actionaid

Saving Lives, Protecting Rights

Psychosocial guidelines

Capacity building guidelines on providing psychosocial care and support during emergencies

International emergencies and conflict team

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Contents

Chapter 1
Understanding the Psychosocial Concept

Why is psychosocial protection and support important?

Armed conflict and natural disasters cause significant psychological and societal suffering to affected populations, on top of the more visible death and physical destruction. The psychological and social impacts of emergencies may be acute in the short-term, but they can also undermine the long-term mental health and psychosocial well-being of affected populations, resulting in an increased morbidity rate (the incidence and prevalence of sickness or disease in a population). Emergencies can threaten peace, development, community cohesion and lead to human rights abuses.

Materials such as food, water, non-food items (NFI's), shelter etc., are all necessary lifelines in emergencies, but they fail to address the emotions and well-being of an individual. Psychosocial protection and support addresses both the **reactions** and **emotions** associated with a traumatic event, along with the **impacts** and **consequences** of the events themselves, which in the immediate stages are often the source of greatest distress.

AAI places people at the heart of all its human security work and believes that it is not enough to just meet people's material needs in emergencies. **AAI believes that addressing the emotional needs, and responding to the psychosocial impacts and consequences of disasters and conflicts, are absolutely crucial to help people regain their dignity, confidence, trust and entitlements.** AAI recognises that the 'right to live with dignity' and 'rights' in general can be achieved faster and better by including psychosocial work in emergency response efforts. In turn, appropriate assistance delivered in a dignified and participatory manner strengthens a person's resiliency and hence vulnerability to future traumatic events.

According to the IASC Guidelines: *"Emergencies create a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies erode normally protective supports, increase the risks of diverse problems and tend to amplify pre-existing problems of social injustice and inequality.[1]"* Natural disasters and conflicts have a disproportionate impact upon poor and vulnerable groups, and it is these groups that ActionAid seeks to assist in emergencies.

In the first instance, psychosocial programmes ensure that people are in the appropriate mental state to receive relief supplies and become active agents within their own recovery process. This is not a stand alone programme response and should very much be located in the context of other responses like humanitarian assistance and advocacy initiatives in any given situation.

What is well-being?

Well-being is the state of feeling good and being able to function adequately in our daily lives.

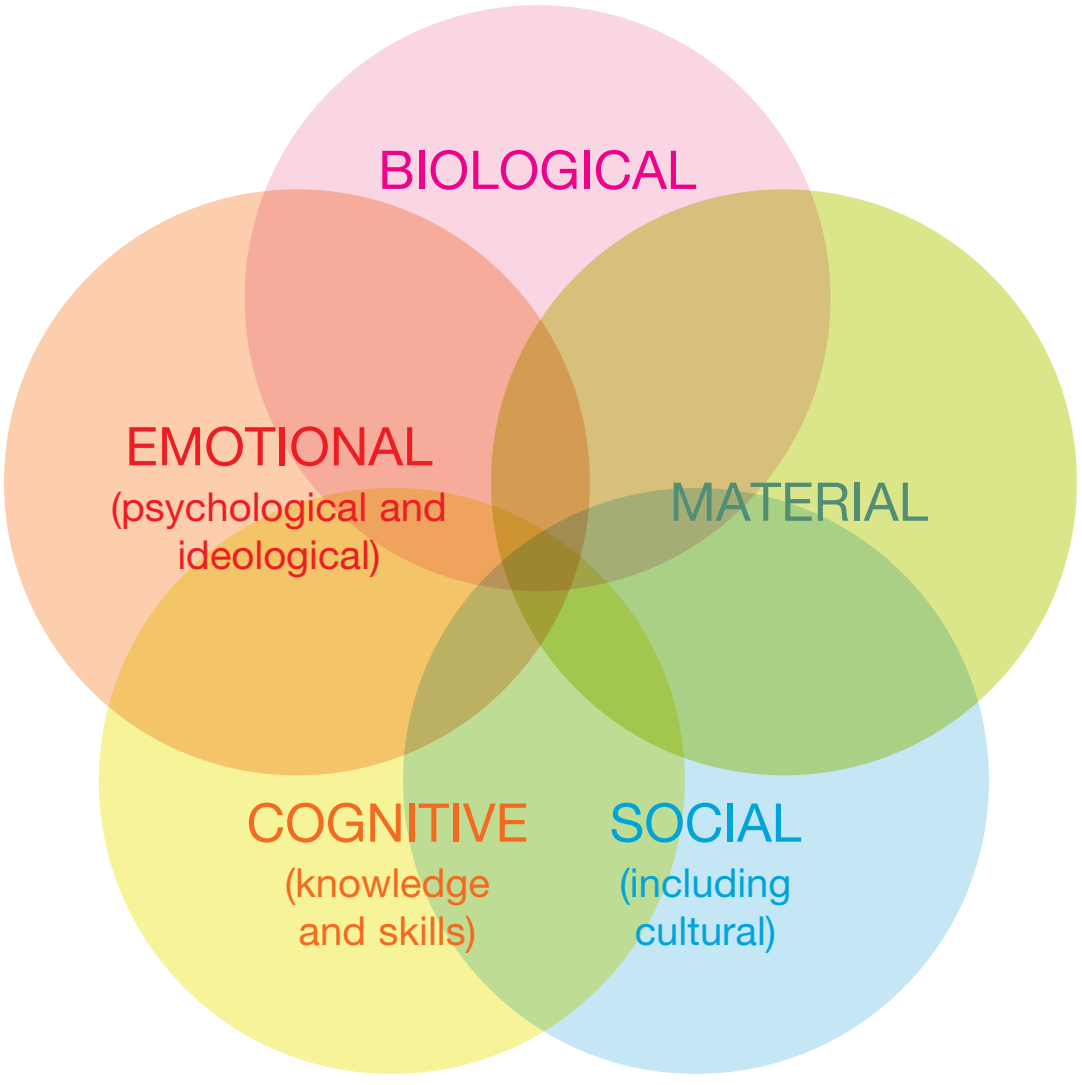
Well-being depends on the fulfilment of many human needs. Some of these needs are very different from each other. For this reason, very few people ever achieve a complete sense of well-being, where all their needs are met.

[1] *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, IASC, Geneva, September (2007).

Everyone wishes to be healthy and feel well as it enables us to:

- Manage our daily lives
- To engage in positive relationships
- To be productive
- To help us cope with adverse situations
- Builds our resilience.

The domains of well-being[2]



[2] Adapted from Williamson, John and Robinson, Malia (2006). 'Psychosocial interventions, or intergrated programming for well-being', *Intervention: The International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict*, Vol: 4 (1), (2006).

Examples across domains:

Biological/ Health: mentally strong and physically healthy

Social: social support networks, need for interaction with others, community, school, work

Natural disasters bind communities together, whereas, conflict based emergencies fragment community ties and relations.

Emotional: need to be loved, to feel competent and wanted, confidence, to live with dignity

Material: need for clothing, food, shelter, safety and security

Economic: livelihoods, right to work, to earn an income, to provide for ones family

Ideological: belief in God/ higher power, freedom to practice ones religion, customs, traditions and political beliefs/ affiliations

Cognitive: need for intellectual stimulation, learning and interest in family and environment.

The above affects on well-being, are **normal reactions to abnormal events**

How does an emergency affect a person's well-being?

Armed conflict and natural disasters affect every aspect of a person's well-being, leading to great fear and distress and feelings of being overwhelmed, in addition to the material and physical damage.

Some examples:

Biological: people may be physically injured as a result of an emergency. This can exacerbate pre-existing physical and mental health problems and increase a populations morbidity and mortality.

Social: It can separate communities from each, disrupt social ties between former neighbours, causes families to become separated and prevent people from carrying out their traditional customs and traditions.

Emotional: Emergencies can cause great distress, fear, anger, frustration, guilt, heroic feelings, helplessness and a sense of being overwhelmed.

Material: People may loose their house/ shelter, their possessions, and be unable to cook, feed or clothe themselves as a result of the emergency. A person's safety and security can also be placed in jeopardy in the middle of the emergency (during flight), in addition to after the emergency, by creating protection risks.

Economic: Loss of livelihoods, inability to provide for one's family and increasing poverty levels.

Ideological: Emergencies may reaffirm a persons faith and beliefs or turn them away. Emergencies can also prevent a person from practising their faith due to displacement.

Cognitive: Emergencies can prevent children from attending school, adults from attending training, literacy and university courses; libraries and learning institutions may be damaged or unable to function. As a result of an emergency people may become apathetic, withdrawn, introverted and disinterested in their family and surroundings.

What does psychosocial well-being mean?

Psychosocial refers to the dynamic relationship between psychological processes and social processes; each in turn influencing the other.

Psychological processes are **internal** to the person:

- Thoughts
- Emotions
- Feelings
- Learning ability
- Memory
- Perception
- Understanding.

Social processes refer to a person's **external** relationships and environment:

- Family
- Community and other social networks
- Economic status
- Traditions and values.

Our psychological and social processes are interconnected and thus these components are:

Interdependent

Reciprocal

Mutually reinforcing

Any change in one of these areas and processes will **affect** something in the other.

Our feelings, thoughts and emotions influence how we relate to people and how we behave.

&

Our relationships, services, economic status, values, beliefs and traditions influence our psychological state and therefore our ability and response to situations.

Psychosocial protection and support is not just about counselling, advice or the right or wrong ways to behave. Instead, it aims to **empower individuals** by helping them understand their own internal processes so they can adequately take control of their own situational responses and decision-making processes.

Psychosocial problems in emergencies are highly interconnected. Significant problems of a **social** nature include:

(a) **Pre-existing** social problems such as extreme poverty, belonging to a group that is discriminated against or marginalised, political oppression

(b) **Emergency-induced** social problems, such as family separation, disruption of social networks, destruction of community structures, resources and trust; increased gender based violence

(c) **Humanitarian aid related** social problems such as the undermining of community structures or traditional support mechanisms.

Similarly, problems of a predominantly **psychological** nature include:

(a) **Pre-existing** problems, such as mental disorders, learning difficulties or alcohol abuse

(b) **Emergency-induced** psychological problems, such as grief, distress, fear, depression, anxiety disorders

(c) **Humanitarian aid related** problems, such as anxiety, due to a lack of information about food distribution and a lack of access to services.[3]

ActionAid believes that a **community-based** approach to psychosocial work in emergencies is most effective thus:

- AAI believes in the community's capacity for recovery and resilience
- AAI supports the affected population at the community level by strengthening existing structures and resources to enhance this capacity
- AAI does not undertake individual psychotherapy, we refer such individuals for further specialised support
- AAI adopts a rights-based approach that is attune to the needs and rights of poor and vulnerable groups.

The objectives of a community based psychosocial approach are to assist affected people to attend a stable life and integrated functioning, to empower people, to restore hope, dignity, emotional and social well-being and a sense of normality.

Core Principles of an effective psychosocial approach

- Human rights and equity
- Active participation of affected populations
- Do No Harm
- Building on available resources and local capacities
- Integrated support systems

[3] *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, IASC, Geneva, September (2007), pp2-3.

Working in a culturally sensitive context

A central aspect in healing is understanding what has happened and giving it meaning; making some sense out of it. Ideological beliefs, practices, ceremonies and rituals in traditional societies are an integral part of well-being and can be an important source of understanding, and coping with, traumatic experiences. Traditional healers and extended community networks can all play a helpful role in the healing process. Sometimes political ideology can offer insight.

Support from aid workers should be built on a community-based approach that considers **cultural traditions and culturally appropriate coping behaviours** as an integral part of well-being and hence healing.

Healing is a process of transition towards greater meaning, balance, connectedness and wholeness, both within the individual, and between individuals and their environment.

Many societies have rules and traditions about how to express emotions i.e., sometimes it is shameful for men and boys to cry. In other communities it is disrespectful or even insulting for a stranger to ask someone to talk about their painful experiences. In some societies where children live in a communal context, their sense of identity is self-embedded in the community. In collectivist cultures, people tend to experience traumatic events not so much in a private sense but in a **collective manner**. Many indigenous healing systems emphasise a community context and an ideological dimension.

Many non-Western oriented medical, ideological and social systems do not distinguish body, mind and self. Social relations are understood as a key contributor to health and to the individual's sense of well-being. In helping people to manage their experiences it is important to have knowledge of their cultural context and to build support on it. These traditional strategies are the foundation for all systems supporting well-being and should be respected by aid workers, providing that cultures and traditions respect and uphold the human rights of all: men, women, boys and girls.

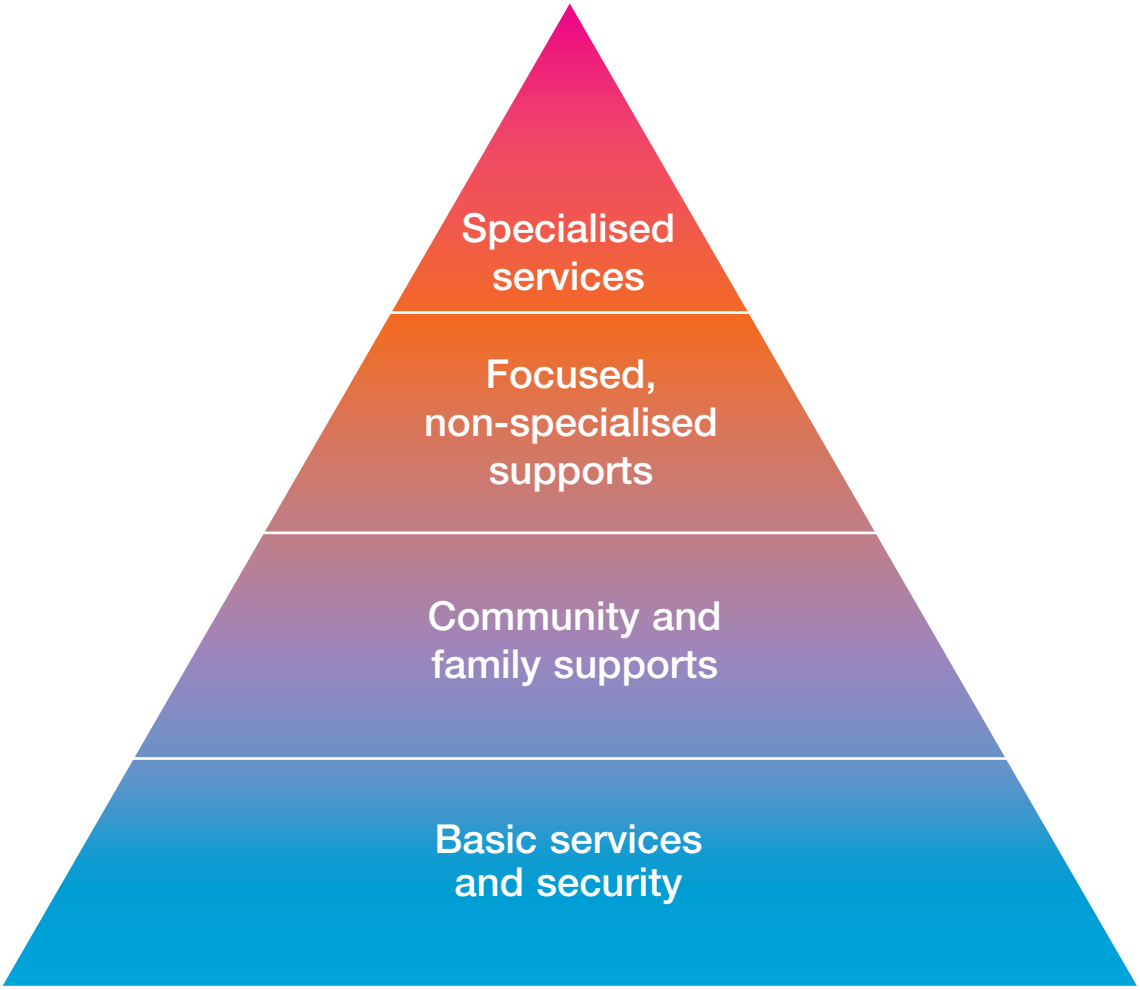
The link between psychosocial and mental health

The terms *mental health* and *psychosocial support* are closely related and overlap. For many people working within this field, they reflect different, yet complementary, approaches.

Organisations and agencies working **outside** the health sector tend to speak of *supporting psychosocial well-being*. Organisations and agencies working **within** the health sector, tend to speak of *mental health*. Exact definitions of these terms vary between and within organisations, disciplines and countries.

ActionAid uses the term psychosocial protection and support to emphasise the community-based, non-biological approach to psychosocial well-being.

Intervention pyramid for mental health and psychosocial support in emergencies[4]



Multi-layered supports

In emergencies, people are affected in different ways and require different kinds of supports. The key to organising psychosocial support is to develop a layered system of complementary supports that meet the needs of different groups. All groups should receive basic services and security, and additional layers can then be laid on top of this first level of emergency response. This approach is illustrated in the pyramid above.

Action Aid focuses upon the bottom three layers of the pyramid:

- **Basic services and security**
- **Community and family supports**
- **Focused, non-specialised supports.**

[4] This section was borrowed and adapted from *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, IASC, Geneva, September (2007).

Basic services and security

The well-being of **all** people should be protected through the (re)establishment of security (particularly in conflict related emergencies), adequate governance and services that address basic physical/ material needs: food, shelter, water, basic healthcare, sanitation and shelter. These basic services should be established through participatory, safe and socially appropriate methods that protect local people's dignity, strengthens local social supports and mobilises community networks.

Please also see the 'Psychosocial protection and support across relief sectors' chapter.

Community and family supports

The second layer represents the emergency response for a smaller number of people who are able to maintain their psychosocial well-being if they receive help in accessing key community and family supports. In most emergencies, there are significant disruptions of family and community networks due to the loss, displacement, family separation, community fears and distrust. Moreover even when family and community networks remain intact, people in emergencies will benefit from help in accessing greater community and family supports. Useful responses in this layer include: family tracing and reunification, mass information and communication campaigns, positive coping methods, formal and non-formal educational activities, women and youth groups and livelihood activities. ActionAid is most active at the bottom two levels of the pyramid from a psychosocial emergency response perspective.

Focused, non-specialised supports

The third layer represents the supports necessary for the still smaller number of people who additionally require more focused individual, family or group interventions by trained and supervised workers (but who may have not had years of training in specialised care). For example, survivors of gender based violence might need a mixture of emotional and livelihood support from community workers. This layer also includes psychological first aid, basic mental health care by primary health care workers and structured group sessions for women, youth and children.

Specialised services

The top layer of the pyramid represents a small percentage of the affected population, whose suffering, despite the supports already mentioned, is intolerable and who may have significant difficulties in basic daily functioning. This assistance should include psychological/ psychiatric supports for people with severe mental disorders whenever their needs exceed the capacities of existing primary/ general health services.

Principles of psychosocial support at the individual, family and community levels:

"EAR & SEE"

Empowerment - mobilise, activate people

Active listening

Relaxation, recreation, routine and normalcy

Social support - providing a context to enable people to heal

Empathy - a view of the world through survivors eyes

Externalisation of interests - vocations, community.

For further information please see: the Declaration of Co-operation between the World Health Organisation and Humanitarian NGO's in the provision of psychosocial protection and support in emergency settings.

Chapter 2
Reactions to traumatic events: 'Normal reactions to abnormal events'

Reactions to traumatic events

Everybody responds in some way to a disaster or a traumatic event. Most of these reactions are **entirely normal responses to extremely unusual and often painful situations** that cause a great deal of stress. The 'flight or fight' response to traumatic events is an innate, protective mechanism that enables us to handle an event or situation that is outside of our normal day-day experiences. It is normal to have reactions following a traumatic experience. It would be dangerous to have no reaction, despite reserves of resilience and relevant coping mechanisms. Our symptoms have important **protective functions** that allow us to survive and recover. Many reactions to traumatic situations are entirely natural and are the same reactions that can be understood as grief, loss, separation or mourning.

Most of us experience stressful events in our lives on a regular basis. We manage these events and find some form of balance. Some of us even thrive on periodic stressful situations, finding them challenging. Some events, such as natural disasters and conflict, overwhelm almost everyone's ability to cope.

Traumatic events

- **Are beyond the experience or imagination of most people.**
- **Are beyond any one person's ability to control.**
- **Generate great fear, terror, helplessness or horror.**
- **Threaten individuals or their loved ones with death or severe injury.**
- **Manifest differently at various periods of time after the event.**

Traumatic events can be brief in duration, such as cyclones; some events such as flooding, earthquakes and aftershocks are repetitive. Other events, like conflict, continue over seemingly endless days, months or even years, and some events, such as famine and drought, are gradual in the beginning.

What is trauma?

Trauma is a word used for any event that causes major distress to a person. Trauma may be physical, such as a wound, or it may be emotional such as acute fear, powerlessness, grieving a death or a perceived inability to cope. It is a situation that goes beyond an ordinary experience and thus is a stressful event for anyone. Psychological trauma is a threat towards a person's physical and psychological integrity, that is experienced as an overwhelming assault on the senses. The trauma resulting from an emergency can also make people loose faith in the fact that life has a certain meaning.

Trauma can affect your:

- Sense of reality
- Autonomy
- Feelings
- Thought processes.

Traumatic experiences can leave painful **psychological reactions**:

- People are always alert for the next wave, tremor, explosion or gun fire (hyper-vigilant).
- People feel helpless, hopeless and disoriented.
- People avoid reminders, but it continues to invade their thoughts (flashbacks).

The **psychological consequences** include:

- Lack of self-worth and respect
- Distrust in others
- Helplessness
- Loneliness
- Overwhelming feelings
- Lack of continuity.

There are two types of trauma:

Individual trauma: stress and grief reactions etc., (common across emergencies)

Collective trauma: break in social ties

The consequences of traumatic events are numerous, pervasive and many have a **medium and long-term impact**:

- They disturb relationships at the individual, family and community level
- They alter life pathways (loss of livelihoods, disability etc)
- They affect, interrupt, or even stop the normal process of childhood development.

It is important to remember that in the early stages after an emergency/ disaster (phase one/ acute phase), the **medium and long-term impacts and consequences** of a traumatic event have a far greater impact on the psychosocial well-being, protection and development of children and adults - if not addressed - than the more visible stress reactions.

Reactions to traumatic events

All the below symptoms are **normal reactions to abnormal events**. Everyone who witnesses a traumatic event is affected by it. An important part of psycho-education is informing people that even if they do experience these reactions, they are **not** weak or unable to cope.

Reactions to traumatic events are seen in all facets of human functioning across the well-being spectrum: physical, emotional, cognitive, social and ideological. The physical reactions often appear first and are most visible.

Immediately after a traumatic event, the hormone adrenaline is released into the body, which creates the protective 'fight' or 'flight' response. It is this adrenaline that causes the physical symptoms, which enable people to run to safety or alternatively to stand and fight (if a conflict related situation). It is an entirely normal biological response.

The following list illustrates the different **symptoms, impacts and consequences** experienced by people following a traumatic event. Some of these reactions contradict each other as different people can experience them at different times. These reactions are commonly referred to as **post-traumatic stress symptoms (PTSS)**, some of which arise due to the release of adrenaline.

Physical symptoms:

- Elevated heart rate
- Elevated blood pressure
- Dizziness
- Sweating, fever
- Nausea, diarrhoea
- Fatigue
- Burns - heat, acid, cold
- Lack of power
- Miscarriage
- Burst of strength
- Tunnel vision/ awareness
- Physical injuries - bullet wounds, shrapnel, loss of limb, loss of eyesight, hypothermia etc.
- Sensory sensitivity (light, sounds, smells, touch)
- Psychosomatic complaints
- Muscle tension
- High activity level.

Emotional/Cognitive symptoms:

- Hyper-alertness
- Emotional numbness
- Fear, anxiety
- Helplessness
- Suicidal thoughts
- Joy of survival/ feeling high (euphoria phase)
- Closeness to everyone
- Difficulty concentrating
- Stunned. Dazed
- Confused
- Repetition of events
- Grief
- Worry
- Denial/ “This is not happening”
- Passive/docile.

Emotional reactions change over time, which is commonly referred to as the **healing process**.

Social/Relationship

- Leadership
- Dependence, follow the group
- Need to be connected
- Irritation, anger
- Loss of trust between communities
- Discontinued education
- Migration - separation of communities and families
- Single parent families (loss of a family member - widows)
- Disorganisation of life and routines
- Withdrawal
- Revenge-seeking
- Suspiciousness
- Lack of privacy
- Homeless
- Loss of livelihoods.

Ideological symptoms

- Need to pray and meditate
- Sense of being punished
- Awareness of God's/ high power presence
- Search for greater meaning to life.

People's reactions change frequently in the early stages after a traumatic event. It is common for people to be quite tired after the initial adrenaline rush wears off. The feelings accompanying traumas are usually much more intense than day-to-day feelings. This intensity also contributes to the exhaustion that people report.

The symptoms that people display following a disaster have an important function in helping the person survive the intensity of the trauma. Some help the person respond quickly (hyper-awareness, tunnel vision, muscle tension). Others help to soften the impact of the event (concentration difficulties, emotional numbness). People are sometimes embarrassed by their reactions. In the long-run, these reactions are very helpful and adaptive. The vast majority of people survive traumatic experiences and go on to lead healthy and fulfilling lives.

The healing time-spa

(1) Stress reactions – Acute phase (lasts minutes, hours and days)

- 'Flight or fight response' – preparation for physical activity
- Hyper-alertness
- Narrowing of focus – tunnel vision/awareness
- Emotional reaction: disbelief, consternation, denial
- Emotional numbness – stunned, dazed
- Rigid behaviour – irritability, anger, impatience etc., can affect communication
- Panic – rare but immediate action needed.

(2) Stress reactions – Reaction phase (lasts one-six weeks)

- Delayed reactions – previously repressed or denied feelings may surface
- May be overwhelming bringing feelings of powerlessness
- Characteristic reactions are:
    - Fear of returning to the site of the event
    - Dreams or nightmares
    - Relief/ euphoria at having survived
    - Anxiety, restlessness and insomnia
    - Muscular tension, tremors and exaggerated startle response
    - Increased irritability, isolation and depression
    - Disturbing thoughts about survival, relief, guilt and grief
    - Loss of interest in life

- Reduced levels of activity
- Difficulty concentrating
- Difficulty breathing and pressure/ weight on the chest
- Flashbacks
- (Survivor) guilt and grief
- Engaging in risky behaviours - drugs, alcohol, unprotected sex etc.

(3) Stress reactions – Repair Phase (lasts one-six months)

- Feelings of hurt continue but can be coped with
- A renewed interest is taken in everyday life
- Plans begin to be made for the future.

(4) Stress reactions – Reorientation phase (approximately six months after a traumatic event and reoccurring)

- Heightened stress reactions substantially reduced
- Grief reactions may not be resolved but accepted
- Families and communities begin rebuilding their lives and making connections again
- Most reactions will diminish gradually as people resume their normal routines.

In complex emergencies, the different stages of responding to a traumatic event may not follow such a linear process. Many people may find themselves stuck in the reaction or repair phase, and this is particularly the case in conflict related complex emergencies.

Psychosocial support focuses upon **facilitating the healing process**, by supporting traditional mourning and healing practices, aiding a person's recovery to normal levels of functioning. It is important **to help people regain control**, which is the psychological antidote to the normal responses of anxiety (helplessness) and depression (hopelessness). Family, friends and the community's natural social support system provide the primary comfort to those who have been affected, contributing to needed care and attention. Psychosocial support can provide immediate relief, reducing the risk of some natural reactions developing into something more serious, and can help people meet their physical and material needs.

Trauma over time and the consequences of traumatic events[1]

It is common for people to continue to suffer from the emotional effects of trauma for quite some time after the event. New reactions may show up weeks later, as people start to feel safe again and life begins to return to normal. Research shows that after several months as many as 50% of people are showing emotional effects related to the disaster. These effects are entirely normal and do gradually subside. It can also be common for reactions to arise again at key dates such as anniversaries of the disaster or when a separate event triggers a disaster-related memory.

Trust and intimacy are often struggles for trauma survivors. The intensity of the pain tends to make the survivor feel that he or she is isolated, that no-one else can really understand. The depth of their pain and suffering is often hard to articulate in words and people give up trying sometimes, or find it just too painful to discuss their emotions and fears, even with their family members. The perceived isolation around a

[1] Adapted and borrowed from *Community Based Psychosocial Approach: A Facilitators Guide*, ACT Network, Geneva, September (2005).

trauma survivor can lead to marriage difficulties and may contribute to a high degree of divorce. Sexuality is often affected during the months following a tragedy, with sexual expression. Widowed women and young girls may be forced into prostitution or 'survival sex' to obtain relief supplies. Children who are isolated from their parents are at a greater risk of being trafficked.

The stages of grief

- The experience of shock and denial
- The experience of emotional outbursts
- Inability to concentrate on anything but loss
- The experience of physical distress
- The experience of depression and utter gloom
- The sense of guilt
- The sense of hostility
- Unwillingness to participate in normal activities
- Gradual realisation: returning to life's reality
- The movement back into mainstream life.

Complex emergencies

The term 'complex emergency' refers to situations, where an individual has suffered from a catalogue of human rights violations, underpinned by pervasive poverty, which can overwhelm and erode an individual's resilience and their coping mechanisms. It is used to differentiate between those situations where armed conflict and political instability are the principal causes of humanitarian needs, from those where natural hazards are the principal cause of such needs.

A 'typical' complex emergency is characterised by:

- A collapse of state functions
- Intra-state rather than inter-state conflict
- Difficulty in differentiating between combatants and civilians
- Violence directed towards civilians and civil structures
- Fluidity of the situation on the ground
- A lack or absence of normal accountability mechanisms
- The potential and actual development of war economies
- The potential for humanitarian assistance to prolong the conflict
- A multiplicity of actors.

All the above can lead to impaired psychosocial functioning for individual's and communities, as they fear the collapse of: their social support systems, internal resilience and coping mechanisms. Psychosocial programming within complex emergencies needs to adopt a **multi-layered, long-term approach, with a particular investment made at the programme design stage**.

The challenge for rights-based interventions in such emergencies is to ensure that any programming approach is inclusive and addresses all five 'rights': **physical, basic, economic, socio-cultural, and civil & political**. Thus, Country Programmes must take into account the impact of a complex emergency on a community's development and levels of poverty, and ensure that both a rights-based and a development perspective are integrated into psychosocial programmes. Future situations of risk, human rights violations and hence damage to psychosocial well-being can be prevented, by following the ALPS principles, of involving communities in the design and implementation of interventions, which enhances their capacity and resilience.

Survivors of prolonged trauma or repeated and severe traumas (in complex emergencies) have particular difficulties throughout the healing process. These difficulties may include: challenges in finding a livelihood to support their family, to locate lost family members if separation has occurred, accessing basic services - health, education, and difficulty regulating feelings or the feeling of being overwhelmed. Their sense of identity may be changed. Gender roles may change within the family. Survivors may feel that they no longer have the same value, or are the same person. There may be disturbing states of consciousness like periods of amnesia, or intrusive thoughts, making the person wonder if they are "going crazy". The symptoms may be disturbingly persistent and often disrupt people's relationships with close friends and family.

Some people express their distress through 'somatic' complaints. This discomfort manifests itself through headaches, stomach and back aches, heart problems, faintness, feeling hot or cold etc. People go to the doctor for help with these symptoms. It is important not to minimise these complaints, as they can be just the ripples on the surface of much larger problems within a person. **It is necessary to distinguish between pain caused as a result of injuries sustained in the traumatic event, and illnesses that are a result of the emotional distress of the trauma**.

Family and community relationships

Family relationships often suffer from the emotional distress following trauma. Children may have become orphaned leaving them open to abuse, exploitation and altered developmental pathways. Women may have lost their husbands, again leaving them open to abuse, exploitation, prostitution and difficulties accessing services, loans and their rights to inheritance. People talk about feeling distant from their spouses and domestic violence may increase as stress is displayed by aggressive behaviour towards children, siblings and spouses. Child abuse, inside and outside the 'home', often increases in an emergency. The use of alcohol and drugs by adolescents, youth and adults are common 'negative coping mechanisms' in an attempt to dull feelings and forget intrusive memories or flashbacks. Families that are able to work out safe ways to express their distress while supporting each other, increase the speed of the healing process.

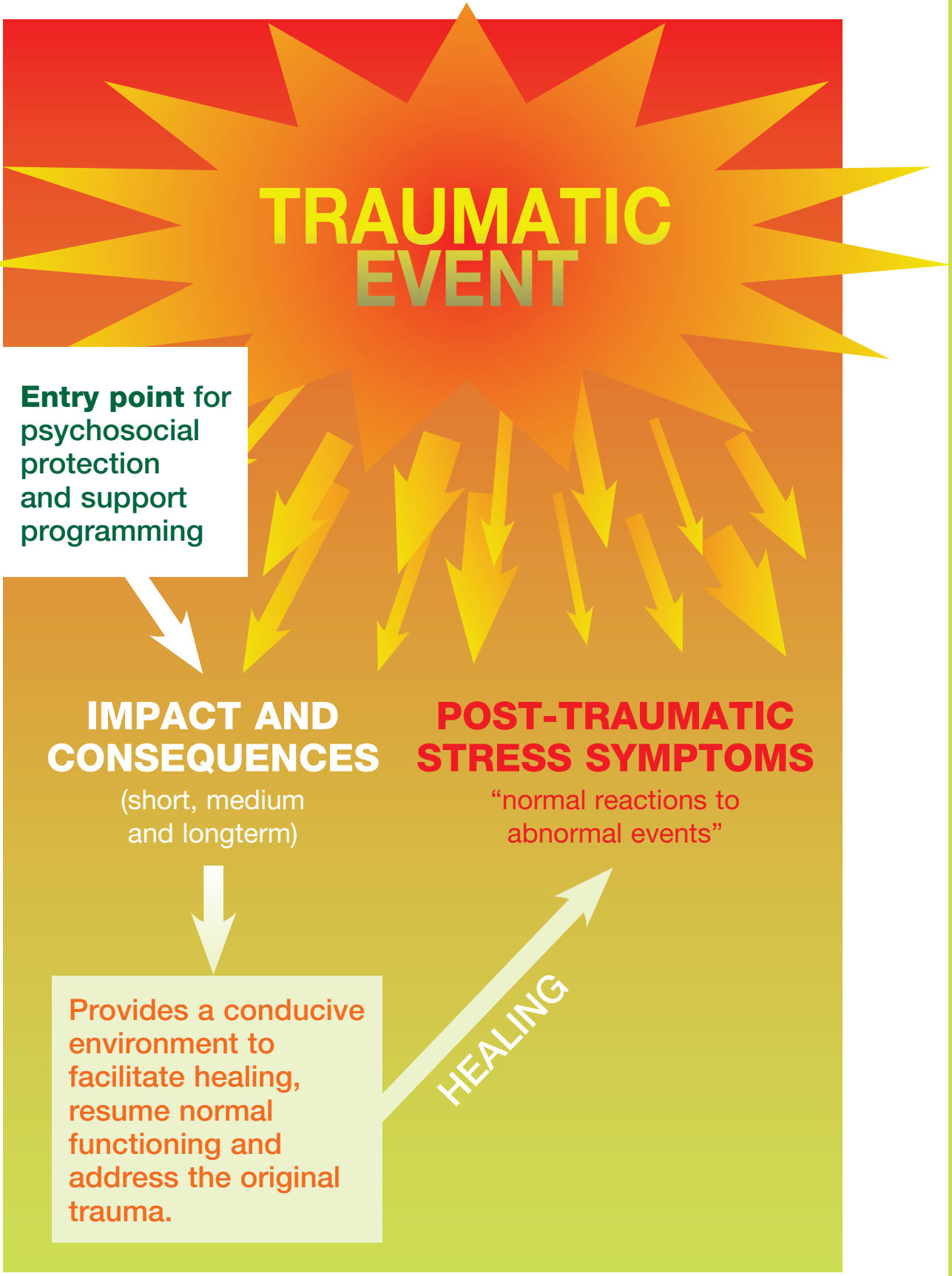
Likewise, communities often have difficulties as a result of traumatic events, aside from the possible physical destruction, the loss of leadership and loss of structure can handicap the functioning of the community. Pain and distress can cause conflicts within the family and the community. People can be much more suspicious, especially if the traumatic event included civil unrest or conflict. At this time, there is potential for new persons to rise to leadership and people to provide meaningful assistance. These can be healing actions for the whole community and become the basis for fostering resilience.

