HEALTH EMERGENCY RESPONSE UNIT

PSYCHOSOCIAL SUPPORT COMPONENT
DELEGATE MANUAL

September 2012

Psychosocial Centre
International Federation
of Red Cross and Red Crescent Societies

Health Emergency Response Units - Psychosocial Support Component
Delegate Manual

International Federation Reference Centre for Psychosocial Support
Blegdamsvej 27
DK-2100 Copenhagen
Denmark
Phone: +45 35 25 92 00
Mail: psychosocial.centre@ifrc.org
Web: www.ifrc.org/psychosocial

Chief Editor: Nana Wiedemann

Authors and editors: Birgitte Sloth Yigen, Sara Johansson, Lene Christensen

Contributors: Judith Fairholm Canadian Red Cross, Ea Suzanna Akasha Danish Red Cross

Reviewer: Barbara Juen Austrian Red Cross

Proof reading: Wendy Ager
Design:
Front page photo: xxxx

Printed in Denmark. First edition September 2012 by xxxx

ISBN xxxx

This manual is published by the International Federation of Red Cross and Red Crescent Societies Reference Centre for Psychosocial Support. We want to thank all the organizations who have kindly allowed us to include their material in this handbook.

WELCOME

Among humanitarian actors it is recognized that armed conflicts and natural disasters cause significant psychological and social suffering to affected populations. Emergencies erode protective supports that are normally available, increase the risks of diverse problems and tend to amplify pre-existing problems. The psychological and social impacts of emergencies may be acute in the short term and can undermine the long-term mental health and psychosocial well-being of the affected population, threaten peace, human rights and development. Previous emergencies have shown high numbers of patients presenting multiple somatic complaints; this group of patients places a heavy burden on the available health care delivery system.

The International Federation has wished to address this issue through the establishment of an optional and additional component to health emergency response units. This was developed in 2008 by the International Federation's Reference Centre for Psychosocial Support with the support of Norwegian Red Cross. After the first joint psychosocial delegate training (held February 2009 in Oslo) with Norwegian, French, Spanish, Canadian and Danish Red Crosses, it was initially piloted through deployment with Red Cross Health ERUs (Basic Health Care Unit or Referral Hospital) in Haiti following the 2010 earthquake. Lessons learned from this deployment clearly proved the added value and importance of integrating psychosocial support into emergency response.

This Health ERU psychosocial delegate manual is the most important document guiding your work as a psychosocial delegate deployed to a health emergency response unit in a conflict or disaster zone.

Nana Wiedemann
Head of International Federation's Reference Centre for Psychosocial Support

Contents

CHAPTER 1: INTRODUCTION 5
What is an ERU? 7
Impact of emergencies 8
Psychosocial support in the ERU 9
Location of the psychosocial support component 9
The main functions of the ERU psychosocial support component 10
Limits to ERU psychosocial work 15
At-risk groups 16
Multi-layered supports 17
Recognizing signs of stress 19
Community mobilization – considering local culture 20
Protection and human safety 21
Do no harm 21
CHAPTER 2: GETTING STARTED 23
Setting up the psychosocial support component 24
Launching psychosocial activities 32
Daily and weekly reporting requirements 33
Monitoring 34
Visibility and the media 34
Psychosocial support and restoring family links (RFL) 35
Violence in emergencies 38
After the initial phase 42
Ending the ERU mission 43
CHAPTER 3: ACTIVITIES FOR CHILDREN 44
Supporting children after emergencies 44
PS ERU play kits 47
A. PLAY KIT 1 FOR CHILDREN UP TO SIX YEARS 47
B. PLAY KIT 2 – FOR CHILDREN AGED SIX TO 18 YEARS 53
Arts activities 55
Sports activities 55
Board games 59
Music, song and dance 61
Equipment for volunteers 62
CHAPTER 4: ACTIVITIES FOR ADULTS 63
Reaching specific groups 67
CHAPTER 5: TRAINING 70
Training kit 3 70
Facilitating training 71
A. Volunteer training 72

