC], 2020; World Bank, 2022).

- These events result in displacement, trauma, loss of livelihoods, and heightened vulnerability to mental health and psychosocial distress (Department of Health [DOH], 2019).
- Local actors—including barangay health workers, teachers, social workers, and faith-based leaders—are typically the first responders to psychosocial needs. Their role in providing Psychological First Aid (PFA) and other community-based support mechanisms is central to resilience and recovery (Inter-Agency Standing Committee [IASC], 2007; DOH, 2019).
- National guidelines for MHPSS in emergencies were established through NDRRMC Memorandum No. 62 s.2017, informed by lessons from Typhoon Haiyan, and serve as a framework for integrating MHPSS into disaster risk reduction and response (NDRRMC, 2017).
- The COVID-19 pandemic further emphasized that MHPSS is not optional but essential in emergency response and recovery, given the sharp rise in anxiety, depression, and stress-related conditions across the population [WHO], 2020; DOH, 2021).

Overview of Services and Referral Systems

Despite the passage of the Mental Health Act (RA 11036), which mandates integration of mental health into public health systems, implementation is uneven. Specialized services are concentrated in urban centers like Metro Manila, with limited reach into rural and geographically isolated and disadvantaged areas (GIDAs). Many provinces still report having no resident psychiatrists, relying instead on visiting specialists or informal support.

Referral systems are often ad hoc, depending on personal networks or individual initiative rather than standardized protocols. In practice, Barangay Health Workers (BHWs), teachers, social workers, and faith leaders serve as entry points. Cases are typically escalated to municipal or provincial health offices, and then to tertiary hospitals if specialized care is needed. However, follow-up mechanisms are weak, and feedback to the original referring party is rarely guaranteed.

Crisis hotlines exist, including the DOH 1553 and the NCMH hotline, as well as NGO-operated lines such as In Touch's Crisis Line. Regional hotlines have also emerged in Bicol and Tacloban. Yet awareness and usage remain low in many areas, especially in rural and conflict-affected communities where connectivity and promotion are limited.

Current Service Landscape

- The Mental Health Act (RA 11036, 2018) provides a legal mandate to integrate mental health services into the public health system.
- Implementation is uneven:
  - » Urban concentration: Psychiatric hospitals and specialists are clustered in Metro Manila, Cebu, and Davao.
  - » Rural and GIDAs: Many provinces lack resident psychiatrists; services are dependent on visiting specialists, NGOs, or community volunteers.
  - » BARMM: A regional MHPSS framework was developed to address urgent needs, highlight gaps, and align services with both humanitarian and development goals.

Government and Stakeholder Initiatives

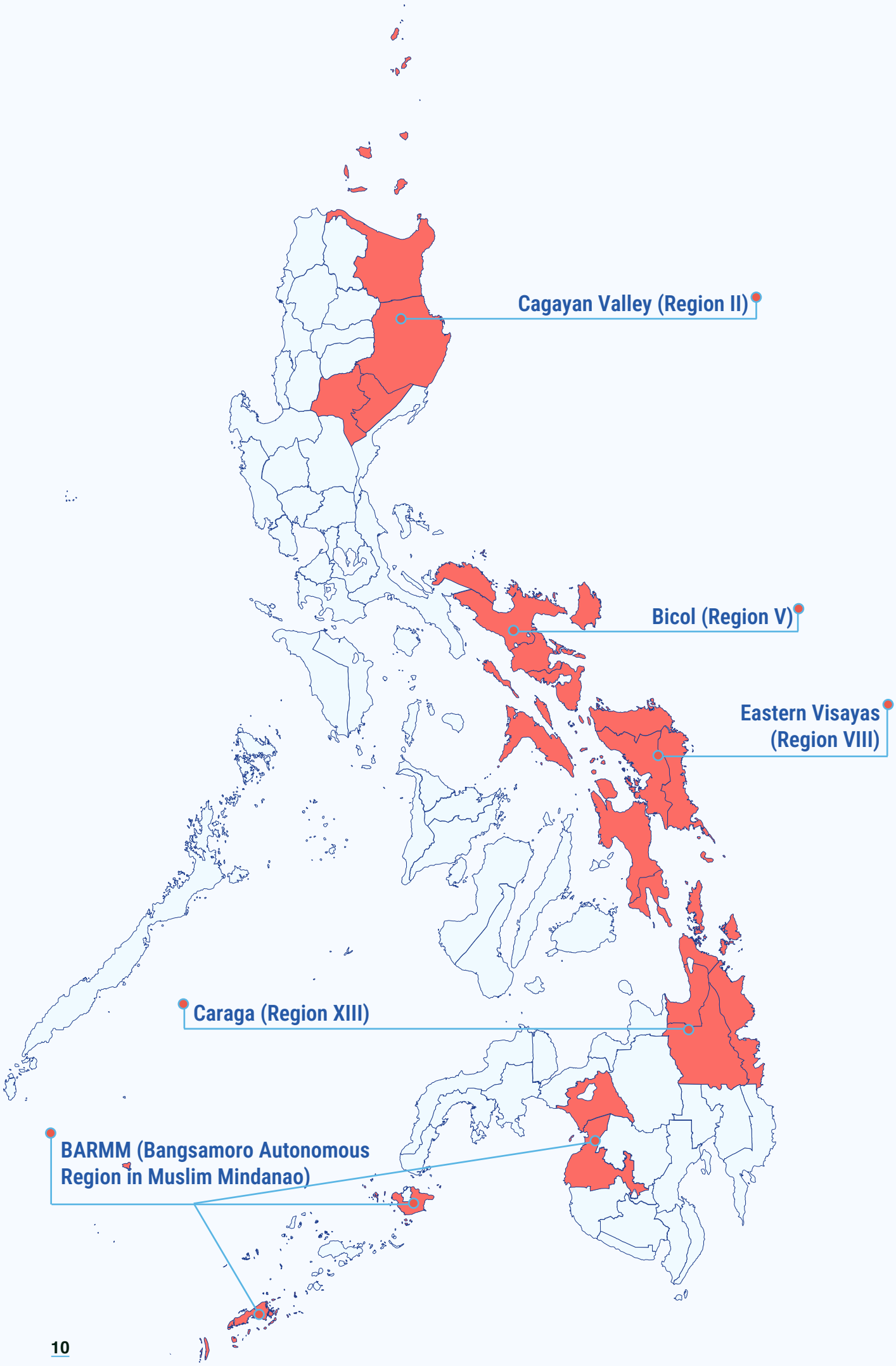
- The **Philippine Council for Mental Health Strategic Framework 2024–2028**, developed by DOH with WHO and partners, prioritizes:
  - » Strengthening standardized referral pathways.
  - » Expanding PhilHealth's Mental Health Benefits Package (outpatient consultations, diagnostics, and psychosocial support).
  - » Training frontliners through the Mental Health Gap Action Programme (mhGAP).
- Despite these efforts, mhGAP-trained providers often report low confidence in diagnosis and intervention delivery at the primary care level.

Hotlines and Crisis Services

- Government-operated: DOH Hotline (dial) 1553 and NCMH's 24/7 crisis hotline.
- NGO-operated: In Touch Crisis Line and similar services.
- Regional hotlines: Active in Bicol, Tacloban, and other disaster-prone areas.
- COVID-19 initiatives: Hotline (dial) 1158 (Philippine Red Cross, supported by UNICEF) received over 319,000 calls between 2020–2021.
- Challenges: Limited awareness, low utilization in rural areas, and barriers due to stigma and connectivity.

Community and Education-Based Programs

- The Department of Education (DepEd) and the Department of Social Welfare and Development (DSWD) deliver psychosocial support for learners, families, and disaster-affected communities.
- Online platforms were developed during the pandemic to link beneficiaries with trained providers.
- Community programs led by NGOs such as the Philippine Mental Health Association (PMHA) and the Philippine Red Cross provide psychoeducation, skills training, crisis response, and "care for carers" initiatives.


Cagayan Valley (Region II)
Bicol (Region V)
Eastern Visayas
(Region VIII)
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Regional Landscape and Mapping Findings

Cagayan Valley (Region II)

Cagayan Valley demonstrated strong integration of PFA into emergency response, particularly during beneficiary interviews to avoid retraumatization. Partnerships with universities and testing centers provided limited referral options, though stigma continues to restrict open discussion of MHPSS. Referral pathways often flow through BHWs and city social workers to the Cagayan Valley Medical Center, but these remain informal and inconsistently documented.

Bicol (Region V)

Bicol showcased community innovation through the Bilog ng Buhay framework, where volunteers are trained as MHPSS facilitators. Psychoeducation and caring-for-carers activities are embedded into programming, and the Bicol Mental Health Council serves as an important institutional referral hub. Reliance on volunteers, however, raises questions of sustainability, as referral pathways remain dependent on ad hoc availability of trained staff and local councils.