Example: Delphine was raped aged 20 years (traumatic event) when she fled the conflict in northern Uganda with her family. What are the **medium and long-term consequences** of this traumatic event for the girl?

- Delphine may be rejected by her family, creating protection risks
- She maybe isolated from her friends and other community members, making it difficult for her to heal
- She may be unable to pursue her education at college/ university
- She may have low self esteem and engage in risky behaviours, such as unsafe sex and alcohol or drug abuse
- It may affect her ability to marry or have children in the future
- She may have contracted an STI, or HIV, or fallen pregnant as a result of the rape
- She may have physical pain when urinating for example, have developed a fistula or other medical complications requiring treatment.

All the above **consequences** of the traumatic event are in addition to the post-traumatic stress symptoms (PTSS) mentioned earlier. In the early stages of an emergency, interventions should focus on responding to the consequences of the event, rather than focusing on the symptoms - which are **normal reactions to abnormal events**. It is only by addressing the consequences of a traumatic event that a sense of normalcy can return to a person's life and they can begin the healing process.

A Psychosocial Framework:
Making sense of emotions, impact and consequences



Post-Traumatic Stress Disorder (PTSD)

In every emergency, a very small percentage of people (between 5-10% depending on the emergency) will develop **post-traumatic stress disorder (PTSD)**, even after their basic needs have been met, safety and security has been restored and developmental opportunities have returned. These are the people located at the very top of the pyramid described in the previous chapter, who after 6 months are still exhibiting extreme distress and other reactions. These people usually have experienced a very high exposure to the trauma, have little resilience and are highly vulnerable. **PTSD does not occur until about 6 months after exposure** to a traumatic event, if the 'normal' healing process is taking place. People suffering from PTSD should be referred in the **early recovery phase** of an emergency to specialised mental health and psychosocial services, such as counsellors, psychologists or psychiatrists. Please see the programme response chapter for more details.

PTSD is the re-experiencing of a traumatic event through:

- Flashbacks
- Nightmares
- Repetitive behaviour.

Signs and symptoms of PTSD:

(a) Reliving the trauma through intrusive memories or dreams which are painful and come uninvited

(b) Avoidance of all activities and situations reminiscent of traumatic events

(c) Numbness, emotional blunting and detachment from other people

(d) Hyper vigilance and startle reaction

(e) Panic reactions

(f) Acute outbursts of violence.

Other delayed reactions:

(i) Loss of productivity

(ii) Irregular menstruation cycles/ no menstruation/ loss of fertility/ miscarriage

(iii) Lack of interest in sex and relationships

(iv) Family problems

(v) Alcohol and other substance abuse

(vi) Increased vulnerability to stress

(vii) Poor physical health

(viii) Suicidal thoughts.

Resilience

Some people have the ability and capacity to survive and resist trauma with little long-term damage, whereas other people can struggle for months and years. The ability to withstand trauma is known as resilience. Resilience is the capacity to transform oneself in a positive way. Our resilience helps us to overcome difficult situations[2].

Resilience is:

- The capacity to manage oneself when faced with difficult circumstances
- The capacity to transform oneself in a positive way (empowerment)
- The capacity to recover or resume normal functioning again.

The overwhelming majority of children and adults are resilient and have a great capacity to cope with adverse situations once their:

- Basic survival needs are met
- Safety and security have returned
- Developmental opportunities are restored
- Within the family, social and community context

What characteristics contribute to resilience?

Resilience is built through a person's relationships and activities. In turn, a person's relationships, and activities are strengthened by their resilience[3].

- A combination of innate and learned skills including independence, social ability, a feeling of being valuable, creativity, the ability to master difficult challenges etc., (individual qualities from birth).
- Family relationships surrounding an individual.
- The networks and social supports in which people relate.

Resilience is linked to vulnerability. The greater a person's level of resilience, the lower their vulnerability to natural disasters and conflicts.

One of ActionAid's **key human security objectives** is to **build people's resilience to conflict and emergencies**, precisely because it quickens the healing process and reduces a person's vulnerability to future disasters.

[2] Annan, J., Castelli, L., Devreux, A. & Locatelli, E. *Handbook for Teachers*, AVSI, Uganda, February (2003), p12.

[3] Annan, J., Castelli, L., Devreux, A. & Locatelli, E. *Handbook for Teachers*, AVSI, Uganda, February (2003), p12.

Individual resilience factors (inner resources):

- Natural resources, resources with which the individual is born. Resources may be physical, emotional and intellectual
- The ability to master and cope with difficult challenges
- Independence
- Social ability, having an easy temperament
- The feeling of being valuable, a sense of self-worth
- Experience of meaning and continuity, a sense of coherence
- Creativity
- Hobbies and Interests
- Internal locus of control; self-confidence, self-worth, safety, awareness of self
- The ability to be of help to others
- Responsibility
- Trust, attachment
- Competence and confidence.

External resilience factors:

Family:

- Clear structures
- Traditional rules and rituals
- Sensible boundaries (for examples rules that parents set for children)
- Common values
- Strong links to the extended family and community.

Network:

- Group identity and cohesion
- Common values
- Community-based events, traditions and ceremonies.

Trauma and resilience factors in comparison

Trauma	Resilience factors
Loss of self-worth respect and dignity.	Good feeling of self-worth.
Loss of control, feelings of being helpless.	Internal locus of control, mastery and coping.
Loss of coherence and meaning.	Sense of coherence. The world may be seen as understandable and meaningful.
Overwhelming emotions.	Outlet of emotions, symbolising creativity.
Relational - loneliness, loss and breaking up of relations.	Belonging to something/ somebody, community, close relations.
Losing the concept of time - discontinuity.	Experience of continuity, planning for the future.

A life-span perspective[4]

Age Groups	Impact of Traumatic Events	Trauma Recovery/ Resiliency Support
Young children 0 - 5 years	• If with parents, child will reflect the distress or calm of parents. • Increase in clinging behavior, comfort behaviors such as thumb sucking, regress to younger behavior. • Displacement from home increases risk of illness and distress.	• Keep young children with parents. • Support positive parenting skills, family routines. • Promote breast-feeding. • Provide safe play space, well child clinic to monitor health.
6 - 12 years	• Feels losses acutely and grieves. • May be nervous, have difficulty sleeping, show increased activity, irritability or aggressive behavior. • Problems with concentration or memory in school are common. • Memories of trauma intrude.	• Support and modeling from parents and teachers in the management of feelings. • Help remember good times. • Child friendly spaces and schools. • Opportunities to be competent and helpful aids in resilience.

[4] Adapted and borrowed from *Community Based Psychosocial Approach: A Facilitators Guide*, ACT Network, Geneva, September (2005).

Age Groups	Impact of Traumatic Events	Trauma Recovery/ Resiliency Support
13 - 18 years	• Losses are traumatic and feelings at times are overwhelming. Stress reactions are common. • Depression and anxiety appear at times. • Feelings of incompetence and helplessness sometimes paralyse action. • Rape complicates everything.	• Support groups with peers to validate feelings and reduce isolation. • Opportunities to be competent and in control aids in resilience. • Adolescent and youth friendly spaces. • Support for rape recovery.
Youth 19 - 30 years	• Overwhelmed, little experience to help. • Responsibility for children increases problems. • Property and job losses trigger depression, drinking, violence. • Changes in gender roles such as female headed households. • Loss of support system from displacement. • Rape complicates everything.	• Support groups for women and mothers to reduce isolation and encourage networking. • Use skills available among affected to reduce sense of helplessness and loss of control. • Childcare for preschoolers. • Job training, employment recovery for men and women. • Support for rape recovery.
Middle Adults 31 - 50 years	• Loss of employment and home is very hard. • Changes in family roles and employment. • Being at home often triggers depression, alcohol use, domestic violence. • Deaths of family and friends increase trauma. • Rape complicates everything.	• Active assistance in job relocation, income support. • Recognise and use people's expertise. • Participation. • Encourage active decision making, planning for the future.
Older Adults/ Elderly 50+ years	• No difference than younger adult responses. • Elderly may have slower responses to danger because of poor hearing or mobility. • Losses are common but experience is helpful. • Rape complicates everything.	• Use older adults and their experience as resources to help community. • Connect people to aid and support networks when they cannot go themselves. • Home-based community care.

Please note that the above age boundaries, are for reference purposes only and they can differ from organisation - organisation and from community - community.

Reactions to trauma across the ages

Traumatic events do not affect everyone the same way, or one individual in the same way across their life-span. A person's level of resilience will change across their life-span, and across different environments. ActionAid works with poor and vulnerable groups who are often **disproportionately affected** by emergencies as they have **lower levels of resilience and limited coping mechanisms available, which can lead to protection threats**. The following groups are regarded as vulnerable in most emergencies and thus, require priority psychosocial protection and support.

Women - widowed, single, female-headed households, pregnant and lactating mothers.

Women contribute to the larger community through their skills in organising people, attending to the basic needs of everyone, and caring for the needs of those who cannot care for themselves (children, the elderly, and those who are ill). In many societies, they are often the breadwinner.

Women are particularly vulnerable to violence. They are often the targets for rape in war situations, as a demonstration of power and a way of shaming a community/ family and its values. They are often the objects of domestic violence. They are less mobile while caring for the children and elderly making them more likely to be caught up in the traumatic situation (famine, floods, conflicts etc.) Women are often criticised for being a greater problem than men and are shamed for rapes (this can be very common in many African societies). This attitude blames the women for making contributions to the care of the community. It is delivering this care that makes them more at risk of violence. This blame also absolves the perpetrator of wrong behaviour.

In the early recovery stages of an emergency, women can be discriminated against for livelihood opportunities as customs, traditions and cultures can prevent them from accessing loans, micro-credit; permission may be denied to work away from their husbands/ male guardian, and they may experience difficulties juggling work and caring for children at the same time. They may be denied access to employment in favour of men, lack access to property and land titles. This is called the **feminisation of poverty** which delays the healing process in women and girls, and adds to their poverty and vulnerability. The junction of relief and development (the early recovery phase) lies is the **reduction of poverty and vulnerability and the increasing of a person's resilience**. Women's rights is a core theme that is mainstreamed across ActionAid's work, and it remains a priority in emergency and early recovery contexts.

Specific protection for women and girls

(i) **Protection against sexual violence.**

(ii) **Women deprived of their liberty**- incarcerated women must be held under the immediate supervision of female guards.

(iii) **Expectant mothers and maternity cases** - parties to an armed conflict are to ensure safe spaces for pregnant women and mothers of young children.

(iv) **Preservation of family links** - women are the main initiators of requests for news of family members, bearing the emotional and economic burden of missing loved ones.

Protection risks for women and girls during armed conflict[5]

As women are not generally recruited to fight, they remain largely unarmed and unprotected at a time when traditional forms of moral, community and institutional safe guards have disintegrated and weapons are more common. Women working in forests or fields as agricultural labourers can be among the victims of anti-personnel mines and unexploded ordnance. Women, who may be wives, mothers, daughters and sisters of combatants (although still civilians themselves) may be specifically targeted within a community to put pressure on one warring faction, or as a form of retaliation. Women who are forced to feed and shelter arms bearers are subjected to the risk of not only violence resulting from the presence of armed bearers in their homes, but also from reprisals by those in opposition, who may incorrectly perceive them to be combatants themselves or collaborators.

Resources are often scarcer during an armed conflict emergency, which can increase the protection risks for women and girls as their access to services are curtailed. Women cannot realistically access services unless they know they will be safe in doing so. For example, in some societies, women may fear reprisals by their own community for transgressing cultural limitations on mobility (such as visiting food distribution points when unaccompanied); they may be reluctant to leave children unattended in a conflict-prone region to visit distribution points; or they may hesitate about reporting any threats of violence against them.

Women who fear, or have been subjected to, sexual violence may seek to obtain protection and assistance through relations with members of the armed forces. They may submit to allying themselves with a male, who offers them and their dependants protection, rather than risk being subjected to repeated violations by many men. Women and girls should be protected at all time, from having to seek such alliances as their only means of safeguarding themselves and their families.

Children

Children respond sensibly and appropriately to disasters, especially if they experience protection, support and stability from their parents and other care givers or trusted adults. Like adults, they demonstrate a wide range of symptoms in response to their distress.

Specific risk factors for children

Children and adults can respond very differently to traumatising events. Often the signals that a child is in need of help are somewhat different from those of adults. This is in a large part because children are unable to express themselves, verbally, due to their limited vocabulary.

The following symptoms are typical of children who are exhibiting signs of distress:

- A lack of interest or energy.
- Withdrawal from relationships with adults or other children.
- Excessive clinging to familiar people.
- Prolonged sadness or generalised anxiety.
- Loss of appetite.
- Sleep disturbances.
- Headaches or other somatic complaints.
- Poor concentration, restlessness, sudden changes of mood.

[5] Extract taken from *Addressing the Needs of Women Affected by Armed Conflict*, ICRC Guidance Document, March 2004, p20.

- Sexual behaviour inappropriate to age.
- Aggressive or destructive behaviour.
- Preoccupation with violence, suffering or separation in play.

Below are some examples of post-traumatic stress symptoms specifically for younger children (aged 0 - 8 years). It is important to emphasise that these are **normal reactions to abnormal events**.

- Numbing
- Nightmares
- Flashbacks
- Easily startled
- Uncontrollable crying
- Psychosomatic complaints
- Withdrawal
- Rocking
- Struggle to put on weight or feed properly.

Children may 'regress' to an earlier age (developmentally):

- Children become clingy
- Bed-wetting
- Agitation and lashing out - particularly in adolescents and youth
- Inability to concentrate (can also manifest in an inability to feed properly off the breast for young babies).

All children need the support and protection of parents and caring adults. It is an unfortunate reality that children are exploited in many ways, and due to their innocence are unable to anticipate these dangers and protect themselves. It is for this reason that they are highly vulnerable and hence are a priority for ActionAid.

Small children (0 - 5 years): Anxiety and fears are shown through increased difficulty separating from parents, or other caretakers, fear of the wind/ the sea/ rain (if a natural disaster), and loud noises (if a conflict related emergency) and fear of "strangers". Children will often act out their worries, repeating stories over and over and can often be seen 'rocking' backwards and forwards. At times children's play will be very restricted, or they may seem less interested in play than normal. Young children may also regress to behaviour typical of younger ages, such as "forgetting" how to feed themselves, or reverting to wearing nappies/ soiling their underwear.

School-aged children (6 - 12 years): Regressive behaviour (acting younger than their age) is very common following a trauma. Children of this age often talk or play out the traumatic event repeatedly, in either direct or symbolic ways. An increase in aggressive behaviour and rebelliousness are quite common, as are increased worries. The loss of pets, prized possessions/ toys and people are especially difficult for these ages. Difficulties in school with memory, concentration, intrusive thoughts and avoidance are also typical. School performance is often affected because of the emergency, lack of access to educational facilities, as well as an inability to do homework in a camp environment - impairing learning and their development.

Teen years (13 - 18 years): Teens can provide positive contributions during conflicts and natural disasters, bringing skills and energy at difficult times. They are also vulnerable to being overwhelmed,

getting frustrated, angry, acting out, or feeling guilty. The feelings of adolescents are often intense and they often require support to manage these feelings and channel their energy positively. The risk of suicide is greater for teens than for other age groups. Peer relationships are very important. Acceptance from friends and the assurance that their feelings and fears are normal helps with the adjustment. Academic performance may drop because of the emergency, lack of access to educational facilities, as well as an inability to do homework in a camp environment - impairing learning and their development.

Youth (19 - 30 years): Youth can also be an invaluable group in an emergency; they usually have lots of energy, motivation and a wish to keep active even within a camp environment. They are, also, vulnerable to feelings of being overwhelmed, getting frustrated, angry, acting out and feeling guilty. Youth is a period of great creativity, optimism and experimentation, which can be disrupted in an emergency, forcing many youth to change their 'world view'. Displacement to a camp due to a conflict may create an additional set of problems resulting from poor housing, loss of control, family separation and a lack of privacy. This accumulation of trauma can lead to a build-up of anger and frustration, which maybe directed towards government officials and aid workers, and often manifests as domestic abuse (violence against their spouse, siblings and children), or other targeted people within the camp or neighbourhood. Male adolescents and youth often struggle with feelings of great anger and frustration at their inability to protect their family or control the situation. It is this anger and frustration that can lead to GBV as they try to assert control over the surroundings and protect their loved ones.

Unaccompanied children: Children separated from their families are at a particular risk of long-term negative consequences and difficulties. Separation from parents/ families/ care-givers is without question the highest stress factor for children, and the greatest protection concern. Every effort should be made to quickly reunite children with their families. When parents are not present, children should be kept with siblings, grandparents of other familiar caring people in a stable situation where their needs can be met.

Child soldiers[6]: Child soldiers often become terribly traumatised. They have missed out on their childhood. They have missed out on going to school, or playing with friends, and having parents to care for them. When they try to return to their homes and communities, they find people who are afraid of them. For weeks and months, they have been bullies, terrorising those who they meet. They must now confront a new reality in which they learn to make peace with their former victims and must find ways to trust others, co-operate with their neighbours and make amends for their past so that they can begin life anew as members of the larger community. All the characteristics of trauma are present in these children, nightmares, loss of hope, a lack of safety etc., but often they are hidden from sight by tough attitudes and behaviour. These children are people in real need of psychosocial protection and support at the community level and for specialised individual support by psychosocial professionals.

Child-headed households

Child-headed households refer to children living independently in groups. Many of these groups are supported by extended family living nearby or even in the same compound. Children often express a strong preference for remaining together as a group without adult care, and point to a number of advantages:

- Siblings can stay together
- They can retain the family home (though not in refugee or displaced contexts)
- Some children see it as preferable to fostering

[6] *Community Based Psychosocial Approach: A Facilitators Guide*, ACT Network, Geneva, September (2005).

- They may experience less isolation and discrimination than living apart in families
- Older children can be more independent.

It is important to remember that in many societies it is common for children, from an early age, to undertake various domestic and child care tasks in respect of younger siblings. This may mean that children from the age of around 12 and upwards can have a great deal of parenting experience.

Protection risks for child headed households

Children living without immediate adult care – whether in a sibling-headed household or as a group of unrelated peers living together – are perceived as having a number of areas of vulnerability and disadvantage, including:

- Livelihood problems
- Health problems or complications
- Lack of experience in solving a range of problems
- Vulnerability to abuse and exploitation
- Loneliness and isolation in the community
- Problems for the oldest child in finding a marriage partner
- Problems for the oldest child in attending school due to the responsibilities of fending for siblings (e.g. priority being given to income-generating activities).

Other key groups

The elderly: The elderly have a great contribution to make given their lifetime of experiences and accumulated wisdom. However, their diminishing physical capacity and consequently limited mobility make them at a high risk in disasters, particularly earthquake and conflict related emergencies. When moving the elderly from their familiar environments, it is important to keep them together with family members where possible and to remember to attend to their medication and other health needs. Depression and confusion are often seen, especially when the elderly are separated from their families and familiar people, which can be augmented if they are isolated from other community members. Elderly people are also at greater risk of victimisation by unscrupulous people following a disaster. It is not uncommon for them to say that they are too old to start over after a life-changing trauma, and to consider death a better option.

The physically, mentally or developmentally disabled: Although people who are physically and mentally disabled have distinct needs from one another, all three groups are at an especially high-risk in disasters and conflict. The normal patterns of care or assistance that they receive are disrupted, which in turn alter their normal routines and levels of functioning. Supplies of medication, equipment and devices such as wheelchairs, familiar caretakers, and previously effective programs of treatment may become unavailable. This situation may drastically reduce their quality of life. Anxiety and stress resulting from this situation may create disorientation, confusion, or deterioration in their health status. In earthquakes, physically disabled people, either prior to the earthquake, or as a result of it, are a key vulnerable group.

This population may not be able to care for themselves without help. As a result, they are at a great risk of marginalisation and isolation, making it harder for them to begin healing. Post-disaster malnutrition, infectious diseases, bed-sores and the lack of adequate health care are particular risks since their ability to be their own advocate is so limited.

People from war or other violent environments: Violence perpetrated by other human beings inflicts physical damage, destroys trust and often the ability to receive help. Areas which are key to a **person's resilience** - family, social networks, ability to provide and care for one's family and a sense of control - are destroyed by human inflicted violence. As a result, safety, security and basic needs are of paramount importance.

The development of trust occurs slowly and is easily disrupted by the appearance of broken promises and perceived intrusions. Displacement to a camp due to the conflict may create an additional set of problems resulting from poor housing, loss of control, family separation and a lack of privacy. This accumulation of trauma can lead to a build-up of anger and frustration, which maybe directed towards government officials and aid workers, and often manifests as domestic abuse (violence against their spouse, siblings and children), or other targeted people within the camp or neighbourhood. Male adolescents and youth often struggle with feelings of great anger and frustration at their inability to protect their family or control the situation. It is this anger and frustration that can lead to GBV.

Uncertainty about the future is also common among those who come from conflict situations. Where people were once industrious skilled members of a community, now everything is in question. Will I ever return home? How will I support myself and my family? Will I be able to move to another country and start life again? As a result of this uncertainty, people may appear restless, hopeless, depressed, grieving, confused, and very reluctant to hope for anything or begin to plan for the future.

Specific trauma: Rape, Trafficking and Torture

Trafficking and prostitution are growing problems involving women, young girls and boys. Trafficking and prostitution often follow conflict and disasters and are present when large groups of people are forced together in abnormal situations and when accessing relief supplies due to their high levels of vulnerability and wish for a better life. Traffickers prey on vulnerable people and are often seen hanging around displaced person camps, waiting to capitalise on women, young girls and separated children's hopes and dreams of a better life. Trafficking causes great distress to the person being taken away as it usually results in abuse and sexual exploitation, as well as causing fear and loss for the family and friends left behind. It can be very difficult to reunite families who have been separated due to trafficking.

Rape and torture, are unfortunately common during conflict related emergencies. Men are also at risk of being raped, and tend to face a stigma that is different from women and children. The fact that a man was unable to defend himself, can make it very difficult (if not impossible) to admit that he has been raped in some societies.

Why do people rape?

- Rape can be used as a way of humiliating your male opponents
- Rape as a form of ethnic cleansing/ superior caste/ clan/ tribe via impregnation so that there are more children in the dominant group
- As a form of social bonding amongst men - usually young soldiers (army, militia or peace-keepers)
- To destroy a particular family, community or culture - women lie at the heart of many communities.

The effects of being raped are devastating for the survivor, especially as in many societies they are often abandoned and stigmatised. In some cultures rape victims are banned from their society and community and are forced to live the life of an outcast. This isolation and alienation disrupts a person's healing process.

People who have been exposed to torture and/or rape are often in need of special care, physical therapy, and protection from others. People who are abandoned by their families need new forms of family and community support. It is important to help these people understand that their reactions are normal for people who have been exposed to this particular type of acute trauma. These people are in need of help from others, and in some cases medical professionals including gynaecologists, psychologists and possibly ideological support.

Some typical rape reactions might be:

- Feelings of shame and disgrace
- Guilt because of the disgrace they have brought on their family
- Fear of bearing a child because of the incident (for females)
- Fear of strangers
- Feelings of resignation to fate or destiny
- Feeling of being dirty, soiled and 'infected' (STI's)
- Risk of suicide
- Engaging in risky behaviour such as seeking comfort in drugs, alcohol or unprotected sex (in an attempt to forget)
- Fear of entering into a loving relationship.

Survivors of torture

Torture, unfortunately, occurs in one third of all countries around the world. In times of armed conflict and great instability within a country, the number of torture survivors increases. The signs and symptoms of being exposed to torture are the same as those in disasters, although often more severe. Torture survivors often have a mistrust of others, a difficulty in relating to their peers and may struggle to form new social bonds after the event.

It can be useful within some communities, to bring torture survivors together in small groups of 6-10 people to discuss and share their experiences and emotions. The network and support of community helpers and facilitators that interact with tortured people within these groups is essential. The helpers need to be trained to manage to cope with what they are hearing from the torture survivors, to provide support and guidance, in addition to leading/ facilitating group healing processes.

Supporting victims of torture can be a long process; it is often a question of relationship building, forming support groups and trust. Due to possible physical injuries and complications, any assistance often depends upon the co-operation with medical teams, doctors and physicians. Torture victims will require a portion of specialised follow-up and should be referred accordingly.

Experience illustrates that people who have survived incidences of torture and received the necessary help and support from professionals, their family and community, respond better to programmes that help restore self-respect and trust in their surroundings.

Chapter 3
Psychosocial Appraisals Chapter

ActionAid places poor and excluded people at the centre of all its emergency preparedness and response work. AAI recognises that people affected by natural disasters and conflicts should not be discriminated against, and should enjoy the same human rights and freedoms as others. Appraisals are information gathering exercises undertaken by organisations and agencies to inform their emergency response programming. ALPS dictates that all interventions should be preceded by an appraisal. **An appraisal is an enabling process and is primarily for action.**

The rigid project cycle format does not always occur in emergency settings, as often appraisals and interventions can occur concurrently across all stages, until there is the time for more detailed analysis. Participatory appraisals, if done properly, can act as an intervention in themselves. The key to doing a participatory assessment is to facilitate the community members' understanding and interpretation of their situation so that they can make informed decisions for actions, empowering people and ultimately promoting psychosocial well-being.

The following chapter outlines the key areas of a **psychosocial appraisal**, which should enhance all other appraisals mentioned in Chapter 3 of the Emergency Response Guidelines. It is important to remember that in the first two phases of an emergency (acute stage/ phase one and phase two), **the psychosocial needs of a population are very much interwoven with the social environment**. Thus, the primary focus in the early stages should be on food, water, shelter, safety, security and protection; and then moving towards family reunification, schools, hospitals etc.

See the 'phases in assessing and supporting psychosocial well-being in emergencies' chart later on in this chapter.

It is important to orient local partners, CBO's, religious leaders and the community about the goals of the assessment, its guiding principles and the methods that will be employed. This will help shape the community's expectations right from the start and perhaps keep them from becoming unrealistic. When speaking with the community members try to not use jargon or technical terms. **When in the field, it is best to avoid using the words "psychosocial" or "trauma" because they typically cannot be translated to local languages and can thus be confusing or even frightening. It is better to use simply "well-being" or "problems and difficulties."**

Assessments should meet the following basic conditions:

- **Consistency**
- **Flexibility**
- **Relevance**
- **Participatory process**
- **Rapidity.**

The most successful psychosocial appraisals are undertaken in a collaborative and coordinated manner. Where possible ActionAid should be involved in a joint psychosocial needs assessment.

The following actors are often active in the psychosocial field within most emergencies, and can be found attending health, protection and psychosocial cluster groups:

- International Organisation for Migration (IOM) - usually chairs the psychosocial sub-cluster
- UNICEF - particularly child protection, which includes psychosocial issues
- UNFPA - particularly on gender based violence (GBV) issues
- World Health Organisation (WHO) - usually chairs the health cluster
- Red Cross and Red Crescent Societies (plus IFRC/ ICRC)
- Relevant National Government departments
- Local authorities such as University Social Work Departments, Teacher training colleges and
- Local partners, churches and CBO's.

Psychosocial needs change greatly immediately post disaster, through the rescue, relief, recovery and development stages. A phased approach to psychosocial appraisals is, therefore, recommended - which according to ALPS, demands multiple appraisals, reviews and reflection processes. An appraisal should be undertaken within the first 30 days then again at 6 months. Appraisals may run concurrently with monitoring visits.

Suggested composition of a psychosocial appraisal team

An appraisal team should consist of 5-8 core people (there can be many more trained volunteers). The following are some practical pointers to consider when forming a team:

- One person should have experience in appraising psychosocial protection and support in emergencies, with a focus upon **resilience** rather than **vulnerabilities**
- One person should have an in-depth understanding of ALPS and PVA techniques - an impact assessment and shared learning officer is ideal
- At least two people should speak the local language(s) - one female, one male
- Balance gender and age

- Team members should have a commitment to humanitarian work and an understanding of psychosocial issues, are able to remain calm under pressure, are able to manage stress effectively and have excellent communication skills

A possible team could comprise of the following:

(1) IECT Regional Advisor/ AAI staff with a psychosocial background (x1 person)

(2) AAI Impact assessment and shared learning officer (x1 person)

(3) Social workers/ psychologists/ counsellors/ psychiatric nurses from a Social Work College or University Psychology/ Psychiatric department (2-3 people)

(4) Teachers or community/ religious leaders that have experience in working with children, adolescents and youth (1-2 people)

(5) Local partners - NGO's or CBO's (1-2 people).

Key psychosocial appraisal questionnaires

There are two key areas that any psychosocial assessment should address.

- The first is to assess the **individual stress symptoms** resulting from the traumatic event, such as the levels of grief, feelings of hopelessness, suicidal thoughts, nightmares, bed wetting etc.
- The second is to assess the **impact** and **consequences** of the traumatic event on individuals, families and communities. The impact and consequences of a traumatic event are often the source of greatest stress for a person, and are where protection concerns lie, rather than the emotions/ symptoms associated with the traumatic event directly. This is why the first level responses are based around social issues: safety, security and protection, access to water, healthcare, sanitation, food, shelter and information.

The following questionnaires should be mainstreamed throughout the first rapid appraisal in any given emergency. These tools are designed to focus on the **symptoms** (emotions, cognitive functioning etc.) of an individual affected by the disaster, and therefore focus more on the **psychological** side of psychosocial protection and support. Speed is the key rights-based intervention here, in addition to, assessing psychosocial protection and support needs, to ensure that people do not develop clinical manifestations.

The individual assessment tools, in the first stages of an emergency, should be used to highlight the **issues** (not individual cases) that people are suffering from as a result of the emergency. In the later stages of the emergency, phase three onwards they can be used for case management purposes and to build a case for referral.

The questionnaires are designed to meet the following goals:

- To assess the mental health and psychosocial needs of the displaced population through the stakeholder's understanding
- To map the existing mental health and psychosocial services offered to the affected population (this helps to prevent duplicate projects and agencies or organisations 'competing' for beneficiaries)
- To collect relevant and consistent data and information to plan for future interventions, which aim at addressing the affected population's needs.

Samples and instructions on how to use these tools are available in the appendix.

- *Self Reporting Questionnaire*
- *Impact of Events Scale.*

Other assessment instruments

Mental health and psychosocial support resources include individual, family, community, psychological, social and economic strengths, which can help individuals and groups of people, cope with stress, trauma and suffering. This is an **holistic approach to well-being**, which also includes human, financial and institutional resources (including policies and action plans) which can be mobilised to support the establishment of psychosocial protection and support programmes. In order to undertake a comprehensive psychosocial appraisal, multiple methods and forms of inquiry are required. The **IOM Qualitative Household Questionnaire tool** (available in the appendix) focuses more on the social side of psychosocial support. This tool should be used at the rapid appraisal stage and is just as important as the individual tools mentioned above.

Ethical considerations

Some points to remember when undertaking assessments.

- When conducting assessments ask questions with a view to understanding the possible differences in experience for women and girls, boys and men.
- Appraisals should build on what is known in a crisis and be anticipatory, considering needs as well as protection risks.
- Start with the smallest social unit – the household and its dynamics. Understand how each family member participates, what role they play, and what they need in order to improve their well-being, security and dignity. Who is head of the household? The ability for a family or household to access services will matter depending on the situation of the head of household. Child-headed households, adolescents, widowed women, people with disabilities and single mothers may all have problems in accessing services and support during emergencies.
- What factors affect access to services? Is there a difference between female/ male food consumption, preparation and cooking within the family? Who obtains resources? Who decides on the use of the resources? Link with ALPS analysis of power dynamics.
- How will the programme interventions address the immediate and long-term practical and emotional needs of men, women, boys and girls?
- What are the power dynamics within a family, household or community? Link with ALPS analysis of power dynamics.
- Adolescents and youth must be consulted on their needs and capacities. They have a wealth of ideas and resources, which will not be included if only adults and young children are spoken to.
- Very young children (under 3yrs) will exhibit the same symptoms as that of their caregivers (primarily their mothers). So, if the mother is stressed, the child will pick up on this and will also be stressed. The well-being of very young children can therefore be assessed by speaking to their caregivers.
- Undertake participatory assessments with women, men, boys and girls together and separately. In some cultures, men will not speak about certain issues in front of women and vice versa, and boys and girls often have very different perceptions to men and women.

- What special support may some vulnerable groups require to participate in assessments – advanced notice for meetings, transportation, child-care, mechanisms of redress, a male relative to accompany them?

A contextual approach to undertaking appraisals[1]

The appraisal team should seek to be informed about the cultural traditions and practices of an affected community. Respect and appreciation of the differences, and identifying the similarities between team members' culture(s) and the culture(s) of the affected population are essential in establishing and maintaining a connection with them. The team should be attuned to: 'context', 'culture' and 'perspective'.

During the appraisal process:

- Be aware of the ways to ask questions politely
- Social hierarchies should be respected whenever possible but should not override the need to protect the confidentiality and privacy of individual participants
- Codes of dress, ways of eating, should be respected whenever possible.

Equity and Non-discrimination

The appraisal team must ensure that the selection of participants, be they adults or children is non-discriminatory. The processes and methods in the appraisal process should **'serve to correct, not reinforce patterns of exclusion'**. This requires attention to socio-economic barriers, including gender and age discrimination, and to the ethnic and religious differences in a given area.

The appraisal process should:

- Seek to achieve a gender balance in the selection of participants
- Try to include members of different ethnic and religious groups in all phases and activities.

The 'Do No Harm' Approach[2]

Gathering information on psychosocial issues is deeply personal and private. In many societies around the world, people find it difficult to discuss their thoughts, feelings and fears to their friends and relatives, aside from 'strangers'. When gathering information on sensitive subjects such as the effects of armed conflict or disasters on children, inquiries into rape and other GBV cases, the appraisal team must be aware of the potential harm it can do to the participants.

Interview techniques and home visits need to be carefully designed so as not to reactivate the emotional pain, grief and/ or humiliate the participant in the eyes of others if in a group, or towards the interviewers. In addition, taking part in any appraisals should not place that interviewee at any risk from stigmatisation, external threats from armed groups or authorities etc.

[1] Adapted from *Handbook on psychosocial assessment of children and communities in emergencies*, Regional Emergency Psychosocial Support Network Workshop Paper, UNICEF (2005).

[2] Borrowed and adapted from: *Guidelines for undertaking an assessment of the situation of children affected by armed conflict and unstable environments*, UNICEF - Child Protection Section: New York, November (2000), p7.

Participants must be told that they can refuse to answer any questions on any grounds without repercussions. If this occurs, then the interviewer should thank the participant for their time and gently close the interview. A comment should be made in the field notes that an interview terminated early for what ever reason(s).