B. Briefing session on psychosocial issues **80**
CHAPTER 6: LINKING RESEARCH AND PRACTICE **85**
CHAPTER 7: POLICIES AND GUIDELINES **89**
ANNEX 1: JOB DESCRIPTION **94**
ANNEX 2: COLLECTING INFORMATION AND MAPPING RESOURCES ON PSYCHOSOCIAL ISSUES **98**
ANNEX 3: DAILY AND WEEKLY MONITORING FORM **102**
ANNEX 4: READING ON VIOLENCE IN EMERGENCIES **104**
ANNEX 5: CHECKLIST FOR ORGANIZING TRAININGS **105**
ANNEX 6: ONE-DAY VOLUNTEER TRAINING PROGRAMME **107**
ANNEX 7: FURTHER READING **109**
ENDNOTES **110**

Chapter 1: Introduction

This manual covers the emergency phase of a crisis response. Our aim in writing this manual is to provide you, as **the psychosocial (PS) delegate** in a deployment, with guidance on how to integrate a psychosocial support (PS) component into the work of a Health Emergency Response Unit (ERU).

Emergencies create a wide range of challenges experienced at individual, family, community and societal levels. Emergencies tend to weaken protective support and increase the risks of new and pre-existing problems. As a PS delegate in a Health ERU, you will be working in chaotic circumstances. There will be situations where you will have to improvise to find the best solutions to unforeseen challenges and problems. This manual will help you navigate these challenging circumstances, as the PS delegate with the main responsibility for the implementation of the PS component.

What's in the manual?

Chapter 1 starts off by describing a Health ERU PS component and the impact of emergencies on psychosocial wellbeing. This is followed by a description of the PS component's main functions and activities, an explanation of the training requirement for volunteers and addresses other important aspects of psychological and social issues and problems in emergency settings. The chapter ends by addressing the importance of cultural sensitivity when implementing PS activities and how to avoid doing harm.

Chapter 2 describes how you set up the ERU PS component including some of the important and specific tasks involved for PS delegates. It provides guidance on how to structure initial activities, how to deal with issues in restoring family links and in relation to violence. Both are serious challenges that you are likely to encounter in most emergencies. During and after emergencies, children are a particularly vulnerable group.

Chapter 3 deals with providing support to children after crisis situations, highlighting safe practice and the benefits of play. It lists the contents of the two PS ERU play kits with details on each item and how they can be used.

Chapter 4 deals with providing psychosocial support to adults who are affected by emergencies. Different types of activities are described and particular concerns of the most vulnerable groups are addressed too. Resources for adults are also available and are listed here.

Chapter 5 goes into details on the organization and facilitation of training sessions for volunteers, as well as outlining an orientation session on psychosocial support for ERU and external staff from other humanitarian organizations. Training in its broadest sense is a key task for PS delegates in the ERU psychosocial support component. In your work you will be conducting formal training sessions and using opportunities in the field to teach and apply knowledge and skills with the volunteers and staff in your area.

Chapter 6 makes links between research and practice, providing a foundation for your work as a PS delegate in a Health ERU and grounding psychosocial support in the current consensus for what is seen as effective for the recovery of affected populations.

Finally **Chapter 7** wraps up the manual by briefly introducing you to relevant global polices and guidelines related to psychosocial support in emergencies. These provide guidance in the actions most humanitarian workers are engaged in with relation to psychosocial support work across the world.

About the manual

You will see blue and red boxes:

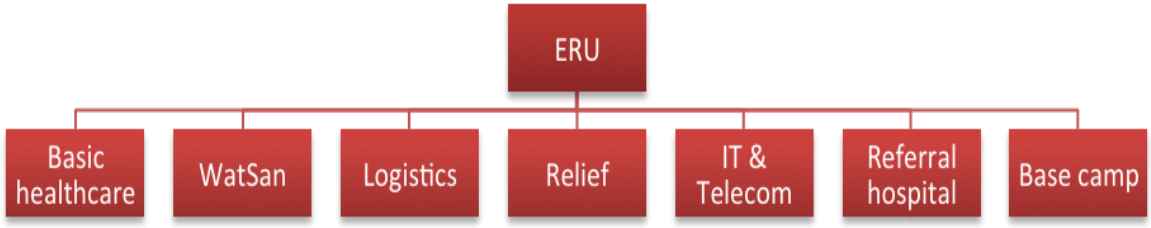
- **Blue boxes** feature real life examples of work in the field.
- **Red boxes** reinforce information given in the chapters.