Eastern Visayas (Region VIII)

Eastern Visayas reported more limited practice of MHPSS. Efforts are often small-scale—group debriefings, peer support, and occasional staff care—implemented largely at the barangay level. Most severe cases are referred to provincial hospitals, but referral directories and structured pathways are lacking. Respondents emphasized the urgent need for volunteer training and clearer systems of coordination.

BARMM (Bangsamoro Autonomous Region in Muslim Mindanao

In BARMM, both PFA and basic counseling are widely practiced by trained LGU staff and humanitarian actors. The Amai Pakpak Medical Center (APMC) provides a formal referral hub, though utilization is limited by stigma and low reporting. Informal cultural supports, such as faith leaders and community-based psychoeducation, remain highly influential. Stakeholders consistently called for face-to-face training, reflecting a strong demand for practical, field-based capacity development.

Caraga

Caraga showed progress in embedding MHPSS within DRRM systems. A typical referral pathway follows the flow of: BHW → Rural Health Unit → Provincial Hospital, although this structure is still largely informal. During Typhoon Odette in December 2021, coverage gaps became apparent when only families in evacuation centers received psychosocial support, leaving others outside without access. Despite these gaps, LGU social welfare officers expressed readiness to institutionalize MHPSS within DRRM plans, provided sustainable training and referral mechanisms are available.

Table 1. Matrix of Available MHPSS Services

Region	Available MHPSS Services	Referral Centers / Facilities	Hotlines	Key Notes / Gaps
Region II Cagayan Valley	• DOH-retained hospitals with psych units • DSWD regional office • LGU MH programs	• Cagayan Valley Medical Center (Tuguegarao) • Provincial/ District Hospitals	• DOH 1553 • NCMH Crisis Hotline	• Services concentrated in Tuguegarao • minimal community programs
Region V Bicol Region	• Bicol Medical Center MH Program • LGU MH desks • NGOs	• Bicol Medical Center (Naga) • Bicol Regional Training & Teaching Hospital (Legazpi)	• DOH 1553 • Bicol crisis lines	• Fragmented referral pathways • weak coordination
Region VIII Eastern Visayas	• Eastern Visayas Regional Medical Center MH Program • Save the Children psychosocial support • DepEd guidance services	• Eastern Visayas Medical Center (Tacloban)	• DOH 1553 • Tacloban City hotline	• Services urban-centered • limited MH professionals • rural areas underserved
BARMM	• Ministry of Health MH Programs • NGOs like UNICEF and IOM) • faith-based counseling	• Cotabato Regional Medical Center	• DOH 1553 • local LGU lines	• Very few mental health professionals
Region XIII Caraga	• Caraga Regional Hospital MH Unit • NGOs (World Vision, Plan PH psychosocial activities) • DSWD PSS programs	• Butuan Medical Center • Caraga Regional Hospital	• DOH 1553 • provincial hotlines	• Scarce psychiatrists • some trained responders

Note: For guidance on the MHPSS referral pathway, please refer to **page 23**. This section provides step-by-step instructions on how to identify, support, and refer individuals to appropriate services within the Philippines context.

Summary

Across the five regions, the picture is mixed. On one hand, there are encouraging innovations—culturally grounded models like kumustahan circles, faith-based support in BARMM, and volunteer-driven initiatives in Bicol. On the other, systemic weaknesses persist: concentration of services in urban centers, heavy reliance on volunteers, informal referral pathways, stigma, and severe workforce shortages.

These findings reinforce the need for standardized manuals, practical training modules, and harmonized referral systems that are not only responsive to emergencies but also sustainable in long-term community resilience. Through the PIN MHPSS Learning Project and the START Network, in collaboration with In Touch Community Services, this manual seeks to address these gaps by providing concrete tools, minimum standards, and contextualized frameworks for MHPSS delivery in the Philippines.

SECTION C

Minimum Standards for MHPSS and PFA

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Foundational Principles

The IASC Guidelines highlight three universal principles: Do No Harm, Human Rights and Equity, and Participation and Dignity. These align with RA 11036's provisions on the right to health, equitable access, and community participation.

- **Do No Harm:** Interventions must avoid re-traumatization and coercion. Harmful practices, such as forced psychological debriefing, are explicitly prohibited (IASC, 2007; WHO, 2013).
- **Human Rights and Equity:** Mental health care is a right for all, with priority given to marginalized and at-risk groups, including children, older persons, women, persons with disabilities, and indigenous peoples.
- **Participation and Dignity:** Programs must engage individuals, families, and communities meaningfully in planning, implementation, and evaluation, ensuring that services are empowering and relevant.

These principles are further operationalized through cultural sensitivity (adapting interventions to Filipino and local practices such as Kumustahan circles or faith-based rituals) and Accountability to Affected Populations (AAP), which requires mechanisms for community feedback and continuous improvement (Sphere Handbook, 2018).

IASC Services Pyramid and Philippine Application

The IASC Services Pyramid provides a framework for layered interventions, which mirrors RA 11036's call for integration of mental health into the national health system:

Basic Services and Security
Provision of safety, shelter, food, and health care as essential foundations for psychosocial well-being.

Community and Family Supports
Mobilization of natural support networks such as families, schools, peer groups, and barangay units.

Focused, Non-Specialized Supports
Delivery of structured psychosocial activities by trained non-specialists (e.g., teachers, social workers, barangay health workers).for psychosocial well-being.

Specialized Services
Clinical care by licensed professionals for severe mental health conditions, consistent with RA 11036's mandate for psychiatric units in provincial and regional hospitals.

PSYCHOLOGICAL FIRST AID (PFA)

PFA is recognized as the minimum frontline intervention in both emergencies and day-to-day psychosocial support. PFA is defined as a humane, supportive, and practical response to individuals exposed to adversity (WHO, War Trauma Foundation & World Vision, 2011).

Key Actions: Look, Listen, and Link – ensuring safety, providing supportive presence, and connecting people to resources.

Contextual Adaptation: FGDs and surveys show that PFA is widely used across five Philippine regions, especially by LGUs and NGOs, but delivery is inconsistent. Frontline workers report the need for refresher trainings, clearer protocols, and stronger integration into LGU DRRM systems.

Regional Adaptations

Application of minimum standards requires contextual adaptation:

- **BARMM:** Engagement of religious leaders and traditional healers is critical to community trust.
- **Eastern Visayas:** Post-Yolanda capacity gains must be sustained through integration of MHPSS into LGU health and social service plans.
- **Bicol and Caraga:** Disaster-prone areas benefit from embedding PFA and community-based MHPSS in DRRM protocols.
- **Cagayan Valley:** With limited specialists, task-shifting to teachers, social workers, and BHWs expands coverage.

Definition and Rationale for Minimum Standards

Minimum standards are agreed benchmarks that safeguard ethical, safe, and consistent delivery of MHPSS and PFA. For the Philippines, the rationale is threefold:

- **Policy Alignment:** Ensures compliance with RA 11036 and integration of MHPSS into national and local health systems.
- **Localization of Global Guidance:** Adapts IASC MSP and WHO mhGAP tools to local contexts and resources
- **System Coherence:** Provides a unifying framework for LGUs, START Network partners, NGOs, and CSOs, reducing fragmentation.

Core Principles in Practice

- **Do No Harm:** Avoid retraumatization; prohibit forced debriefings.
- **Cultural Sensitivity:** Respect local norms, integrate faith-based and community rituals.
- **Rights-Based Approach:** Ensure equitable access to all populations.
- **Accountability to Affected Populations:** Establish feedback mechanisms (hotlines, reflection forms, community consultations).

Operational Standards

Preparedness and Rapid Response

- MHPSS and PFA should be embedded in LGU and START Network Members disaster preparedness plans
- Barangay Health Workers (BHWs), teachers, social workers, faith leaders, and NGO staff must be pre-identified and trained as facilitators, ready to activate sessions immediately after crises.
- Safe spaces such as barangay halls, schools, or multipurpose centers must be pre-designated as psychosocial hubs, equipped with basic materials for grounding and group activities.

Referral and Follow-Up Care

- Referral tools—including standardized forms, triage checklists, and directories—must be used consistently across LGUs, NGOs, and START partners (see Annex 2 on page 47).
- Every referral must include a feedback loop so that the referring party is informed of the outcome and continuity of care is maintained.
- Case conferences should be convened for high-risk or complex cases, with participation from LGUs, START partners, and service providers.

Staff Care, Supervision, and Well-Being

- All responders should receive orientation in self-care and stress management before deployment.
- Agencies must provide structured supervision, peer support sessions, and regular debriefings.
- Psychosocial support for responders must be institutionalized to prevent burnout and secondary trauma, making “caring for carers” an organizational responsibility, not an individual burden.