In the event of a participant exhibiting a negative emotional or psychological response to an interview, or other types of appraisal method, the appraisal team has a duty to find support for the participant. Prior to initiating the appraisal, the team members should identify available support services within or near the community that people can be directed to. The appraisal team has a duty to protect any child if they receive information of incidents likely to cause significant harm[3].

During the appraisal process:

- Identify resource persons in the community who may be able to assist a child, adolescent, parent, mentally or physically disabled person or an elderly person requiring special attention
- Protect the safety and security of respondents and appraisal team members
- Do not cause distress; if it occurs find ways to deal with it and diffuse the situation.

Informed consent

ActionAid's rights-based approach and ALPS, state that consent from the community must be sought before embarking upon an appraisal. Where children or mentally disabled people are participants within the appraisal process, the consent of a parent or guardian should be sought before any discussions begin. An additional adult should always be in the room when interviewing these groups.

The appraisal team should first explain to the parent, adult of guardian who we are, the mission, values and mandate of ActionAid, what the appraisal is about, the purpose and objectives of the appraisal, what information is being sought, what appraisal methods will be used, how the information collected will be used and the possible consequences of participation. **The participants must be given space to ask any questions, prior to, during and after the appraisal.** Children should be given the same information in an age-appropriate language and approach to determine if they are willing to participate.

The appraisal team must stress to all parties, particularly to children, that declining to participate in the appraisal is an option at any point in the process and will have no negative repercussions. This is especially important in situations of dependancy, such as where displaced persons rely on relief aid for their survival.

Ownership

In accordance with ALPS, and ActionAid's values on transparency and accountability, communities and individuals must be informed of the results of the appraisal, in a language and format that they understand. For example, children will likely express themselves through drawings and diagrams and they should be given the right of ownership over such 'data'. This means that all participants should have the right and the opportunity to say how the materials they produce and information they impart will be used.

[3] *Guidelines* for Research, National Children's Bureau: www.ncb.org.uk/resguide.htm

During the appraisal process:

- Permission must be asked and granted to use pictures, or other assessment products. The team must explain how they will be stored and used.
- A copy of the appraisal report should be made available to the community or individuals in a format and language they understand. This could be through group feedback sessions.

Privacy, confidentiality and protection against exploitation

Appraisal team members are obliged to create and maintain an environment that prevents abuse and exploitation. Any form of exploitation and abuse by members of an appraisal team constitutes gross misconduct and an absolute disregard for the rights, respect and dignity of the very people we claim to assist. The exchange of money, employment, goods or services for sex, including sexual favours or other forms of humiliating, degrading or exploitative behaviour, is prohibited.

Team members should resist the urge to probe for information that a person does not wish to disclose. Be respectful of people's life and right to privacy. Likewise, confidentiality is critical to the protection of participant's physical security, peace of mind and dignity. In conflict areas in particular, people who provide sensitive information are at risk of retribution, such as from armed groups, the authorities etc. It is essential that the identity of anyone interviewed or contacted for the appraisal remains confidential.

During the appraisal process:

- Do not reveal the identities of people who have participated in the appraisal (use a pseudonym or a letter e.g. Mrs P...)
- Monitor who is allowed to accompany any team member on appraisal missions (e.g. journalists, photographers, government officials etc.) and be aware of their purpose
- Do not probe for information when it appears that a person would rather not give an answer
- Do not ask intrusive questions
- Do not take pictures or videos of individuals without their informed consent
- Keep data in a locked and secure place. Restrict access to the data. If there are cases where names have been recorded, such as on individual self-reporting questionnaires then assign a new value or a number to a name, and record results accordingly. Names should be kept separate from any raw or analysed data.
- In group exercises (such as focus groups), require that participants respect one another's confidentiality.

Expectations and Appraisal Results

Community members have a right to know how their participation in the assessment will benefit them. The appraisal team should never promise anything that cannot be delivered or followed up. Many people living in conflict or disaster affected areas, or evacuation/ shelter areas are surviving in very difficult and desperate conditions.

As soon as the appraisal team meets interviewees, they should explain what they will get out of the appraisal mission. The appraisal team should be attuned to hearing horrific stories and may genuinely wish to help, however, it is dangerous to promise that any appraisal will positively impact upon a displaced person's situation. The recommendations of the appraisal might lead to assistance or policy changes, but in reality they may have no immediate impact (especially if direct interventions do not take place), meaning that lives of children, and communities affected by armed conflict and disasters might not change at all due to this appraisal.

During the appraisal:

- Explain the objectives and purpose of the appraisal, what it can achieve and what it cannot
- Explain how the appraisal will and will not benefit participants
- Keep all promises made to communities, and especially any made to children. Failure to do this will lead to mistrust and resentment between ActionAid and the rights-holders.

Who are the most vulnerable groups?

The following groups are regarded as 'at risk' from a psychosocial protection and support perspective, in any emergency, and should thus receive immediate attention.

- Child-headed households*
- Separated and unaccompanied children*
- Street children (part of urban displaced)*
- Orphans*
- Child combatants*
- Widows
- Pregnant and lactating women
- People with physical and mental disabilities, and limited mobility - particularly in earthquake and conflict related emergencies
- People suffering from HIV or AIDS
- Survivors of gender based violence (GBV)
- Single women
- Minority groups - class, castes, tribes etc.
- Older persons/ elderly.

** Please use the international legal definition for a child which is 18 years of age.*

Psychosocial and Protection questions specifically for armed conflict emergencies.

The following questions are **in addition to the individual and social appraisal tools**:

- How sudden was the displacement?
- When and how did refugees/ displaced persons arrive in present locations? What have they gone through?
- Killing, executions, missing family members and friends?
- Ongoing/ daily violence, harassment: against all or selected groups (women, ethnic/ minority groups, religious groups)?
- Torture?
- Sexual violence - men, women, girls and boys?
- Domestic violence, including child abuse?
- Armed attacks, artillery shelling, gunfire, bombing?
- Separation of family units?
- Forced to perpetrate violence against their family, community or nation?
- Disruption to important cultural and social rituals, family and community structures?
- Abduction?
- Imprisonment, detention in re-education/ education camps etc.?

In natural disasters (floods, cyclones, disease outbreaks).

The following questions are **in addition to the individual and social appraisal tools:**

- When and how sudden was the disaster? Any warning system?
- Separation of family units?
- Witnessing death of family, friends, or body identification?
- Likelihood of own death or severe injury, being trapped awaiting rescue?
- Loss of home, livelihood, livestock?
- Ongoing concerns for physical safety?
- Extent of disaster – whole villages lost, massive destruction?
- Delays in help arriving, additional deaths during wait?
- Is this a repeat of other disasters (floods and cyclones etc.)?

Slow onset disasters (e.g. famine and drought):

The following questions are **in addition to the individual and social appraisal tools**:

- Witnessing death of family, friends and livestock etc.?
- Sense that own death is inevitable, unavoidable?
- Belief that aid and relief supplies are distributed unevenly or withheld?
- Loss of home, livestock, livelihood?
- Loss of dignity/ self-worth due to begging or prostitution for food etc.?
- Helplessness due to massive nature of disaster?

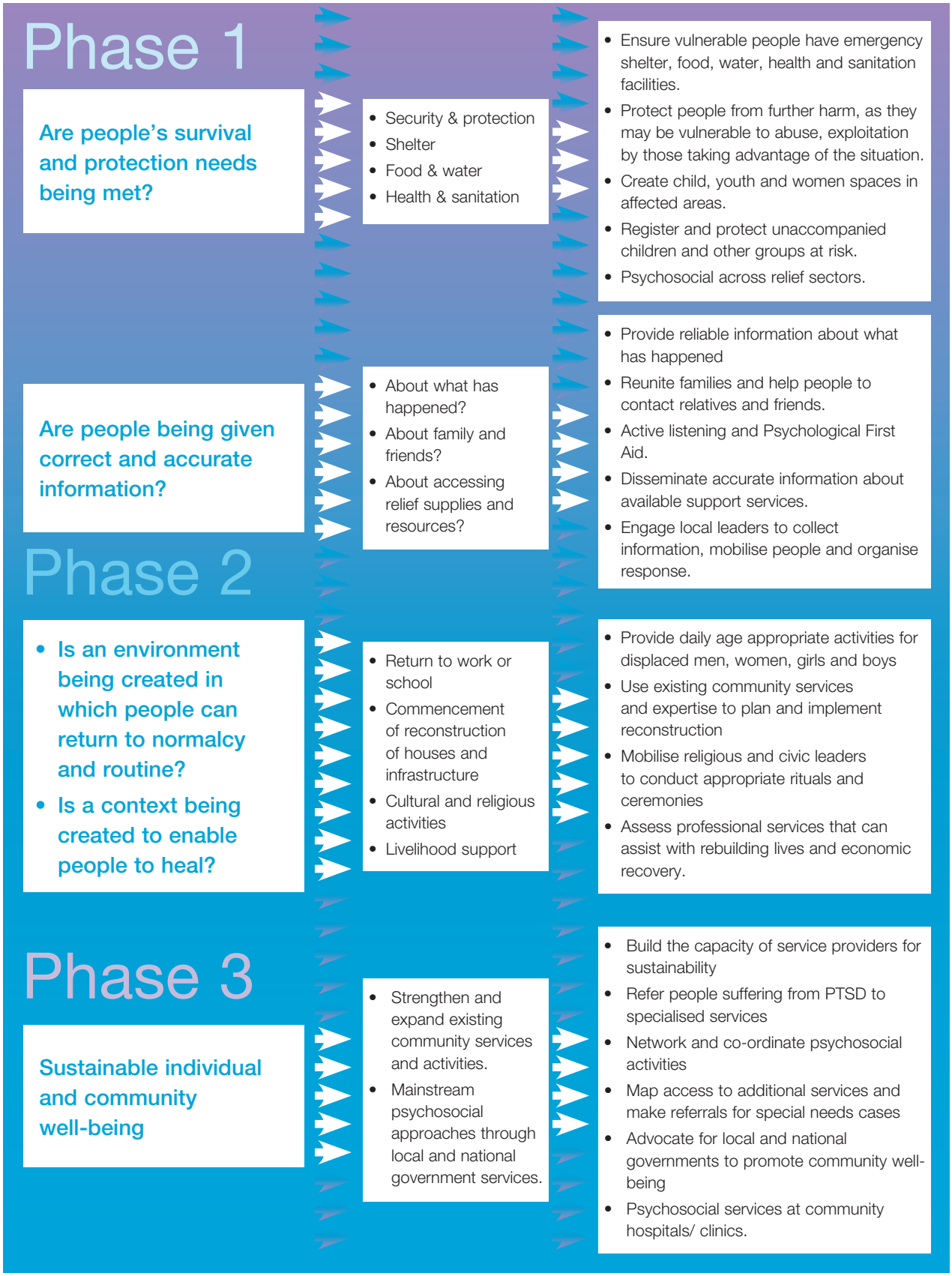
National level sources of appraisal information.

- Is there a national mental health office, policy, and organisation(s) of professionals? Is there a national plan for disaster response? Are there community-based services? How does one contact the persons in charge?
- Were any other mental health needs assessments carried out - check WHO's website? By who and are copies available?
- Who is co-ordinating mental health services in this emergency (often it is IOM, WHO or UNICEF and corresponding Government departments)? How can they be contacted? Are there regular updates of the changing situation? Check the OCHA Country website.
- Is the religious community responding to the crisis? How does one contact a response team? Do they have others trained in psychosocial protection and support care that can be mobilised?

Appraisal of community resources to meet psychosocial needs.

- Are there trained professionals among the survivors who can be organised to help their own people (teachers, social workers, psychologists, nurses, home health care workers, religious, traditional healers, etc.)?
- Are there physical resources in the community, which can be used to deliver psychosocial programs (buildings, vehicles, books, playgrounds, copy machines, computers etc.)?
- Are there environmental resources available (land, water, forests)?
- What traditional practices of this cultural group may help them through this crisis (family networks, income generating activities, ability to organise in small self-help groups, rituals of healing, etc.)?
- Do formal or informal educational activities currently exist?
- Is there communication between tribes, ethnic/ political/ minority groups etc.? Does this extend to co-operation on mutually agreed upon projects?
- Is the community showing cohesion/ solidarity, or are there competing factions?
- Are there self-help groups forming within the displaced persons community (women working together to care for families, children's play groups etc.)?

Phases in assessing and supporting psychosocial well-being in emergencies[4]



[4] *Handbook on psychosocial assessments,* REPSN, EAPRO, UNICEF, (2005).

What should we be aware of when undertaking assessments on sexual violence?[5]

Unfortunately, sexual violence is under-reported almost everywhere in the world. Emergencies break down the 'normal' family and community support systems, which often results in survivors of sexual violence feeling unable or even less likely to disclose incidents. Obtaining sexual violence information requires individuals (both survivors and interviewer) to confront and admit to extremely stressful, possibly traumatic and sensitive issues that may have cultural and social consequences.

In many societies, it is impossible to directly and publicly ask community members to talk openly about sexual abuse issues, as the survivors fear reprisals, social isolation and in some circumstances they may risk losing their life. In addition, there can be risks for the information collector and the wider community. Therefore, before any sexual abuse inquiries can begin, certain ethical and safety issues should be considered and addressed-mainly that the reasons for collecting this data is legitimate. Only staff with appropriate training and expertise in working with sexual violence should be permitted to collect information on sexual abuse in emergencies. Failure to do this, could lead to physical, psychological and social harm to individuals and ActionAid.

The following set of interrelated ethical and safety recommendations apply specifically to the collection of information on sexual violence in emergencies. They should be used in conjunction with other guidelines (especially the IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings and IASC Gender Handbook in Humanitarian Action: Women, Girls, Boys and Men: Different Needs – Equal Opportunities), and should not be viewed as all-inclusive, stand-alone guidelines.

The eight safety and ethical recommendations[6]:

(1) The benefits to respondents or communities of documenting sexual violence must be greater than the risks to respondents and communities in the collection of this information.

(2) Information gathering and documentation must be done in a manner that presents the least risk to respondents, is methodologically sound, and builds on current experience and good practice.

(3) Basic care and support for survivors must be available locally before commencing any activity that may involve individuals disclosing information about their experiences of sexual violence.

(4) The safety and security of all those involved in information gathering about sexual violence is of paramount concern and should be continuously monitored in emergency settings. Empathy should guide all interactions with people of concern, facilitated by a balance in women and men as humanitarian staff.

(5) The confidentiality of individuals who provide information about sexual violence must be protected at all times. Individuals must not be exposed to protection risks because of their participation (e.g. survivors of sexual violence becoming known to the community, boys recruited by armed groups subjected to reprisals for discussing their difficulties, internally displaced persons suffering repercussions).

(6) Anyone providing information about sexual violence must give informed consent before participating in the data gathering activity.

(7) All members of the data collection team must be carefully selected and receive relevant and sufficient specialised training and ongoing support.

[5] Sections extracted from *Ethical and Safety Recommendations for Researching, Documenting, and Monitoring Sexual Violence in Emergencies*, World Health Organisation, 10 August 2007.

[6] *Ethical and Safety Recommendations for Researching, Documenting, and Monitoring Sexual Violence in Emergencies*, World Health Organisation, 10 August 2007.

(8) Additional safeguards must be put into place if children (i.e. those under 18 years) are to be the subject of information gathering.

- Ensuring that interviewers and translators (if used) are carefully selected.
- Ensuring that interviewers and translators (if used) are appropriate to the context (including their age, sex, religion, ethnicity and political affiliation).
- Ensuring that all interviewers receive proper training and support and, also have, as a minimum, the following knowledge, skills and qualities:
    - Interviewing skills (i.e. appropriate questioning skills, including an ability to use non-judgemental language and tone, and to generally present a non-judgemental manner and attitude)
    - Communication skills (i.e. listening skills, coupled with appropriate non-verbal - facial expressions, body language - and verbal responses)
    - Empathy
    - Ability to record accurately what the participant is saying (as opposed to noting what one might expect to hear or wish to hear)
    - An understanding of the health, social, economic, emotional and psychological consequences of sexual violence.
- Ensuring that the objectives of the information collection activity are clearly understood so as not to create unrealistic expectations among participants or in the community. It is important that interviewers are as transparent as possible and are able to clear up any expectations or misunderstandings that the interviewees may have.
- Ensuring that there are support services available for both medical care and psychosocial support. Establish procedures for making confidential referrals for follow-up care and support of participants (with participant consent) when such referrals are needed.
- Ensuring that all interviewers are familiar with, and abide by, the organisation's or agency's ethical and safety recommendations when carrying out survey research. (Please see the eight ethical and safety considerations earlier on in the chapter.)

Important questions for organisations to answer when planning and designing information collection activities on sexual violence in emergencies:

- How will the information be used?
- What is the purpose of the proposed data collection activity?
- Is our data collection method the most optimal and sympathetic to achieve our intended purpose?
- What are the likely physical, psychological, social and legal risks to survivors and their families, supporters and communities?
- What are the likely physical, psychological, social and legal risks to those involved in the collection of data?
- How can we minimise the risks of data collection?
- Who will see the information?
- How will the information be reported and to whom?
- For what purpose will it be reported?
- Who will benefit from it and when?
- Is the information collected really necessary?
- Is it fair to the individuals and the community to ask them to be involved in this data collection activity? Must this population be used?
- How and where will the information be stored?

Note: All the above questions should be sufficiently answered **before** any interviewing and investigations regarding sexual violence are permitted.

What do we need to be aware of when undertaking appraisals with children?[7]

- Consultation and appraisals involving children recognises their capacities, their views and their unique position within the community. Children are the experts on the lives of children in their communities and have their own perspectives and needs. They know the protection issues and circumstances in their area and what is affecting their peers. Children in particular groups know best the needs of their peers in that grouping; for example, adolescent girls know the issues and perspectives of female adolescents.
- In many cases, children who have experienced conflict, trauma and displacement do not need specialised therapy or intervention. The majority of children who manifest distressed behaviours (e.g. disrupted sleep, increased awareness, bed wetting, profound sadness and increased aggression) will benefit from a routine within a familiar, well-resourced environment.

[7] This section was extracted from: *The Participation of Children an Young People in Emergencies: A guide for relief agencies, based largely on experiences in the Asian tsunami response*, UNICEF, October 2007, pp26-31.

- Carefulness and humility are essential when conducting assessments or intervening in cultures where the place and role of children in society and the meaning of play may be radically different across cultures.
- There are ethical questions attached to undertaking assessments: in an acute emergency, collecting data will raise people's expectations of assistance without providing support in some cases.
- Ensure that marginalised groups are consulted, such as migrants, street children, children with physical and mental disabilities and child-headed households.
- Ensure that children are safe when they are involved in any consultation or assessment.
- Be creative in obtaining information from children. Children's vocabulary is not as well developed as adults, and they may struggle expressing their needs and wants in words. Other approaches include: drawing, modelling and observing them at play.

The **Identifying Feelings** chart located in the appendix can be a useful tool when assessing the impact of traumatic events on a child's mood, or to describe a child's emotions. It may be easier for a child to point at the picture that best describes their mood, if they cannot articulate it in words, or when working with an illiterate person.

Checklist:

- Who is responsible for ensuring children are included in appraisals and programme design?
- Ensure that children are consulted in the appraisal and any planned programme response - and there are focus groups for different ages of children; individual interviews should include a diversity of children and young people
- Ensure that children and young people are included in research teams and are interviewed.

What should we be aware of when undertaking assessments with people affected by HIV & AIDS?

Due to the high levels of stigma associated with HIV and AIDS in many societies and communities around the world, humanitarian workers should be acutely aware of not doing harm. It is more effective for assessors to compile data on HIV and AIDS status by mainstreaming it across other questions and methods of approach. For example, a woman and child's HIV status can be tested when they attend for routine vaccinations, or a mother and child clinic, to prevent them from being stigmatised within their community or camp. Observation of children in a 'life-skills' class will provide an indication of the level of awareness of HIV and AIDS, by both the children and teacher. Random sampling and spot visits to communal community places such as hospitals, schools, religious venues, community halls etc., will indicate how many HIV and AIDS prevention or advice posters are in public view.

What should we be aware of when undertaking assessments with older people?

In emergency settings, it is important that we include the elderly in our assessments. The social knowledge, experience and credibility of older people are critical in identifying and targeting the most vulnerable in a community. Elderly people can also be a group with protection concerns in some emergencies (particularly conflict and earthquake related emergencies).

See the **HelpAge International Form** in the appendix which can be used to identify and service the special needs of older people, mainly from minority groups. It can also form the basis of referrals to other organisations such as HelpAge and Handicap International.

The below appraisal matrix and checklist is not meant to be followed exhaustively. The nature of an emergency, will determine who is most vulnerable. Not all of the listed vulnerable groups will be vulnerable across emergencies, and hence appraisal team members can pick and choose the relevant sections from the matrix.

Appraisal checklist and matrix

Vulnerable group	Appraisal tool or approach	Who to ask	When
Child-headed household	• Self reporting questionnaire • Household questionnaire • Identifying feelings	• Children • Neighbours (including children's peers) • Community leaders • Teachers	• First assessment within 30 days • Second assessment around 6 months
Separated and unaccompanied children	• Self reporting questionnaire • Household questionnaire • Identifying feelings • Referral for tracing	• Children • Neighbours (including children's peers) • Community leaders • Teachers	• First assessment within 30 days • Second assessment around 6 months
Orphans	• Self reporting questionnaire • Household questionnaire • Identifying feelings • Referral for tracing	• Children • Neighbours (including children's peers) • Community leaders • Teachers	• First assessment within 30 days • Second assessment around 6 months
Child combatants	• Self reporting questionnaire • Identifying feelings • Referral	• Children • Peers • Parents (if available • Community	• First assessment within 30 days • Second assessment around 6 months
Street children	• Self reporting questionnaire • Household questionnaire • Identifying feelings	• Children • Business owners • Community leaders • Religious leaders • Teachers	• First assessment within 30 days • Second assessment around 6 months

Vulnerable group	Appraisal tool or approach	Who to ask	When
Widows	• Self reporting questionnaire • Household questionnaire	• Widow • Family members • Friends • Any children she may have	• First assessment within 30 days • Second assessment around 6 months
Pregnant and lactating women	• Self reporting questionnaire • Household questionnaire • Referral for medical care (if necessary)	• Woman • Family members • Community members • Friends • Any children she may already have	• First assessment within 30 days • Second assessment around 6 months
Mentally and physically disabled	• Self reporting questionnaire • Household questionnaire • Identifying feelings • Referral for medical care	• The disabled person • Their carer • Family members • Community members • Doctors/ Nurses	• First assessment within 30 days • Second assessment around 6 months
People suffering from HIV or AIDS	• Self reporting questionnaire • Household questionnaire • Referral for medical care	• The HIV or AIDS infected person • Family members • Any children they may have • Doctors • Nurses	• First assessment within 30 days • Second assessment around 6 months
GBV survivors	• Self reporting questionnaire • Household questionnaire • Referral for medical, legal and psychological care	• The GBV survivor • Their family members (husband and children are key) • Doctors/ Nurses • Community leaders • Religious leaders	• First assessment within 30 days • Second assessment around 6 months
Single women	• Self reporting questionnaire • Household questionnaire	• Women • Their children • Extended family members • Community members	• First assessment within 30 days • Second assessment around 6 months

Vulnerable group	Appraisal tool or approach	Who to ask	When
Minority groups - clans, tribes, castes.	• Self reporting questionnaire • Household questionnaire	• Minority group peer members • Minority group leaders	• First assessment within 30 days • Second assessment around 6 months
Older persons/ elderly	• Self reporting questionnaire • Household questionnaire • Help Age Vulnerability checklist • Referral	• Elderly person • Their carer • Doctors/ Nurses • Family members	• First assessment within 30 days • Second assessment around 6 months
Urban displaced	• Self reporting questionnaire • Household questionnaire	• The urban displaced • Community members • Teachers • Religious leaders • Lawyers	• First assessment within 30 days • Long-term follow-up is often required.

Interpreting the appraisal data

Outsiders tend to view children and communities in situations of conflicts and natural disasters as passive, helpless, weak and vulnerable victims. Typically, the reality is more complex: Communities can be resourceful and resilient; they can find and have ways of coping and protecting themselves in adversity. Too often people are characterised as 'traumatised victims' rather than regarded as survivors who have assumed responsibly for themselves and possibly for others too.

The challenge for any appraisal team is to identify and respect a community's capacities and strengths, and to determine how they can be used to further pursue and protect vulnerable groups' needs and rights. A mixed appraisal approach is the most effective, whereby a variety of individual and household questionnaires are used to assess psychological functioning, in addition to, more community-based and service-oriented approaches, that assess a person's social world

Team members conducting an appraisal are encouraged to write field notes, which should contain the following:

- An initial assessment of the data (for individual and household questionnaires)
- Reflection on the processes, methodologies and issues encountered
- Impressions of the contact people - this can be obtained through observations focus groups and transit walks.

Just as the appraisal should be undertaken in a phased approach with a different emphasis at each stage, so too should the appraisal report. The following section outlines the key sub-titles and sections in which recommendations should be made, and at which phase of the emergency response.

Team members should consider the following when writing the appraisal report:

- The well-being of the affected population; their definition of well-being, their rights and knowledge and ways of upholding their rights
- Perceptions and life stories as well as objective data such as demographics, individual questionnaire results that emphasise the issues resulting from a traumatic event
- Biases, personal history, emotional appearance, mental state and level of coherence - the standard rapid questionnaire and impact of events scale are very useful here
- Services available to the population - relief supplies, healthcare, information, schooling, shelter, access to markets and livelihoods. The household questionnaire is the most useful tool for this as it focuses upon the impact and consequences of the traumatic event
- Privately held stereotyping (personal or cultural) prejudices (such as possible stigma attached to single, widowed women, or people who have been raped) and expectation from the population
- Facts versus opinion, which are subject to interpretation, understatement or exaggeration - this is particularly the case in the very early stages when people may be in the 'heroic stage and may deny or not understand the impact of the traumatic event and what they may be experiencing.
- The need for cross-checking information gathered from various sources and soliciting comments from the community about the collected data.
- The quality, degree and amount of information collected. The larger the sample size for individual and household questionnaires, the greater the reliability of information collected, the more informed and tailored programme response will be and more effective advocacy.

Conclusions and Recommendations within an appraisal report

Developing recommendations for psychosocial support is part of the appraisal process and should be done in consultation with the community. These recommendations are intended to be used as the basis for programming (see the following chapter) and planning for long-term psychosocial support. The 'how to' part of the recommendations will depend upon the specific emergency context. For further information please see the 'programme response' chapter.

1. Immediate/first level of response.

- Promote a sense of safety and security
- Establish trust
- Strengthen relationships and form groups
- Enhance resilience
- Increase awareness, access to information, services and relief-supplies
- Ensure sustainability.

Strategies to promote Psychosocial Well-being

(a) Re-establish a stable family life

- Promote family reunification
- Promote parental well-being and 'positive parenting skills'
- Promote family self-sufficiency - link with livelihoods and early recovery.

(b) Re-establish a sense of normalcy

- Re-establish schooling
- Create recreational activities
- Resume cultural activities and traditions
- Promote simple and individual ways of relieving stress.

(c) Provide opportunities for expression and participation

- Sharing one's experiences with a group of people with similar experiences
- Community participation in planning, feedback and advocacy matters
- Group and community activities.

2. Second level response and early recovery

Mobilising a person's existing care system.

- Teacher training
- Support or training for health personnel
- Specialised training and assistance for relief personnel and other support-givers
- Network and referral systems
- Access to information on support services
- Raising awareness on what has been identified as an issue or concern during the appraisal process through mobilisation and advocacy activities.

3. Preparedness and Prevention Measures

- At the individual level
- At the family level
- At the community level.

Chapter 4
Psychosocial Programme Responses: a phased approach

This chapter gives guidance and information to support planning for the initial and longer-term psychosocial protection and support responses, and suggests specific activities for vulnerable groups.

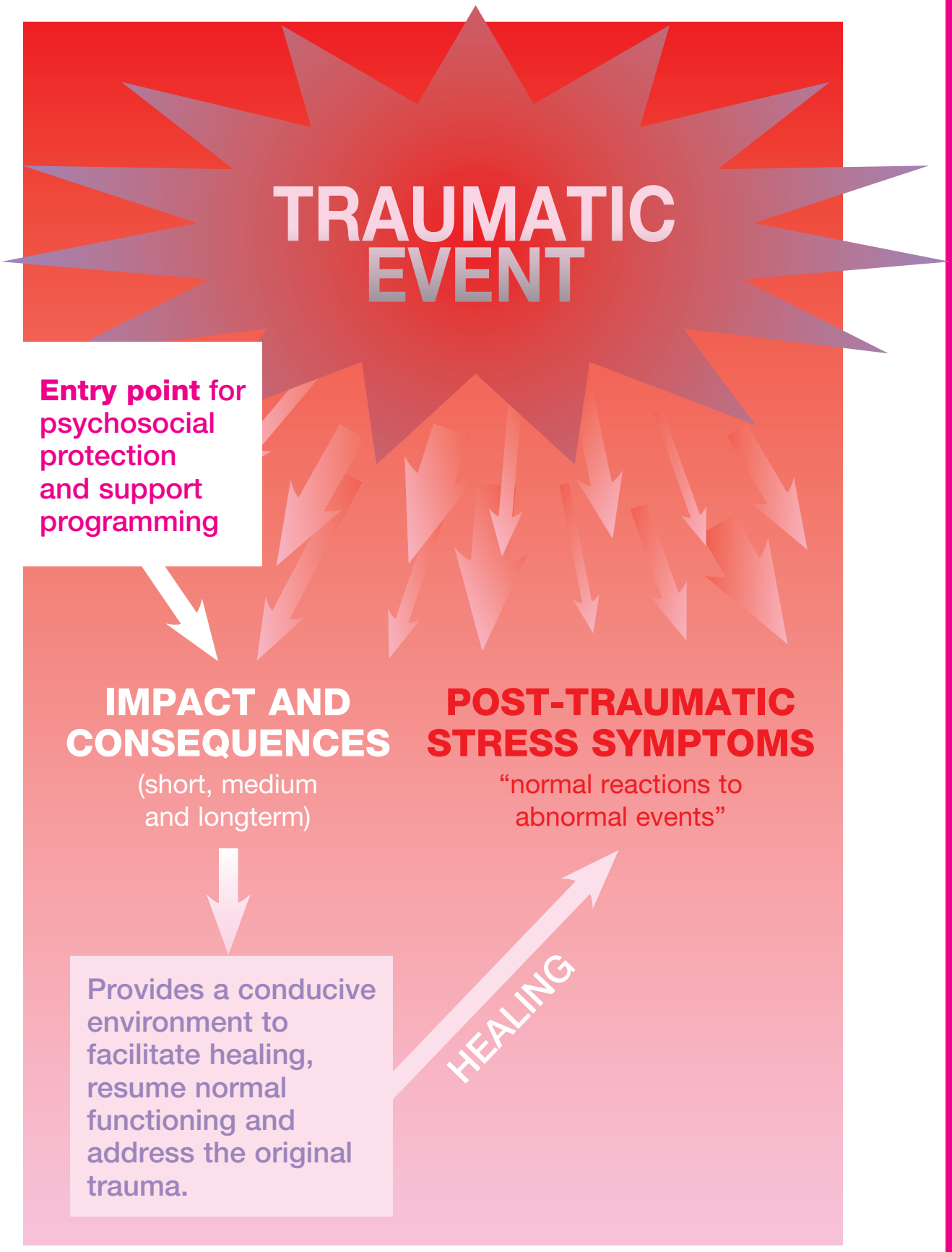
The greatest sources of distress in the early stages of an emergency are the **impact and consequences** that result from a traumatic event. Such consequences include displacement, lack of access to food, water, shelter, medical supplies; a person's safety and security may be in threat, boys and girls can no longer go to school, and men and women may have lost their livelihoods. Families may become separated, whilst others may have died.

The entry point for all psychosocial protection and support work, as illustrated in the diagram below, is to **address the impact and consequences of a traumatic event, and not to focus upon the symptoms, and emotional reactions, as these are normal reactions to abnormal events**. Specifically addressing the emotional reactions and symptoms to a traumatic event arise in the later stages of an emergency response, often called the early recovery phase, after people's basic needs have been met, safety and security are assured and developmental opportunities have returned.

This chapter outlines the steps, from a psychosocial protection and support perspective, that need to be taken at each phase of emergency response: pre-disaster, acute (first phase), second phase and early recovery. The chapter, also, provides specific programme recommendations for the various phases of emergency response, with a particular focus upon vulnerable groups. It is not necessary to implement all the recommendations listed in this chapter, but rather to pick and choose based upon the needs of the affected population and the emergency context.

Developing recommendations for psychosocial protection and support programming is part of the appraisal process. However, it is important to remember that psychosocial issues arise across relief sectors, and thus, this chapter should be read in conjunction with Chapter Five, Programme Implementation, of the Emergency Response Guidelines.

The Psychosocial Framework: Making sense of emotions, impacts and consequences



The aims of psychosocial programmes:

- To enhance well-being
- To contribute to the protective framework
- To strengthen weaker or vulnerable groups
- To restore vitality and energy (empowerment)
- To build local competence in psychosocial work
- To build peace and reconciliation
- To provide a conducive environment for healing.

Important principles:

- To build on people's own resources (resilience and empowerment)
- To bring back a normal situation
- Co-operation between and with local partners
- Integrated, multi-layered approach
- Focus on vulnerable groups through a community-based approach.

Levels of psychosocial intervention:

- Advisory intervention and information dissemination
- Self-help and mutual support activities
- Network strengthening
- Local community-based activities
- Psychological support and referral
- Physical survival interventions (relief supplies)
- Political and legal interventions
- Advocacy.

The basics of 'good' psychosocial programming

Any response to an emergency should, as ALPS dictates, be owned, controlled and guided by the people that it is trying to assist: the affected population. It should make use of existing support structures (however precarious they may appear to be), at the individual, community, camp, local and national levels. The State is the primary body responsible for the protection of its citizens and thus government structures and institutions should be supported and enhanced to respond to the needs of its citizens and any other displaced persons, such as refugees.

Community-mobilisation refers to efforts (both internal and external to the community) **to empower its members to be active agents in their own recovery and healing processes.** Community members, such as: families, relatives, peers, elders, neighbours and common interest groups, should be involved in all decisions, discussions and actions that affect them and their future. This is also the case for children and youth, who are often not consulted on their needs and rights in emergency settings.

Participation is a form of empowerment, which greatly facilitates an individual's recovery process. The more an individual is included within the recovery efforts, the more confident, hopeful and **resilient** they become. This empowers people to cope with the impact of the traumatic event and to become active agents in the re-building of their own lives and communities. It is important to note that communities tend to include multiple sub-groups that do not always follow the same agenda, have the same needs, and compete for influence and power. Facilitating genuine community participation requires, as ALPS states, **an understanding of the local power structures and patterns of community conflict, working with different sub-groups, highlighting the needs of the socially-marginalised and avoiding the privileging of particular groups.**

Affected groups of people typically have formal and informal structures through which they organise themselves to meet the collective community needs. Even if these structures have been disrupted, they can be reactivated and supported as part of the process of enabling an effective emergency response. Strengthening and building on existing local support systems and structures will enable locally owned, sustainable and culturally appropriate responses. In such an approach, the role of outside agencies is less to provide direct services, than to facilitate psychosocial supports that build the **capacities of locally available resources**. It is dangerous to do something on behalf of a person when they have the capacity to do it for themselves.