Abbreviations and acronyms used include:

IFRC	International Federation of Red Cross and Red Crescent Societies
PFA	Psychological first aid
PS delegate	Psychosocial delegate
PSS	Psychosocial support

What is an ERU?

The Emergency Response Units (ERUs) are part of the IFRC's global Disaster Response system, used when global assistance is needed in emergencies. They cover different sectors (seven to date) and are deployed after an emergency to fill gaps and ensure efficient provision of emergency assistance to the affected population. The seven sectors are shown here:



The psychosocial support component
Two ERUs are dedicated to disaster health needs - *the basic health care unit* and *the referral hospital*. These ERUs have tended to focus on medical care in acute emergency settings, often replacing damaged or destroyed local facilities. However recent disasters have shown the importance of addressing public and community health concerns and priorities and providing dedicated personnel to focus on these intervention areas.[1] A priority in emergencies is therefore to protect and improve people's mental health and psychosocial wellbeing.[2]

This is achieved by providing a psychosocial support component within the ERU. The term 'component' covers all the psychosocial support activities, including the kits and materials, training of volunteers, community outreach, awareness-raising etc. undertaken by the PS delegate.

What is psychosocial support?
Psychosocial support is defined as any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent mental disorder. Within the International Federation, psychosocial support is seen a process of facilitating resilience within individuals, families and communities. This is done by implementing relevant and culturally appropriate activities that respect the independence, dignity and coping mechanisms of individuals and communities. In this way psychosocial support promotes the restoration of social cohesion and infrastructure within communities that have lived through disasters or crisis situations.

The psychosocial support component is of course a service to the community to which the ERU is deployed, but supporting staff and caring for colleagues and volunteers is crucial as well. It is the responsibility of the ERU team leader to ensure the psychological wellbeing of all ERU staff, but you may be able to assist the team leader by providing support and

advice to colleagues, where this is appropriate in the course of your deployment.

Integrating a psychosocial support component into the work of the ERU means that vulnerable groups in affected communities can be reached, including those who suffer from mild to severe psychological or have experienced abuse, violence or are suffering from social distress. Previous ERU deployments have shown high numbers of patients presenting multiple symptoms; this group of patients places a heavy burden on the available health care system.[3] Your work as a PS delegate is therefore a valuable contribution to the care provided.

A timeline for the implementation of the ERU psychosocial support component is shown on page 26.

Purpose of the psychosocial component

The overall aim is to improve psychosocial wellbeing, to protect and prevent further harm. The specific purpose of the ERU psychosocial support component is to enable a positive, safe, social and physical environment where children and adults find opportunities for stimulation, skill building and socialization.

Impact of emergencies

Problems
Emergencies create a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies weaken the protective support that is normally available to people, and increase the risk of new problems arising as well as making pre-existing problems even worse.

Pre-existing problems and problems caused by the emergency and the humanitarian response are closely connected. They are often predominantly social or psychological in nature. The table below shows the kind of problems that affected populations may experience:[4]

	Social problems	Psychological problems
Pre-existing	Belonging to a group that is discriminated against or marginalised; political oppression; domestic violence	Severe mental disorder; depression, alcohol abuse, anxiety disorders

Caused by emergency	Family separation; disruption of social networks; destruction of livelihoods, community structures, resources and trust; violence	Grief, non-pathological distress; alcohol abuse; depression and anxiety disorders, including post-traumatic stress disorder (PTSD)
Caused by humanitarian response	Undermining of community structures or traditional support mechanisms; exclusion due to lack of access to services; misuse of power	Anxiety due to a lack of information about food distribution; aid dependency; helplessness

Resources
Affected groups often have assets or resources that support mental health and psychosocial wellbeing. A common error in work on mental health and psychosocial wellbeing is to ignore these resources and to focus solely on 'deficits' – the weaknesses, suffering and pathology – of the affected group. It is important to be aware of local resources, and whether they are helpful or harmful, and the extent to which affected people can access them.[5]

Psychosocial support in the ERU

Psychosocial support in the ERU is based on the principle that most acute stress problems during emergencies are best managed without medication, using the basic elements of psychological first aid (PFA).[6] This involves non-intrusive emotional support, coverage of basic needs, protection from further harm, and organization of social support and networks.[7] PFA is described in detail in session 3 of the volunteer training.