Quality Indicators and Benchmarks

To ensure that minimum standards are measurable, practical indicators should be applied:

- **Accessibility and Coverage:** Proportion of barangays with trained PFA providers; number of Kumustahan or other psychosocial sessions delivered after disasters.
- **Referral and Continuity:** Percentage of referrals documented and confirmed with feedback provided to the referring actor.
- **Staff Support:** Frequency of supervision or debriefing sessions; proportion of responders with access to peer support or staff care activities.
- **Community Accountability:** Availability of feedback mechanisms such as hotlines, reflection forms, or community meetings; percentage of participants reporting satisfaction with MHPSS services.
- **Do No Harm Compliance:** Zero tolerance for harmful practices, including forced debriefings, breaches of confidentiality, or discriminatory behaviors.

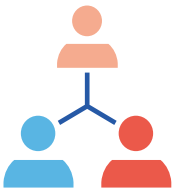
Benchmarks should be understood as targets that can be scaled gradually. For example, an 80% referral feedback confirmation rate may be ambitious at first but provides a goal for progressive improvement. Importantly, all indicators should be integrated into existing LGU MHPSS and Health Cluster reporting systems at the provincial and municipal levels, as well as into the MEAL and reporting systems of the START Network members and other humanitarian response agencies. This will ensure that psychosocial responses are systematically monitored.

SECTION D

Referral Pathways and Protocols

SECTION D

Referral Pathways and Protocols



Networks and Actors

Referral pathways for Mental Health and Psychosocial Support (MHPSS) in the Philippines involve a range of actors across community, municipal, and regional levels (Department of Health [DOH], 2019; National Disaster Risk Reduction and Management Council [NDRRMC], 2017). At the community level, Barangay Health Workers (BHWs), teachers, guidance counselors, social workers, and faith leaders serve as frontline gatekeepers, often identifying distress through observation, self-disclosure, or family referral (Inter-Agency Standing Committee [IASC], 2007; DOH, 2021).

Local Government Units (LGUs), particularly through Municipal and City Social Welfare and Development Offices (MSWDOs/CSWDOs) and Rural Health Units (RHUs), provide the next layer of support through case management, initial counseling, and coordination with higher-level services (Department of Social Welfare and Development [DSWD], 2021; DOH, 2019). These local mechanisms are guided by national frameworks such as the NDRRMC Memorandum No. 62, s.2017 and the Philippine Mental Health Strategic Plan 2019–2023, which emphasize early identification, referral, and integrated care pathways across sectors.

Specialized services are concentrated in regional hospitals such as the Cagayan Valley Medical Center, Bicol Medical Center, Amai Pakpak Medical Center in BARMM, and Eastern Visayas Medical Center. Non-Governmental Organizations (NGOs), Civil Society Organizations (CSOs), and faith-based organizations supplement these systems, often filling gaps through community-based psychosocial activities, crisis hotlines, or mobile outreach. Humanitarian actors coordination platforms should be used as inter-agency platforms for coordination, peer supervision, and case conferencing across partners.

Identified Gaps in Access and Coordination

Despite the presence of these networks, several challenges persist:

- **Informal protocols:** Referrals are often dependent on personal networks or individual initiative, with inconsistent use of forms or documentation.
- **Geographic disparities:** Services remain concentrated in urban centers, leaving geographically isolated and disadvantaged areas (GIDAs) underserved.
- **Human resource shortages:** Many frontline workers are inadequately trained in risk assessment, triage, and referral documentation, while volunteers frequently assume MHPSS roles without supervision
- **Weak feedback loops:** Referring actors rarely receive confirmation or updates once cases are transferred, leading to discontinuity of care.
- **Stigma and awareness gaps:** Cultural stigma discourages help-seeking, resulting in underutilization of formal referral systems.
- **Irregular inter-agency coordination:** While collaboration occurs during major crises, routine coordination and case conferencing are not institutionalized.

PROPOSED REFERRAL PATHWAY

The MHPSS referral pathway outlines the process by which individuals in distress are identified, supported, and connected to appropriate services. It is designed to be community-based, culturally grounded, and aligned with national policies such as the Philippine Mental Health Law (RA 11036) and DRRM systems.

1. Entry Points: Identification of Need

The process begins when an individual experiencing distress is identified within the community. This may happen through Barangay Health Workers (BHWs), Barangay Health Centers, social workers, teachers or guidance counselors, or family/friends who notice signs of psychological distress, trauma, family conflict, grief, or behavioral changes.

- **Immediate actions:**
  - Apply Psychological First Aid (PFA) following the Look–Listen–Link principle.
  - Create a safe, calm, and confidential environment for the person in distress.
  - Document the initial encounter using a referral or intake form (see Annex 1, on page 46).

Decision Point 1:
Is the person in distress showing signs of immediate danger or crisis (e.g., suicidal thoughts, psychosis, severe agitation)?

Yes → Proceed immediately to Emergency Referral (Level 1). Escort the individual to the RHU, hospital, or crisis hotline (NCMH, DOH, In Touch). Notify the MSWDO or DRRMO for logistical support.
No → Proceed to Triage and Risk Classification for further assessment.

2. Triage and Risk Classification

The first responder (BHW, MSWDO, or PFA-trained volunteer) conducts a quick triage to determine the level of risk using behavioral observation and basic questioning.

Decision Point 2:
Is the distress mild, moderate, or severe?

Mild (Adaptive Stress)

The individual is experiencing fatigue, irritability, or difficulty coping but can still function.

Continue PFA or kamustahan sessions, link to peer or community support groups, and schedule follow-up monitoring.

Moderate (Functional Distress)

The individual shows significant emotional distress (panic, grief, burnout) but remains cooperative and oriented.

Refer to social worker, guidance counselor, or psychologist for continued support.
Log referral in RHU/MSWDO records and track within 7 days.

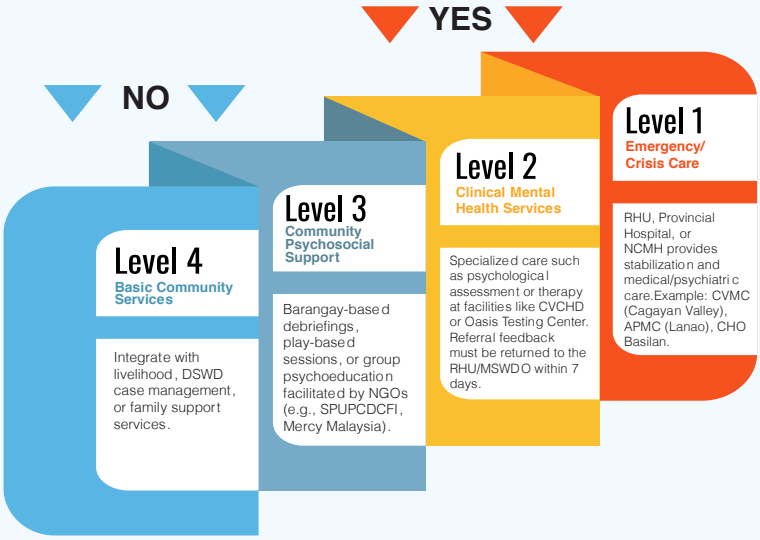
Severe (Crisis Situation)

The person exhibits suicidal ideation, violent behavior, or disorganized thought.

Immediately escort to the nearest hospital or RHU, activate crisis hotlines, and coordinate with emergency responders.
Notify MSWDO and DRRMO for transportation or crisis management.

3. Referral Levels and Service Flow

Once the risk level is identified, the case moves through the appropriate service level.



Decision Point 3:
Does the case require higher-level intervention beyond community capacity?

4. Inter-Agency Coordination and Referral Pathway

After triage, the referral follows the standard vertical flow:

Barangay RHU/City Health Office → MSWDO/PSWDO → Provincial Hospital/Regional Facility → National or Partner NGO.

Each level maintains communication and documentation, ensuring that information and case updates are returned to the referring unit.

Decision Point 4:
Has the receiving agency accepted and acknowledged the referral?
- **Yes** > Continue coordination and share progress reports with the referring party.
- **No** > Reassess available alternative pathways or escalate to the DRRMC or PHO for guidance.

5. Documentation and Feedback Loop

All referrals and follow-ups shall utilize the prescribed LGU forms.

Decision Point 5:
Has the referred individual received support and shown signs of stabilization or improvement?
- **Yes** > Proceed to case closure and monitoring. Document outcomes, update the MHPSS focal logbook, and return case information to the referring office.
- **No** > Schedule follow-up visit or refer to a higher level (e.g., psychologist, psychiatrist, or specialized NGO partner).

6. Self-Care and Responder Wellbeing

At every stage, responders (BHWs, MSWDOs, volunteers, NGO workers) are encouraged to apply self-care and peer debriefing practices.

After each emergency or high-risk referral, they participate in debriefings or peer supervision sessions.

Decision Point 6:

Is the responder showing signs of stress or burnout?

- **Yes** > Refer to Caring for Carers or internal MHPSS support (e.g., peer check-ins, RHU mental health days).
- **No** > Continue routine service and monitoring duties.

7. Feedback to the System and Continuous Learning

Every referral contributes to improving the system:

- Regularly update referral directories (RHU, MSWDO, PHO).
- Integrate lessons into MHPSS Cluster or DRRMC meetings.
- Use data for capacity-building and policy improvement (e.g., ToT programs, trauma-informed care, supervision).