Pre-disaster

The following are preparatory activities that should be undertaken by ActionAid and our local partners:

- Training and education of staff
- Development of psychosocial back-up and local community-based support organisations
- Development of a staff care programme, education, support and post-disaster care
- Planning and orientation for the emergency response team
- Integration of psychosocial awareness into other disaster-related sectors (health, camp management, shelter, WASH, education etc.,). Please see psychosocial protection and support across relief sectors.

First-level response (acute phase):

- Gather a team of experienced psychosocial professionals from local partners, ActionAid staff, University Social Work, Psychology Departments or Teacher training colleges etc.

- Identify the **nature, impact and consequences** of the traumatic event at the individual, family and community levels by talking to survivors through household visits, appraisal questionnaires, focus groups, transect walks, and visiting hospitals, schools and religious centers.
- In the initial days, survivors are in a state of shock or some will be going through the 'heroic phase' where they tend to overlook emotional issues, and may not be able to articulate all their needs.
- Treat every person with dignity; respect their human rights, and inform people of their rights. Remember the most vulnerable groups.
- Document specific cases (especially highlighting the plight of **women, boys and girls**) in the appraisal report to **explain the level of shock and grief (the symptoms)**, and thus build the case for response. Case studies can be shared with the donors and the media in a sensitive and anonymous manner.
- Use approved assessment tools such as the **Standard Rapid Questionnaire and the Impact of Events Scale** (see appendix and the appraisal chapter) during the first 30 days. These tools assess **individual psychosocial functioning** and the data will act as a baseline to monitor the impact of our psychosocial interventions.
- Use the **Household survey questionnaire** to document the **social impact** and consequences of traumatic events at the household and community levels. See the appraisal chapter and the appendix.
- Assure basic needs: water, food, non-food items, shelter, healthcare, safety and security.
- Prioritise psychological and medical needs (acute cases that require referring).
- Keep families together and reunite families that have been separated (for more details, see later sections within this chapter).
- Maintain gender balance when identifying local staff; recognise the needs and strengths of target groups.
- Limit length of service to 3 months for staff working within harsh situations (hardship postings). Enforce compulsory short-term leaves (rest and recuperation). Provide on-site support if possible.

Some responses require **immediate assistance** from mental health professionals. Help in locating these professionals is often available through the local WHO, IOM and UNICEF offices, and by co-ordinating with other agencies. Three groups of people are at risk and need more support during an emergency than 'average' trauma survivors. These below groups will be identified through the appraisal process:

Most acute: People who are dangerous to themselves or others: suicidal people, people who are violent towards others, and people engaging in high-risk behaviour with little regard for the danger.

Acute: People unable to protect themselves, or care for their own basic needs: people in shock, very passive people, people hearing voices, people not eating or performing other basic self-care, and dependant children who are separated from their families.

Needing support: People able to do basic things but not able to think of the needs of others, especially dependent children. This group includes people making poor decisions, or people who are not thinking of the consequences of their choices. These people exhibit poor relationship skills, may become isolated, and are prone to have numerous disagreements with others.

The positive effects of family, friends and neighbours

A person's ability to function is often observable. People who lie within the most acute and acute groups (above) will often display behaviour that distinguishes them from the wider community. The community, family and neighbours, will often note such behaviour and bring it to the attention of local administrators, hospital personnel, police or camp officials.

When you receive such information, it is important to have direct contact with the person in question. Find out as much as you can about what others have been worried about.

Possible questions include:

- The frequency of the behaviour?
- The context in which the behaviour began?
- The person's family history.
- Whether the person is alone or with a support system?
- Whether this type of behaviour has ever occurred before?
- What this behaviour means within this particular cultural setting?

The **physical aspects** (appearance, dress, mannerisms etc.,) should also be considered when assessing behaviour.

Possible questions include:

- Has this person been eating and sleeping regularly?
- Was this person injured in the disaster or is there an illness, which may be unrelated to the disaster but causing symptoms in this person?
- Does this person normally take medication that they have not been able to take due to the disaster?

Some social interventions suggested for the acute phase (phase one).

- People have access to ongoing, reliable flows of credible information on the disaster/ conflict, associated relief efforts and reactions to traumatic events. Distribution of pamphlets, posters and postcards with relief rations in the local languages, as well as radio broadcasts are all useful mediums. This aids with identifying and reaching the most poor and vulnerable people, who are the focus of our response, whilst enabling poor and vulnerable people to identify and approach us (this is called self-referral). See the appendix for examples of posters, postcards and storyboards from Kenya, India and Myanmar.
- Normal cultural and religious events are maintained or re-established (including grieving rituals conducted by relevant spiritual and religious practitioners). People are able to conduct funeral ceremonies
- As soon as resources permit, children and adolescents have access to formal or informal schooling and to normal recreational activities. See the Education section below. Children and adolescents are incredibly inventive and will play with almost anything, so buy and distribute locally produced toys and games, even if it is just footballs, tennis balls, sticks, rope, paper, pencils, crayons and rubber bands, until more formal/ structured spaces can be created.
- Adults and adolescents are able to participate in concrete, purposeful, common interest activities, such as emergency relief activities through cash for work (particularly for male youth), looking after children in safe spaces and working in community kitchens.

- Isolated persons, such as: separated or orphaned children, survivors of GBV and torture, child combatants, widows, older people, minority groups - clans, tribes, castes, class etc., and others without family, have access to activities that facilitate their inclusion in social networks. Youth and child friendly spaces promote this social interaction. Women's groups, shelter and safe havens for survivors of GBV also foster social interaction amongst peers, which aids the healing process.
- When necessary, a tracing service is established to reunite people and families (especially any child sponsorship cases). IFRC, Red Cross and Red Crescent Societies, and Save the Children are particularly active in this field. So referral to these organisations may be necessary.
- Where people are displaced, organise shelter with the aim of keeping family members and communities together whilst also maximising their dignity.
- The community is consulted regarding decisions on where to locate religious places, schools, water points and sanitation facilities. The design of settlements (camps/ shelter areas) for displaced people includes recreational and cultural spaces.

Second level response (phase two).

- Ensure that psychosocial related activities are initiated straight from the beginning. Some such activities are: groups debriefing sessions, information dissemination sessions on relief goods, activities, family tracing programmes etc, facilitating meetings of women, child and youth friendly spaces and play groups. Provide venues for meeting in safe circumstances, where sharing and processing experiences can take place. This is of special importance for people whose voices are often not heard, such as women, children, youth, the elderly and the socially marginalised. Teachers, community/ religious leaders and social workers are useful facilitators for the above groups. Detailed and specific activities to carry out in these spaces can be found in the appendix.
- Start this work from day one onwards- this will help to prepare the communities' state of mind to receive aid and engage in relief efforts (a pillar of psychosocial protection and support). In the early stages of an emergency, survivors are open and willing to talk about their experiences, when given an opportunity and a context (safe place) people do begin to talk - beginning the healing process.
- Training and capacity building in psychosocial protection and support for community workers, including teachers, doctors and volunteer camp/ relief workers. Community level workers need to understand the psychosocial needs of the people they will be working with to help provide appropriate physical and emotional support.
- In conflict induced emergencies, (riots, fighting, banditry, war) it is advisable to find positive outlets in which people can express their anger and energy - co-operative sporting activities are such positive channels to release energy.
- Distribute disposal cameras to school-aged children and adolescents and teach them how to take photographs. The children can then document their healing process and relief efforts from their perspective. Photographs can be shown in a display for the media in an advocacy event or at schools. This can be a powerful healing tool for children, as well as involving them in their own advocacy efforts.
- Undertake psychological first aid (P.F.A). See the description of this in the section below.
- Help with legal issues such as rights of asylum seekers, right to return/ resettle, cases of GBV and torture, and land-tenure. Legal rights are particularly key for women, girls and socially marginalised groups, who are often discriminated against in an emergency.
- Explore collaboration with medical and social work colleges and other agencies who are experienced on psychosocial protection and support (UNICEF, WHO, IOM etc). Ensure there is

sufficient staff time spent on this - it is not always a matter of how many people work on this issue, but how much time each one is spending on this.

- At the national level, engage in cluster meetings of **protection** and **health** clusters. Issues of trauma also come up in **GBV**. Engage in national or 'hub level' **psychosocial sub clusters**, if active (they are not active in every emergency).
- Monitor staff well-being, particularly those that have been active 'in the field' since the beginning of the emergency response.
- Psychological First Aid, as described in the box below, is a general response that can be practiced by anyone towards a person exhibiting signs of distress.

Psychosocial First Aid (PFA)

PFA can be undertaken ***after*** the acute phase of an emergency:

- Listen patiently in an accepting and non-judgmental manner
- Convey genuine compassion
- Identify and provide basic practical needs and ensure that these are met
- Ask for people's concerns then isolate the emotions and the problems (the emotions from the message)
- Do not force talking but provide an opportunity for survivors to talk about the events
- Discourage negative ways of coping e.g. alcohol, substance use, unprotected sex
- Protect from further harm
- Encourage, but not force, company from one or more family member or friends
- Offer further social support through community self-help groups
- Information on where to seek further help, e.g. counseling services, gynaecologists etc.
- Encourage facilitation in normal daily routines and use of positive methods of coping - culturally appropriate relaxation methods, accessing helpful cultural and spiritual supports.

Additional responses to support those at risk

Try to create a social support system. People need the comfort and support of other people, especially when there have been extraordinary events. Creating a mini stable community for a vulnerable person can provide great comfort. Whenever possible, these people should be sourced from within the family, neighbourhood, ethnic/ tribal group and/ or community of the vulnerable person. Try to encourage the vulnerable person to ask for what she/ he wants and needs. The process of **advocating for oneself in the face of disasters is a powerful step towards healing.** Finally, try to protect the vulnerable, from additional traumatising events, false attributions from one's peers, stigmatisation, discrimination or having to re-tell their story if they are not ready to do so. It is also important to ensure that agencies, organisations and journalists in the field co-ordinate their activities and assessments to prevent a vulnerable person having to retell their experiences to multiple organisations, risking further traumatisation.

The following table provides guidance for project staff, interns and volunteers, on when to refer a person for specialised mental health and psychosocial support. Unless a person is showing signs of acute distress (as outlined earlier on in this chapter) then referrals usually begin in the **second phase, and subsequent phases, of emergency response**.

Referrals should only occur if:

- **Basic needs have been met**
- **Safety and security are assured**
- **Developmental opportunities are restored**
- **Follow-up and stable support can be guaranteed.**

When to refer someone for specialised psychosocial care?

Domain Area	Handle the situation if...	Consider referral if...
Speech	• The person has an appropriate feeling of depression, despair and discouragement. • Doubts her/ his ability to recover. • Is overly concerned with minor things and neglects more pressing problems. • Denies problems or states she/ he can take care of herself/ himself. • Blames her/ his problems on others, is vague in planning and bitter or angry that they are victim.	• The person hears voices, sees visions or has hallucinations. • States the body feels unreal and fear she/ he is losing her/ his mind. • Is excessively preoccupied with one idea or thought. • Has the delusion that someone or something is out to get her/ him and the family. • Is afraid she/ he will kill herself/ himself. • Is unable to make simple decisions or carry out everyday functions. • Shows extreme pressure of speech, like her/ his talk is overflowing, or struggling to actually speak the words.

Domain Area	Handle the situation if...	Consider referral if...
Behaviour	• The person wrings her/ his hands and clenches her/ his fist or jaw. • Is restless, mildly agitated and excited. • Has sleep difficulty. • Has rapid or halting speech.	• The person is depressed and shows agitation, is restless and paces up and down. • Is apathetic, immobile and unable to move. • Is discontent and mutilates (cuts) herself/ himself. • Uses alcohol or drugs excessively. • Is unable to care for herself/ himself - does not eat, drink, bathe or change/ wash their clothes. • Repeats ritualistic acts.
Emotions	• The person is crying and weeping, with continuous retelling of disasters. • Has blunted emotions, hardly reacts to what is going on around her/ him right now. • Shows high spirits, laughs excessively. • Is easily irritated and angered over small events.	• The person is very quiet and shows no emotions. • Is unable to be aroused and is completely withdrawn. • Is excessively emotional and shows inappropriate emotional reactions
Alertness and Awareness	• The person is aware of who she/ he is, where she/ he is and what has happened. • The person is only slightly dazed or confused, or shows slight difficulty thinking clearly or concentrating on a subject.	• The person is unable to give their name, or the names of the people she/ he are living with. • Cannot recollect the date or state where she/ he is from, or say what she/ he does. • Cannot recall events of the past 24 hours; complains of memory gaps.

When to refer children:

- Child re-experiences traumatic event through nightmares and flashbacks, ***6 months after the event***. No decrease in the intensity of reactions. Reactions are distressing for the family and child.
- Child appears apathetic, distant from friends and relatives and is not interested in playing, has no body posture - limp, does not eat well, gets thinner, unable to sleep at night.
- Child avoids anything that reminds them of that day - such as the sea, high winds, rain, going to certain places where conflict may have erupted such as the market place or at places of worship.
- Increased state of alertness - nervousness and startle response.
- Behaviour conduct problems - disobeys people, violent towards peers, steals or tells lies.

- Reactions interfere with the daily routines of the child, prevents them from developing social relationships and affects their school work.
- Hyperactivity - unable to sit still, day-dreams, difficult concentrating, low tolerance for frustration, limited patience, destroys things, becomes over-excited in large groups.

Adolescents:

- Engages in alcohol and other substance abuse (smells of these substances)
- Engages in reckless behaviour such as unprotected sex with multiple partners
- Moves between extreme restlessness and lethargy
- Unable to sleep
- Slurred speech and inability to communicate
- Decline in school and other work
- Over-spending of money or claims to misplace money
- Indiscriminate sexual behaviour.

General referrals

- **Livelihood issues** - appraisal of needs, procurement of material and grants
- **Child Protection issues** - educational needs, adoption, monitoring, fostering and financial assistance
- **Paralegal issues** - compensation, property, land rights, GBV cases
- **Medical issues** - special needs, health problems
- **Housing plans** - shelter, land/ plot allocation and construction
- **Women support groups** - micro-credit schemes and survivors of GBV.

Third level response (early recovery)

It is imperative that enough **effort and money** is directed towards this phase in the emergency response. AAI is very active within the Global Early Recovery cluster, in the belief that humanitarian support should be more sustainable and take a longer-term perspective. At present, there is too large a gap between humanitarian and development work and funding, which hampers the effectiveness of programmes and, more importantly, people's ability to recover and heal from traumatic events.

- Collaborate with medical and social work colleges on **training** key people in **community counselling techniques** to assist with specialised support, such as for survivors of GBV, torture, trafficking and people exhibiting extreme stress.
- Set up **mobile community-based psychosocial support units** if people are still in camps (usually in complex emergencies) or in villagers and places of return in natural disasters. Possible activities within these mobile units include: information dissemination, handle referrals, fairy-tale sessions, group recreation activities, family mediation (to monitor and follow-up on separated and unaccompanied children), medical, legal and psychosocial assistance, suicide prevention, traditional healing ceremonies and rituals, post-rape psychosocial and medical care.

- **Create community - level 'information hubs'** within villages, townships or camps explaining the reactions to traumatic events, simple self-care techniques to manage the symptoms, where people can access psychosocial services and relief supplies etc. It is better if this is a collaborative effort with other agencies. Examples of such information can be found in the appendix.
- What is the economic situation? Are people able to find work/ rebuild their livelihoods? Are some groups of people excluded? Is the wealth controlled by a few - remember ALPS principles? What are the different groups?
- What is the **status of educational resources**? For whom is it available? Are supplies available? Teachers? What prevents boys and girls from attending school? Assess the level of damage and children's access to schools, including school equipment - furniture, books, uniforms, school kits etc. It is paramount that children return to school (and a normal routine) at the earliest opportunity to minimise any disruption to their long-term development. Routines provide meaning and structure to a child's world. **Training for teachers** on emergency psychosocial protection and support within an educational setting.
- Temporary schools may have to be erected or adapted from existing community facilities. If the emergency becomes protracted (complex emergency) then formal schooling may have to occur within the camp environment. Often teachers and social workers are also displaced persons and could run the school within the camp. Look within the displaced persons population for such resource persons, as getting them back to work is a form of empowerment and healing, whilst also providing a useful community function.
- **Debriefing/ end of assignment/ exit interviews** for emergency response staff and volunteers.
- In the early recovery stages of an emergency, the physical infrastructure is beginning to be repaired, people are moving back home and services are up and running again. A person's social environment is being rebuilt, however their psychological (inner world) is still immersed in the healing process. Emotions can become very intense during this stage, as people have time to sit and deeply process the traumatic event. It is during this time, that people who are unable to manage these intense feelings or are unable to re-connect with their family, friends and community should be **referred for specialised support**. Their emotions have moved from **post-traumatic stress symptoms (PTSS) to post-traumatic stress disorder (PTSD).**

Responses to Post-traumatic stress disorder (PTSD):

1. Psycho-education, letting people know that their reactions are in response to stress and they are not going 'mad'
2. Support from family, friends and neighbours helps facilitate the healing process
3. Teaching anger management strategies such as relaxation, breathing techniques and diverting the individuals mind through active involvement in other activities
4. Lifestyle - adequate sleep, healthy diet, avoiding stimulants and intoxicants.
5. Referral for specialised mental health and psychosocial care.

Complex emergencies

Complex emergencies arise within failed States or parts of a State that have been suffering from the effects of conflict, human rights violations and poor, or no, governance for long periods of time. In essence, the affected areas and population have been displaced for many months and years, usually in camps, and have not reached the early recovery stage. Programming within this context needs to be flexible whilst taking the long-term perspective in **securing and upholding human rights.**

- Assess psychological needs. Create and offer the possibility of participating in groups for sharing and processing experiences, and develop coping skills (this can often be done around an activity e.g. sewing, weaving, card games, sport activities). Debrief in groups and individually. Special care and attention is required for referrals for those individuals with pre-existing mental health conditions or those who have developed psychiatric symptoms. Create networks for psychosocial support.
- Encourage reconciliation work; identify agents for peace, create venues for opposing sides to meet; always implement **conflict sensitive programming**. See the next chapter: psychosocial protection and support across relief sectors.
- Offer education and training programmes: practical skills towards economic independence (data and IT, sewing, literacy and reading, agriculture, language) – livelihood regeneration programmes. Cash for work programmes are particularly useful in this context.
- Increase the awareness, through information campaigns, in different areas that are found to be a problem e.g. spread of disease, mined areas, HIV and AIDS, and hygiene and sanitation practices.
- Support **community development;** foster capacity-building towards self-governance and collective decision making skills. The setting up of internal camp committees, such as community-security committee, community-education committee, community-water committee, are a useful tool for this.
- If access to education has not been formalised, ensure that a safe and clean space is made available within camps for both primary and secondary schools. Semi-permanent structures will have to be erected and protection ensured through fences.
- **Create safe havens for survivors of GBV.** Ensure that the male and female parts of the safe haven are separate, and that there is a safe space with recreational activities for children within the safe haven. Trained counsellors/ matrons/ nurses should be assigned to the safe haven and be 'on call' 24 hours a day. Security guards should also be 'on duty' 24 hours a day monitoring access.
- Advocacy on the needs of the displaced (internally displaced persons (IDP's) and refugees).

Please see the IASC Guidelines on Mental Health and Psychosocial Support poster in the appendix.

The role of the community-level worker/ helper (CLW/ H)

Community level workers have proven to be an extremely useful resource in previous natural disaster emergencies. CLW's are sourced from within affected communities and trained on 'front-line' psychosocial protection and support. CLW's are usually volunteers, however they can, also, be paid for their time as a community resource person. They are equipped with the skills of understanding people's reactions to traumatic events, how they can be managed, and minimised within the first 12 weeks of an emergency. In many emergencies the CLW's have helped communities begin the healing process.

Below are some activity suggestions for community-level workers:

- If displaced person camps have been created, CLW's, upon arrival, should meet with as many families as possible using culturally appropriate greetings.

- Identify and target poor and vulnerable people, this may require visiting villages and urban poor areas.
- Engage in home-visits, to build up trust with survivors, impart knowledge and information, help children get back to school, motivate individuals, hold group meetings and organise recreational activities.
- Empower people to understand the changes that they are experiencing and reassure them that these are normal reactions to abnormal events. Undertake psychological first aid if necessary.
- Help survivors to decrease the physical and emotional affects of a traumatic event by listening, helping people to relax, externalise their interests and resume daily life again.
- Support and help people to rebuild their shattered lives in the areas of housing (shelter), work, health and the community - disseminate information on their rights and the relief effort, guidance paralegal work, practical help accessing supplies, access to services, livelihood support and monitoring.

Please see the appendix for a poster showing the roles of community level workers.

Diagram showing areas of support for a survivor by Community level workers (CLWs)

CLW's will need to be creative in: learning about people and identifying and targeting poor and vulnerable groups. Once a survivor starts describing their emotions and experiences, maintain the conversation using the following queries:

- How are you and how are your other family members?
- How have you been recovering? How are you handling the situation?
- Can you describe the losses experienced by you or your family?
- How do you visualise the future?
- What other help do you require?

CLW's need to adopt an **ecological (holistic) approach** when working with survivors of traumatic events. CLW's are helping to create a **conducive social environment** to facilitate a person's **internal healing process**. Thus, they should provide advice and support at all levels: individual, family, community, and across the phases of emergency response. For more information and IEC materials please see the appendix.

Key messages from CLWs:

To individuals:

- Listen to authentic advice about the situation; do not believe in rumours
- Stay with family members
- Be with people from your community or locality
- Try to re-establish your normal routine as soon as possible
- Share your experiences/ release your emotions
- Take part in relief and rehabilitation
- Avoid alcohol and other substances; resist engaging in risky behaviours such as unprotected sex
- Sleep for 8 hours a night and eat well
- Take time off to relax - games, reading, knitting, sewing, weaving, meditation, talking
- Make time for yourself and admit that you will not always be functioning at your usual level of efficiency for a few months.

To families:

- Share any feelings of loss, grief and fear as a family
- Contact relatives to mobilise support and facilitate recovery
- Participate in traditional rites and rituals
- Make time for recreation with what is available
- Resume pre-disaster routines and activities as a family
- Support one another; stay together as a family unit - do not send children away
- Create family activities together such as meal times
- Be open and honest with each other about your thoughts and feelings
- Provide lots of warmth, love and affection to children.

To the community:

- Group mourning
- Group meetings
- Support group initiatives such as community hygiene and information campaigns, clearing rubble and looking after children in safe spaces etc.
- Take part in protests and rallies, on delays in implementation, restoration of buildings, compensation, land allocation etc.,
- Group participation in rebuilding efforts.

The Rainbow Framework of support to survivors for CLW's.

- Violet - Problem solving, decision-making and empowerment
- Indigo - Support services, and building a network around a person
- Blue - Affect/ mood management
- Green - Be a good friend, lead a balanced life, social interaction
- Yellow - Focus upon the positives, begin planning for the future
- Orange - Normalcy and routine
- Red - Help people reframe their negative thoughts.

Self-help groups (SHG) and 'protection circles'

Self-help and other support groups provide valuable roles in practical assistance, information, lobbying and often considerable guidance in interpersonal interaction which assists survivors to work through their grief. Groups encourage social interaction, are a protective mechanism and facilitate healing.

Why use groups?

- We can reach more people
- Groups create contact and social relationships
- Helps people to realise that many people are suffering from the same symptoms and problems; they are not alone. Whatever people are suffering from, is normal, they can recover and return to their activities (the idea of expectancy)
- Creates a safe and supportive environment
- Peer-peer learning and support - it can be cathartic for one individual to help another (the act of helping can be healing).

For information on how to form facilitate and manage self-help groups, please see the appendix.

Types of group sessions

Information sessions – information sessions presented jointly with AAI and local partners are intended for the whole community. They consist of providing general information and dealing briefly with current difficulties; reactions that may be shown by the survivors; services available; and the problems typically associated with returning to normal life. The activities suggested for information sessions are all optional. None are mandatory, neither for the disaster survivors nor for the members of their families, or witnesses of the event.

- The physical and emotional symptoms are part of a stress reaction and are considered normal.
- These symptoms occur in most people in a situation of stress, threat or loss. They are protective reactions of the mind and body, and their purpose is to help the individual to survive.
- Stress symptoms, although normal, can, however, present health risks if they persist, since they rob people of energy and make them vulnerable to illness. In some cases, they can even have repercussions on a person's whole life.
- There are many ways of dealing with stress reactions, such as surrounding oneself with people one feels good with, and with whom it is easy to talk about what one is experiencing, taking exercise or using relaxation techniques.
- Verbalising the source of stress or your emotions can often minimise their effects.

Verbalisation sessions

Verbalisation sessions are a simple but effective method of assisting a population to cope and carry on with normal life after an event. Verbalisation sessions usually permit the alleviation of **acute stress reactions**, which reduces or prevents reactions from developing clinical manifestations

The focus is on three specific objectives:

- To help people express their feelings
- To assist them in understanding their emotional reactions and their behaviour
- To promote a return to a state of equilibrium in each individual.

Active Listening Techniques (applicable for all ages):

- Acknowledge that you are listening - through verbal and non-verbal cues
- Distinguish between the content and the emotion behind the message being delivered
- First focus upon the emotion behind the message (its intensity) and reflect this back to the speaker
- As the speaker understands that you are hearing her/ his emotions correctly, they usually decrease in intensity and the content becomes clear
- Switch to techniques of para-phrasing, reframing and clarifying.

Principles underpinning effective listening:

- Safe and appropriate environment
- Listener is focused and attentive
- Listener is patient, and does not jump to conclusions
- Listener can show genuine empathy
- Listener uses techniques that permit the speaker to verify or correct the emotion and content of the message.

How to achieve the goals of active listening:

- **Be alert and non-distracted**
- **Be interested in the needs of the other person and let them know that you care about what is being said**
- **Be non-judgmental, non-criticising and a 'sounding board'.**

Programme Responses for specific vulnerable groups

Children

There are seven different types of protection that children require in emergencies, all of which affect their well-being:

- Protection from physical harm
- Protection from exploitation and gender-based violence
- Protection from psychosocial distress
- Protection from recruitment into armed groups
- Protection from family separation
- Protection related to abuse from forced displacement
- Protection from denial of children's access to quality education and other services.

The following pneumonic is a useful tool to aid practitioners to ensure that the key principles of good early practice to support children affected by conflict and other emergencies are in place:

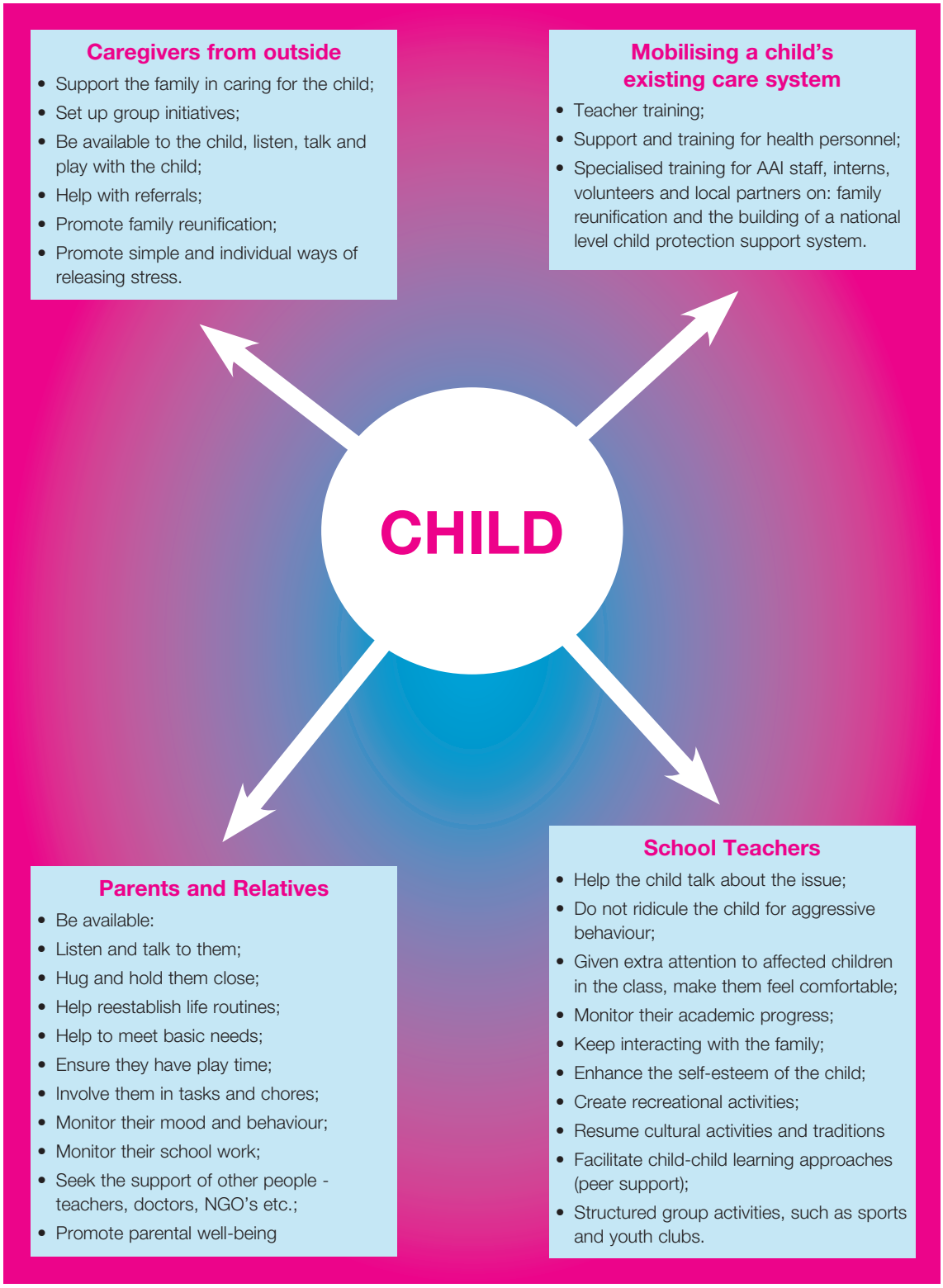
S - space and structure
T - trust, time and talking
O - opportunities to play
P - partnership with parents.

Space and structure are vital to any early years programme. For a child affected by an emergency, getting to know the predictable routine of the early years setting will be an antidote to the chaos they may have experienced. For families living in temporary housing, conditions maybe cramped, and children benefit from the physical space of the setting.

Children who have been exposed to violence, loss and disruption to their lives often express a change in their beliefs and attitudes, including a loss of trust in others. The re-establishment of familiar routines and tasks creates a sense of security, of purpose and meaning and enables them to start functioning again. The role of play and education in normalising the children's lives cannot be overemphasised. We all need predictability in our lives, and the routines of school life can be vital in helping children to recover, and to learn to build trusting relationships again[1].

[1] *Early Childhood Matters*, Bernard van Leer Foundation Publication, Number: 104, July (2005).

Key responses for children: A holistic approach



Responses across the developmental ages[2]

Small children:

- Re-establish routines, provide opportunities for verbal and non-verbal expressing of feelings and thoughts
- For a limited period of time permit the child to sleep close to a parent
- Provide opportunities to express emotions through play
- Allow repetitive re-enactment of disaster through fantasy play, with parent clarification of what actually took place.

School-aged children:

- Encourage expressions and play enactment of their experiences
- Resume normal functions, as soon as possible, but relax routine expectations
- Provide opportunities for structured but not demanding chores and responsibilities
- Encourage physical activity
- Answer questions about the disaster honestly and simply
- Avoid giving children access to very vivid descriptions of the event in order not to overwhelm them.
- Give the children permission to discuss their uneasiness by acknowledging your own fears.
- Encourage children to become involved in a newspaper or a children's journal aimed at children with some articles written by children. This is particularly effective way of disseminating information to children through peer-peer support as well as providing non-formal education to children caught up in conflict and complex emergencies.

Teenagers:

- Encouraging group discussions with peers and adults is effective in reducing the sense of isolation and in normalising the child's feelings.
- Provide opportunities for physical activities (preferably in peer groups) to help reduce tensions.
- Provide reassurances that the ability to concentrate will return.
- Reduce expectations temporarily for the level of performance at school and home.
- Encourage participation in home and community recovery efforts.
- Encourage expression of feelings.
- Encourage teenagers to maintain contact with friends and to resume sporting and social activities.
- Encourage discussions of disaster experiences with peers and significant others.
- Group discussions are helpful in normalising feelings. Encourage healthy outlets of aggressive feelings: screaming into a pillow, playing sport, walking and running.
- Encourage children to become involved in a newspaper or a children's journal aimed at children, with some articles/ pictures by children. This is particularly effective way of disseminating information to children through peer-peer support, as well as providing non-formal education to children caught up in conflict and complex emergencies.

[2] *Community-based psychosocial support: A Facilitators Guide*, Action for Churches Together Network, (2005).

General programming for children

Programmes to help stabilise and develop routine:

- Disaster childcare.
- Childcare recreation teams.
- Celebration of holidays.
- Arts and crafts program.
- Sports leagues.
- Story/recreation times conducted on a regular basis.
- Establish regular feeding, sleeping and school times.

Help with returning to 'normal functioning':

- Re-establishment of family functions – meals as a family, family chores.
- Support parental authority/ teaching of their children.
- Expressive arts group – telling stories.
- Support/ education groups to learn how to deal with intense feelings.
- Grief centre to support and normalise the grieving process.

Development of community:

- Establish helper clubs like a litter patrol, or helpers to carry water for the elderly.
- Support the observance of local customs.
- Develop peer mediation training for children.
- Support the development of worship communities or religious education.
- Establish playgroups or teams to include orphans or other marginal and vulnerable groups.
- Consider peace-building through theatre and the arts.

Programmes to burn energy:

- Sports league
- Playground – safe spaces (UNICEF)
- General recreation opportunities
- Adventure or exploring trips - useful for children in complex emergencies, that may have little interaction with the 'world' outside of the camp environment.

Medical services:

- Well-baby clinics – screening clinics
- Immunisation programmes
- School health education
- Simple yoga

Legal services:

- Facilitate connection with Red Cross to reunite families.
- Facilitate connection with UNHCR for children seeking asylum or immigration.
- Provide advocacy for human rights and protection.

The importance of playing

Play helps to rebuild self-esteem and self-confidence. Children learn by watching other children; it provides them with confidence and a role model. This is called child-child learning or peer support. Play helps in developing a child's understanding of the world. It can teach them sharing, perception and contributes towards their cognitive development. Play helps to gain mastery over issues and a sense of power. Through play, children have the power to create, protect and destroy within a safe environment, which gives them a sense of control over their lives. Children can express/vent their fears by playing, drawing and building. All fears can be enacted without danger, enabling children to address their pain and overcome events. Finally, play facilitates skill development - problem solving, communication, decision-making, social skills, patience, listening and sharing. Learning through play (also called experiential learning) happens in an indirect manner, so children do not feel as though they are in school and yet are able to learn effective skills.

Suggestions for games and other forms of 'structured' play are available in the appendix.

Children and Education

Education helps **empower** people to determine their own future. Basic education for all children should be a corner stone of any psychosocial emergency response programme.

Basic education for children should be established, as soon as possible, after the onset of an emergency. The establishment of the familiar schedule and institution of the school has a calming effect upon the community as a whole. For the children, it assists their psychological adjustment to the disaster, promotes social adjustment, distributes life-saving information and provides basic academic skill development. Children's involvement in school, also, allows parents time to address family survival needs.