If you are able to create an enabling social, emotional, and physical environment in your work, you will be helping to increase the resilience and reduce the vulnerability in the population you are working with. Restoring social structures and providing stability allows people to cope with the effects of a disaster, and return to economic activities, family life, and supportive roles for each other.[8]

Location of the psychosocial support component

If space allows it, the ERU psychosocial support component can be housed in one or two tents for the various activities.

There may be settings where space and security issues will make it necessary to share a tent with other ERU components, such as community health. There may also be settings where the only space available for the psychosocial activities is outside the ERU compound. Not everyone will be mobile. Some people may be confined to hospital beds and not be able to join the psychosocial activities. The psychosocial activities will then have to be conducted in the wards etc.

Activities use the materials in the kits and (in some cases where this is relevant) involve community outreach activities. Set-up, activities and materials are explained in chapters 3, 4 and 5.

After the Haiti earthquake in 2010, the psychosocial delegates arranged a meeting with the local administration during the first couple of weeks of the operation. The objective of the meeting was to promote a plan for establishing a school-based programme as soon as possible. The school-based activities were conducted in a tent, as most buildings were destroyed.

The main functions of the ERU psychosocial support component

There are four main functions:

1. Play and recreational activities for children
2. Assisting adults with practical information, emotional and social support
3. Community outreach
4. Training interventions

1. Play and recreational activities for children

Children's activities are facilitated through creating a child-friendly space[9] i.e. a space that is perceived as safe by both the children themselves and their parents or guardians. Policies and procedures are followed that mean the adults who are working with the children and the activities that are done create a safe space, as far as is possible. For example, staff and volunteers are screened and trained; codes of conduct are observed; there is training on child protection/violence prevention and there is on-going monitoring and support[10].

Child-friendly spaces create a sense of normality and provide a safe place for children to play, learn and socialize. Activities have a strong psychosocial support element, providing a caring and normalizing environment to lessen the impact of the crisis on the children, while their parents or guardians may be otherwise occupied.

Activities are organized regularly and include games, drama, art activities, non-formal educational activities and sports. They are facilitated by volunteers using materials from the play kits. As PS delegate, you are responsible for training and then supervising all activities led by volunteers.

Child-friendly space set up at the German-Finnish Red Cross Hospital in Carrefour, Port-au-Prince, following the devastating earthquake in Haiti. ©Stefan Trappe.

Try to combine the types of activities on offer in a child-friendly space. Mix structured and less structured, physical and quiet, and indoor and outdoor.

This table shows how you can use activities to accomplish different purposes:[11]

11

Child-friendly Spaces - Activities for Different Purposes			
Activity	**Examples**	**Purpose – How it Helps Children**	**What We Can Do**
Creative	Painting, drawing, clay, collages, making dolls, puppets, and animals, pasting pictures using grains of wheat, corn, sand, etc., bookmarks / greeting cards from dried flowers, finger painting, posters	Helps children to express their feelings and ideas. Externalizes emotions, promotes understanding, self-esteem, and empathy. Promotes experimentation. Promotes creativity and respect for the resources available by using local materials or materials from nature.	Guide children with a theme – their family, the mountains, the ocean/beach, nature, etc. Encourage children to decorate an area. Organize displays and invite parents/community members to see them.
Imaginative	Dance, theatre/drama, music, singing, role play, acting performances (dance, drama, singing)	Develop creative and social skills, coping skills, self-esteem. Helps children understand what happened/happens in their lives, as they act out experiences. Creates fun, relaxes, and promotes team spirit, active participation.	Invite community members to perform and hold workshops with the children. Organize performances for the community.
Physical	Sports – football, volleyball, outdoor team games, handball, local traditional children's games	Develops self-confidence. Builds relationships and teamwork skills – interaction with peers, rules, and cooperation. Develops motor skills, muscles, coordination.	Designate specific safe areas for sports and games. Create a rotation system for sports equipment. Form teams. Hold tournaments. Schedule different times for boys and girls if needed.