REFERRAL PATHWAY

1 Identification & First Contact

Staff identifies a person in distress

Provide PFA

(Listen – Link – Support)

Is the person in immediate danger or at acute risk?

YES → 3

NO → 2

2 Triage & Risk Classification

Is the level of distress severe or life-threatening?

No → Continue assessment to classify level:

- Mild (manageable distress, stable)
- Moderate (persistent distress, needs structured support)

YES → 3

3 Referral Level & Service Allocation

- **Level 1–2 (High risk)** → Escalate to specialized clinical or protection services.
- **Level 3–4 (Low-moderate risk)** → Continue local/community-based support systems.

1–2 → 4

3–4 → 5

NO → 3

Reassess and consider higher-level support.

4 Inter-Agency Coordination & Acceptance

Send the referral to the appropriate agency.

Has the receiving agency confirmed acceptance?

- **Yes →** Proceed with referral; handover case details securely.
- **No →** Reassess options and redirect to another appropriate service.

5 Follow-Up, Documentation, & Feedback

Monitor the case after referral

Has the individual's condition improved or stabilized?

YES → **Close case with documentation** → 6

6 Responder Wellbeing Check

Assess whether the staff member who handled the case is showing stress or burnout

YES → refer to **"Caring for Carers"** or **peer check-ins**

7 Continuous Learning & System Improvement

- Consolidate feedback from cases and referrals.
- Use insights to strengthen coordination, improve the pathway, and enhance training.

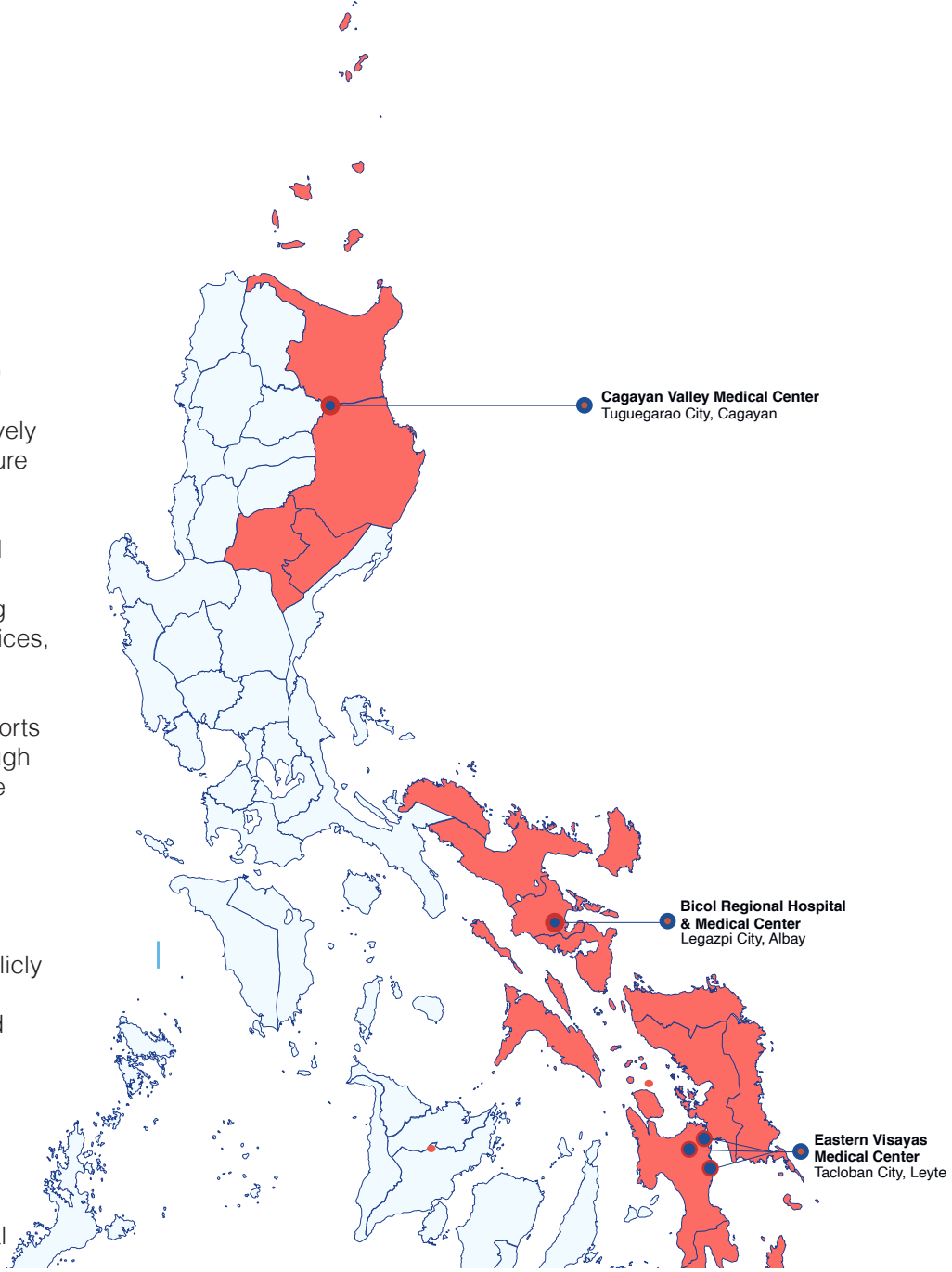
Region	Location	Facility / Program	Services Offered / Notes
Cagayan Valley	Tuguegarao City	Cagayan Valley Medical Center	Tertiary government hospital; Level-4 specialized mental health care. Consultation, in-patient, medication; tele-counseling via hotline.
	Bayombong / Nueva Vizcaya	Region II Trauma & Medical Center (Nueva Vizcaya)	500-bed tertiary hospital; mental health services not explicitly listed.
	Regional	DOH Tele-counseling helpline	Tele-counseling through CVMC and local RHUs.
	Isabela Province	DOH Drug Abuse Treatment & Rehabilitation Center	50-bed residential rehabilitation center for substance abuse.
Bicol (V)	Daraga, Albay	Bicol Regional Hospital & Medical Center	Government hospital with psychiatry unit, crisis hotline.
	Naga, Camarines Sur	Bicol Medical Center (200-bed)	Advanced psychiatric center; inpatient/outpatient services, ECT, neuromedical capacity.
	Ligao, Albay	Bicol Center for Behavioral Medicine	Private Level-3 clinic with consultations and inpatient care.
	Legazpi	Ranga Psychosocial Services	Private counseling/psychotherapy (~₱2,000/session).
	Naga	Ateneo de Naga Psychological Services	Registered psychologists; user-recommended.
	Regional	DOH Caravan & mhGAP rollout	Trained primary care workers for mental health service provision.

Region	Location	Facility / Program	Services Offered / Notes
Eastern Visayas (VIII)	Tacloban City	Eastern Visayas Medical Center (EVMC)	Tertiary teaching hospital; psychiatry dept offering consultations, therapy, assessments, training ("Level-4 MH care").
	Region VIII	WHO mhGAP Program	98% of RHUs trained, psychotropic meds available; integrated into primary care.
	Tacloban City	Tacloban "PROTECT" youth peer-support program	Peer-to-peer support program.
BARMM	Isabela Province	DOH Drug Abuse Treatment & Rehabilitation Center	50-bed residential rehabilitation center for substance abuse.
	Daraga, Albay	Bicol Regional Hospital & Medical Center	Government hospital with psychiatry unit, crisis hotline.
	Naga, Camarines Sur	Bicol Medical Center (200-bed)	Advanced psychiatric center; inpatient/outpatient services, ECT, neuromedical capacity.
Caraga (XIII)	Ligao, Albay	Bicol Center for Behavioral Medicine	Private Level-3 clinic with consultations and inpatient care.
	Legazpi	Ranga Psychosocial Services	Private counseling/psychotherapy (~₱2,000/session).
	Naga	Ateneo de Naga Psychological Services	Registered psychologists; user-recommended.
	Regional	DOH Caravan & mhGAP rollout	Trained primary care workers for mental health service provision.

Regional Overview

Cagayan Valley (Region II)

Cagayan Valley has a relatively stronger MHPSS infrastructure through the Cagayan Valley Medical Center (CVMC), a government tertiary hospital providing specialized mental health care including consultation, in-patient services, and medication, as well as operating a tele-counseling hotline. The DOH also supports mental health referrals through local RHUs. Additionally, the DOH-operated Drug Abuse Treatment & Rehabilitation Center in Isabela provides inpatient substance abuse counseling. Despite these resources, there are no publicly listed private psychiatrists or mental health clinics, and community hubs beyond telehealth remain scarce.