Primary education for children should be co-ordinated with the Ministry of Education for the country in which displaced persons originated. This will facilitate a smooth reintegration back into home communities. Co-ordination with the Ministry of Education on where displaced children are currently located (camps, urban centres or within host communities) can also be beneficial. Teachers for the displaced population should come from within where possible. This will hopefully provide a smooth transition between previous schooling and future schooling. Using teachers from the displaced population helps to dispel some of the helplessness that is prevailing after a disaster. This helplessness undermines the recovery process. Teachers, should also receive training on psychosocial protection and support in an emergency educational setting.

Educational activities can begin informally through the development of activity groups, teaching cultural information, music, drama, and recreation activities. Develop a mechanism to document the student's academic work, which can be used as a source of information for the monitoring and evaluation of relevant psychosocial protection and support programmes.

Key education programmes

- Primary school education for all children above 5 years
- Pre-school/ early childhood stimulation programme
- Mobile school to bring education to areas without school facilities
- Mobile libraries are very effective within camps, or areas where children do not have access to books
- Holiday/ weekend schooling for children affected by conflict and complex emergencies, or for children that are behind in school work, or require additional specialised assistance
- Trade/ skill education for teenagers/ child headed households

- Conflict resolution education/ peer mediation education
- Agricultural and/ or fisheries education
- Environmental education (sanitation, hygiene, fire-breaks within camps)
- Cultural education programmes (teaching local music, dance, traditions, story telling, nursery rhymes)
- Second language classes
- Landmine awareness.

For more information please see the chapter Psychosocial protection and support across relief sectors.

Communicating with distressed children (Action for the Rights of the Child)[3]

(i) **Allow the child to set the pace** - Children should not be forced to discuss or reveal experiences and the lead should always come from the child. Allow the child to set the pace of the interview and take note of non-verbal signals, which indicate that the child does not wish to continue. It may be necessary to stop the interview, or if it critical to find out the information, to have a break and come back.

(ii) **Give adequate time to the child** – Don't expect her/ him to reveal the whole story in one session; very often it is best for the child to reveal a little of her/ his painful memories at a time. Don't rush to fill silences. These may provide important spaces for quiet reflection.

(iii) **Provide emotional support and encouragement to the child** – In what ever ways are appropriate to the child's culture and stage of development.

(iv) **Accept the child's emotions, such as guilt and anger** – Even if they seem to you to be illogical reactions to the event. Talking through painful experiences may enable the child to view them in a different light, for example, to let go of a sense of responsibility for what's happened. Talking through events that lead to the child being abandoned, for example, may enable her/ him to understand the situation that was faced by her/ his parents and this may lead to the child being able to let go of the feelings of anger and bitterness. It is often helpful to convey to the child that the feelings she/ he is experiencing are quite normal, and understandable.

(v) **Never give false reassurances** – For example, telling a separated child that "we will soon find your parents" raises expectations, which if not met, may increase the child's loneliness and lack of trust towards adults. Helping the child to face the reality of her/ his situation is almost always preferable to avoiding it, provided this is done in an atmosphere of trust and support.

(vi) **Talking about difficult situations may enable children to work out their own solutions** – Especially in the case of older children and adolescents. Simply listening in an attentive and supportive way can be experienced as extremely helpful. If young people can arrive at their own decisions (this applies to adults as well), this is more often satisfactory than being provided with advice from an adult. For example, it may be more helpful for a separated child who is not attending school to talk about her/ his situation and discuss the advantages and disadvantages of attending school than for the adult simply to advise her/ him to attend school.

(vii) **Sometimes it's necessary to allow regression (be flexible)** – Regression is a return to behaviour typical of younger children. For example, children or adolescents may need personal care, affection, and physical contact more characteristic of younger children, in order to, overcome the emotional problems they are facing.

[3] Action for the Rights of Children (ARC) Working with Children: www.savethechildren.net/arc/

Responding to the uncommunicative child

Identify possible reasons:

- Is the adult expecting the child to confide in her/ him before establishing mutual trust?
- Has the child been given an explanation of the adult role and the purpose of the interview?
- Is the language being used, one in which the child doesn't fully understand?
- Is the adult uncomfortable or embarrassed by silence, by the child's emotions, or talking too much or responding in a way which is perceived by the child as critical?
- Do the child's experiences bring back painful memories for the adult from her/ his own experiences that he/ she is struggling to deal with?

If the reason for bad communication is likely to be found in the child, the following might help to unblock the communication:

- Be patient and allow time to build up trust. Give positive messages of warmth and acceptance.
- Use games, activities, drawing, writing, outings etc., to help develop trust and open lines of communication.
- Find out more about the child from others who know her/him.
- Convince the child that it is normal to think about the traumatic event.
- Make sure you use child-friendly language and explanations.
- Tell the child that adults too are confused and upset about what happened.
- Share some of your thoughts and feelings about the event.
- Check for signs of any abuse, inappropriate behaviour or feelings of guilt that can all block communication.
- Be honest, open and clear - try to understand things from the child's viewpoint.

Orphaned children

It takes time to reach out to children and to build up trust; it can take even longer if the child has been orphaned. It is important to respect the pace at which children may relate to you. CLW's and aid workers need to wait until a child feels safe and wishes to talk to you. A child's wishes and emotions must be respected.

Responses for children that have been orphaned:

- The child needs to be with relatives that can look after her/ him
- Integration with new family members is important for the child
- Find space to share the pain of loss of parents with people around them
- Encourage the child to remember anniversaries, talk about the good times
- Help the child to mourn loss but also to relate to new people
- Relate to her/ his new environment
- Listening, being available and monitoring is very important
- Help the child to create a normalising environment, to facilitate their healing.

Unaccompanied and separated children

Unaccompanied and separated children have a right to family, and families have a right to raise and care for their own children. The family is defined in some societies by the child's immediate relatives: parents, brothers and sisters. In other societies, there may be a far wider extended family, including grandparents, aunts and uncles and more distant relations within a clan, tribe, village or community. The methods of caring for children vary, but generally all societies recognise that the best place for a child is to be with her/ his family.

Unaccompanied and separated children should be provided with services as quickly as possible, aimed at reuniting them with their parents or customary caregivers. Any interim care provided should be consistent with the aim of family reunification and should ensure children's protection and well-being. In the majority of circumstances, most separated children have parents or other family members who are willing and able to care for them. Long-term care arrangements, including adoption, should, therefore, not be made during the emergency phase. The grounding of all psychosocial interventions within the relevant cultural context, unless it is not in the best interests of the child (i.e., contravenes human and child rights), is both ethical and more likely to sustain recovery.

The breakdown of social structures and services accompanying major crises means that communities and States, by themselves, may not be in a position to provide the necessary protection and care for children. This is particularly the case in conflict and complex emergencies. **Separation does not occur in isolation from other events:** a separated child may also have witnessed frightening and possibly violent events and may have experienced loss on a huge scale – loss of parents and family, of home, relatives, friends, school and the security that comes from a familiar environment. In situations of armed conflict emergencies or other disasters, the very survival of unaccompanied and separated children may be threatened. It is therefore imperative that ActionAid and our local partners ensure that the most vulnerable children receive protection.

There are essentially three complementary types of action to help unaccompanied and separated children:

- **Responsive action**, aimed at preventing, putting a stop to, and/ or alleviating the immediate effects of a specific pattern of abuse
- **Remedial action**, aimed at restoring dignified living conditions through rehabilitation, restitution and reparation
- **Environment building**, aimed at creating and/ or consolidating an environment (political, institutional, legal, social, cultural and economic) conducive to full respect for the rights of the individual and to facilitate healing.

Difficulties in locating separated children

While it is essential that separated children are identified, as soon as possible, experience demonstrates that this can be extremely difficult for some of the following reasons:

- Communities may be suspicious of questions asked by outsiders, unless they understand the reasons behind the questions and trust the people asking them. This problem can be ameliorated by undertaking participatory assessments with local people acting as guides, interpreters and interviewers.

- Families who take in children, in order to benefit from their presence (e.g. to benefit from their labour or ration card) may be reluctant to reveal their presence for fear of losing the children. Sometimes categories of 'hidden' separated children or socially marginalised children will have a marked gender imbalance in some societies.
- Children themselves may fear that if they are identified as 'orphans' or 'fostered' children, they will experience discrimination and disadvantage in the wider community. If the children's fear is justified (i.e., if there are obvious customs and behaviours that discriminate against these children) then it may be necessary to undertake some form of community-wide psycho-education to highlight these children's needs and resources.
- Groups of children living without adult care may fear that if they are identified they will be split up in different foster homes. The principle of 'Do No Harm[4]' should decrease the chances of this situation occurring. Groups of children that are familiar and trust each other, should be kept together, where possible, to secure their resilience and social support network.

Family reunification

- All unaccompanied and separated children should be registered as a matter of urgency for two reasons: registration enables tracing of the child's family, and it facilitates assessment and monitoring of the care situation.
- Tracing is the process of searching for family members, primary legal or customary care-givers. All those engaged in tracing should use the same approach, with standardised forms and mutually compatible systems. UNICEF, IOM, IFRC/ ICRC and Save the Children all have template forms that are used in most emergencies.
- Registration activities should be conducted only by or under the direct supervision of government authorities and mandated agencies with responsibility for, and experience in, this task.
- The confidential nature of the information collected must be respected and systems put in place for safe forwarding and storage of information. Information must only be shared among duly mandated agencies for the purpose of: tracing, reunification and care.
- Care for separated children should be provided in a way that preserves family unity, including that of siblings, ensures their protection and facilitates reunification. Children's security should be ensured, their basic needs adequately met, and assistance provided for their emotional support.
- Children not in the care of their parents or customary caregivers may be at heightened risk of abuse and exploitation. The most appropriate carers may need extra assistance to assure children's protection and material needs are met. Provision must, therefore, be made for monitoring and support to foster families.
- To promote a child's sense of self-identity when placed with a foster family, a life-book comprising information, pictures, personal objects and mementoes, regarding each step of the child's life should be maintained with the child's participation and made available to the child throughout her/ his life.
- The reintegration of the child into her/ his family should be designed as a gradual and supervised process, accompanied by follow-up and support measures taking into account the child's age, needs and evolving capacities, as well as the causes of the separation.
- For those children for whom institutional care is the only solution, centres should be small, temporary and organised around the needs of the child. It should be made very clear that the objective of residential care is reunification or placement in the community and rigorous screening

[4] Anderson, M., (Ed), *Do No Harm Checklist*: www.cdainc.com

procedures should be in place to ensure only appropriate admissions. Children should be placed within institutions for the shortest time possible.

- Community care, including fostering, is always preferable to institutional care, as it provides continuity in socialisation and development.

Adults and Education:

Education for adults is a priority too, especially in **complex and conflict-related emergencies**, where adults are often denied the opportunity to attend college, university or further training courses. It is common for people to take on new roles and responsibilities following an emergency. Learning new skills allows people to recover from an emergency. The following are educational opportunities that may be offered to adults in the **second phase** of the post-disaster period. This is especially important if there is a period of waiting before people can return to their homes.

Education for adults should reflect the skills the recipients need to re-establish their community life. Trainers from within the displaced population should be used to develop local capacity. Volunteers can be requested from the local community or from local partners. Education for adults and children should be co-ordinated with other NGO's working in the area. Often similar programmes are being offered and collaboration allows more people to be served at a lower cost.

- Basic literacy education
- Life-skills training (useful for youth)
- Job skills training
- Second language classes
- Sustainable agriculture/ fishing
- Human rights and domestic violence
- Health, hygiene and sanitation
- Sexual and reproductive health education
- HIV and AIDS prevention information
- Community-based self-care and information on reacting to traumatic events
- Information for parents about helping children with trauma
- Information about accessing aid for rebuilding, compensation claims, land issues, prosecuting GBV cases etc.
- Landmine awareness
- Basic nursing/ midwifery/ TBA (traditional birth attendant) skills (especially where AIDS is prevalent)
- Child development
- Community mobilisation and formation of CBO's/ co-operatives
- Disaster Risk Reduction (DRR) and Participatory Vulnerability Analysis (PVA).

The elderly

After emergencies, older people find that they suffer from a variety of economic disadvantages – inflation, loss of employment, lack of pensions, loss of markets and lack of access to credit schemes. Economic problems can sometimes have an impact on the elderly's social functioning and well-being. It is therefore important that older people are also given the opportunity to learn literacy, numeracy, new language skills, and new practical and income-generating skills.

Challenges for the elderly in emergencies:

- **Basic needs**: shelter, fuel, clothing, bedding, household items.
- **Mobility**: incapacity, population movement and transport, disability.
- **Heath**: access to services, appropriate food, water, sanitation, psychosocial needs.
- Family and social: separation, dependants, security and changes in social structures, land, and status.
- Economic and legal: income, land information, documentation, and skills training.

Possible programme responses:

Livelihoods.

- Try to include older people in credit and savings schemes for livelihood regeneration. Experience illustrates that older people are among the most consistent and reliable in the management of savings and the return of loans[5]. In some societies, the elderly may be responsible for managing the family finances and so they maybe a useful target group for loans for livelihood regeneration.
- Support older carers as part of child care protection initiatives, such as through material support and parenting skills.

Conflict resolution.

- Encourage the role of older people in micro-conflict resolution in the context of community reconciliation. Elderly persons can act as potential connectors in conflict emergencies to diffuse the negative effects of any conflict.
- Encourage older people to exercise conflict resolution skills, e.g. to help build estranged family networks and conflicts regarding honour, shame and property.
- The elderly are a useful resource to integrate the memory and history of pain, loss, and trauma in the process of reconciliation and healing. Within many traditional societies, the elderly are a source of advice and guidance for younger generations, and are a link to ancestors.

[5] *'Older people in disasters and humanitarian crises: Guidelines for best practice'*, UNHCR and Help Age International, London: Palmers Print, (2000): http://www.helpage.org/News/Casestudies/Emergencies

Education:

- Enlist older displaced persons to be teachers of cultural history - useful in conflict-related emergencies
- Enlist elders as storytellers
- Access services to help elders re-establish their lives
- Provide information about small business development
- Provide information about reactions to traumatic events
- Train people as community outreach counsellors.

Stabilisation and routines:

- Schedule meal times, congregate meals for people living alone
- Schedule activity times to help organise the day
- Pair older citizens with partners, to listen, assist in physical tasks (such as fetching water) and advocacy. This is a version of community-based home care.

Returning to normal:

- Provide cooking/ work teams especially for those living alone
- Consider community gardening (this can be a useful activity in complex emergencies, where the elderly may have been residing in a camp for a long time)
- Establish mini-neighbourhoods with families to foster grandparents

Develop community:

- Develop a local newspaper
- Develop a radio programme with information, entertainment and education
- Have an elder become the information officer for those who do not have a radio
- Teach cultural traditions and music
- Re-establish traditional justice systems within the community (providing that these justice systems respect the human rights of all community members equally)
- Provide a gathering place for people to talk, play checkers, chess, backgammon, cards and local games etc.

Medical services:

- Routine medical care
- Community volunteers
- Congregate meals where necessary - this can be done by block in a camp environment
- Yoga
- Tai Chi.

Physically disabled persons

Disabled people will commonly be among the most vulnerable people in an emergency, particularly if it is a conflict or earthquake related emergency due to their limited mobility and opportunity to be their own advocates. The understanding and approach to disability is shifting away from simply removing the barriers for disabled people, and moving towards the full **recognition of their rights**.

Disabled persons have basic needs, they have the same need for love, dignity, family life, protection and stimulation as all other people. However, the lack of attention paid to people with disabilities and their views, places them at a disproportionately higher risk of abuse, neglect and a violation of their human rights. Unfortunately, many disabled children are purposely targeted in some conflicts by opposing sides; which creates fear and instability, in addition to, 'dishonouring' families for not protecting their children, thereby guaranteeing obedience to the ruling parties. Children are often attacked, forced to witness or commit violence, kidnapped to be soldiers or slaves, consciously maimed using physical, mental or sexual violence and tortured.

Disabled people are easy prey for attackers, and the experience creates an emotional scar or has lifelong effects for the child that go far beyond the direct experience of violence. Furthermore, the families and/ or caregivers have to live with the humiliating experience that they were not able to protect their disabled child against the aggressors.

Possible responses for disabled persons.

- Disseminate information on relief efforts, where they can access relief supplies and what they are entitled to, where they can access services etc.
- Place disabled persons in a safe place where they are cared for and can recover
- Source medical equipment and specialised services if necessary - rehabilitation aids and Vocational Rehabilitation Centres
- Social security benefits and compensation (where relevant)
- Provide space to discuss their disability, within the community or amongst their peers - particularly if the disability is a direct result of the traumatic event
- Disability certificates, income certificates and ID cards
- Carry out community sensitisation campaigns on the rights and needs of disabled persons.

Programme responses for survivors of torture:

- Feeling safe is essential. Try to create a secure, safe and private meeting venue. Safe havens within camps can be an ideal space.
- Help the survivor to address what is **medical, physical, existential,** whilst being aware of the fact that they are all intimately connected. For example: what is a medical injury; what is an actual part of their environment (physical); and what is a nightmare/ flashback (existential).
- Be aware of the need for survivors to assume control. If they need assistance in this, find ways to support them. Enabling them to make decisions and to plan for the future can be useful interventions to help them regain a sense of control and mastery over their emotions; it is also a form of empowerment.
- Be aware of environmental triggers, such as returning to the site of torture. Relaxation exercises, such as deep breathing or gentle exercise can sometimes help.

- Head injuries can interfere with cognitive processing, emotional expression and coping. Be patient with survivors.
- Support the need for justice.
- Give opportunities for people to tell their story, in what ever format they feel comfortable – pictures, theatre, dance, verbally, written format etc.

How can we help individuals heal after experiencing or witnessing violence?

- Psychological First Aid - informing people that their symptoms are as a direct result of the acute trauma they have been subjected to; they are not sick, weak or guilty
- They are safe, secure and in a trusting environment
- Group protection circles - helps people to vent/express, share their pain and feelings. This slowly helps people overcome their negative memories
- Provide a safe, quiet environment in which a person can talk
- Respect the person, treat with sensitivity and understanding
- Motivate the individual to undertake relaxation exercises.

How can we help and support rape survivors (males, females, girls and boys)?

Many survivors of sexual violence require emotional support and/ or counseling, which includes confidential and compassionate listening; gentle reassurance that the incident was not the survivor's fault and that her/ his emotions are normal responses to an extreme event. This type of support can often be made available in communities through existing natural helpers such as midwives, and family members (e.g. a sisters or aunts). Sometimes religious leaders and traditional healers can play an important role in providing community support for survivors. Parallel to providing psychosocial support should be some form of psycho-education and advocacy within the community to spread the knowledge about sexual violence, a crime that can affect men, women, boys and girls. The message should emphasise that sexual violence is prohibited, at all times, and that it is the 'perpetrator' who is 'dishonoured' rather than the victim, or her/ his family.

Sexual violence is preventable. It is important to reiterate whenever and wherever possible that sexual violence is unacceptable and not inevitable. To ensure that this message is not lost within certain communities, it may be useful to print the relevant prohibitions against sexual violence on food and medical relief parcels for distribution in both written and picture form. It may also be useful to distribute leaflets on psychological first aid to communities, or to place posters at food distribution points, water and sanitation facilities and 'safe-spaces' so that all community members are able to support the most vulnerable amongst them, and contribute to the social support network. Try to convey psychological first aid information through the medium of pictures, theatre, story-telling, dance etc., rather than as a written document. This will help to 'bring the advice to life' and ensure that all people (including illiterate people) can access and understand the information.

It is important to approach survivors of rape with sensitivity and an awareness of the **cultural effects** of their trauma. Men and women respond differently to the effects of rape, and these differences should be respected when undertaking programme implementation. Provide these people with a place where they can feel safe, and encourage them to meet with others who share the same experiences

as this can make it easier to reveal what has happened to them. Any counsellor should be a trained professional selected from within the community, who understands the cultural heritage, language, customs and **how rape is understood within that community**. Depending on the community, some people may prefer a counsellor from the same sex (this is usually true for females), whereas in other societies, men who have been raped may only feel confident in talking about their experience with a trained female.

Try to pay special attention to physical injuries, sexually transmitted diseases, pregnancy, and the loss of virginity - which can have a profound effect within some cultures. It is important to maintain strict confidentiality, at all times, and any documentation must be kept safe to prevent retaliation on those who report such matters.

Basic response:

- Confidentiality is of vital importance. Trust needs to be built up.
- Recognise that it is common for an abused person to feel ashamed.
- Help her/ him overcome the feelings of being 'unclean', and to understand that what happened was not her fault.
- Convince her/ him that the pain and disturbing thoughts are entirely normal.
- Encourage access to post-exposure prophylaxis (PEP's), medical examinations for pregnancy and for sexually transmitted diseases. These should be encouraged, but voluntary.
- Give support. Listen; do not make any moral judgements or criticisms.
- Allow the survivor to talk when she/ he is ready; don't push or force them.
- Do not make the survivor repeat the story many times - this can be extremely traumatising.
- Let her/ him express their anger; it helps to release emotion.
- Find ways to end the social isolation of the abused; try to get the community and family involved. This may require a degree of mediation between the survivor and her family, and the survivor and the community.
- Organise support groups for rape survivors and encourage them to recognise the positive aspects of their life. Livelihood support can act as the entry point for the organisation and facilitation of such groups.
- Provide support for staff working with these traumatised patients. Using support groups and loosely based 'group-therapy' is one way to meet this need.
- Collaborate with local, national and international organisations and institutions to distribute advocacy information within communities.

Women

Women, in general, have less resilience in emergencies than males; this is usually due to socio-cultural factors, such as having to be escorted by a male guardian when in public, and lack of inheritance rights. There are some groups of women, however, that are more vulnerable that others, and thus are a priority for ActionAid and our local partners. Vulnerable women include: pregnant and lactating mothers, single (young) women and girls, divorced women, women from minority groups, female-headed households, widowed women and those with pre-existing mental and physical disabilities.

Psychosocial Responses applicable to all women:

- Keep women amongst family members or familiar people, alone females are at a risk of being trafficked, abused, exploited or marginalised
- Encourage women to form groups (also known as protection circles), where they can talk about their fears and emotions in a safe environment
- Disseminate information about their husbands and children if they are missing/ separated
- Encourage them to pick up their old routines: cooking, washing, looking after the children.

Protection and security measures for women can be broken down into two measures:

1. Reduce exposure to risk of sexual violence.

2. Address underlying causes and contributing factors of sexual violence.

How can we help **prevent** sexual violence in emergencies?[6]

- The overwhelming majority of perpetrators of violence are young males, who act out their frustrations, anger and disempowerment at the easiest target within a camp/ shelter area - women, girls and boys. **Providing livelihoods, skills training, recreational and motivational activities, and camp management activities - such as community kitchens and digging sanitation trenches are effective was to prevent GBV.**
- Identify individuals who maybe targeted for abuse, for example, unaccompanied children, child-headed households, female-headed households, widows, disabled people, socially marginalised and ethnic minorities.
- Identify assets and resources in the community such as expertise, previous experience, innovation, courage, and effective leadership that may contribute to providing protection and prevention as a response to sexual violence.
- Establish community-based groups that can contribute to protection from sexual violence including the judiciary, police, local government and health authorities, traditional healers, spiritual and community leaders, women's groups and youth groups.
- Within a camp environment, women and girls are vulnerable to sexual violence when using the sanitation and water facilities. Women should be consulted in the setting up and co-ordination of these facilities, to ensure that they feel secure when using them.
- Assess cooking requirements to ensure that we are not placing women and girls at a greater risk of sexual violence, by forcing them to travel outside of a camp/ shelter area for firewood and water.

[6] *Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies*, Inter-Agency Standing Committee, September (2005).

- Create ‘safe-spaces’ for women at food distribution points – appeal to men in the community to protect women and ensure safe passage of women from distribution sites to their homes. Camp managers should also make sure that distribution points are away from male groups or alcohol establishments and armed personnel.
- Health Centres may serve as a first ‘neutral’ location to provide information and counselling on women and girls reproductive health. Women and girls are more likely to access and be responsive to information helping them to prevent sexual violence, if it is subsumed within normal and basic health care and not provided by stand-alone programmes, which can contribute to isolation and stigma.
- Undertake psycho-education and advocacy with communities through workshops, distribution of leaflets and information events regarding the effects of sexual violence on women and girls. Speak to community (male) leaders and spiritual leaders to obtain their support and recognition of the importance in protecting the women and girls within the community from violence, as well as an acknowledgment of the importance of women to the well-being of the community.
- Ensuring that boys and girls can go to school in protective learning environments in emergencies may help protect them from sexual violence. Try to ensure that children are able to safely access school facilities by protecting them as they walk to school, asking the teachers to meet the children in a camp and then walking them en masse to school, or enabling mothers and fathers to walk their children to school to help ensure that they are not vulnerable to attacks.
- Support and promote quality educational activities at schools, within child safe areas and women’s groups through the teaching of ‘life-skills’ on the risks, protection and prevention methods that young people can adopt to protect them from sexual violence and abuse. As opposed to creating separate programmes on preventing sexual violence, incorporate protection and education measures into existing projects, such as talking about sexual violence in a women’s knitting group, whilst they are collecting water around the well or are food distribution points and when all groups (females, males, boys and girls) access basic health facilities.

For more information please see the Protection section in the psychosocial protection and support across relief sectors in the next chapter.

How can we help families respond to sexual violence?

It is absolutely paramount that psychosocial programmes provide guidance and support to the partner or spouse of a survivor (usually the partner/ spouse is male). **Men need to be empowered, supported and advised on how to manage the reactions and symptoms that the females within their family may be suffering from as a result of violence.** Many men also feel great shame and embarrassment, at their inability to protect the female within the family, and thus feel as though they have failed in their family duty. Account should also be taken of the suffering of close relatives of survivor’s of sexual violence, who did not know how to, or could not succeed in, preventing acts of sexual violence and who may have even been forced to witness the act. Family mediation and support is, often, required. Hence, programmes and activities should also, where appropriate, work towards reintegrating survivors and their families into society through social support networks and mediation.

It is important to take special care as the survivor can:

- Keep thinking all the time about painful past experiences
- Feel as though she/ he is reliving the same experiences, repeatedly
- Have difficulties falling asleep - nightmares, flashbacks, hallucinations

- Develop physical pains and problems
- Lose interest in life, sex and feel tired all the time
- May fear any new relationships or fear engaging in sexual relations
- Have a tendency to get angry over small things or change moods quickly
- Feel humiliated, weak, afraid or nervous
- Have a tendency to exhibit strong feelings of shame and revenge.

When feasible, raise the support of family members. Families (those who are not the perpetrators) can play a key role in supporting survivors emotionally and practically. For example, they may help survivors to return to usual daily activities (e.g. child care, job, household chores, work or school) after physical recovery of sexual violence. Conversely, families can contribute to increased emotional trauma if they blame the survivor for the abuse, reject her/ him, or are angry at her/ him for speaking about the sexual violence.

How can we help communities respond to sexual violence?

Sexual violence must be understood as an ongoing trauma with repercussions that can affect the lives of many women, girls, boys and men. Survivors may suffer anxiety due to living in a community where violations continue to be perpetrated; where they suffer economic distress; and where armed conflict remains unresolved. Sexual violence is often employed to disrupt community life and family relations. **Treating the individual survivor does not address the community aspect. ActionAid's rights-based approach determines that we should address the context of human-rights violations**, and thus look at a community's relationship with sexual violence.

Key actions on providing community based psychosocial support for sexual violence survivors.

(1) Identify and mobilise appropriate existing resources in the community, such as women's groups, religious leaders, and community services programmes.

- Discuss issues of sexual violence, survivors' needs for emotional support, and evaluate the individuals, groups, and organisations available in the community to ensure they will be supportive, compassionate, non-judgmental, confidential, and respectful towards survivors.
- Establish systems for confidential referrals among and between community-based psychological and social support resources, health and community services, and security and legal sectors.
- Establish coordination mechanisms and orient local partners.

(2) At all health and community services, listen and provide emotional support whenever a survivor discloses or implies that she has experienced sexual violence. Give information, and refer as needed and agreed by the survivor.

- Listen to the survivor and ask only non-intrusive, relevant, and non-judgmental questions for clarification only. Do not press her for more information than she/ he is ready to give (e.g. never initiate a single-session psychological debriefing). Note that she/ he may describe the event out of sequence, and details may change as her/ his emotional state changes. This does not indicate that she/ he is lying but rather that she/ he is emotionally upset.
- If the survivor expresses self-blame, care providers need to gently reassure her/ him that sexual violence is always the fault of the perpetrator and never the fault of the survivor.

- Assess her/ his needs and concerns, giving careful attention to security; ensure that basic needs are met; encourage but do not force company from trusted, significant others; and protect her/ him from further harm.
- Ensure safety; assist her/ him in developing a realistic safety plan (such as safe shelters and safe havens), if needed.
- Give honest and complete information about services and facilities available. Do not tell the survivor what to do, or what choices to make. Rather, empower her/ him by helping them problem-solve by clarifying problems, helping her/ him to identify ways to cope better, identifying her/ his choices, and evaluating the value and consequences of those choices. Respect her/ his choices and preferences about referral and seeking additional services.
- Discuss and encourage possible positive ways of coping, which may vary with the individual and culture. Stimulate the re-initiation of daily activities. Encourage active participation of the survivor in family and community activities. Teach relaxation techniques.
- Discourage negative ways of coping; specifically discourage use of alcohol and drugs, because trauma survivors are at high risk of developing substance abuse problems. Young males can be particularly prone to seek solace through alcohol or other substances.

(3) Address the special needs of children (girls and boys).

- Persons interviewing and assisting child and adolescent survivors should possess basic training on child development and sexual violence
- Use creative methods (e.g. games, story telling, and drawing) to help put young children at ease and facilitate communication
- Use age-appropriate language and terms
- When appropriate, include trusted family members to ensure that the child/ adolescent is believed, supported, and assisted in returning to normal life
- Do not remove children from family care to provide treatment (unless it is done to protect from abuse or neglect)
- Never coerce, trick, or restrain a child whom you believe may have experienced sexual violence. Coercion, trickery, and force are often characteristics of the abuse, and “helpers” using those techniques will further harm the child
- Always be guided by the best interests of the child.

Always adhere to the guiding principles for action:

- Ensure safety and security
- Guarantee confidentiality
- Respect the wishes, choices and dignity of the survivor
- Ensure non-discrimination
- Any training in psychological support should be followed by supervision
- Help the survivor to understand that healing is a process: a journey.

(4) Organise psychological and social support, including social reintegration activities.

- Advocate on behalf of the survivor with relevant health, social, legal, and security agencies if the survivor provides informed consent. When appropriate, organise confidential escorting to any service needed.
- Initiate community dialogues to raise awareness that sexual violence is never the fault of the survivor and to identify solutions to honour killings, communal rejection, and isolation.
- Provide material support, as needed, via healthcare or other community services.
- Facilitate participation and integration of survivors in the community. This may be achieved through concrete, purposeful, common interest activities (e.g. reconstruction and reintegration projects, teaching children), activities that enhance self-sufficiency and mediation.
- Encourage the use of appropriate traditional resources. If feasible, collaborate with traditional healers or clergy, who, respectively, may conduct meaningful cleansing ceremonies or prayer for sexual violence survivors. Many such practices can be extremely beneficial; however, ensure that they do not perpetuate blaming the victim or otherwise contribute to further harm to the survivor.

(5) Prevent sexual violence and maximise child survivors access to services by raising awareness among students and teachers about sexual violence and implementing prevention strategies in schools, youth groups and child-safe areas.

- Inform teachers about sexual violence, prevention strategies, potential after-effects for children, and how to access help and sexual violence services in the community.
- Actively recruit female teachers.
- Include discussion of sexual violence in life-skills training for teachers, girls, and boys in all educational settings.
- Ensure all teachers sign codes of conduct, which prohibit sex with children and young people.
- Establish prevention and monitoring systems to identify risks in schools and prevent opportunities for teachers to sexually exploit or abuse students.
- Provide materials to assist teachers (for example, “School in a box” and recreation kits that include information on gender-based violence and care for survivors from UNICEF).
- Provide psychosocial support to teachers who are coping with their own psychosocial issues, to ensure that they are not over burdened, as well as those of their students. Such support may help reduce negative or destructive coping behaviours.

(6) Establish community-based protection activities and mechanisms in places where children gather for education to prevent abuses such as sexual violence and/ or recruitment by armed groups.

- Provide facilities for recreation, games, and sports at school and ensure access and use by both boys and girls. Be sensitive to the community’s cultural practices and preferences related to gender.
- Gain community support for school-based sexual violence programming by communicating with parent groups (PTA’s) and communities about sexual violence.

(7) Identify existing resources and potential channels for communication that can be mobilised to inform the community about prevention of, and response to sexual violence.

- Community-based workers/ animators in health, nutrition, WASH, community services, children's programmes, midwives, traditional birth attendants, etc.
- Women's leaders, teachers, religious and cultural leaders.
- Places where community members gather, where posters or other informational materials could be available, such as distribution points, health centres, registration centres, communal shelter areas for new arrivals.
- Popular radio programmes.
- Compile a resource list of organisations and services in prevention and response to sexual violence.
- Establish co-ordination mechanisms, orient partners and distribute widely in the community and between humanitarian and relevant government organisations.

(8) Determine the key messages to be disseminated, based on a co-ordinated situational analysis and the resources available in the setting. Some, or all, of the following messages may be needed and appropriate:

- Potential health consequences of sexual violence (unwanted pregnancy, injury, reproductive health problems, infection, STIs, including HIV infection.)
- Emotional and social consequences of sexual violence (fear, anxiety, panic attacks, withdrawal, depression, feeling hopeless, social isolation.)
- Who might need help (e.g. girls, boys, adolescents, women, concerned family members).
- Where to go for help — exactly where to go, which organisation(s), which door to use, hours of operation (preferably 24 hours), etc.
- What kind of help is available (e.g. confidentiality and privacy, trained midwives, trained counsellors, confidential treatment, medicines, help you plan for your continued security).
- The importance of protection and safety for the survivor.
- The community's responsibility to protect and care for survivors, not blame them and not reject them.

(9) Adapt or develop simple methods and materials to communicate the messages.

- Consult with women and girls to verify that the information is culturally appropriate, clear, and conveys the intended message(s).
- Inform community leaders about the need for the information dissemination and consult with them to ensure that materials and messages are culturally appropriate.
- Be sure to emphasise the message that sexual violence services are confidential.
- Prepare materials using a variety of methods to ensure communication with literate and non-literate persons.
- Some examples are: posters and pamphlets with words and pictures; radio spots; and meetings or groups where women and girls gather, such as health talks and after-school programmes.

[7] Source: VeneKlausen & Miller 2007:170-174

Urban displaced persons

As mentioned in earlier chapters, the profile of an urban displaced person is different to a displaced person living in a camp environment. Whilst, the needs and rights of a person displaced within an urban setting is the same as a displaced person within a camp, the operating environment is very different.

- For further details on the definition of urban refugees and urban displaced persons, and the challenges they face, please see the next chapter: 'Psychosocial protection and support across relief sectors'.

What are some of the problems in working with urban refugees?