Communicative	Story telling – books/ oral, reading, story time, conversation time, discussion groups	Helps children express feelings in words without personalizing. Appreciates local culture and tradition. Develops imagination. Allows children to discuss issues that are important to them.	Have a storytelling hour, encourage children to make up stories. Start a story with one sentence and ask the children to continue (add on) to the story. Use a story to start a discussion. Facilitate discussions with groups of children, following their areas of interest and / or guiding them through a theme, such as one of the risks they or their peers face. Encourage children to develop key messages for others in the community, authority figures, and other people; facilitate the communication of these messages to these audiences by children, e.g. through performances, discussion, scheduled meetings, or written / visual media such as posters, letters and pamphlets.
Manipulative	Puzzles, building blocks, board games,	Improves problem-solving skills. Builds self-esteem and cooperation.	Children can work alone or in groups. Set aside a quiet area.

In the ERU, play and recreational activities may have a dual function. They offer direct support and care to the children, whilst possibly also occupying them, while they wait for examination or treatment of themselves and/or parents. Eventually these activities may transition into formal schooling, after-school recreational activities for school-age children, out-of-school activities for adolescents, and club activities or community social activities.

2. Assisting adults with practical information, emotional and social support

Adults who are either transferred from triage in the health ERU or seek assistance directly from the ERU psychosocial support component are given practical help, such as information about the emergency or assistance to find missing family members, as well as emotional and social support. The help is offered through supportive listening, providing psychological first aid, and information about local resources. Interaction with adults is facilitated through volunteers who have been trained to provide this type of support. A set of leaflets and information sheets is also available (details are in chapter 4).

A psychosocial delegate working in Bam, Iran, after the earthquake in 2003 realized people needed information about how to find their relatives. Lots of people had come to the psychosocial tent to search for their family members. She shared this information with the ICRC (the RCRC entity mandated to restore family links - known as RFL) and then organized a campaign to get information out to local communities. Posters showing where and how to register missing family members and how to report family reunifications were located throughout the area.

3. Community outreach

The ERU psychosocial support component is potentially a hub for reaching out into the surrounding communities. If feasible, support groups and other outreach activities may be organized. Activities can be located inside the ERU psychosocial support component itself and in surrounding communities. Community outreach is usually carried out in collaboration with local resource organizations, such as local health authorities, the operating National Society, NGOs etc., identified during the initial assessment and mapping procedures. Please see chapter 2 for more details on this.

Myanmar, May 2008, in the immediate aftermath of Cyclone Nargis. 2.4 million people were affected. It is estimated that around 10,000 volunteers were active at any one time at the height of the relief response. The operation attracted additional volunteers, with many trained as trainers and facilitators in first aid, health promotion and psychosocial support. © IFRC

4. Training interventions
Different types of training interventions also take place in the ERU psychosocial support component. One of your initial tasks after deployment is to recruit volunteers to facilitate the activities described above (see also chapter 2). Volunteers are trained in supportive listening and psychological first aid (see chapter 5) and receive instruction in how to use the materials contained in the kits. Initial training is followed by refreshers and/or training of newly recruited volunteers.

You may also organize orientation sessions for ERU colleagues and other humanitarian staff working in the area and awareness-raising sessions aimed at the general population of the area or specific groups that have been identified. The outline for an orientation session is in chapter 5.

Limits to ERU psychosocial work

Providing psychosocial care as part of emergency health work has great potential and is a fundamental part of the ERU psychosocial support component. However this does not include psychiatric or psychological care, like individual or group counselling or psychotherapy. It is important to differentiate between psychosocial support on the one hand and psychiatric and psychological care on the other.