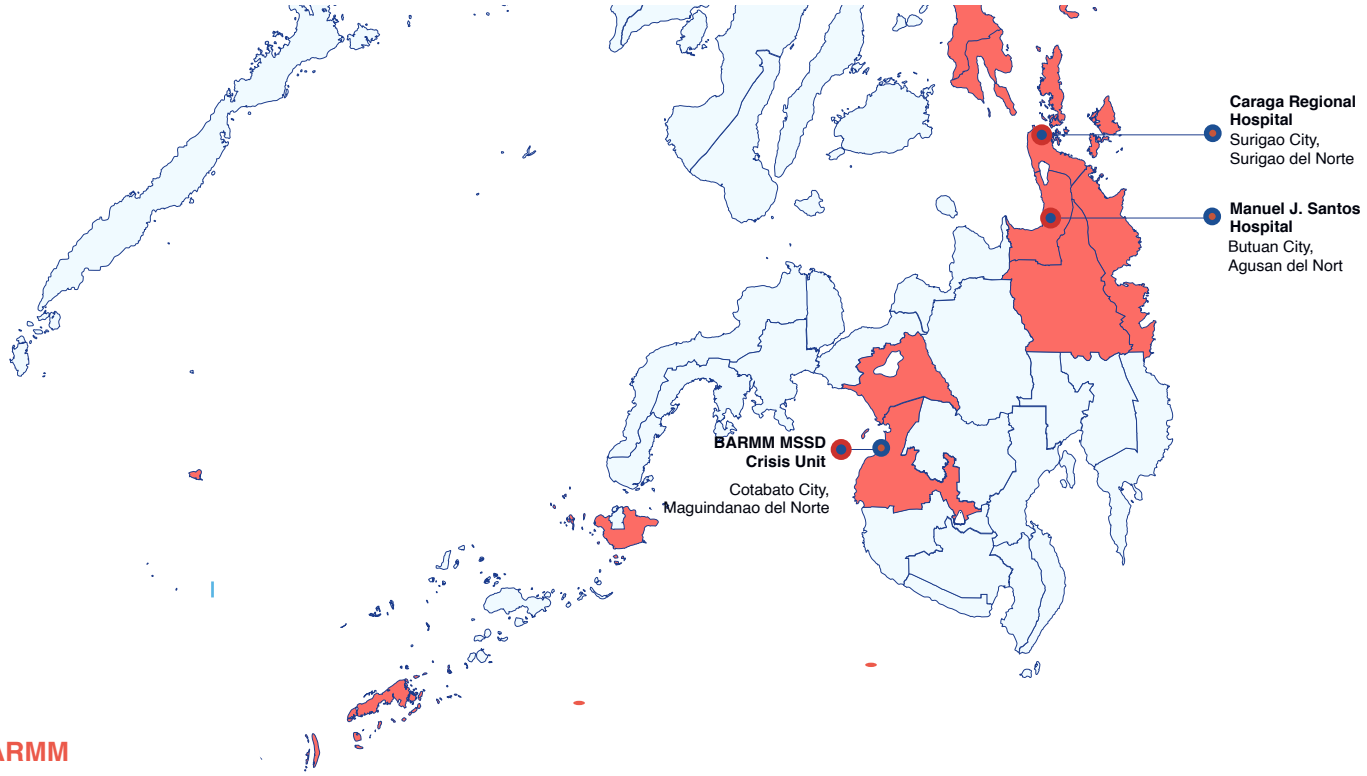


Bicol (Region V)

Bicol offers a diverse mix of services. The Bicol Regional Hospital & Medical Center hosts a psychiatry unit with a 24/7 crisis hotline, while the Bicol Medical Center in Naga offers advanced psychiatric care, including inpatient services, ECT, and neuromedical facilities. The privately run Bicol Center for Behavioral Medicine in Ligao further expands inpatient services, and Ranga Psychosocial Services in Legazpi delivers quality private counseling. Ateneo de Naga's psychology center adds academic credibility and psychologist access. The DOH's mhGAP caravan enhances outreach through trained primary care workers across the region. Rural communities, however, remain underserved, and costs and limited local coverage remains a constraint.

Eastern Visayas (Region VIII)

Eastern Visayas demonstrates robust primary-level integration of MHPSS, with the Eastern Visayas Medical Center offering Level-4 psychiatric care, including therapy, assessments, and training. Following Typhoon Haiyan, WHO's large-scale mhGAP implementation equipped 98% of RHUs and 91% of district hospitals with mental health capacity and psychotropic medications. The youth-led "PROTECT" peer-support initiative illustrates local innovation in psychosocial support. Yet, with only a few hospitals providing specialist services and only 16 psychiatrists for the whole region, much of rural Eastern Visayas depends on general health workers for continuity ofbeyond telehealth remain scarce.



BARMM

BARMM is currently underdeveloped in terms of formal MHPSS infrastructure. Centers such as the BARMM MSSD Crisis Unit and the MOH-BARMM MHPSS Hotline offer PFA, counseling, and referral links. Discussions around the Bangsamoro Mental Health Act (Bill 344) propose establishing mental health centers and a regional office. High stigma, limited professional presence, and lack of funding continue to impede service development across most BARMM provinces.

Caraga (Region XIII)

In Caraga, MHPSS is gradually being incorporated into regional health planning. While the Caraga Regional Hospital offers general services, details about psychiatric infrastructure are unclear. Manuel J. Santos Hospital reportedly has resident psychiatrists, though availability is limited. Emerging supports include Hiraya Diwa, an online psychosocial support platform, and DOH's regional health office provides counseling and referral coordination. However, services remain decentralized, under-publicized, and unevenly accessible.

Referral Protocols, Documentation, and Feedback Loops

To standardize practice, all referrals must be documented using agreed referral forms and case tracking tools. Key requirements include:

- **Referral forms** that summarize case history, presenting concerns, initial support provided, and reasons for referral (see Annex 1, on page 46).
- **Triage checklists** to guide frontline responders in classifying severity and urgency (see Annex 2, on page 47).
- **Feedback mechanisms** where receiving agencies must acknowledge receipt of the case and provide updates to the referring actor (see Annex 3, on page 48).
- **Case conferences** at municipal or START Network levels for complex or high-risk cases, ensuring shared responsibility and coordinated care (see Annex 4, on page 49).
- **Data integration** into existing LGU MHPSS Health Cluster Reporting System (see Annex 6, on page 51).

Embedding these protocols within START Network coordination and LGU systems ensures that MHPSS referrals move beyond ad hoc arrangements and become reliable, accountable, and sustainable.

SECTION E

Kumustahan Training of Trainers (TOT) Module

SECTION E

Kumustahan Training of Trainers (TOT) Module

Description of ToT Module Design

The **Kumustahan Training of Trainers (ToT)** Module was developed to equip frontline gatekeepers with the knowledge and skills to deliver structured, culturally grounded psychosocial support in their communities. Based on findings from the regional assessment, many responders—Barangay Health Workers (BHWs), teachers, social workers, faith leaders, and volunteers—are already informally providing psychosocial support, but with uneven training, limited supervision, and few standardized tools.

In Touch Community Services, as technical lead for the PIN MHPSS Learning Project, refined the ToT module to respond to these realities. It combines global standards with locally validated approaches, particularly the Kumustahan model, which resonates with Filipino cultural practices of storytelling, collective reflection, and peer support. The module is designed to be highly participatory, practical, and adaptable across START Network communities.

The ToT was organized into two main phases:

- **Conceptual Learning** – providing a solid understanding of Mental Health 101, Introduction to MHPSS, and Psychological First Aid (PFA), and situating Kumustahan within the IASC service pyramid and RA 11036 mandates. Participants explored the principles of emotional safety, stigma reduction, cultural adaptation, and ethical considerations.
- **Experiential Learning** – allowing participants to experience a Kumustahan session themselves, participate in guided role plays using real-life case vignettes, and practice facilitating sessions. Emphasis was placed on creating emotional safety, applying PFA principles (Look, Listen, Link), and incorporating basic psychoeducation.

The objectives of the Kumustahan intervention within the ToT were to:

Understand Kumustahan as a culturally grounded framework for delivering PFA and basic psychosocial support.

Experience the session from the perspective of a participant to deepen empathy and understanding.

Practice facilitation skills using the key elements of emotional safety, psychological first aid, and basic psychoeducation. As part of the Philippines' approach to operationalizing the IASC Guidelines on Mental

Health and Psychosocial Support in Emergency Settings and the Mental Health Act (Republic Act No. 11036), the Kumustahan intervention model is introduced as a key community-based protocol aligned with national minimum standards (Inter-Agency Standing Committee [IASC], 2007; Republic Act No. 11036, 2018; Department of Health [DOH], 2019). Kumustahan is a structured, culturally rooted psychosocial support activity that strengthens social cohesion, collective coping, and emotional support. It is grounded in the Filipino value of pakikipagkapwa (shared humanity) and draws from cultural practices such as pakikinig (attentive listening) and pagmamalasakit (compassionate concern).