- It can be difficult to ascertain where the refugee or displaced persons community starts and stops, in comparison to the urban poor (including street children), complicating identification and targeting
- It can be difficult separating out 'irregular movers' from economic migrants
- Identification, registration and distribution of relief goods is more complex. Most refugees come to UNHCR offices, or another organisation working with urban cases to receive relief goods, rather than UNHCR and other organisations reaching out to them to deliver 'where they reside'. This complicates community-based work, as outreach becomes increasingly important
- Refugees live in urban centres in many parts of the world, illegally. They are thus under constant fear of arrest, deportation, imprisonment and detention and are largely not entitled to protection or assistance.
- Governments are against refugees residing in cities; they prefer the policy of encampment. Thus there may be 'negative consequences' if a refugee does come forward to seek assistance.
- There is little 'donor money' available to work with the long-term care and maintenance of urban caseloads. UNHCR and many donors believe that urban caseloads have greater reserves of resilience in comparison to encamped displaced persons, and so often adopt a policy of displaced person's 'self-reliance'
- Urban displaced people, including street children, require an individual case management approach, and intensive work, rather then dealing with large numbers and large-scale relief distributions. Individual case management is more time-consuming and expensive in the long-term, in comparison to working with other vulnerable groups in emergencies.

The importance of resilience

Urban refugees and street children often exhibit great resilience, demonstrating personal strength and resourcefulness, and increased solidarity, social support and generosity. Resilience and solidarity are, however, under increasing pressure when crises become protracted (such as Somali refugees in Nairobi, and Iraqi refugees in Amman) and social resources become exhausted. Despite great distress, with the correct support, people and communities often are able to overcome the mental health and psychosocial risks of living in extremely difficult circumstances. Programmes, therefore, should focus upon **resiliency rather than vulnerability**.

Programme Responses:

- Child protection monitoring and follow up for street-children and child-headed households - home visits and follow-up care and support will be required
- Access to services e.g. healthcare, education, legal advice, housing etc.
- Quality of services provided (prevent discrimination, cultural and language problems)

- Family reunification, particularly for children and female-headed households
- Self-reliance and resilience
- Structured support and case management for applications for asylum
- Building networks of community support
- Handling distressed people, psychological first aid, active listening
- Access to information, its dissemination and modality
- Advocacy, protection and material assistance etc., with local officials; government, human rights organisations, NGO's, CSO's and UN agencies
- Micro-credit and livelihood support and training.

Chapter 5
Psychosocial support across relief sectors

Psychosocial protection and support activities should never be undertaken in isolation from other emergency response work. Where possible, psychosocial work should be integrated into other programming areas. This is not only the most effective form of emergency response, but it also minimises any stigmatisation or discrimination that people may face in certain societies when accessing mental health or psychosocial support services.

According to the IASC Guidelines: "The proliferation of stand alone services, such as those only dealing with rape survivors or with people with a specific diagnosis, such as post-traumatic stress disorder (PTSD) can create a highly fragmented, and hence, ineffectual care system. Activities that are integrated into the wider systems (e.g. existing community support mechanisms, formation of formal/ non-formal school systems, general health services, general mental health services, social services etc.,) tend to reach more people, often are more sustainable, and tend to carry less stigma"[1].

This chapter examines the different sectors of emergency response, humanitarian-aid related problems and outlines the key psychosocial considerations that must be taken into account in other areas of relief work. Much of the information below draws on the recommendations and minimum standards as outlined in the IASC Mental Health and Psychosocial Support Guidelines.

It is important to remember that the way in which relief supplies are provided to a displaced population, and the lay-out of camps/ other shelter areas, all have an impact upon a person's well-being. In the early stages of an emergency, the greatest source of distress and discomfort are humanitarian-aid related problems: the lack of relief supplies, insecurity, separation from loved ones, inadequate provision of relief supplies and/ or poor camp management and layout, **rather than the symptoms of the traumatic event itself.** The provision of adequate and timely relief supplies, and the participation and active involvement of displaced persons, plays a key role in the creation of an enabling environment to help people heal from the original traumatic event.

(1) Psychosocial support and protection

Human rights violations are unfortunately pervasive in many emergencies. Emergencies disrupt traditional support and value systems at the family and community levels, leading to the separation of children from their parents and further fragmentation of communities. A culture of violence, absence of accountability and a lack of access to heath care, psychosocial support and legal assistance can all lead to human rights violations. An inextricable link exists between the promotion of mental health and psychosocial well-being, and the protection and promotion of human rights.

Groups who are at particular risk in emergencies include: orphans, separated and unaccompanied children, adolescents, single and widowed women, pregnant and lactating women, the elderly, and mentally and physically disabled. Emergencies exacerbate the differences in power within affected populations, increasing the vulnerability of already marginalised people (link with ALPS analysis of power dynamics). Such people are more likely to suffer rights violations and are at an increased risk of emotional distress, psychosocial problems and mental disorders. Advocating for the implementation of human rights standards such as the right to health, education, livelihoods, or freedom from

[1] Source: VeneKlausen & Miller 2007:170-174

discrimination contributes to the creation of a protective environment, including access to social and legal protection, in addition to a person's well-being.

Survivors of emergencies report that their greatest stress arises from threats of attack, forced displacement, denial of access to certain areas, gender-based violence, separation from family members, extreme poverty, exploitation and abuse. Protection problems cause immediate suffering and may interfere with the rebuilding of social support and community networks, all of which enhance psychosocial well-being.

The provision of humanitarian assistance, and the participation of affected groups in the provision of this assistance, reduces the risk of discrimination and abuse, and ensures that assistance is tailored to need. The provision of psychosocial support, including life skills and livelihood support, to women and girls may reduce the risk of having to adopt survival strategies such as prostitution, providing sex for relief supplies, child trafficking or other human rights violations.

Safety, dignity and integrity are fundamental concepts to both international humanitarian and human rights law, and to a psychosocial approach to humanitarian action. Legal protection promotes mental health and psychosocial well-being by **shielding people from harm, promoting a sense of dignity, self-worth and safety**, whilst strengthening social responsibility and accountability for actions.

The Sphere Handbook outlines important guidance and overall minimum standards for the provision of humanitarian assistance in emergencies. In addition, all mental health and psychosocial responses should adhere to:

- *IASC Guidelines on Mental Health and Psychosocial Support in Emergencies Settings* (2007)
- *IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings* (2005)
- *IASC Gender Handbook in Humanitarian Action: Women, Girls, Boys and Men: Different Needs – Equal Opportunities* (2005).
- *The Global Protection Cluster's Handbook for the Protection of Internally Displaced Persons*, Provisional Release, December (2007) is also an invaluable resource.
- AAI *'Stand Up: Stand With'* Protection Manual (forthcoming 2009).

The key actions outlined below give guidance on psychosocial considerations relevant in working towards such standards.

(a) Key actions in the prevention of protection risks:

- Advocate for compliance with international and national human rights standards and law, in all forms of mental health and psychosocial support.
- All humanitarian workers must sign the Code of Conduct, promote human rights regardless of sector and protect vulnerable groups from abuse and exploitation.
- Help recipients of mental health and psychosocial support to understand and access their rights.
- Promote inclusive and non-discriminatory service delivery, and avoid unnecessary institutionalisation of people with mental disorders.
- Strengthen community social support structures through mobilising communities in discussion forums to assert their rights.
- Promote the inclusion of the psychosocial impact and consequences of human rights violations on survivors in training for staff of human rights organisations and for government officials.

- Establish mechanisms for monitoring and reporting of abuse and exploitation, paying particular attention to the storage and dissemination of such information.
- Effective social protection occurs as local people organise themselves to address protection threats, thereby building a sense of empowerment and the possibility of sustainable mechanisms for protection.
- Prevent and monitor presumed protective resources – such as police, soldiers, teachers, or humanitarian aid workers – from creating protection threats.
- Collect age, gender and special needs disaggregated data where possible to better inform progamming.
- Provide access to education as a protection measure, ensuring that education personnel understand how to make education safe.
- Organise child, youth and women's safe spaces to increase protection and well-being.
- Post-distribution monitoring of food and non-food aid to ensure that it reaches children and others in need.
- Monitor shelter programmes to ensure that those who may need special assistance receive support in obtaining adequate shelter.
- Ensuring that sanitation facilities are close to people's living quarters, and that they are well-lit and safe for women and children to use.
- Avoid singling out or targeting specific sub-groups for assistance, unless this is necessary to prevent further harm (e.g. create general women's groups, rather than groups for women who have been raped/ survivors of sexual and gender-based violence (SGBV)).
- Work with community leaders and relevant local authorities (such as elders, community leaders, camp managers) to mobilise and educate affected people on their legal rights and how to achieve realisation of their rights in a safe manner.

(b) Key actions in the response to protection threats:

- Ensure that human rights organisations are attune to the need for psychosocial support for survivors (particularly those of sexual and gender based violence) and provide them with information on where they can access psychosocial services, amongst others.
- Identify and support mechanisms that end impunity and hold perpetrators accountable for their acts, particularly for cases of sexual and gender based violence.
- Orientate those working in the legal system (lawyers, judges, para-legals) on how their work affects psychosocial well-being. For example: sensitive and appropriate techniques for interviewing witnesses and survivors, and an understanding on how inheritance and land rights provide essential economic support for widows and children, encouraging self-reliance and resilience.
- Include essential information on mental health and psychosocial support, helping workers across all sectors to understand what to do, not to do, when they encounter people who need legal protection, including appropriate referrals.
- Establish systems for the identification, documentation, tracing, reunification and temporary care arrangements for separated children.
- Activate local processes of mediation, reconciliation and dispute resolution.

- Where applicable organise medical, psychosocial and legal support for survivors of abuse who are in severe psychological distress.
- Develop an advocacy strategy in collaboration with other organisations and local people to stop the placing of children in orphanages and institutions. Community-based alternative care arrangements are far more effective. Children should only be placed in institutions as an absolute last resort, and for the shortest time possible.

For more information please see Action Sheets: 3.1, 3.2 and 3.3, pp 50 - 70 of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings and the Handbook for the Protection of Internally Displaced Persons*, Provisional Release, Global Protection Cluster Working Group, December (2007).

(2) Psychosocial support and the dissemination of information

Information, communication and documentation are important tools to facilitate coping and healing. Being informed and being able to communicate provides an opportunity to deal with feelings and for an individual to make an informed decision regarding their situation. IEC materials can also provide **security, identity, signs of hope** and is therefore key to a person's **empowerment**.

Unfortunately, emergencies tend to destabilise conventional channels of information and communication. Communications infrastructure may be destroyed, existing communication channels maybe abused by those with specific agendas e.g. the spreading of rumours or hate messages, or the fabrication of stories to cover neglect and dereliction of duties. Rumours and the absence of credible and accurate information tend to be major sources of anxiety for those affected by an emergency and can create confusion and insecurity. Moreover, a lack of knowledge about rights can lead to exploitation; appropriate information received at the appropriate time might counter this.

Information and communication systems can be designed to help community members play an active role in their own recovery process, to be active agents of change, rather than passive victims. Information and communication technology (ICT) and traditional methods of communication and entertainment – such as sketches, songs, plays, storyboards, posters, role-plays – can play a crucial role in disseminating information on survivor's rights, entitlements, psychological first aid, positive coping methods, where people can access medical, legal and psychosocial help etc.; while appropriate information about relief and the whereabouts of displaced people can also reunite families.

(a) Key actions:

- Find the organisation or organisations that are undertaking tracing programmes for separated families (particularly for children).
- Determine which agencies and networks work with information and communication. In many organisations and agencies, there are NGO's that work with the explicit aim of co-ordinating the information collection and data flow during an emergency. OCHA and ICRC are major information hubs, however there may also be information hubs at the local level. WFP for example usually has one for logistics and food pipelines.
- Facilitate the formation of an information and communication team to provide information on the emergency, relief efforts and legal rights, and to strengthen the voices of any marginalised groups. Members of the community, themselves, may play a key role in disseminating information about services.
- Analyse who controls channels of communication, asking whether particular groups are disseminating information in ways that advance specific agendas.

- Find out who can be a spokesperson to carry information. Spokespeople should represent different parts of communities (e.g. community and religious leaders, women, men, elderly, youth, girls and boys, and other forms of representatives).
- Ask different stakeholders in the population, about any key information gaps that must be addressed e.g. lack of knowledge about services, entitlements, location of family members etc. Work with survivors to identify the type of messages they would like to disseminate and the best methods for doing so.
- Develop a communication and campaign plan.
- Create channels to access and disseminate credible information to the local population, and wherever possible arrange communication with the outside world with friends, families, other communities and authorities.
- Engage local people at every stage of the communication process, and make sure that messages are empathetic and uncomplicated.
- Ensure that there is no unnecessary repetition of past traumatic events in local media by organising media briefings and field visits.
- Encourage media outlets to carry not only images and stories of people in despair, but also to print or broadcast images and stories of resilience and the engagement of survivors in recovery efforts.
- Ensure co-ordination between communication personnel working in different agencies. Co-ordination is vitally important to maintain the consistency of any information provided.
- Involve staff and beneficiaries in documenting the situation. This can also act as an important positive coping mechanism.

(b) Conduct, when necessary, further assessments that address the following questions:

- Which communities/ groups of people are on the move, which have settled?
- Who are the people at risk: are they commonly recognised vulnerable groups, or are they new groups of vulnerable people?
- Are there reports of survivors who have lost mobility? If so, identify where they are located and the existing response.
- Where can people locate themselves safely and which places are dangerous?
- If mental health and psychosocial supports are available, who is providing these supports? Which agencies are active in this area? Are they covering all affected communities and segments of the population? Are there sections of the community that have been left out? Information about psychosocial services and its goals should be given to: staff, authorities, networks and beneficiaries.
- What opportunities exist to integrate information and communication campaigns with ongoing relief efforts?
- What is the level of literacy among men, women, children and adolescents in the population?
- Which pre-existing communication channels are functional? Which channels would be the most effective in the current situation to carry messages related to the emergency, relief efforts and rights?
- Which are the population groups that do not have access to the media?

- Which are the groups that have no access to media due to disability? What methods may need to be developed for dissemination of information to reach such people?

(c) Collect and collate relevant information on a daily basis. This may include information relating to:

- Availability and safety of relief materials
- Ceasefire agreements, safe zones and other peace initiatives
- Recurrence of emergency related events (e.g. earthquake aftershocks or violence)
- The location and nature of different humanitarian services
- The location of safe spaces and the services available there
- Key results of assessment and aid monitoring exercises
- Major decisions taken by political leaders and humanitarian co-ordination bodies
- Rights and entitlements (particularly regarding food and non-food item distribution).

In all emergency settings, people experience a degree of psychological distress (grief, anger, sadness, guilt etc.). It is important to remember that these are completely normal reactions to abnormal situations, and the vast majority for affected individuals will gradually regain a sense of well-being if they are provided with positive coping mechanisms to handle any stress, and if they receive support from their families and communities.

By making culturally appropriate educational information available, it will encourage affected individuals to adopt **positive coping mechanisms**. The aim of such information is to increase the capacity of individuals, families and communities to understand the common ways that people might respond to stress and their present circumstances. This is a form of psychological first aid, as well as a form of **empowerment** as peer-peer support can often be facilitated, boosting both the carer and the survivor. Dissemination of information on positive coping mechanisms through printed material or via radio is one of the most frequently used emergency interventions, and has the potential to reach the vast majority of affected people.

- Determine what information on positive coping mechanisms are already available among the affected population.
- If no information is currently available, then develop information on positive, culturally appropriate coping methods for use amongst the affected population.
- Positive coping mechanisms that tend to exist across cultures are: seeking social support, providing structure to the day, relaxation methods, recreational activities, and gently facing feared situations either through a group, or with the help of a trusted friend/relative.
- Adapt the information to address the specific needs of sub-groups of the population as appropriate.
- Consider including information with a ‘special focus’ on ‘children’s coping’, ‘teenagers’ coping’, noting that in the short-term coping mechanisms such as taking drugs and alcohol abuse are likely to cause long-term harm and damage.

For more information please see Action Sheets: 8.1 and 8.2, pp15 - 167 of the IASC Guidelines on Mental Health and Psychosocial Support.

(3) Psychosocial considerations in the provision of health care

Often there is a gap in emergencies between mental health and psychosocial support, and general healthcare. Importantly, the manner in which healthcare is provided often affects the psychosocial well-being of people living through an emergency. **Compassionate, emotionally supportive care protects the well-being of affected people**, whereas disrespectful or inadequate treatment can cause unnecessary distress, loss of dignity and often deters people from seeking additional medical assistance or adhering to treatment regimes. The strong inter-relationship between social, mental and physical aspects of health care provision are often ignored, despite the frequent co-existence of physical and mental health problems amongst affected populations.

The Sphere Project Handbook provides minimum standards and guidelines on the provision of healthcare in emergencies. The key actions outlined below give guidance on psychosocial considerations relevant in working towards such standards.

(a) Key actions for the social aspects of health care:

- Disseminate IEC materials through posters, storyboards, radio messages and postcards on where people can access mental health care and psychosocial support.
- Work with local community structures and leaders to discover, visit and assist people with severe mental disorders.
- Prevent harmful alcohol and other substance use and dependence through advocating and facilitating for the re-establishing of educational and recreational activities and non-alcohol related income-generating opportunities. Promote 'positive coping mechanisms'.
- Facilitate referrals to key resources outside the health system including social, legal and other protection mechanisms (such as child and family tracing units).
- Communicate important emergency related health information to the affected population, such as hygiene promotion, safe-sex practices etc.
- Maximise access to healthcare by locating any new services within safe walking distance of communities. Aim to balance gender and include representatives of key minority and language groups among health staff to maximise survivor's access to health services.
- Avoid inappropriate pathologising/ medicalisation by distinguishing non-pathological distress from mental disorders requiring clinical treatment or referral. Many people that have witnessed violence or distressing scenes are undergoing normal reactions to abnormal events resulting from the post-election violence, and in 95% of cases 'traumatic' symptoms will decrease naturally over time, if activities are implemented to bring a sense of normalcy back to people's lives.
- Establish mental health and psychosocial care at additional, logical points of access such as child and youth friendly spaces, and outreach clinics at churches and schools that may have absorbed a large number of displaced people.

Key actions for the direct implementation of health care services:

- Protect and promote patient's rights to privacy during consultations and examinations and confidentiality related to the health status of a patient (i.e., HIV and AIDS status).
- Record and analyse sex and age disaggregated data in health information systems.
- Liaise with local government offices to produce birth and death certificates where needed.
- Orientate general health staff and mental health staff in psychological components of emergency health care (psycho-education).

- Make available medium-long-term psychological support for survivors exhibiting extreme (traumatic) stressors. Ensure that any support offered is not one-off, but sustainable and reliable, preferably with the same therapist or group therapy programme.
- Public Health Care workers should document mental health problems in their morbidity data.

Psychological First Aid (PFA):

All ActionAid staff, interns and volunteers, working in direct contact with affected populations should be able to provide psychological first aid encompassing:

- Protection from further harm.
- Provide the opportunity for survivors to talk about any events, free from pressure and in their own time. Avoid pushing for more information than the person maybe ready to provide.
- Listen patiently and accept in a non-judgemental manner.
- Conveying genuine compassion.
- Identifying basic practical needs.
- Discourage negative coping methods (such as dependency upon alcohol and other substances).
- Encourage participation in normal daily routines and use of positive means of coping (relaxation methods, ideological and cultural support).
- Encourage interaction with family members, friends and the community.

For further information please see Action Sheet 6.1, pp11 - 122 of the *IASC Guidelines on Mental Health and Psychosocial Support* and pp295-297 of *The Sphere Project Handbook*.

(4) Psychosocial considerations in the education sector

Education is a vital part of a child's development and growth; it is no different during times of emergencies. **A stable environment for learners restores routines to children's lives again and thus a sense of normalcy, dignity and hope.** Both formal and informal educational activities have a place within a camp, village and urban environment, where displaced people can be found. Key survival messages and enabling learning about self-protection and community-protection issues empowers the affected population to cope with the situation and to be active agents in their own recovery process.

It is of vital importance that we restart formal and informal educational activities immediately, prioritising the safety and well-being of youth and children, including those at an increased risk such as children with special needs, child-headed households, physically or mentally disabled children, orphaned, separated or unaccompanied children. Access to education in a supportive environment build's learners intellectual and emotional competencies, provides social support through child-child, child-educator relationships, strengthens youth learners sense of control and self-worth. Life-skills, economic skills, livelihood regeneration skills and coping skills can all be taught even within settings of displacement.

Teachers and classroom assistants have a crucial role to play in the facilitation of educational activities, which boost a person's psychosocial health and well-being. Women's circles within the camps and youth groups are also a useful resource to engage in non-formal educational activities, particularly with the younger children, such as play activities, singing, sports and games. **Participatory approaches are a form of empowerment restoring people's hope and dignity.**

All education responses in an emergency should adhere to the INEE Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction, as mentioned in the appendix. The key actions outlined below give guidance on social considerations relevant in working towards such standards.

(a) Key actions **internal** to the classroom/ informal school:

- Strongly consider providing emergency psychosocial protection and support training for teachers. Support teaches on how to deal constructively and positively with learner's issues such as fear, guilt, anger, revenge, lack of sleep and inability to concentrate. Training on reconciliation and peace education can also be useful in conflict related emergencies.
- Make education flexible and responsive to emergency-induced emotional, cognitive and social needs and capacities of learners. Shorter lesson times maybe required, minimal emphasis on homework after hours for those living in the camps and who may not have access to resources. Vary lesson schedules to allow for relapses, students who may be struggling to concentrate. See the programme response chapter for more details.
- Use collaborative and interactive games (e.g. games, singing, dancing, playing) rather than competitive games. Try to use local resources where possible (e.g. string from the market for skipping ropes, painted old tyres, bicycle inner tubes for hula hoop, footballs etc).
- Identify key protection threats external to the education system, such as child prostitution, gender based violence and armed conflict, and those that are internal (bullying, violent punishment etc) that may affect school attendance and a child's academic performance.
- Incorporate messages within the classroom/ safe spaces on how to prevent and respond to any human rights violations and protection issues (particularly for child-headed households and separated, orphaned and unaccompanied children), and any community-based efforts (either within the camps or external to the camps) that could address this.
- Aim to provide education that restores a sense of structure and routine for children, creates opportunities for expression (both the positive feelings and any negative emotions), social interaction and group work, which all build a child's life skills and competencies.
- Consider the possibility of life-skills training, particularly regarding how to prevent sexual and gender based violence, which is common place within some camps, inter-personal skills, relationship building and health promotion/ hygiene programmes.
- Support adult literacy circles and vocational/ livelihood training for youth and young adults. For adolescents, informal educational activities must be a supplementary to formal schooling.
- Promote psychological first aid within the classroom, by helping learners to help each other, as well as ensuring an expressive outlet for any emotions.

(b) Key actions that are **external** to the classroom/ informal school:

- Maximise the participation of the affected community, including parents, youth and appropriate education authorities in the creation of formal and non-formal education (safe spaces) for children and youth within the camps, and on the content of any 'education/activity curriculum'.
- Make learning spaces 'zones of peace' both within the camp and in host communities. Make sure that schools are located in a safe, secure area of the camp, village, urban centre. In schools that have absorbed a large number of children from local/ nearby displaced communities, ensure that children have a safe access to and from school.
- Rapidly organise informal education child and youth friendly spaces, or community educational groups, utilising women (mothers) and youth from within the camp population to work in these centres. This participation is a form of empowerment for many people and enables them to bring a sense of control to their lives again. Education can also be a form of community mobilisation through focus-groups and the creation of committees to facilitate activities within the camp.

- Help school staff such as administrators, counsellors, teachers and social workers understand where to refer children with severe mental health and psychosocial difficulties to appropriate mental health and social services within the community. Link up with the relevant displaced persons' psychosocial committees if they exist.
- Be aware that emergency affected people may not have all the documentation necessary to enrol their children in the local school. This should not prohibit them from accessing school.
- Try to secure school kits and school supplies (e.g. stationery and uniforms) for children living in affected areas to facilitate their access and active engagement with local schools.

For more information, please see Action Sheet: 7.1, pp148 - 156 of the IASC Guidelines on Mental Health and Psychosocial Support.

(5) Psychosocial considerations in the provision of food security and nutrition:

Hunger and food insecurity can damage the psychosocial well-being of displaced persons. Conversely, the psychosocial effects of an emergency can impair food security and nutritional status. The content of the food items and the manner in which they are distributed can greatly impact upon the quality and effectiveness of food aid whilst also supporting human dignity. For instance, long queues at food distribution sites and irregular distribution timings can cause people unnecessary anxiety, especially for: mothers with children, who may be unable to look after their children and receive food supplies, and pregnant women or people with disabilities who struggle to stand for long periods.

The Sphere Project Handbook outlines important guidance and overall minimum standards for food security, nutrition and food aid in emergencies. The key actions outlined below give guidance on social considerations relevant in working towards such standards.

Key actions

- Maximise the participation of affected populations in the planning, distribution and follow-up monitoring of food aid. Priority should be placed on the participation of women in this process, as women and children make up the majority of people living within the camps. Women also play an active and positive role in ensuring that food aid reaches all intended recipients without undesired consequences.
- Consider food assistance to create/ restore informal social protection networks/ self-help groups by distributing rations via volunteers, particularly to those people with limited mobility and access (e.g. the elderly, disabled, infirm, pregnant women etc).
- Ensure that the distribution of food aid adheres to conflict sensitive programming, that groups are not marginalised and it is not used for political purposes. Transparency in distribution mechanisms and proper planning and registration of the affected population should minimise this risk.
- Measures should be taken to prevent the misuse of food aid and to prevent abuse, including the trading of food for sex by humanitarian aid workers (including volunteers, police, armed forces and government officials).
- Inform the camp population of their rights and entitlements regarding food aid, with a particular emphasis on stating that all relief items and rations are free of charge.
- Ensure that the amount of food distributed is adequate, so as to: minimise the anxiety of the camp population, minimise any related malnutrition and subsequent health concerns, and minimise the risk

of women and girls being forced to look for supplies elsewhere (sometimes through the provision of sexual services to obtain additional relief goods).

- Ensure that workers in food aid (including interns and volunteers) know where and how to refer people exhibiting acute social or psychological distress.
- Raise awareness among the camp population and food distribution workers, that certain micro-nutrient deficiencies can impair children's and the elderly' cognitive development and harm foetal development (for pregnant women).
- Special attention and nutritional supplements maybe needed for pregnant and lactating women.
- Consider school feeding programmes, especially in those primary schools, that have absorbed a large influx of children from local/ nearby camps to address any possible malnutrition/ malnourishment issues.
- Stimulate community discussion for long-term food security planning, such as direct cash transfers, cash for work and income generating activities. The 'idle youth' are a key target group for this type of intervention, which can be very empowering and thus aids healing.
- Community-driven food and livelihood security programmes, such as farm tools, seeds, fertiliser etc., grants for small businesses, can reduce helplessness and resignation, and engages the community in socio-economic recovery. It also empowers people to become active agents in their own recovery process; it brings a sense of normalcy to their lives and boosts their psychosocial well-being.

For more information please see Action Sheet 9.1, pp168 - 173 in the IASC Guidelines on Mental Health and Psychosocial Support and pp174 - 182 of The Sphere Project Handbook.

(6) Psychosocial considerations in the provision of shelter and camp management

The provision of safe and suitable shelter in emergencies, saves lives, reduces morbidity and enables people to live in dignity without excessive distress. The participation of people affected by an emergency in decisions regarding shelter and site planning, reduces the helplessness seen in many camps or shelter areas, promotes people's well-being , and helps to ensure that all family members have access to appropriate private spaces and protection. It is vital that women and children are consulted in the camp layout and planning of shelters to ensure attention to gender needs, especially as the overwhelming majority of displaced persons are women and children. The participation of displaced people promotes self-reliance, builds community spirit and encourages local management of facilities and infrastructure – it is especially key to engage the 'idle youth' within displaced populations to utilise them as a labour force, making them active agents in their own recovery.

The organisation of sites and shelters can have a **significant impact on well-being**, which is reduced by over-crowding and the lack of privacy commonly found in camps and other shelter areas. Psychosocial problems can arise, when families and individuals are denied private spaces, within camps and other shelter areas, many of which are congested. Families should have a shelter for their own private use, and if possible a shelter for any youth within families, to minimise any inter- and intra-familiar tension. The sharing of tents between families increases the incidence of sexual and gender based violence, in addition to tensions between families with young children who may be distressed and not sleep through the night-thus disturbing many others. Hence, the sharing of tents is not advised.

The Sphere Project Handbook outlines important guidance and overall minimum standards for shelter and settlements in emergencies. The key actions outlined below give guidance on social considerations relevant in working towards such standards.

Key actions

- Organise support for people who are unable to maintain their shelters. The 'idle youth' that are in evidence in many camps are a useful resource for this, it also empowers them and makes them feel as though they are contributing towards something, breaking the dependency and apathy cycles.
- Consult women in particular about privacy and security, including safe, ready access to local resources (e.g. firewood) for cooking, heating and the location of latrines. Communal kitchens should be located close to shelters, can be built by the youth and men in the camps (again a form of empowerment), and they minimise the risk of fires spreading throughout the camp, through the unnecessary storage of firewood.
- Ensure that the camp population has ready access in and out of the camp to the local communities, in order for them to be able to access services (education, health, places of religious worship, local businesses etc.).
- Ensure that camps/ shelter areas are secure during the day but most importantly at night-time to prevent unwanted and unknown intrusions. Security should be particularly vigilant around WASH facilities, as the risks of sexual and gender based violence increases at night-time around these facilities. Community-based security and policing is most effective.
- Develop communal safe spaces that offer psychological assurance and enable social, cultural, religious and educational activities, and the dissemination of information. These safe spaces, should also include spaces for children, youth and women where they can meet their peers, play and discuss any concerns.
- Any documentation and registration system should include age and gender disaggregated data.
- Ensure that people can move easily through group shelters or around family dwellings without invading the privacy of other people or cause significant disruption.
- Avoid separating families at all costs, or communities/ groups of people that wish to be together. Separation disrupts their social support structures which should remain intact where possible, to bring a sense of normality back to people's lives.
- Enable reunited families to live together.
- Support through peer-peer linkages, vulnerable individuals who are living alone due to physical/ mental disorder or disability.
- Involve IDP's and refugees on the camp management/ co-ordination committees. This is a useful feedback mechanism that allows displaced persons concerns to be addressed efficiently and effectively at a high level. It is also a form of empowerment as it views people as active agents in their own recovery process.
- Encourage early return and resettlement of displaced people as a durable solution and provide support to those families who want to return to their areas of origin and are able to do so.
- Ensure that people have voluntary right of return and that services are provided not only in the camps and other shelter areas but also in the areas they wish to return to.

For more information please see Action Sheet 10.1,pp 174 - 178, in the IASC Guidelines on Mental Health and Psychosocial Support and pp238 - 241 of The Sphere Project Handbook.

(7) Psychosocial considerations in the provision of Water, Sanitation and Hygiene (WASH)

In emergencies, providing access to clean drinking water and safe, culturally appropriate hygiene and sanitation facilities are high priorities, not only for survival but also for restoring a sense of dignity. The manner in which humanitarian assistance is provided has a significant impact upon the well-being of the affected population. The engagement of local people in a participatory approach helps to build community cohesion, empowers people and enables them to regain a sense of control over parts of the lives, in an otherwise fluid and unfamiliar context. All the above reassures the affected populations and minimises any distress or anxiety in the provision of their basic needs.

Depending on how WASH facilities are provided, they can either improve or harm mental health and psychosocial well-being. Unlit or poorly lit latrines, have the potential to become sites of gender-based violence, including rape, especially as few are securely guarded at night-time. The lack of security and fear of attack, when using the facilities causes unnecessary distress to already vulnerable groups. WASH facilities should also be private and large enough to accommodate a pregnant woman, and a woman with a small child. Inadequate latrine size is an unnecessary form of distress and discomfort.

The Sphere Project Handbook outlines the overall standards for WASH provision in emergencies. The key actions outlined below give guidance on social considerations relevant in working towards such standards.

Key actions

- Involve camp members, especially women, children, people with disabilities and elderly people, in decisions on the placing and design of latrines, and if possible water points and bathing facilities.
- Work with the camp/ shelter co-ordination teams to set up WASH committees to restore facility provision and to create a sense of camp ownership over the facilities to ensure proper use, security and maintenance. Participation is also a form of empowerment, and it will reduce any conflict around access and use of water points.
- Ensure that adequate water points are close to and accessible to all within the camp, including vulnerable people such as those with restricted mobility.
- Ensure that all latrines and bathing areas are secure, private and if possible well-lit. Providing male and female guards, torches or lamps are simple ways of improving security.
- Provide access for women's menstrual cloths or other materials (the lack of which creates unnecessary discomfort, embarrassment and distress). Space needs to be created to allow women and girls to wash and dry any menstrual cloths. Women should be consulted on their needs and the location for any such washing facilities. Where existing water supplies cannot support washing, alternative sanitary materials should be provided.
- Encourage community clean-up campaigns and communication about basic hygiene.
- Distribute soap and other hygiene materials, in accordance with advice received from women, men, girls and boys, including the disabled and elderly.
- Initiate child-to-child WASH activities that are interactive and fun, such as group hand washing before meals.
- Ensure that displaced persons are represented on camp management committees, so they can report any concerns regarding the WASH facilities. Ensure that a feedback mechanism exists for stakeholders to report problems or concerns to the water committee or relevant agencies

responsible for WASH provision. The same mechanism can be used to keep the camp population informed as to what facilities and services can be offered.

- The monitoring of sites and facilities to ensure that they are clean and well-maintained helps to restore displaced persons' dignity, and brings a sense of normalcy to their lives again.

For more information, please see Action Sheet 11.1, pp179 - 182, in the IASC Guidelines on Mental Health and Psychosocial Support and pp89 - 92 of The Sphere Project Handbook.

(8) Psychosocial support and Disaster Risk Reduction (DRR)

DRR work is very much focused on **minimising the effects** of natural disasters and conflicts, through a mixed approach of **preparedness, prevention** and the **building of resilience**. The psychosocial approach to DRR focuses on both the 'building back better' mantra, particularly when it comes to infrastructure such as community and household shelters, schools and hospitals, as well as, the prevention of protection risks such as separation and abuse.

As mentioned in earlier chapters, the **impact and consequences** of traumatic events are far more distressing in the early stages of an emergency than the actual traumatic event itself. The collapse of schools, markets, hospitals and damaged roads all disrupt a persons routine and the sense of normality. Damaged schools mean that children are unable to attend school, which if not rectified can hinder their long-term development. Damaged hospitals increases the morbidity and mortality rates in emergencies, and decreases peoples access to life-saving services, often when they are needed the most. The collapse or disruption of markets affect people's livelihoods and their ability to provide for their families. Damaged roads can affect the movement of goods to markets, the delivery of relief supplies, as well as cutting communities off from each other leading to social isolation. In the early stages of an emergency, the above factors combine to create a very challenging 'survival environment', which makes it extremely difficult for people to begin to heal from the original trauma.

(a) Psychosocial issues to think about when implementing a DRR programme

- If schools or hospitals have been damaged during the disaster and require re-building, it is advisable to make them more resilient to disasters, with reinforced joints and walls in cyclone and earthquake affected regions, placing them on stilts in flooding areas etc. This may require input from specialist construction engineers or architects, to ensure that we are really 'building back better'. Schools and hospitals are vital resources within a community, and become symbols of normality and security. In many cyclone affected areas, schools also double up as 'safe shelters', further emphasising their symbolic and practical importance.
- DRR should be a part of the school curriculum in disaster prone areas. It can be incorporated into assembly times or 'life-skills' lessons. Evacuation and hibernation drills should also be practised once per term, so that children know what to do when a disaster occurs. These 'drills' build a child's and the community's **resilience** to the **effects of a disaster**.
- Families living in disaster and conflict prone areas should 'tag' their children with a wristband and teach them what to do should they ever become separated. Separation and the unknown whereabouts of loved ones is a source of enormous distress in a disaster, as well as, creating protection concerns for separated and unaccompanied children.
- Training on the physical and emotional impacts of traumatic events, empowers people, helps them understand the way their body is reacting to an unusual situation and helps people learn positive coping skills for themselves, their children and towards other community members. This training can be integrated into PVA work. Information can be disseminated through radio messages, posters and

pamphlets in key areas such as hospitals, schools, shelters, religious centres and other community buildings.