After the earthquake and devastating tsunami in Japan 2011, psychosocial delegates from the Japanese Red Cross Society were not welcomed by local authorities in some affected areas. In dialogue with the authorities, it was apparent that there were some misunderstandings about what psychosocial support would include. The authorities thought that the staff and volunteers would force survivors to talk about their traumatic experiences. By maintaining a dialogue with authorities and explaining that psychosocial support would be offered in a non-intrusive way, focusing on immediate practical needs and integrating it with other interventions, permission was given to start psychosocial support activities for affected children and adults.

People with psychiatric disorders must receive specialized help (where possible), as psychosocial activities and care do not address psychiatric disorders i.e. depression, post-traumatic stress disorder and related conditions. Assistance to people with severe mental disorders requires medical diagnosis and treatment and is undertaken by medical personnel with a specialized training in this field. Usually it involves a combination of biological, social and psychological interventions.[12]

Most often such people require referral to specialized services and the decision on appropriate action will be taken by the ERU medical staff. On some occasions, you as the PS delegate may be the first person to encounter someone with a mental disorder. In this circumstance, you will need to liaise with the local authorities in identifying the relevant help. Sometimes you may also be requested to assist other ERU staff in the assessment of patients with mental disorders.

People with severe mental disorders belong to an extremely vulnerable group in disaster settings. Often it is beyond the scope of ERU work to care directly for this group. However it might be possible to interact with local health authorities to look for possible solutions and to make referrals to specialized health services if available in the country. Supporting the caregivers of individuals suffering from mental disorders is also an indirect way of addressing this complex issue.[13]

At-risk groups

In emergencies, not everyone has or develops significant psychological problems. Many people show resilience – the ability to cope relatively well in situations of adversity. Depending on the emergency context, different groups of people are at increased risk of experiencing social or psychological problems. All sub-groups of a population can potentially be at risk, depending on the nature of the crisis. The following are groups of people who frequently have been shown to be at increased risk of various problems in diverse emergencies[14]:

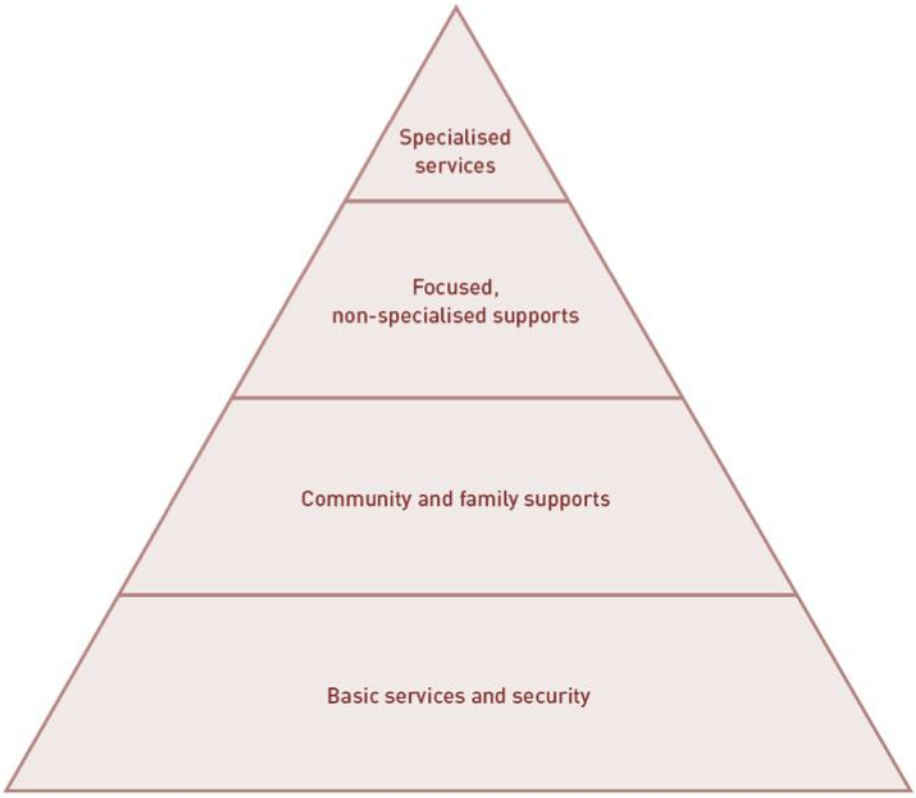
Group	At risk groups characteristics
Women	Pregnant women; mothers; single mothers; widows and, in some cultures, unmarried adult women and teenage girls; women with disabilities
Men	Ex-combatants; men with no work who have lost the means to take care of their families; young men at risk of detention, abduction or violence; men with disabilities
Children (from new-born infants to young people 18 years of age)	Separated or unaccompanied children including orphans; abused children; children recruited or used by armed forces or groups; trafficked children; children in conflict with the law; children engaged in hazardous labour; children who live or work on the streets, undernourished or under-stimulated children; unwanted children; children with disabilities
Elderly people	Especially when they have lost family members who were caregivers
Extremely poor people	Low income and poor access to services, often marginalized
Refugees, internally displaced persons (IDPs) and migrants in irregular situations	Especially trafficked women and children without identification papers
People who have been exposed to extremely stressful events/trauma	People who have lost close family members or their entire livelihoods; rape and torture survivors; witnesses of atrocities, etc.
People with disabilities or health conditions	People in the community with pre-existing, severe physical, neurological or mental disabilities, disorders or health conditions
People in institutions	Orphans; elderly people; people with neurological/mental