By providing a safe, non-clinical space for people to check in on one another's well-being, Kumustahan promotes healing through connection, shared storytelling, and emotional normalization. The model exemplifies how MHPSS interventions can be adapted to local culture and community dynamics while maintaining alignment with global humanitarian standards (IASC, 2007; World Health Organization [WHO], 2018).

The Kumustahan model is adaptable and can be facilitated by community volunteers, teachers, faith leaders, or trained non-specialists (Department of Health [DOH], 2021). It incorporates the core actions of Psychological First Aid (PFA)—**Look, Listen, and Link**—as outlined in the World Health Organization (WHO) Psychological First Aid Guide for Field Workers and the Inter-Agency Standing Committee (IASC) Guidelines on MHPSS in Emergency Settings (IASC, 2007; WHO, 2011). The model aligns with the IASC MHPSS intervention pyramid, particularly within the layers of community and family support and focused, non-specialized services, emphasizing early, community-based care rather than clinical intervention (IASC, 2007).

Beyond addressing immediate psychosocial needs, Kumustahan reinforces community resilience by fostering trust, empathy, and collective strength—core principles reflected in the Philippine Mental Health Strategic Plan 2019–2023, which promotes the integration of MHPSS into local systems and disaster response (DOH, 2019).

Day 1: Conceptual Learning

Rationale

Day 1 lays the foundation for participants' understanding of mental health, psychosocial support (MHPSS), stigma, and Psychological First Aid (PFA). Many trainees, especially gatekeepers (BHWs, teachers, social workers), may have had prior exposure to disaster response but not a structured framework. By STARTing with concepts and myths, the day ensures everyone shares a common language before moving into skills.

Delivery Guidance

- Use simple, everyday language—avoid overly clinical terms.
- Draw on real examples from participants' communities (e.g., typhoon response, displacement)
- Encourage active participation: myths and stigma exercises work best when trainees voice what they have heard in their own barangays.

Do's and Don'ts

- Do affirm participants' lived experiences as valid knowledge.
- Do stress that PFA is support, not therapy.
- Don't overwhelm them with diagnostic labels or statistics they can't apply.
- Don't shame participants for sharing culturally rooted beliefs, even if they're myths—redirect them gently toward evidence-based practices.

What to Expect from Trainees

- Expect lively discussions on stigma and myths, often mixed with humor and local proverbs.
- Some participants may initially see mental health as “not their role”—emphasize their importance as frontline gatekeepers.
- Many will already have informal helping practices (listening, comforting, praying with survivors); connect these to PFA principles.

Day 1: Table of Instructional Design

Time	Session	Objectives	Method/ Activity	Materials	Output
8:30 – 9:00	Opening & Expectations	Set the tone, clarify objectives	Welcome, icebreaker, training overview	Cards	PPT, meta cards
9:00 – 10:30	Mental Health 101	Introduce basic concepts and signs of distress	Lecturette + Q&A	Slides, handouts	Participants define MH and stress signs
10:30 – 10:45	**Break**				
10:45 – 12:00	Introduction to MHPSS	Explain IASC pyramid & In Touch framework	Interactive lecture, group reflection	PPT, flipcharts	Group reflections posted
12:00 – 1:00	**Lunch**				
1:00 – 2:30	Stigma & Myths	Identify local myths and clarify facts	Brainstorming, plenary discussion	Flipcharts, markers	Myth–Fact matrix
2:30 – 3:30	PFA Principles	Learn Look–Listen–Link model	Lecturette + case scenarios	Scenario cards, handouts	Participants explain PFA steps
3:30 – 3:45	**Break**				
3:45 – 4:45	Scenario Mapping	Apply PFA to local crisis vignettes	Group work, mapping exercise	Case vignettes, flipcharts	PFA scenario maps
4:45 – 5:00	Reflection & Closing	Synthesize learning	Journaling + plenary	Note cards	Key takeaways

Day 2:
Kumustahan Framework

Rationale

Day 2 introduces Kumustahan as a culturally resonant intervention, emphasizing its psychological grounding and practical flow. Participants learn not only the structure (opening, grounding, connection, psychoeducation, closure) but also cultural tools like Bahay sa Gitna ng Unos and Kwentuhan ng Katatagan. This ensures that group sessions feel natural and safe, rather than imposed.

Delivery Guidance

- Model Kumustahan by STARTing sessions with warm greetings, grounding, and storytelling.
- Emphasize the role of ritual, metaphor, and shared experience in Filipino resilience.
- Break trainees into small groups to practice segments; supervise closely and encourage experimentation with local idioms or symbols.

Do's and Don'ts

- Do highlight that Kumustahan is not a rigid script—it is adaptable.
- Do encourage inclusivity (e.g., adapting activities for children, PWDs, or older adults).
- Don't let one or two voices dominate; facilitators must draw out quieter participants.
- Don't skip the closure ritual; it is essential for safety and containment.

What to Expect from Trainees

- Expect enthusiasm—Kumustahan resonates because it feels "Filipino."
- Some may struggle with facilitation structure; provide gentle reminders about flow.
- Trainees often enjoy creative activities like metaphors but may overcomplicate—remind them to keep it simple and relatable.

Day 2:
Kumustahan Framework

Time	Session	Objectives	Method/ Activity	Materials	Output
8:30 – 9:00	Recap & Energizer	Refresh Day 1 learnings	Group quiz / energizer	Cards	Shared recall
9:00 – 10:30	Cultural Roots of Kumustahan	Explore grounding in Filipino culture	Lecturette + sharing	PPT, handouts	Group stories shared
10:30 – 10:45			**Break**		
10:45 – 12:00	Session Flow	Learn the 5 stages (opening, grounding, connection, psychoeducation, closure)	Demonstration + Q&A	Kumustahan manual, scripts	Flow visualized

10:45 – 12:00	Session Flow	Learn the 5 stages (opening, grounding, connection, psychoeducation, closure)	Demonstration + Q&A	Kumustahan manual, scripts	Flow visualized
12:00 – 1:00			**Lunch**		
1:00 – 2:30	Activity Practice 1	Practice Bahay sa Gitna ng Unos	Small group facilitation	Visual props, paper, markers	Participants facilitate activity
2:30 – 3:30	Activity Practice 2	Practice Kwentuhan ng Katatagan	Role-play, story sharing	Handouts, space for circle	Shared resilience stories
3:30 – 3:45			**Break**		
3:45 – 4:45	Group Practice	Participants run segments of session flow	Small groups, peer feedback	Scripts, feedback forms	Documented adaptations
4:45 – 5:00	Reflection & Closing	Synthesize cultural tools	Journaling + plenary	Note cards	Key takeaways

Day 3: Experiential Learning

Rationale

Day 3 is about practice and feedback. Trainees facilitate mini Kumustahan sessions using real-life crisis vignettes. This deepens confidence and integrates trauma-informed principles such as safety, choice, empowerment, and cultural sensitivity. Structured peer feedback fosters mutual learning and supervision skills.

Delivery Guidance

- Create a supportive atmosphere: clarify that practicum is for learning, not judgment.
- Assign varied case vignettes (e.g., child separated during flood, GBV survivor, farmer after crop loss
- Rotate roles so everyone facilitates at least once. Use structured feedback forms to ensure constructive comments.

Do's and Don'ts

- Do emphasize trauma-informed care—no probing questions, no forced storytelling.
- Do correct unsafe practices immediately but gently.
- Don't allow role-plays to escalate into dramatization that retraumatizes participants.
- Don't rush feedback; allow space for reflection and self-assessment.

What to Expect from Trainees

- Expect nervousness—many are new to facilitation. Normalize mistakes.
- Some may default to lecturing; coach them toward listening and guiding group sharing.
- Others may over-disclose personal experiences; remind them to maintain professional boundaries.

Peer support often strengthens here—participants encourage each other when they see shared struggles.

Day 3: Experiential Learning

Time	Session	Objectives	Method/ Activity	Materials	Output
8:30 – 9:00	Recap & Energizer	Review Day 2	Quiz game, energizer	Cards	Shared recall
9:00 – 10:30	Practicum Round 1	Apply Kumustahan facilitation to vignettes	Small group practicum	Case vignettes, checklist	Participant-led sessions
10:30 – 10:45	**Break**				
10:45 – 12:00	Practicum Round 2	Practice trauma-informed facilitation	Role-play + peer feedback	Trauma-informed checklist	Adjusted facilitation styles
12:00 – 1:00	**Lunch**				
1:00 – 2:30	Peer Feedback & Supervision	Practice structured feedback	Group reflection + supervision model	Feedback forms	Feedback notes
2:30 – 3:30	Trauma-Informed Skills	Deepen on safety, empowerment, cultural respect	Lecturette + reflection	Slides, handouts	Participant examples
3:30 – 3:45	**Break**				
3:45 – 4:45	Practicum Round 3	Consolidated facilitation	Small groups	Case vignettes	Each participant facilitates

Day 4:
Systems Integration

Rationale

Day 4 situates Kumustahan within larger systems: the In Touch MHPSS framework, the PIN Learning Project, referral pathways, and DRRM plans. This ensures Kumustahan is not just an isolated activity but part of a sustainable, coordinated system. Action planning enables participants to cascade their skills to LGUs, CSOs, and START Network communities.