(b) The 'Keeping Children Safe Checklist'

Emergencies can create serious problems for children. Children can become displaced or separated from their family, may loose family members or their primary care givers and are often forced to live in crowded shelters or with other families.

The checklist below is a simple tool to prevent many protection risks for children occurring in emergencies. It can be used in natural disasters, in addition to conflict settings and other complex/ protracted emergencies. Wherever possible, this checklist should be mainstreamed throughout DRR programmes.

The below child-specific checklist can be easily translated into local languages, and distributed to households and schools prior to the beginning of a hazard season (for those communities living in hazard prone areas) as well as being mainstreamed in other community-based DRR or disaster preparedness approaches. It can be used in natural disasters, in conflict settings and other complex/ protracted emergencies.

Practical steps in keeping children safe in emergencies

Here are some practical steps that you can take to help you protect your children while you plan for and, also, if you have to, respond to a conflict or disaster.

1. Place identification bracelets on young children. Include details of full name, date of birth, parents' names, allergies, specific illnesses and special needs. If the child is separated from the parents, this information can help authorities to reunite you with your child.
2. Avoid separating from your child. "Protecting" children by sending them away from the potential disaster scene or conflict often adds to the trauma children and adolescents suffer following the event.
3. Remind your child to tell you about anyone or a situation that does not feel right (these are signs of potential abuse). Believe your child and act accordingly.
4. Learn beforehand the physical and emotional signs of trauma and stress in children and adults. Seek appropriate psychosocial services for your child, and yourself, if required.
5. If you are having difficulty coping with the effects of the disaster, or are adopting unhealthy coping methods, seek appropriate support for yourself early. Your children's recovery is linked to your own.
6. If you have to go to a shelter or to a new living arrangement, work with persons there to help establish routines for children. Routines help to foster a safe, calm, nurturing and normalising environment.
7. Encourage your children's positive friendships and peer support.

   Children and adolescents with strong emotional support from their peers are better able to cope with adversity; this is called resilience. Positive friendships can help decrease isolation and reduce the potential dangers isolation can foster for unattached adolescents.

And remember, some of the best prepared plans put children first!

(9) Psychosocial protection and support in the Early Recovery phase

(a) Making early recovery psychosocial sensitive

According to the Cluster Working Group on Early Recovery's Guidelines, the foundations for early recovery should be laid at the very beginning in an emergency, this means from the rapid appraisal stage onwards.

The processes and actions in appraisal and follow-up programming should have an integrated approach to psychosocial well-being. This means recognising that psychosocial interventions don't operate in a vacuum and that they need to be linked to **individual and social quests for truth and justice. The rebuilding of communities destroyed by conflict or a natural disaster, and reconnecting people to their sources of livelihoods cannot be separated from psychosocial recovery and healing processes.** The eventual goal of the appraisal process and succeeding actions is to contribute to the community's pursuit of peace, social justice and respect for human rights, all of which lie at the core of ActionAid's work.

In conflict related emergencies, many survivors who have lost family members, friends, property and jobs, because of the violence, often air extreme views such as revenge. While some such actions may be normal in the current abnormal situation, it is absolutely necessary to ensure that rebuilding efforts and early recovery initiatives to get them back on their feet are made **sensitive to the various dimensions of conflict**.

The impact of violence and subsequent displacement greatly **impacts** upon women and girls, as they often suffer from rape and other forms of violence and abuse, forceful confinement and separation from their families. Cases of sexual exploitation and abuse (SEA), particularly by humanitarian workers, unfortunately, increases during conflict-related emergencies.

Conflict sensitive programming suggests specific activities to address the immediate needs of women and girls, as well as their organisation, creation of safe and private spaces, healthcare, protection and livelihoods.

Suggested psychosocial activities to support conflict sensitive programming:

(i) Creation of women and youth community-based protection and advisory committees.

- Group debriefing sessions
- Feedback and monitoring on relief and response activities
- Addressing GBV issues (examination of causes, and dealing with consequences)
- Facilitating gender sensitive programming
- Alert on any protection threats and risks.

(ii) Youth committees for peace and livelihood activities

- Youth protection committees to highlight any protection threats and risks
- Livelihood activities that focus on youth empowerment and peace
- Girls empowerment and psychosocial support.

(iii) Empower communities to play an enhanced role in decision making and early recovery activities.

(iv) Teachers are trained to promote positive reconciliation and peace education.

(b) Psychosocial support and livelihoods[2]

Everyone has the right to a livelihood. For displaced persons, the loss of a livelihood creates a number of protection risks. It may affect the psychosocial well-being of individuals by affecting a person's ability to provide for her/ his family- this may lead to feelings of anxiety, shame and inadequacy, ultimately lowering their self-esteem and leading to feelings of worthlessness. A person's ability to generate an income during and after displacement not only improves the **quality of life** for individuals; it **empowers** them and helps avoid protracted dependancy and exposure to further discrimination and abuse.

Livelihood refers to the capabilities, assets and strategies that people use to make a living; in other words to secure food and an income through a variety of economic activities. Although livelihood programmes, as such, may not be sustainable, they should aim to sustain livelihoods in the short term - to save lives. And in the long term - to build resilience and address vulnerability[3].

When displaced persons can no longer rely on familiar ways of generating income (both from a practical and environmental perspective), they have difficulty adjusting to new markets, learning new skills and fully integrating with surrounding communities. This situation can be very overwhelming, fearful and daunting for a person, particularly if they are an older adult who has only worked in one trade all of their life. Additionally, it can trigger a larger number of protection risks, which may seriously affect many aspects of an individual's life and the life of the host community in a variety of ways, such as:

(i) The disruption of livelihoods can create additional pressures on a person's healing process due to the original trauma as it limits their coping skills. Prolonged humanitarian assistance in protracted situations makes it harder for a displaced person to become self-reliant and to provide for her/ his family. The earlier livelihood interventions take place, the easier it will be for displaced persons to regain their self-esteem and their ability to be self-reliant.

(ii) Breakdown in socio-economic support networks e.g. co-operatives, as a result of displacement.

(iii) The lack of a livelihood can also trigger family separation, with parents having to leave their children or older relatives behind to find work. Children may have to abandon their schooling to contribute towards their families income.

(iv) GBV is often a negative consequence of the lack of sustainable livelihoods, affecting particularly displaced women, girls and boys who may be forced to provide sex in exchange for food and basic supplies.

(v) In some displaced societies, men may find themselves unable to play their traditional role of 'breadwinner', as gender roles may have been re-defined during displacement. This can lead to a loss of self-esteem, abuse of alcohol or drugs and increased domestic violence.

(vi) Surrounding communities might perceive the presence of displaced persons as a threat to their already scarce resources, leading to discrimination and exclusion, particularly regarding the labour market.

(vii) Interventions that focus only on identifying sustainable livelihoods for displaced persons may create tensions with the host population and negatively affect the ability of displaced persons to find durable solutions. Livelihood interventions for the host communities, when they face similar constraints, can contribute to a peaceful co-existence and ensure that livelihood strategies intended for displaced persons are sustainable.

[2] Portions of this section have ben borrowed and re-adapted from the *Handbook for the Protection of Internally Displaced Persons*, Provisional Release, Global Protection Cluster Working Group, December (2007).

[3] Adapted from *Livelihoods Connect, Creating Sustainable Livelihoods to Eliminate Poverty*, Institute of Development Studies, (2007).

(viii) Authorities may view livelihood interventions as a way of consolidating a specific durable solution and hampering others. For instance, a government trying to facilitate the return of displaced persons, may be unhappy with organisations undertaking livelihood activities within camps/ temporary shelter areas. Mediation with government authorities may be required to promote the idea of a displaced persons' self-reliance and the need to focus on long-term support, if durable solutions are to be actualised.

Key Actions

(A) Advocacy

- Advocate for non-discriminatory access to public services, such as health, education, social welfare and housing loans to secure a stable and dignified environment, so that displaced persons can become self-reliant.
- Advocate for displaced persons access to justice and the labour market whilst taking into account their specific needs, including recognition of academic and professional credentials, land titles, non-discriminatory job recruitment policies and psychosocial support. This is an important step towards empowering people to become active agents in their own recovery process.
- Advocate for close co-operation of psychosocial and health institutions with employment and income-generation projects to strengthen the link between healing and self-reliance.
- Promote rapid and well-planned income generation support immediately following displacement to help restore human dignity and help people to avoid illegal or unsustainable strategies.

(B) Protection and psychosocial monitoring and reporting

- Identify instances of child labour and ensure adequate livelihood support to families with the aim of eradicating such practices. Refer cases of children performing work that may be hazardous or harmful to their development or growth to specialised organisations so they can be immediately removed from dangerous environments.
- Monitor possible increases in local commercial sex work ('sex for survival') or instances of sexual exploitation (e.g. 'sex for relief supplies'). Identify any possible links with the increase in displaced persons and their lack of alternative, dignified livelihoods.
- Monitor livelihood support programmes and micro-finance schemes to ensure that there are no instances of economic and sexual exploitation (this is called sexual exploitation and abuse (SEA).

(C) Community participation and mobilisation

- Identify existing community traditional support mechanisms, self-help groups, CBO's, social clubs and community-care facilities that can be supported. This is particularly important in situations of urban displacement or rural dispersion where it is difficult to identify and reach displaced persons directly.
- Support the implementation of quick orientation programmes for groups or individuals with specific needs, such as persons who are illiterate, prior to skill-training programmes to ensure they can participate.
- Support the development of sustainable assistance and community-support projects to assist displaced persons and other affected communities to care for older persons and persons with mental and physical disabilities (particularly in earthquake related emergencies) and other community members, with specific needs.

- Ensure differentiated livelihood strategies for:
- Persons with physical and mental disabilities, who may require specific support to identify suitable employment opportunities.
- Female headed households who may require additional support to access self-reliance activities through community-based care centers where they can safely leave their children and go off to work.
- Youth (above 18 years) formerly associated with armed groups who may require dedicated support for their reintegration into civilian life. Generating youth employment is vital in providing an alternative to warfare as a means of living, in addition to decreasing instances of GBV. The main perpetrators of GBV are unemployed, frustrated, bored and disempowered male youth living in very difficult cramped camp or shelter areas. By empowering the male youth and channelling their energy into positive areas - such as camp maintenance, playing with younger children and playing sport they are less likely to undertake acts of violence.
- Minority groups who are often exposed to increased levels of discrimination, including by displaced communities. Supporting the development of a certain skill or area of work can lead to an improved social status within society,

For more information please see Action Sheet: 16, pp292 - 301 in the Handbook for the Protection of Internally Displaced Persons, Provisional Release, Global Protection Cluster Working Group, December (2007) and: Guidance Note on Early Recovery, Cluster Working Group on Early Recovery, in co-operation with the UNDG-ECHA Working Group on Transition, April (2008).

Urban displaced (IDP's and refugees)

Urban displaced populations (IDP's and refugees) are marginalised: culturally, socially, economically and politically, in almost every part of the word and they are denied participation in most aspects of life. Host societies, also, have a tendency to adopt negative attitudes towards displaced people in urban areas, as witnessed in Johannesburg during 2008. Host societies struggle to trust urban refugees, and tend to blame them for economic ills, crime rates, high unemployment and overloaded social services in their areas. A significant proportion of urban displaced, in turn, fail to integrate into the host society, adopt its customs and cultures. Cultural integration often takes longer for a displaced person than picking up the language or starting a livelihood. Mediation between host populations and displaced persons is crucial to the security, safety and well-being of urban displaced.

What is the definition of an urban displaced person?

There is no internationally recognised or accepted definition of an urban refugee or displaced person, however, a commonly cited one is: *"an individual of urban origin, usually a student, former politician a professional, a trader or a skilled, non-agricultural labourer.[4]"* For North Africa and Central Asia, an urban refugee is *"any refugee living in an urban area regardless of her/ his origin[5]".*

[4] Mougne, C., *UNHCR's Policy and Practice Regarding Urban Refugees: A Discussion Paper*, UNHCR Evaluation Reports, (1995).

[5] Mougne, C., *UNHCR's Policy and Practice Regarding Urban Refugees: A Discussion Paper*, UNHCR Evaluation Reports, (1995).

What are the profiles of urban displaced?

Urban displaced persons often have different profiles to those residing within designated camps. Below are some of the characteristics of an urban displaced person:

- people with an urban background in country of origin
- people who have been politically active (politicians, human rights activist or lawyers and students etc.)
- professionals and people with higher education
- female-headed households
- people with rural background seeking work or an education
- sick or disabled people who have been referred from camps and other rural settlements for medical treatment
- refugees who have left countries of first asylum
- urban caseloads tend to be predominantly young, single, separated and male
- small - sized households
- minority groups - castes, clans, tribes etc.
- people who dislike camps and don't want to be 'warehoused' or have their freedom curtailed.

What are some of the problems in working with the urban displaced?

(1) It can be difficult to ascertain where the displaced community starts and stops, in comparison to the urban poor

(2) It can be difficult separating out 'irregular movers' (those seeking asylum) from economic migrants

(3) Identification, registration and distribution of relief goods is more complex. Most refugees come to UNHCR offices, or another organisation working with urban displaced cases to receive relief goods, rather than UNHCR and other organisations reaching out to them, to deliver 'where they reside'

(4) Refugees, in particular, live in urban centres in many parts of the world, illegally. They are thus under constant fear of arrest, deportation, imprisonment and detention and are largely not entitled to protection or assistance.

(5) Governments are against refugees residing in cities; they prefer the policy of encampment. Thus there may be 'negative consequences' if a refugee does come forward to seek assistance.

(6) There is little 'donor money' available to work with the long-term care and maintenance of urban refugees or IDP's. UNHCR and many donors believe that urban refugees have greater reserves of resilience in comparison to encamped refugees, and so often adopt a policy of 'self-reliance'

(7) Urban displaced people require an individual case management approach, and intensive work, rather then dealing with large numbers and large-scale relief distributions. Individual case management is more time-consuming and expensive in the long-term.

What are some of the common problems of the urban displaced?

Social

- Cultural integration takes longer than language or economic integration
- Greeted with hostility they become scapegoats for the cause of crime in an area, are viewed as the vectors of disease and a threat to local economic opportunities

- Xenophobia or racism threats
- Curtailed movement
- Difficulty in tracking urban refugees and follow up on asylum applications
- Ambiguous legal status, discrimination and violence – insecurity
- Psychological, emotional and physical hardships and exposure to new patterns of production, and disparate, dynamic values and identities in host country.

Psychological

- Low aspirations
- Fear, thoughts about death and insecurity
- Risk of domestic violence and exploitation
- Depression among men in particular due to the change in social roles and status, and an inability to provide for their families
- Sense of hopelessness and helplessness
- Loss of control
- Anger and frustration
- Low self-esteem
- Emotional difficulties and behavioural problems (particularly if the children are unable to attend school).
- Longer term impacts may include: greater distrust and alienation among different populations, vivid memories of attack and victimisation may increase collective fear and hate. There may also be an increased use of violence within communities and acceptance of violence as a means of resolving conflicts. Continuing uncertainty about the future is likely to lead to an increased sense of insecurity.

Information, Education and Communication (IEC) Materials and Advocacy

Many urban displaced may have:

- No direct exposure to anyone who can inform them of their rights and guide them through the asylum process. Many refugees don't therefore apply for asylum.
- Refugees who do know their rights may struggle in finding the appropriate officer to file a claim. The absence of immigration officers in areas where someone lives may make it too expensive in time and transport to apply. Travelling also exposes them to police and immigration officials. Many refugees don't, therefore, apply for asylum.
- Low density of advocates for urban displaced, that are able to track, monitor and follow up on applications to host governments for services or asylum
- Displaced persons are spread over the city, not in the same place and thus it may be difficult to find like minded people, to know where to access information on their rights, services or other community supports
- Difficulty interviewing displaced persons when many of them live in a close space, particularly interviewing family members as they may not speak candidly, such as: women who may have been raped, or elders ashamed of their legal/ physical status.

Housing:

- Frequent moves creates psychological uncertainty and instability – limits displaced person's ability to build up social capital (livelihoods, access to services, education etc.)
- High and sometimes arbitrary rent prices
- Lack of tenancy rights, lack of land tenure or legal documentation
- Forced evictions, removals and slum clearances can be distressing.

Education:

- Plays a key role in social integration, childhood development and enables people to have a livelihood in the future and become more economically competitive
- Legal obstacles to accessing education and discrimination by teachers
- Many children are at different ages appropriate to the school grade due to past disrupted (or no) education
- Long commuting distances to access schools
- Child labour and child protection concerns for those not in school
- Distressed children may exhibit difficulty in concentrating in the classroom, doing homework
- Difficulty in learning in a different language with different pedagogues and teacher expectations, different cultures, religion, race, creed and nationality – stigmatisation is a possibility.

Health

- Due to living environments (often cramped and inadequate) access to public health care can become a public health concern (e.g. spread of typhoid/ cholera etc.)
- Displaced persons may engage in alcohol and other substance abuse as a coping mechanism, and engage in other risky behaviours – such as prostitution to obtain money
- May have difficulty understanding the language in hospitals and clinics and will thus need interpreter and translation support
- Poor access to health care, which becomes greatly problematic for people with pre-existing mental and physical health conditions
- Reduced mobility due to travel restrictions (fear of arrest, detention, deportation) so may not be able to attend appointments or easily search for work.

Livelihoods

- Severe restrictions on immigrants and asylum seekers right to work and their entitlements to welfare and social support (dwindling resources at the household and individual level)
- Lack of legal documentation (ID cards or professional status and qualifications)
- Exploitation, abuse and labour concerns (especially for children and female-headed households)
- Many refugee professionals e.g. doctors, dentists, lawyers and accountants, usually require additional training or local certification to practice
- Discrimination in access to job market
- Lack of access to financial services and micro-credit for enterprise or training.

For programme implementation information please see the earlier 'Programme Response' chapter.

For more information please see: *Inter-Agency Technical Advice on Mental Health and Psychosocial Support for Displaced Iraqis in Jordan*, as listed in the bibliography.

Phases of psychosocial protection and support across relief sectors.

Acute phase	Second phase	Early recovery
WASH	Education	Education
Food and Nutrition	Livelihoods	Livelihoods
Shelter	Safety and security	Protection
Safety and security	WASH	DRR
Health care	Food and nutrition	IEC materials
Protection	Healthcare	Conflict sensitive progamming
IEC materials	Protection	Safety and security
Conflict sensitive programming	DRR	Rights and Justice
	IEC materials	Reconciliation and Peacebuilding
	Conflict sensitive programming	

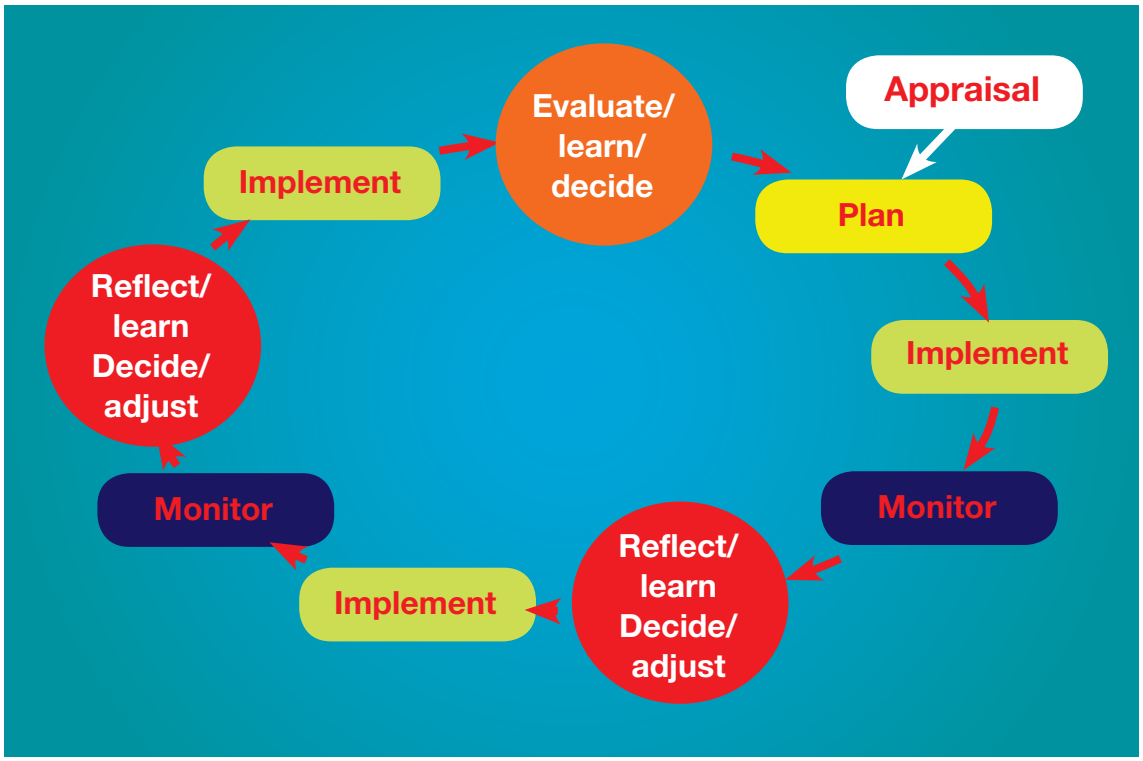
Chapter 6
Participatory Review and Reflection Processes: A psychosocial perspective.

Participatory review and reflection process (PRRP) is a core commitment under ALPS and is to be undertaken within all programmes. PRRP's are ongoing processes involving all stakeholders: affected people, AAI staff, local partners, peer organisations and donors.

PRRP's have three purposes; firstly, to be a critical self-evaluation of ongoing programme implementation (gathered through monitoring visits and financial/ expenditure tracking); secondly, to account and report back to all stakeholders (poor and excluded populations and donors) through social audits, transparency boards, and reports; and finally, to identify what did not work, missed opportunities and emerging issues - which in itself is an appraisal. PRRP's provide feedback and learning, which drive accountability and dynamic change to ensure that poor and excluded people are at the centre of our work.

ALPS sets out the key accountabilities and processes in ActionAid International; it defines the organisation's standards. It is a system that holistically looks at what the organisation does (core processes) in its programmes, but also seeks to look at how these processes are applied (taking into consideration ALPS principles, attitudes and behaviours) in the implementation of its programmes. ALPS demands that poor and excluded people are involved in all aspects of the review and reflection process, including the discussion and dissemination of results, and their implications.

How a participatory review and reflection process operates



Review and reflection processes should examine two levels:

The impact - helps to monitor the achievement and impact of our work on poor and excluded people. So, the change in status or behaviour related to our stated project objective that we can say is a direct result of our project.

The process - measuring the extent to which we have achieved our stated objectives, such as adhering to human rights standards, pro-poor and excluded programme design, participation, targeting, accountability and discrimination.

ALPS demands PRRP to be an ongoing continuous process, with at least one PRRP to be carried out each year. However, in the dynamic nature of emergency settings the strict project cycle is not necessarily adhered to. Due to the time-consuming, process intensive, nature of PRRP's, they should be mainstreamed alongside other activities such as monitoring visits, writing donor reports, field visits and audits (social and financial).

This chapter will focus on the key monitoring and evaluation indicators and methods of inquiry to assess the **processes and impacts of psychosocial protection and support programmes**. Thus, this chapter should be read in conjunction with IECT's Emergency Response Guidelines, which outline the key areas and approaches towards PRRP's for all emergency response programmes.

Programme Design

Since children and adults react to emergencies in unique ways, the types of projects designed to address their needs will also differ. Projects range and include those that are **curative**, **preventive**, and those that **promote** psychosocial well-being.

- **Curative projects:** address the diagnosed psychological effects of emergencies, such as the treatment of severe trauma (PTSD).
- **Preventive projects:** seek to prevent further psychosocial deterioration and may focus upon a particular group of social environment. An example includes protecting women and children from physical assault in displaced person camps, by giving them a voice within the camp management committee and facilitating the organisation of women support groups.
- **Promoting projects:** focus upon promoting healthy psychosocial development through, for example, opportunities to engage in education, social and spiritual activities and access to services.

There are three different approaches in the design of psychosocial programmes:

(1) **Psychological** - focuses more upon the psychological than social factors. Interventions are more tailored towards the individual such as individual counseling, healing and therapy for PTSD survivors, and care for people with pre-existing mental disabilities.

(2) **Predominantly psychosocial** - these projects are self-contained and not integrated into other emergency response projects. Examples include art therapy, screening and referral for at risk populations for individualised mental health services, or counselling programmes.

(3) **Holistic** - psychosocial projects are integrated into a holistic and total response to the needs of a community. Psychosocial elements may not be so visible as they will be mainstreamed other projects such as education, livelihoods and advocacy work. Projects based upon the holistic approach, whilst more expensive and demand a greater investment in programme design, are preferred, since they crate a mutually reinforcing effect that builds upon resilience.

It can be useful when designing a psychosocial project to organise projects into six broad areas that encompass the diverse psychological, social and economic needs of affected populations.

(i) The primacy of family - reunification projects, positive parenting skills, breast feeding etc.,

(ii) Education - getting children back to formal/ informal schooling and vocational courses.,

(iii) Economic Security - livelihood opportunities, small and medium enterprises etc.,

(iv) Engaging/ Empowering Activities - play, traditional recreation games, songs, art, theatre etc.

(v) Community and Cultural connections - protection circles, traditional ceremonies.,

(vi) Reconciliation and the Restoration of Justice - human rights violations, land tenure, peace-building etc.

All psychosocial protection and support programmes should uphold human rights and the rights of the child.

When designing psychosocial protection and support projects, the participation of communities is important so that protective factors and resiliencies may be recognised and harnessed in culturally appropriate and sustainable ways.

Please see the project logic model located at the end of this chapter.

Implementation Planning - writing quality goals, objectives and activities statements

At its most fundamental level, psychosocial protection and support programming consists of activities designed to advance people's psychological and social development, to strengthen protective and preventive factors that limit the negative consequences of complex emergencies, and to promote peace-building processes and reduce tensions between groups.

The promotion of psychosocial well-being may be accomplished through a variety of approaches. It may be the focus of a discrete or stand-alone project, or preferably, it can be integrated with other projects such as food security, health, protection and shelter.

The text box below highlights the fundamental goals of psychosocial protection and support programmes.

Fundamental Goals of Psychosocial Programming:

- Secure attachments with care givers (particularly for orphans, separated and unaccompanied children)
- Meaningful peer, family and community relations or social competence
- Sense of belonging (within a family or community context)
- Sense of self-worth, value, self-esteem and positive well-being
- Empowerment
- Trust in others
- Access to opportunities and services
- Physical and economic security
- Hopefulness or optimism about the future.

Many different types of projects maybe implemented to support these fundamental goals. Below are some examples:

- Tracing and reunification of unaccompanied children with their families
- Food aid distribution projects
- Livelihood training projects for adolescents, youth and adults
- Educational and cultural projects
- Women/ Youth/ Child friendly spaces/ protection circles
- Advocacy for greater protection and implementation of human and child rights.

Indicators

An **indicator** is a measure of project input, output, results or outcomes of interest; it can measure the presence, absence, or level of a social or behavioural condition within a target population.

Indicators:

- Are a unit of information measured over time that documents change
- Provide evidence of how much has been, or has not been achieved
- Are usually quantitative (number related) measures but may also be qualitative (narrative related) observations (see the below sources of information section)
- Enable a large amount of data to be reduced down to its simplest form.

In order to measure the achievement of our objectives, as well as our project implementation and progress, we should identify indicators that are:

- Reliable
- Valid
- Sensitive.

Indicators need to be specific enough to measure needs, and changes in those needs. Thinking about **how** to measure makes us aware of **what** to measure. Thus, the selection of indicators and method of monitoring and evaluating a project should be mapped out at the programme design stage.

Examples of output and outcome indicators for violence against women and girls projects[1]:

Output:

- Number of projects implemented for men and boys that include examining culture and gender norms related to GBV
- Number of programmes helping men and boys relate and manage a female relative who has survived GBV by someone other than their intimate partner
- Proportion of individuals who reported they had heard or saw a mass media message on issues related to sexual violence and youth

[1] Some of the below indicators have been taken from: *Violence Against Women and Girls: A Compendium of Monitoring and Evaluation Indicators*, by Shelah S. Bloom, supported by USDAID East Africa, October 2008.

- Proportion of girls that feel able to say 'no' to sexual activity.
- Proportion of GBV cases that were (a) investigated by the police, (b) prosecuted by law, and (c) resulted in a conviction.

Outcome:

- The proportion of GBV cases (sexual violence) in the emergency area for which emergency action has been taken
- Number of women and girls reporting incidences of sexual violence per 10,000 population in the emergency area(s)
- Number of activities in the emergency area initiated by the community targeted at the prevention and response to sexual violence of women and girls
- Proportion of sexual violence survivors in the emergency area who reported 72 hours or more after the incident, and receive a basic set of psychosocial and medical services.

Examples of process indicators:

Human rights-based approach:

- Psychosocial protection and support programmes comply with international human rights standards, follow a rights-based approach and are designed with a view to protecting the affected population against violence, abuse and exploitation
- Training for AAI staff, interns, volunteers and local partners on psychosocial protection and support, contains a focus on human rights
- Appropriate mechanisms for the monitoring and reporting of instances of abuse and exploitation of civilians are established
- In camps, villages or settlement areas, there is a local protection group or mechanism that engages in protection monitoring, reporting and action
- AAI staff, interns, volunteers and local partners know they are responsible for reporting human rights violations and know how to report human rights violations
- Survivors of human rights abuses receive complementary support from legal protection workers and from people skilled in providing psychosocial support
- Psychosocial orientations and trainings for legal protection workers include information on legal protection and psychosocial well-being, and on the link between the two.

Programme Response and Implementation

- Safe spaces have been established and are used for social mobilisation, planning meetings, social audits etc.
- Local people conduct regular meetings on how to organise and implement the emergency response
- Local women and girls - including those from marginalised groups - are involved in making key decisions in the emergency
- Community processes and initiatives include and support poor, vulnerable and excluded people at greatest risk
- Steps have been taken to enable and facilitate the use of traditional cultural practices that are valued by the affected people and consistent with international human rights standards

- Number of referrals and follow-up to specialised mental health care
- Self-care information that is disseminated has a focus upon positive coping methods and resilience
- Estimated proportion of a population that has access to disseminated information
- Estimated % of the population that has read or listened to the disseminated information
- Information that is disseminated is culturally appropriate and understandable to most of the population.

Psychosocial protection and support across relief sectors

- Parents and care-givers of children can meet in safe spaces to discuss challenges and to support each other
- Women's groups can meet in safe, communal spaces to discuss challenges, advocacy issues and to support each other
- Early Childhood Development Development (ECD) activities are organised for young girls and boys (0-8 years), and their parents or care-givers
- General health staff are able to give psychological first aid (PFA) to their patients as part of their care
- General health staff make appropriate referrals (a) community social supports outside the health system, (b) trained and clinically supervised community workers (support workers, counsellors) attached to health services (if available)
- Assessment of harm related to alcohol and substance use (AOSU) has been conducted
- Condoms are continuously and freely available in areas where people involved in AOSU congregate
- Percentage of learners who have accessed formal education
- Non-formal education venues are open and accessible to girls and boys of various ages
- Percentage of teachers trained in receiving and follow-up support on how to support learner's psychosocial well-being
- Teachers and other educational workers refer children with severe mental health and psychosocial difficulties to available specialised services or supports
- Assessments are conducted to identify whether the affected population is receiving key information on the emergency, relief efforts and their legal rights
- When there is a gap in key information, the relevant information is disseminated in a manner that is easily accessible and understandable by different sub-groups in the population
- Food aid and nutrition assessments and programme planning efforts include social and psychological dimensions
- Effective mechanisms exist for reporting and addressing security issues associated with food aid and nutrition
- Food aid and nutrition field officers link up with psychosocial coordination mechanisms and take an active role in communicating relevant information to the field
- Local people, particularly women, girls, poor and excluded people participate in the design and layout of shelters and in selecting the materials used for construction
- People who are unable to build their own shelters receive support in shelter construction
- Shelter is organised in a manner that maximises privacy and minimises overcrowding

- In monthly focus group discussions, more than 2/3rds of women express satisfaction with the safety and privacy of the sanitation facilities provided
- Water committees must include women, men, girls and boys, are active and meet regularly
- There is no reported conflict between host and displaced communities, over access to relief supplies and services.

Staff care

- CP's apply a written human resource policy that specifies steps relating to recruitment procedures and terms of employment
- CP's achieve a balanced recruitment in terms of female/ males, and minority groups
- Interpersonal psychosocial support tasks are provided primarily by national staff who are familiar with the local culture
- Rights-holders are informed about the standards and about the ways in which they can safely raise concerns about possible violations
- CP's have staff trained and available, and policies in place to undertake investigations of alleged violations, within a reasonable timeframe
- CP's have funded plans to protect and promote staff well-being
- AAI staff and interns who survive a critical incident have immediate access to psychological first aid
- AAI staff and interns, who survive a critical incident are systematically screened for psychosocial problems following the incident, and appropriate support is arranged when necessary.

Please see the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* for further information; process indicators are outlined at the end of each Action Sheet.

An example of indicators specifically for education projects or child/ youth friendly spaces

In order to assess the impact of a psychosocial formal/ informal education project, we need to be able to measure or estimate the difference between the outcome of a project and what the outcome would have been in the **absence** of the project. This requires a control group and a more in depth review and reflection process.

The below indicators can be used for both **direct project beneficiaries** (rights-holders) and a similar affected population that has not received educational support from a project (**control group**). Key people to talk to, **during and after project implementation**, in both of the above groups are: girls and boys (children), teachers and parents.

- Attendance at school - number of sick days that girls and boys are taking over a school term? Is there a gender imbalance in attendance, if so, why?
- Girls and boys academic performance - is there a gender imbalance, if so why?
- Are girls and boys able to concentrate in school, or are they distracted, feeling tired, 'distant' in class or taking longer to absorb new information?
- Are children who have been involved in conflict related emergencies, playing violently within the classroom and/ or drawing graphically violent pictures or models?
- For orphaned, separated and unaccompanied minors, are they able to do homework, where ever they are staying? Do they have support at home?

- Do girls and boys play normally at school, are they interested in learning new things and working independently or are they apathetic?
- Do girls and boys interact with their peers appropriately?
- Do girls and boys exhibit aggressive behaviour towards their peers and teachers?
- Do girls and boys have appropriate tools and materials for school - such as uniforms, books, pencils, pens, notebooks, bags?
- Are there any barriers preventing girls and boys from attending school? If so, what are these?
- Do the family, community and care-givers support girls and boys to attend school?