	disabilities or disorders
People experiencing severe social stigma	Untouchables/dalit; commercial sex workers; people with health status like HIV positive, severe mental disorders; survivors of sexual violence, or indigenous populations
People at specific risk of human rights violations	E.g. political activists; ethnic or linguistic minorities; people in institutions or detention; people already exposed to human rights violations; indigenous populations

Multi-layered supports

In emergencies, people are affected in different ways and require different kinds of supports. A key to organizing mental health and psychosocial support is to develop a layered system of complementary supports that meets the needs of different groups.

This can be illustrated by a pyramid[15]. All layers of the pyramid are important and should ideally be implemented at the same time. (For further readings, please refer to the 2011 Sphere Project Handbook, p. 335-336.)



1. **Basic services and security.** The wellbeing of all people should be protected through the (re) establishment of security, adequate governance and services that address basic physical needs (food, shelter, water, basic health care, control of communicable diseases). These basic services should be established in

participatory, safe and socially appropriate ways that protect local people's dignity, strengthen local social supports and mobilise community networks.

2. **Community and family supports.** The second layer represents the emergency response for a smaller number of people who are able to maintain their mental health and psychosocial wellbeing if they receive help in accessing key community and family supports. Useful responses in this layer include family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women's groups and youth clubs.

3. **Focused, non-specialized supports.** The third layer represents the supports necessary for the even smaller number of people who additionally require more focused individual, family or group interventions by trained and supervised workers (but who may not have 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 (PFA) and basic mental health care by primary health care workers.

4. **Specialized services.** The top layer of the pyramid represents the additional support required for the small percentage of the 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 or psychiatric supports for people with severe mental disorders whenever their needs exceed the capacities of existing primary/general health services. Such problems require either (a) referral to specialised services if they exist, or (b) initiation of longer-term training and supervision of primary/general health care providers.

It is important to realize that the activities taking place in the context of the ERU psychosocial support component relate to the three lower tiers of the pyramid. Care for people requiring specialized services should be pursued through interaction with local health authorities, local organizations or other resource groups involved in caring for people with severe mental disorders. At the same time, people who are affected on a certain level (according to the pyramid) may still benefit from taking part in activities organized primarily for groups on a lower level of the pyramid. This means, for example, that a person suffering from disaster-induced distress and grief can also gain from taking part in community-based social activities.

Recognizing signs of stress

While many people show remarkable resilience and capacity to deal with the hardship of emergency or crisis situations, it is important to be aware of the signs of social or psychological stress or distress that they may experience.

Stress is a state of pressure or strain that comes upon human beings in many different situations. It can be caused by any change – positive or negative. It is an ordinary feature of everyday life and is positive when it makes a person perform optimally, for example in doing a written school exam.