Delivery Guidance

- Begin with a review of the IASC pyramid and how Kumustahan fits at the community support layer
- Facilitate group work on mapping referral pathways; let participants identify gaps and propose solutions
- Lead action planning with clear prompts: Who will you train? How will you supervise? How will you integrate with DRRM?

Do's and Don'ts

- Do stress the importance of referral and follow-up—Kumustahan is not the endpoint for severe cases.
- Do highlight supervision and staff care in action plans.
- Don't let action plans stay too vague—push for concrete next steps (timelines, partners, resources).
- Don't overlook vulnerable groups (children, PWDs, older adults, GBV survivors).

What to Expect from Trainees

- Expect participants to be pragmatic—many will mention resource shortages. Help them identify low-cost, feasible actions.
- Some may be reluctant to take leadership roles; frame action planning as shared responsibility.
- Others will eagerly propose cascading in their schools, barangays, or CSOs—capture these commitments clearly.

Day 4:
Systems Integration

Time	Session	Objectives	Method/ Activity	Materials	Output
8:30 – 9:00	Recap & Energizer	Review Day 3	Quiz game, energizer	Cards	Shared recall
9:00 – 10:30	MHPSS Framework	Situate Kumustahan in In Touch and PIN frameworks	Lecturette + discussion	PPT, handouts	Shared framework maps
10:30 – 10:45			**Break**		

10:45 – 12:00	Referral Mapping	Strengthen referral systems	Mapping exercise in groups	Referral forms, flipcharts	Draft referral maps
12:00 – 1:00			**Lunch**		
1:00 – 2:30	Action Planning Workshop	Develop cascade plans	Group work	Templates, flipcharts	Draft cascade plans
2:30 – 3:30	DRRM Integration	Embed Kumustahan in DRRM and MSP	Group workshop	DRRM guidelines, MSP docs	Integrated plans
3:30 – 3:45			**Break**		
3:45 – 4:45	Commitment Setting	Solidify plans for START partners	Plenary sharing	Commitment templates	Documented commitments
4:45 – 5:00	Closing Circle	Reflect and close	Group sharing	Space for circle	Closing commitments

Facilitation Guide

Adult Learning Principles

Facilitators must treat participants as partners who bring valuable experience. Sessions should be interactive, practical, and reflective, using methods such as group work, storytelling, and peer coaching.

Safe Space and Trauma-Informed Practices

Facilitators are responsible for creating a safe, supportive environment. Emotional check-ins, grounding exercises, and sensitivity to signs of distress are essential. Participation must remain voluntary, with respect for confidentiality and cultural norms.

Dos and Don'ts for Facilitators

Do model self-care, use clear and simple language, and validate participants' contributions.

Don't force disclosure of personal trauma, overload participants with theory, or ignore signs of emotional overwhelm.

Who Can Facilitate Kumustahan Sessions

Facilitators should be trained BHWs, teachers, social workers, faith leaders, or NGO staff who have completed the ToT and demonstrate the ability to lead groups, maintain confidentiality, and apply trauma-informed skills. They need not be mental health professionals, but they must be linked to a functioning referral pathway for cases requiring specialized care.

Follow-up and Supervision Guidance

To ensure sustainability and accountability, trained facilitators must be supported after the ToT. START Network partners and LGUs should:

- Provide regular supervision, ideally through quarterly case conferences or peer review meetings
- Establish refresher sessions and mentoring opportunities to strengthen skills.
- Monitor facilitators using observation checklists, session reports, and community feedback forms.
- Apply the principle of caring for carers, ensuring facilitators have access to debriefing, peer support, and psychosocial resources themselves.

Through this layered approach, Kumustahan ToT graduates are not left to work in isolation but are embedded in a supportive network that sustains both their capacity and their well-being.

SECTION F
Implementation and Application Guidance

SECTION E
Implementation and Application Guidance

Purpose

The Kumustahan Training of Trainers (ToT) Module and the accompanying MHPSS Manual are not intended as stand-alone resources. Their value lies in being integrated into the systems, routines, and policies of local governance, humanitarian action, and community resilience mechanisms. Within the framework of the *People in Need (PIN) MHPSS Learning Project* and the *START Network*, implementation requires deliberate and coordinated actions across organizational, LGU, and inter-agency levels.

Integrating Kumustahan and the Manual into Preparedness and DRRM Response Plans

Local Government Units (LGUs) and partner organizations are encouraged to formally incorporate Kumustahan into their Disaster Risk Reduction and Management (DRRM) plans, contingency protocols, and simulation exercises. Specific actions include:

- **Pre-positioning Trained Facilitators:** Barangay Health Workers (BHWs), teachers, social workers, faith leaders, and NGO staff should be identified and trained to activate Kumustahan sessions immediately after a crisis.
- **Designating Safe Spaces:** Barangay halls, schools, and multipurpose centers should be pre-identified as psychosocial hubs, equipped with simple materials for grounding, reflection, and group connection.
- **Embedding Referral Tools:** Standard referral forms, triage checklists, and documentation tools from the manual should be integrated into the workflows of LGU health and social welfare offices.
- **Including Kumustahan in Drills:** PFA and Kumustahan should be included in DRRM simulations, ensuring that psychosocial support is tested alongside evacuation, relief, and medical operations.

Embedding these measures ensures that MHPSS delivery becomes systematic, predictable, and aligned with emergency response structures, rather than improvised during crises.

Sustaining MHPSS Practices Beyond Emergencies

One of the main challenges in MHPSS delivery is the decline of psychosocial activities once immediate crises subside. To counter this, START Network partners and LGUs should:

- **Institutionalize Peer Support Pools:** Establish barangay- or municipal-level facilitator groups that meet regularly for practice, supervision, and refresher sessions.
- **Embed Kumustahan into Community Programming:** Integrate sessions into ongoing

initiatives such as school guidance counseling, youth clubs, women's associations, and health promotion activities, ensuring continuity in non-emergency contexts.

- **Allocate LGU Resources:** Dedicate budget lines for MHPSS, covering both training costs and supplies for psychosocial spaces (e.g., art materials, refreshments, stationery).
- **Promote Staff Care:** Apply Kumustahan internally as a structured debriefing and staff support mechanism to reduce burnout and secondary trauma among responders.
  Strengthen Inter-Agency Coordination: Conduct quarterly START Network case conferences for experience-sharing, referral updates, and collective problem-solving.

These measures enable Kumustahan to evolve into a sustained community practice rather than a temporary emergency measure.

Monitoring and Evaluation Framework

Monitoring, evaluation, Accountability, and Learning (MEAL) are essential to ensuring quality, accountability, and continuous improvement in MHPSS delivery. The following components are recommended:

Coverage, Accessibility, and Quality Indicators

- Track the number of sessions delivered, disaggregated by barangay, age group, and gender.
- Monitor facilitator coverage to ensure equitable access across communities.
- Assess adherence to minimum standards in session delivery.

Referral Monitoring and Feedback

- Require facilitators to log referrals made during sessions, with confirmation of receipt from receiving agencies (e.g., MSWDOs, hospitals).
- Institutionalize feedback loops so that referring actors are informed of case outcomes.

Staff Support and Caring for Carers

- Document the frequency of supervision, debriefings, and peer support sessions.
- Make staff care a measurable program component, reinforcing that responder well-being is integral to quality service.

Community Accountability Mechanisms

- Establish accessible feedback systems (e.g., reflection forms, FGDs, community assemblies).
- Ensure interventions remain responsive, rights-based, and accountable to affected populations.

START NETWORK

START Network Learning Loops

Consolidate MEAL data into quarterly START Network learning sessions, enabling partners to:

- Review trends and challenges.
- Share lessons across agencies.
- Agree on adaptive strategies.

This process ensures that learning is shared, not siloed, strengthening both accountability and collective resilience.

SECTION G

Best Practices in Humanitarian Contexts

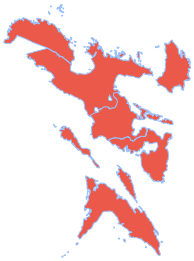
SECTION G

Best Practices in Humanitarian Contexts

Case Examples from the Philippines

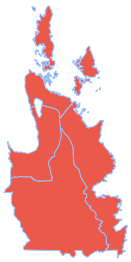
The Philippines has a long history of disaster response, offering rich lessons on how MHPSS can be integrated effectively in humanitarian settings. After Typhoon Haiyan (Yolanda) in 2013, the scale of devastation highlighted both the urgent need for psychosocial support and the challenges of coordination. While NGOs and faith-based groups mobilized rapidly, services were often duplicated in urban centers while remote barangays remained underserved. The experience underscored the importance of harmonized referral systems and inter-agency planning.