Sources of Information

As indicators are identified, their data sources should also be determined. This section identifies the different kinds of data sources used in evaluating the achievement of psychosocial protection and support project goals. The box below describes the range of data sources:

- **Standardised instruments:** Impacts of Events scale, Self-Reporting Questionnaire, Identifying Feelings, HelpAge International Vulnerability Checklist, IOM Household Questionnaire.
- **Structured or unstructured one-on-one interviews** with project participants, e.g. home visits, classroom visits
- **Interviews, judgments, ratings or nominations** made by persons who have contact with project participants, such as teachers, religious leaders, care-givers, doctors, nurses and community leaders
- **Social audits and focused discussions with groups** who are effected by the project or who interact with project participants in some way (including government and local authority members)
- **Systematic behavioural observations** made by staff, interns, volunteers and community level workers who have received some training on case-studies and observational skills
- **Written records** routinely collected on particular behaviours, such as school attendance, number of people tested for HIV, number of women attending protest/ advocacy marches, numbers of posters and postcards highlighting GBV distributed, percentage of people accessing psychosocial services etc.

Most quantitative data sources are fairly straightforward to collect, such as number and frequency of women attending protection circles. Other qualitative indicators require individual and/ or small group interviews, and other ethnographic observations (see below). Sometimes a focus group is chosen, for what its participants can contribute to a discussion on a particular topic, or issue. Individual interviews maybe more appropriate than group methods for other questions - particularly for sensitive topics.

Below are various methods of inquiry that AAI staff, local partners, interns and community-level volunteers can take to assess the **process** and **impact** of a project.

(A) Interviews

- Open ended or focus-groups (separate out male and females, and children - girls and boys)
- Key informants - teachers, carers, religious and community leaders, business leaders
- Unstructured or semi-structured
- Structured
- Self-reporting.

(B) Ethnographic

- Participant observation
- Participatory Vulnerability Analysis
- Systematic observation.

(C) Direct Observation Techniques

- Narratives
- Event records
- Interval recording - randomly focus upon one child, youth or adult, or on one group playing or talking for 15 minutes. Then shift to observe another group after 15 minutes.

(D) Field Notes

- Jottings (brief notes on key details to jog your memory later)
- Diary (valuable record of personal observations, particularly useful for field project staff and community level volunteers)
- Running field log of day - day and weekly timetables, and then how you, actually, spend your time (useful for community level volunteers and field project staff)
- Full notes and reports - either internal or external, such as donor reports.

Quantitative data is represented in the form of numerical or categorial (yes/ no) responses, or other scales and ratings that lend themselves to numerical values. The impact of events scale, self-reporting questionnaire, IOM Household questionnaire and the HelpAge Checklist fit into this category.

Qualitative data measures attempts to get at the richness of human experience by tapping into the participants' reactions, feelings, attitudes and interpretations. Social audits, PVA and examining children's drawings and children/ youth at play fit into this category.

Triangulation (using multiple methods of inquiry) is the most effective PRRP method. Do not just rely on one source, and make sure that women, girls, poor and excluded people are at the centre of our work.

It is important to remember that the **tools** we use for psychosocial protection and support **appraisals**, can also be used for **participatory review and reflect process**. The same tools (self-reporting questionnaire, impact of events scale and identifying feelings) can be used during the appraisal phase, during a monitoring visit and at the end of the project to assess the **impacts** of interventions.

The table below links various data sources and methods of inquiry to project goals.

Examples of data sources for goals of psychosocial projects

Domain Area	Sources of information
Access to opportunities and services - Youth have access to opportunities for cognitive, physical & ideological development, and economic security	• School/ College attendance • Livelihood/ micro-credit opportunities • Marketing of vocational training opportunities and attendance/ completion records • Teacher/ religious leaders/ community leader interviews • Household visits and discussions with family • Number of services accessed over a set period • Self-reporting questionnaire.
Sense of belonging - GBV survivors are socially connected to a community & support group, and feels she/ he are part of a larger social whole.	• Unstructured one-one interview with GBV survivor • Observation in social situations, such as a focus group, in the camp, in the market etc • Observation in the familial setting, through home-visits • Records of participation in organisations (support groups), clubs and advocacy/ protest marches on women's rights.
Trust in others - Torture survivors have the belief that she/ he can rely on others for help, support and advice. Survivor feels that she/ he will not be hurt by others.	• Unstructured interview with torture survivor • Home visits to family • Unstructured interviews with other key informants such as peers, religious leaders etc. • Number of new peer relationships formed • Participation in community social activities • Self-reporting questionnaire • Documented history of recovery and rehabilitation.
Secure attachment with caregiver - Child feels safe and cared for by an adult caregiver (orphaned, separated and unaccompanied children)	• Identifying feelings chart - ask the child to rate the pictures depicting behaviours indicative of secure attachment • Unstructured interview with care-giver and child • Observation of caregiver - child interaction • Impact of Events scale.

Domain Area	Sources of information
Peer relations or social competence - Child has the capacity to create meaningful relationships with peers and adults. Child feels she/ he are able to navigate their social world.	• Unstructured interview with child and peers • Peer nomination rating obtained from friends • Observation of child in social situations • Impact of Events Scale • Identifying Feelings - ask the child to rate the pictures depicting behaviours indicative of confidence and resilience.
Strengthen the social support mechanisms of a community (hopefulness).	• Number and % of community men, women, girls and boys involved in co-operative endeavours, such as re-building a community/ religious centre, hygiene and sanitation campaigns in a camp, co-operative farming/ fishing/ harvesting • Unstructured interviews with a random community sample on the value of team-work • Number of new peer-peer relationships formed.
Training on psychosocial protection and support in humanitarian settings.	• Number and % of staff trained • Number and % of staff that can recall key messages from training 1 & 6 months after training • Observation of staff following training techniques.

Participatory Monitoring

Monitoring tools are used to track progress, such as activity-based budgets, comparison charts of what was planned, budgeted and what was actually implemented and spent, and transparency boards to enable downward accountability to poor and excluded target populations. Participatory monitoring within an emergency context can run alongside a focus group session or a self-help group meeting within a camp environment or village.

Where can we place a transparency board?

Transparency boards can be erected within villages, the meeting places for support groups/ protection circles and at other camp service venues such as the clinic, child/ youth friendly spaces and distribution sites. In many complex emergencies, where displaced camps are semi-permanent, notice boards have been erected throughout camps, specifically for this purpose.

When working with urban displaced populations, transparency boards should be erected at the local office of ActionAid, within urban displaced person camps, and with permission at community hubs such as religious sites, schools and recreational centres.

Evaluation[2]

The primary purpose of a project evaluation should be to help identify the strengths and weaknesses of an intervention from the perspective of all stakeholders, in order to improve that intervention, and others like it, and ultimately to ensure that emerging issues are factored into the future plans of stakeholders.

Over-arching PRRP principles from a psychosocial perspective:

- **Culturally grounded and participatory**
- **Informed consent and feedback**
- **Confidentiality**
- **Sensitivity to consequences.**

Culturally grounded and participatory

The sustainability of programmes, according to ALPS, depends on the ability of communities to self-monitor, critically review, and refine their own, and ActionAid's initiatives. Local ownership and participation is necessary for ActionAid's accountability to the rights-holders, the design of effective psychosocial interventions, and to facilitate culturally appropriate, community-based evaluations and audits. Psychosocial protection and support project results or outcomes fail to be adequately captured without the ownership and participation of rights-holders.

Informed consent and feedback

There are special consent issues that arise when interviewing and conducting evaluations with survivors of GBV, survivors of torture and children. Evaluations that collect sensitive and personal information must be especially sensitive to this. Informed consent is fundamental to conducting ethical evaluations. Participants have an absolute right to know about the risks and benefits of an evaluation in which they are being asked to participate. Participants should understand that whether they decide to participate of not, has no impact on their continued receipt of project services. Rights-holders should receive specific information on how the information will be used, what the process will entail, what level of confidentiality will exist, and what kind of reports will be written based upon this data.

Sensitivity to consequences

There can be negative consequences for the participant in being asked probing questions about emotionally sensitive events. Since evaluation questions and feedback sessions may cause distress, advance planning as to how such situations will be handled in a culturally appropriate manner is necessary. It may be fruitful to arrange referral services or a trained local social worker/ counsellor to be available, so that the rights-holders are not abandoned with their distress following the interview.

[2] This section was borrowed and adapted from: *Children in Crisis: Good Practices in Evaluating Psychosocial Programming*, Save the Children Federation, Inc., (2004), pp28 - 30.

In addition, in emergency settings, communities are vulnerable to inquiries from journalists, political delegations, election observers, and others who seek information that is often very sensitive and evocative of painful memories and feelings.

For further information:

- *Please see the information dissemination section in the earlier chapter: 'psychosocial across relief sectors'.*
- *Please see the section ethical considerations within the appraisal chapter.*

Confidentiality

Data of a confidential nature should be safeguarded and accessible only to designated trained staff. This means that files should be locked and access limited to authorised persons only. This procedure will also prevent the loss of data. It is good practice to use identification numbers on data collection forms (self-reporting questionnaire, identifying feelings, impact of events scale and the IOM household questionnaire) rather than the actual names of participants. A confidential list of names and identification numbers can be kept by a senior member of staff at an off-site location. If individual data is no longer needed, it should be destroyed (incinerated or shredded).

The below table is an example of a project logic evaluation matrix, which may facilitate the process of linking indicators to outcome measures. Examples of quantitative and qualitative indicators are given, along with examples of data sources and how these link to anticipated outcomes.

Example of an Evaluation Matrix: Objectives Indicators and Data Sources[3].

Objectives	Example of Indicators	Example of data sources
Increased capacity of local organisations and community adults to help children affected by conflict-related violence to readjust. • Is there an indication that communities have a better understanding of the psychosocial needs of children?	*Quantitative* • % of community adults and local organisations involved in activities to promote children's well-being • # of communities and % of community leaders/ adults who recognise the value of expressive activities for meeting the psychosocial needs of children; *Qualitative* • Community members' perceptions of their capacity to assist children; • Perception of ability to function better as a community in assisting children	• Records of activities designed to support psychosocial well-being and development; • Survey questionnaire of community leaders and adults; • Semi-structured interviews (with focus groups) and observations.
• Have adult caregivers experienced a reduction in conflict-related stress?	*Quantitative* • % of adults reporting fewer symptoms of conflict-related stress; *Qualitative* • Adults' reported sense of hope, self-efficacy, confidence, ability to plan.	• Survey questionnaire; • Semi-structured interviews with community adults.

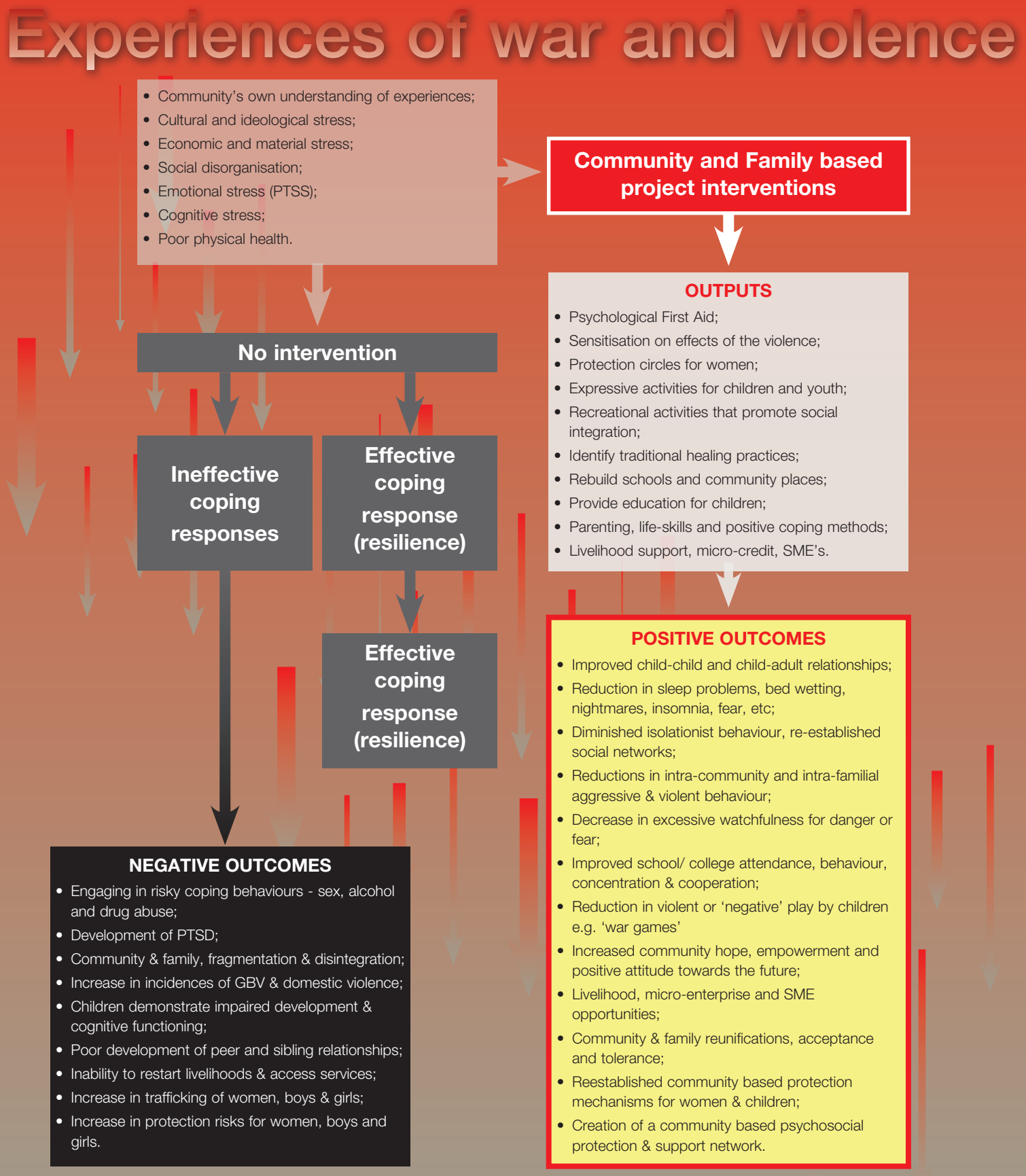
[3] Sections of this table were borrowed from: *Children in Crisis: Good Practices in Evaluating Psychosocial Programming*, Save the Children Federation, Inc., (2004), p54.

Objectives	Example of Indicators	Example of data sources
Women will experience a reduction in war-related stress • Do women experience fewer and less severe symptoms related to experiences of violence?	*Qualitative* • Frequency & severity of conflict-related stress symptoms among women; • Frequency & severity of violence-related symptoms in relation to the actual experiences of violence	• Impact of Events Scale; • Self-Reporting Questionnaire; • Identifying feelings chart
• Are children and youth coping better with stress?	*Quantitative* • Degree of children and youth's ability to concentrate in school; • % of children and youth are able to express difficult emotions.	• Impacts of Events Scale; • Self-Reporting Questionnaire; • Teachers records on children's behaviours; • Identifying feelings chart; • Children's academic performance.
Improved psychosocial well-being, social integration, and return to 'normalcy' • Are survivors of GBV integrating socially, are better able to express and deal with difficult emotions and violence-related symptoms? • Do women have an increased sense of security?	*Quantitative* • # of positive social interactions within a set period *Qualitative* • Participation in women's groups and in other social activities; • Degree of social functioning according to families; • Women's perceptions of what it is to integrate socially (what does it mean to get along well with others etc.)	• Focus group discussions; • Unstructured interviews; • Observations of women in women's groups, and in other social activities; • Focus group interviews with children and family members.
Are children able to form peer friendships?	*Quantitative* • % of children who have more and stronger friendships with their peers *Qualitative* • Problems with peers voiced by children	• Focus group interviews with children; • Discussions with teachers; • Discussions with other women within the community and social workers.

Objectives	Example of Indicators	Example of data sources
Are children and youth rebuilding their trust in adults?	*Quantitative* • % of children contributing more at home *Qualitative* • Caregiver's perceptions of children's cooperation with adults in home and community	• Home visit records and notes on observations and interactions with caregivers
Are adults (females and males) resolving conflicts peacefully?	*Quantitative* • # of aggressive or negative behaviours observed in a set time period; • # of conflicts observed in a given setting within a specified period of time and % of those resolved peacefully; • # of incidences of violence within the family. *Qualitative* • Female and male perceptions of social integration (what it means to get along with others).	• Focus group interviews with children; • Discussions with teachers; • Discussions with other women within the community and social workers.

Chapter 7

An example of a psychosocial project logic model



Sections of this diagram were borrowed from the Province-Based War Trauma Team revised project logic model by Christian Children's Fund/ Angola.

Chapter 8
Staff care in emergencies

Much attention has been devoted to the negative psychological effects of natural disasters, violence, war, famine and torture on refugees and displaced persons. Less attention, however, has focused upon the possible psychosocial difficulties that staff, interns and volunteers face in responding to emergencies. Staff, interns and volunteers are the greatest asset and resource within any organisation or agency, and it is thus, paramount that due attention and support is given to their well-being.

When situations are extreme and personnel are in short supply (as in many emergency settings), there is a perception of there being little time to concentrate on workers and their troubles. High levels of stress prevent staff from implementing programmes appropriately, thereby, decreasing the effectiveness of our programmes. People under extreme stress become poor decision makers and may behave in ways that place them and their team at a greater risk of accident and illness. The psychological difficulties staff face, have the potential to shape the interactions between us and the rights-holders, in some cases leaving a negative impression amongst the very people we are trying to help.

Stress is intrinsic to humanitarian aid work. However, the effects of stress can be prevented and managed by individuals, line managers and wider ActionAid organisational policies. It is important to be aware that even if individual's are prepared, well-trained and experienced, everyone has a breaking point. Good psychosocial staff care has proven to be an important asset in stress management, and in the prevention and treatment of clinical disorders.

Fundamental Goals of Psychosocial Programming:

- **Acute/ traumatic stress,** due to events such as: kidnapping, rape, bomb blasts, violent attack/ ambush etc.
- **Cumulative stress**, whereby a person has been 'in the field' for too long, without taking any leave. This is a particular risk area for community-level volunteers. Cumulative stress can be built up within one assignment, or more longer term i.e., across assignments/ missions, and thus throughout a person's career.
- **Ongoing stress** that staff face on a day-day basis as a result of their job, such as lack of electricity, restricted movement, difficult living conditions, co-ordination and working with other organisations etc.

Aid workers are similar to the survivors of disasters, conflicts and complex emergencies. They are differently armoured and will respond on an individual basis to the same stress due to **varying levels of resilience**. However, staff members are often armoured or shielded by their profession and organisation, which can mask the underlying effects of stress.

Stressors to be aware of are:

Physically exhausting work:

- Long work shifts (unspoken demands for long working hours, usually come from staff, individually, rather than from line managers).

- Frequent travel across difficult terrain or long, multiple flights etc. This is particularly the case for highly mobile 'international' staff, and community level workers/ volunteers.
- Irregular eating and drinking.
- Difficult and/ or cramped living conditions.

Organisational factors:

- Parallel organisations: lack of co-ordination, which can lead to duplication or overlapping work.
- Working in a new group and working with a different kind of leadership and team, working with other organisations and professions.
- Antagonism between different staff groups: experienced vs. inexperienced staff, or different professions. The antagonisms can stem from history or job specific interests in the actual situation.
- Lack of clarity concerning responsibility for financial, logistical and organisational management.
- Leadership performance, competition between leaders, or ineffective line managers etc.

Personal stressors related to working in a new community:

- Loss of routines, social network and relations.
- New culture, habits and customs.
- Witnessing poverty, cruelties, unfair and unjust treatment of people or animals without being able to intervene.
- Ethical issues; having food, safety, shelter etc., whilst others do not.
- Group pressure and relations to work mates and leaders. Norms and habits in the working group that collide with your personal values and convictions.
- Organisational obstacles, relations with NGO's or GO's. Problems with bureaucracy, politics or corruption.
- Threats, provocations, robbery, blackmail and unrealistic demands. These may occur directly or indirectly. You can become a direct target of aggressions.
- Traumatic experiences and dangers. Traffic and driving can pose a big personal risk to safety in many disaster and conflict affected states.
- Short leave time or difficulties finding the time and place to relax and cool off.
- Troubles at home. Problems at home tend to grow with distance. It is hard to solve problems by leaving them; they will catch up with you. Problems can sometimes appear bigger than before too.

Vicarious trauma

Vicarious trauma, also known as 'compassion fatigue', occurs in people whose professions involve them listening/ being exposed to other people's experience of trauma. The intense emotions felt by the survivor are also deeply experienced by the listener. In such a context, emotions can become 'contagious'.

Vicarious trauma reactions:

Emotional:

- Feeling of being vulnerable
- Feelings of anxiety or generalised fear
- Feelings of detachment or weakness
- Anger
- Identification with the victims
- Irritability and frequent bad moods
- Guilt
- Apathy
- Feeling of isolation/ being abandoned
- Difficulty concentrating
- Emotional instability
- Excitation or depression
- Nervousness (tension)
- Feelings of being hunted.

Behavioural:

- Neurotic behaviour
- Increased consumption of cigarettes, drugs or alcohol
- Inefficiency
- Difficulty in relaxing or concentrating, inability to rest, hyperactivity and constant talking
- Short-tempered
- Inappropriate behaviour, e.g. aggression
- Constant intellectualisation
- Cynicism
- Giggling or unstoppable laughter
- Sleep problems (nightmares, insomnia)
- Excessively demanding behaviour
- Hyperkinesias (excessive movement of the body as a whole)
- Impulsive behaviour

- Lack of appetite, or excessive eating
- Startle responses
- Shaking or 'tics'.

Ideological:

- Difficulty in understanding how God could allow this to happen
- Loosing trust in God
- Loosing meaning in life (this can act as a precursor to many of the behavioural and emotional reactions mentioned above).

Reactions afterwards:

- Shock
- Feeling numb
- Talkative, a need to talk about what has occurred
- Withdrawal, a need to be left alone and unwillingness to talk about it
- Overreaction to sounds and smells.

Reactions associated to readjusting back to 'normal life':

- Frustration, anger if there is no credit given
- Difficulties slowing down
- Missing friends from the field, wishing to keep up contacts with victims
- Feeling of alienation, hostility towards those who did not participate "No-one else can understand"
- Feeling like a stranger when meeting family and friends.

'Burn-out'

Line managers must be alert to the possibility that some staff may need a temporary retreat from active work. When workers are 'burned out' they are ineffective and a risk to themselves. Staff, interns and volunteers who are working in hazardous jobs such as people who are operating in active conflict zones may make fatal mistakes if they are 'burned out'. It is important to support staff, interns and volunteers to recognise their own exhaustion and the line manager should be supportive if staff request some rest and recuperation away from the intensity of programme delivery. Advocacy for staff, interns and volunteers needs within ActionAid is essential. Education on the importance of caring for staff, interns and volunteers and the awareness of long-term organisational benefits may be necessary for Country Programmes.

'Burn out' symptoms

- Excessive tiredness
- 'Loss of spirit'
- Inability to concentrate
- Somatic symptoms (e.g. headaches, gastrointestinal disturbances)
- Some staff may make excessive and unrealistic demands
- Sleep difficulties

- Grandiose beliefs about own importance like engaging in heroic but reckless behaviours, ostensibly in the interests of helping others, neglecting own safety and physical needs (e.g. showing a 'macho' style of not needing sleep or breaks)
- Cynicism
- Inefficiency
- Mistrust of co-workers or supervisors
- Excessive alcohol or other substance use, caffeine consumption and smoking.

If you witness any of these symptoms in one of your co-workers then try to sit them down and talk to them about what they are experiencing, any fears that they may have or feelings of being overwhelmed. Invite them to spend a relaxing evening, or have coffee with you, away from the work site to help them to 'switch off'. In addition, sensitively report any concerns to human resources, their line manager or team leader.

What can staff do to minimise stress (self-care)?

Coping Tips

Balance is the key to any coping method in emergency settings. Try to maintain an adequate diet, with plenty of water. Find time for some exercise, rest and recreational activities. Keep in contact with colleagues and your line manager, who can also act as a useful source of support.

Preventative efforts:

- Define and explore stressors in the situation you are approaching. Investigate the context and background to any incidences of trauma and physical/ emotional insecurity.
- Have reasonable expectations about line managers, colleagues and local partners – they too are human beings with needs, wants and limits.
- Have realistic expectations of yourself; don't set them too high. Know your own limits.

Daily life in emergencies:

- Talk about traumatic/ unusual situations and events: what actually happened? Conduct daily team briefing sessions (these need only be short max. 30 mins).
- Separate the place of accommodation from the place of work.
- Write about your thoughts and feelings. Sometimes you may want to have someone with whom you can talk. Keep a diary, for your eyes only. This is a very efficient coping process and will give you relief.
- Although limited in some emergencies, due to security restrictions, try to combine physical exercise and relaxation exercises.
- Maintain good physical care, food, rest and hygiene.
- Consider other recreational activities: play cards, read books, crossword puzzles, drawing, dancing, singing, meditation, praying etc.
- Maintain a balance between work and leisure time. Be sure to take leisure time. You cannot be productive 24 hours a day.
- When conflicts arise in the team, try to manage them immediately. Do not let them become personal

or spill over into other areas of work.

- Avoid the temptation of alcohol and drugs. Do not engage in risky behaviour. If you feel you need to engage in this behaviour to survive then you must seek help.
- Take breaks and get away from the office/ camp/ work site where possible.
- Avoid being exposed to horrific sights and smells. There is no reason to expose oneself if it is not necessary. However, this is not the same as being ignorant or cocoon from what is happening around you in an emergency.

ActionAid and line manager obligations to staff

All line managers are responsible for the well-being of the staff, interns and volunteers that report to them. The Country Director is, ultimately, responsible for the safety, security and well-being of all staff, interns and volunteers within their country programme. At the international level, ActionAid is a signatory to the **People in Aid Code**, which aims to advance best practice in the management and support of aid personnel by organisations and agencies.

People in Aid Code

1. **Human Resources Strategy:** Human resources are an integral part of our strategic and operational plans.
2. **Staff Policies and Practices:** Our human resources policies aim to be effective, fair and transparent.
3. **Managing People:** Good support, management and leadership of our staff is key to our effectiveness.
4. **Consultation and Communication:** Dialogue with staff on matters likely to affect their employment enhances the quality and effectiveness of our policies and practices.
5. **Recruitment and Selections:** Our policies and practices aim to attract and select a diverse workforce with the skills and capabilities to fulfil our requirements.
6. **Learning, Training and Development:** Learning, training and staff development are promoted throughout the organisation.
7. **Health, Safety and Security:** The security, good health and safety of our staff are a prime responsibility of our organisation.

NGO Code of Conduct: Humanitarian Principles

1. The Humanitarian imperative comes first.
2. Ad is given regardless of the race, creed or nationality of the recipients and without adverse distinction of any kind. Aid priorities are calculated on the basis of need alone.
3. Aid will not be used to further a political or religious standpoint.
4. We shall endeavour not to act as instruments of government foreign policy.
5. We shall respect culture and custom.
6. We shall attempt to build disaster response on local capacities.
7. Ways shall be found to involve programme beneficiaries in the management of relief aid.
8. Relief must strive to reduce future vulnerabilities to disaster, as well as meeting basic needs.
9. We hold ourselves accountable to both those we seek to assist and those from whom we accept resources.
10. In our information, publicity and advertising activities, we shall recognise disaster victims as dignified humans, not hopeless objects.

AAI Global HROD policy:

Section 4.3.2 states that "The safety and security of staff is a central organisational concern. Senior managers, particularly Country Directors and International Directors, will take primary ownership for the safety and security of staff that are accountable to them."

Staff support can be organised in the following sequences:

- Preparation
- Clear managerial lines
- Ongoing support (organisational policies)
- Post-assignment follow-up.

Preparation: The most useful support staff, interns and volunteers can be given is to be well prepared, by the in-country team sending as much information as possible about the emergency, prior to deployment. International staff should also receive information prior to deployment about the in-county team, safety, security, logistics and any pertinent cultural codes (such as appropriate dress). In addition, all staff, interns and volunteers should undergo refresher training on self-care to minimise the impact of stress.

A basic training programme before any deployment (both for international, national staff, interns and volunteers) may look like this from the psychosocial point of view:

- AAI line managers should ensure that individuals deployed in conflict or disaster areas have a specific ability to cope and manage stress. This can be done by a brief psychological evaluation and traits questionnaire, which also indicates a person's 'stress threshold'. See **Emergencies Policy** document in the appendix.

- Job description
- Terms and conditions of deployment
- Team-building and training for specific emergency response team
- Country Programme background and attitude
- Personal safety, security and first aid training - this is paramount if a conflict related emergency
- Self care and ways to prevent vicarious trauma
- Cumulative and emergency stress coping techniques
- Use of communication equipment (radios, satellite phones etc.) if operational
- Convey realistic expectations on capacity (linked to financial and human resource availability)
- Debriefing or exit interviews.

Information for line managers on staff support:

- Ensure the Country Programme has developed and activated human resource policies and procedures to mitigate the effects of cumulative, on-going and acute stress
- Monitor staff well-being on a weekly basis
- Support staff with information, contacts, helping out with procedures etc.
- Regular staff meetings with field staff and those at headquarters
- Effective team management - team work, regular team meetings, regular social events, planned holidays and regular pay
- Make sure that staff have clear and consistent managerial lines
- Facilitate professional growth by providing on-going training
- Let staff know that you are available, that ActionAid values their work, and there are no penalties for taking time-off
- All staff, interns and volunteers should have a debriefing or exit interview at the end of the contract or assignment
- Make freely available an external professional counselling agency or organisation to staff who may wish to discuss issues or events outside of ActionAid, or for staff suffering from 'burn out' (see below). Examples of such agencies are InterHealth in London, or Antares Foundation in the Netherlands and Australia, who are also available for consultancies worldwide.

For further information please see AAI's **Human Resources Emergency Policy** - see appendix.

AAI Global HROD policy:

Section 4.2.1 Leave and absence states that: "Rest and Recuperation leave for staff in emergency designated work stations and when staff have faced a traumatic situation at work (conflicts, natural disasters, accidents etc.)"

Section 4.3.1.1 Staff health schemes - Guidelines states that: "Professional counselling or occupational psychologist services should be available in each country for staff exposed to traumatic situations, those who work in conflict and emergency areas and those who have been subjected to harassment. Such counsellors may be made available through telephone or face-face consultations."

Section 5.1.2 Core training and development needs states that: "Core career and professional development training programmes include first aid training, and safety and security drills."

Security: "All CP's will have live operational specific emergency procedures (CSEP) covering security guidelines, evacuation and contingency plans, and community processes. All AA countries should ensure that the Country Specific Emergency Policies are in full compliance with the country's legal requirements.

Evacuation: "All CP's will have well developed security procedures and contingency plans in place (these make up the CSEP's) which include detailed evacuation procedures and clear decision making responsibilities."

Post-assignment care: Caring for staff, interns and volunteers also means taking care of them when they return home, not just dropping them off with a "thank you". The sending country programme or thematic area should have a general plan for international staff returning from assignments. This may be through debriefing sessions with a member of ActionAid's human resources team, a work colleague in 'home country', or the offer of speaking to a trained counsellor from another organisation.

A programme for 'return' may consist of:

- Evaluation of the work done
- Self-reporting by staff
- Medical/ psychosocial check-up
- Debriefing
- Careers advice
- Additional follow-up if required.

Caring for staff, interns and volunteers is sometimes a delicate task. At times they may resist care, thinking that receiving help is an indication of weakness, on their part. All line managers should ensure staff, interns and volunteers understand that their health and well-being is of paramount importance to ActionAid.

ActionAid human resource and organisational general policies on staff care

Global HROD Policy:

Section 4.3.2.1 - Guidelines state that:

- "The work of AAI sometimes requires staff to operate in difficult and risky circumstances. In such conditions, AAI will take all reasonable steps to ensure the safety and security of all staff. In situations where the safety of family members is not assured, such postings will be declared non-accompanied."
- "Unaccompanied staff maybe allowed to make up to two phone calls home per week. Such calls maybe of a reasonable limit, as decided by management."
- "Staff working in conflict areas should have a comprehensive insurance package. If such packages are not provided locally, the organisation should self-insure to cover staff life and provide medical coverage."
- "Each part of AAI will have written safety guidelines assessing the potential risks faced by staff and the organisations procedures for dealing with them."
- "All parts of AAI will have written general safety guidelines and procedures for common, natural and person-made emergencies e.g. fire, earthquakes, floods, cyclones, volcanoes etc."
- "Fire extinguishers should be predominantly displayed and staff trained in their use. Fire drills should be conducted at periodic intervals".
- "During vehicular travel AAI staff must use adequate safety precautions such as seat belts. All AAI vehicles will carry a first aid kit."
- "Senior staff in any part of AAI should travel in limited numbers together whilst using the same means of transport for safety and security reasons".
- "All staff are required to have a full medical every two years and at the end of employment, if more than three months has elapsed since the last medical examination".

Other key documents AAI policy documents (all are available in the appendix or bibliography):

- **Human Resources Emergency Policy**
- **International Terms and Conditions**
- **Open Information Policy**
- **AAI India Human Resources Emergency Policy** - this is a comprehensive policy that Country Directors and Programme Managers may find useful as a template if they wish to draw up their own country specific human resource emergency policy.

Ten Golden Rules for Country Directors and Human Resources on Staff Care

1. Country Programmes must have developed and activated human resource policies and procedures to mitigate the effects of cumulative, on-going and acute stress
2. Provide staff with as much information, as possible, prior to deployment about their: assignment, job description, terms of reference and conditions, operating environment, line manager, security contact and organisational policies (a welcome pack is a useful way of doing this).
3. Hold regular staff meetings (at least weekly) with field staff and those at headquarters
4. Effective staff management - team work, planned holidays, regular pay and meetings
5. Monitor staff well-being on a weekly basis (particularly look for signs of 'burn-out')
6. Ensure that staff have clear and consistent managerial lines
7. Facilitate and actively support staff growth and capacity building through mentoring and training programmes
8. Separate out the place of accommodation for emergency staff from their place of work
9. Ensure that all staff have an exit interview or a debriefing session at the end of their assignment
10. Promote healthy coping methods amongst staff - exercise, social outings, lunch breaks, recreational activities.

10 point summary of staff care

1. There are three types of stress: acute/ traumatic, cumulative and on-going stress

2. Stressors in emergencies to be aware of are: physically exhausting work, organisational factors and personal stressors.

3. Vicarious trauma, also known as 'compassion fatigue', occurs in people whose professions involve them listening/ being exposed to other people's experiences of trauma. The intense emotions felt by the survivor are also deeply experienced by the listener.

4. Vicarious trauma reactions are experienced in the emotional, behavioural and ideological domains.

5. 'Burnout' is where a person is physically and mentally exhausted. When workers are 'burned out', they are ineffective, a risk to themselves and they may make fatal mistakes.

6. Some symptoms of 'burn out': excessive tiredness, loss of spirit, inability to concentrate, sleep difficulties, cynicism, inefficiency, mistrust of co-workers and excessive alcohol and substance use.

7. Education on the importance of caring for staff, interns and volunteers, and the awareness of long-term organisational benefits is necessary for Country Programmes.

8. Coping tips for self-care: balance is the key to any coping method in an emergency. Try to maintain an adequate diet, with plenty of water. Find time for exercise, rest and recreational activities. Keep in contact with colleagues and your line manager.

9. Preventive self-care: try to obtain as much information as possible about the situation you are approaching, have realistic expectations about line managers, partners and yourself - don't set your limits too high.

10. Self-care during daily life in emergencies: talk about traumatic events when they occur, deal with team conflicts as they occur, get plenty of rest and relaxation, take regular breaks and exercise, separate work from place of accommodation, maintain good physical care: personal hygiene, rest and food, avoid alcohol and drugs and maintain a balance between work and leisure time.

Chapter 9
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