Bicol



The Bilog ng Buhay framework has emerged as a notable innovation. Local NGOs trained volunteers to act as MHPSS facilitators, implementing culturally resonant activities such as storytelling, group rituals, and “caring for carers” sessions. This approach not only reduced stigma but also created a community-owned model that was cost-effective and sustainable.

Caraga



Integration of MHPSS into Disaster Risk Reduction and Management (DRRM) planning demonstrated how psychosocial support can be institutionalized. During Typhoon Odette, while challenges remained, LGUs in Caraga were among the first to mobilize Kumustahan-style activities in evacuation centers, reflecting progress toward embedding MHPSS within official preparedness and response systems.

These examples show how context-specific, community-driven approaches can be scaled and adapted through START Network partners under the PIN MHPSS Learning Project.

LESSONS from Past Emergencies

Experience across multiple crises points to several enduring lessons:

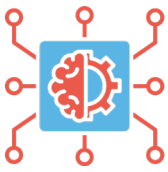
Community Gatekeepers Are Essential: In most emergencies, BHWs, teachers, and volunteers were the first line of psychosocial support. Without them, referral pathways collapsed, especially in rural and isolated communities.

Coordination Prevents Duplication: During Haiyan, overlapping NGO interventions led to overserved areas and neglected barangays. Today, START's practice of case conferences and referral updates reduces duplication and ensures more equitable coverage.

Cultural Resonance Improves Uptake: Interventions like Kumustahan circles, storytelling, and faith-based rituals were more widely accepted than externally imposed models, emphasizing the need to align activities with community values.

Staff Care Sustains Response Quality: Where structured "caring for carers" systems were introduced—such as in Albay under START—frontline responders reported lower levels of burnout and greater consistency in delivering psychosocial support.

These lessons highlight that effective MHPSS delivery requires both technical tools and system-level structures that prioritize local capacity, cultural grounding, and responder well-being.



Adaptable Models and Innovations

From these lessons, several models and innovations have proven adaptable across contexts:

Community-Based Psychosocial Hubs: START partners have converted barangay halls and schools into multipurpose safe spaces for psychosocial activities, ensuring accessibility for children, women, and older persons.

Digital Referral Tools: SMS-based referral tracking piloted in Caraga demonstrated how low-cost mobile technology can improve accountability and continuity of care in resource-limited settings.

Training of Trainers (ToT) Cascades: By equipping frontline gatekeepers through ToT models, START partners have created multiplier effects, enabling rapid scaling of PFA and MHPSS skills while fostering local ownership.

Integration into DRRM Systems: LGUs in Bicol and Caraga have begun embedding psychosocial support into contingency plans and simulation drills, ensuring MHPSS is activated alongside evacuation, shelter, and health services.

These models reinforce the principle that psychosocial support must be both locally grounded and systemically integrated. The PIN MHPSS Learning Project provides an opportunity to refine, document, and replicate these practices across regions, strengthening the resilience of communities most affected by disasters and conflict.

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Annexes

ANNEX 1.
Standardized referral form

Client Information

Name (or Code/Initials for confidentiality): _____

Age / Sex: _____

Address / Barangay: _____

Contact Information: _____

Referral Details

Referring Person/Agency: _____

Date of Referral: _____

Reason for Referral (check all that apply):
□ Severe emotional distress
□ Suicidal ideation or behavior
□ Violence/abuse case (GBV/child protection)
□ Psychiatric symptoms (psychosis, severe depression, etc.)
□ Other:

Interventions Already Provided

□ Psychological First Aid (PFA)

□ Kumustahan/Check-in

□ Basic needs support (food, shelter, medical)

Notes: _____
_____

Receiving Agency / Service Provider

Name of Facility/Agency: _____
Contact Person: _____

ANNEX 2.
Triage Checklist (Risk Assessment)

Step 1: Observe and Ask

- Are there visible signs of severe distress (e.g., uncontrollable crying, withdrawal, aggression)?
- Is the person expressing thoughts of hopelessness or suicide?
- Are there indications of abuse, violence, or immediate safety concerns?

Step 2: Classify Risk Level

- Low: Mild distress, functioning intact, no safety risks.
- Moderate: Ongoing distress affecting daily functioning, needs referral for counseling.
- High: Immediate risk to self/others (suicide, violence, abuse, acute psychosis).

Step 3: Next Action

- Low: Refer to MSWDO/CSWDO, community-based psychosocial activities.
- Moderate: Refer to City/Municipal Health Office or trained NGO/FBO.
- High: Activate crisis response — hotlines, emergency transport, police/protection, psychiatric facility.

ANNEX 3.
Monitoring and Follow-Up Sheet

Client Code/Initials: _____
Date of Referral: _____
Referring Agency: _____

Date	Type of Follow-Up (Home Visit, School Visit, Phone Call, Kumustahan Session)	Observations	Next Steps	Responsible Person

ANNEX 4.
Case Conference Template

Case Conference Details

- Date: _____
- Agencies Present: _____
- Case Code: _____
- Facilitator: _____
-

Discussion Points

1. Case background (summarized from referral form).
2. Services already provided.
3. Current challenges or risks.
4. Action plan (who does what, by when).
5. Next meeting schedule.

Agreed Actions:

-
-
-

Responsible Persons:

-
-
-

What Counts as a Case for Case Conference

A *case* refers to an **individual, family, or group** identified through the MHPSS referral pathway who meets any of the following conditions:

1. **Moderate to Severe Distress:**
   - The person shows persistent symptoms (e.g., withdrawal, aggression, prolonged sadness, trauma-related behaviors) that interfere with daily functioning.
2. **High-Risk Situations:**
   - The person is assessed to have suicidal thoughts or behaviors, is experiencing acute psychosis, or poses immediate safety risks to self or others.
3. **Protection Concerns:**
   - Cases involving gender-based violence (GBV), child protection, or abuse/neglect that require multi-agency coordination.
4. **Complex Needs:**
   - The case involves overlapping issues (e.g., displacement, disability, chronic illness, substance use, conflict-related trauma) requiring coordinated response beyond one agency.
5. **Referral Escalation:**
   - Any client referred to secondary or specialized services (e.g., psychiatric unit, NGO mental health clinic) where follow-up and coordination are required among multiple actors.

ANNEX 5.
Staff Self-Care Log

Name (or Code): _____
Period Covered: _____

- Did I experience signs of stress this week? (□ Yes / □ No)

If yes, what were they? _____

- Did I practice at least one self-care activity this week? (□ Yes / □ No)

Examples: rest, exercise, Kumustahan with peers, journaling, prayer.

- Do I need peer or supervisor support this week? (□ Yes / □ No)

If yes, specify: _____

- Notes for Supervisor (optional):

ANNEX 6.
Monitoring and Evaluation (M&E) Matrix – Kumustahan and MHPSS Practices

How to Use This Matrix

- **Barangay facilitators** fill in basic session logs and referral forms after each Kumustahan activity.
- **LGU social workers** consolidate barangay-level data and supervise adherence to referral protocols.
- **START Network focal points** collate reports across partner organizations and feed results into quarterly learning exchanges.
- **PIN technical team** ensures findings are looped back into training materials and manuals for continuous improvement.

This matrix allows partners to track not only *outputs* (sessions, referrals) but also *quality and outcomes* (satisfaction, facilitator well-being, community impact).

Result Area	Indicator	Definition / Means of Verification	Data Source	Frequency	Responsible Actor
Coverage and Accessibility	% of barangays with at least one trained Kumustahan facilitator	Number of barangays with active facilitators ÷ total barangays in LGU × 100	Training records; LGU DRRM reports	Quarterly	LGU DRRM Office; START focal point
	Number of Kumustahan sessions conducted	Count of documented sessions per barangay/ municipality	Session reports; activity logs	Monthly	Barangay facilitators; MSWDO
	% of referrals with confirmed feedback	Number of referrals with feedback received ÷ total referrals made	Feedback logs; case tracking sheets	Quarterly	MSWDO; START MHPSS coordinators
Quality of Facilitation	% of Kumustahan sessions observed with adherence to session flow	Sessions rated satisfactory on observation checklist	Observatio n checklists	Bi-annual	Supervisors; START trainers
Staff Well-being	Frequency of peer support/supervision sessions for facilitators	Number of debriefing/peer support sessions held	Supervision logs	Quarterly	NGO focal points; LGU supervisors
	% of facilitators reporting improved coping/self-care	Number of facilitators reporting positive changes ÷ total facilitators	Self-care survey; reflection notes	Semi-annual	START MHPSS team
Community Impact	% of community members reporting positive experience in Kumustahan	"Did Kumustahan help you feel supported?" (yes/no)	Community surveys; FGDs	Semi-annual	LGUs; START Network
Documented examples of Kumustahan used in DRRM or recovery	Case stories, integration into local DRRM plans	DRRM reports; FGD notes	Annual	LGUs; PIN technical team	Documented examples of Kumustahan used in DRRM or recovery