However stress becomes **distress**, when an individual is unable to adapt to the stress they are experiencing and often implies a certain degree of suffering. It is however a normal reaction when experiencing an abnormal situation. Sometimes people become disoriented, have intrusive memories and try to avoid being reminded of the crisis situation they have experienced. Other reactions include not feeling anything at all, difficulties in making decisions and isolating oneself from other people.
Roughly the same patterns of reactions are observed across different geographical locations. However, it is important to note that how a person presents a complaint is closely linked to the local interpretation of what it means to go through these reactions. Such interpretations and the local significance of physical, emotional or behavioural reactions can differ widely from one cultural and social context to the next.

Some commonly recognized reactions to psychosocial stress are:

Physical reactions	Emotional reactions	Behavioural reactions
Physical pain, e.g. headache or aches in stomach	Feelings of fear and anxiety	**Change in temperament**
Shortness of breath	Loss of energy and motivation	**Estrangement from friends and family**
Tightness in chest	Inability to make decisions, concentrate, remember	**Inability to work**
Disturbed sleep or nightmares	Feelings of numbness or detachment	**Lost faith and spirituality**
Fatigue or exhaustion	Strong emotional reactions, e.g. anger, irritability, sadness	**Loss of interest in care of family and self**
Abdominal discomfort	Hopelessness or helplessness	**Change in interest in food or pleasure**

It is common that people reporting these complaints are unaware that emotional and physical stress reactions are **normal reactions to abnormal events**. Some are in fact anxious of their own reactions and become even more distressed by fear of not understanding what is going on inside them.[16] Awareness-raising about the normality of such reactions in the aftermath of an abnormal event is an important first step in assisting people to cope with their present situation.

Community mobilization – considering local culture

Community mobilization refers to efforts made from both inside and outside the community to involve its members (groups of people, families, relatives, peers, neighbours or others who have a common interest) in all discussions, decisions and actions that affect them and their future. The ERU psychosocial support component can play an important role, both in supporting community members in coping with the crisis situation that they have lived through and by initiating and organizing activities that will help communities reassume their normal lives.

As people become more involved, they are likely to become increasingly hopeful, better able to cope and more active in rebuilding their own lives and communities. At every step, relief efforts should support participation, build on what local people are already doing to help themselves and avoid doing for local people what they can do for themselves.[17]

It is important to note that communities tend to include multiple sub-groups with different needs, and that these sub-groups often compete for influence and power. Facilitating genuine community participation requires an understanding of local power relations, patterns of community interaction and potential conflict, working with different sub-groups and avoiding the privileging of particular groups. During an assessment it is important to be aware of individuals or groups within a community who may not speak up or even be visible at a first glance. Such marginalized groups may be among the neediest, and so it is the responsibility of humanitarian actors to ensure that their needs are included in the emergency response.

When interacting with local communities, it is crucial to understand the local social, cultural and religious/spiritual factors that influence the way people experience an emergency. It can be a challenge for relief workers to consider worldviews that are very different from their own. There is a delicate balance of respecting a culture or religious values that one does not share or even agree with, while at the same time being aware of potentially harmful practices that may be culturally acceptable in the local setting. Examples of such harmful practices are corporal punishment of children and female genital mutilation. If a volunteer or staff member becomes aware that such practices are taking place, he or she has a responsibility to immediately act, take necessary measures and inform relevant authorities. Culture can never be an excuse for harmful, hurtful behaviours.

Protection and human safety

Threats to the safety of individuals and communities have negative consequences on psychosocial wellbeing. Survivors often report that their greatest stress arises from threats, such as attack and persecution, forced displacement, violence, separation from or abduction of family members, exploitation and ill treatment. These kinds of protection problems cause immediate suffering and may interfere with the rebuilding of social networks and a sense of community, both of which support psychosocial wellbeing.

You may need to work on protection issues on several levels at the same time: There may be an immediate need to protect and care for individuals or groups whose safety has been compromised, while at the same time addressing protection issues at a higher level, e.g. by interacting with relevant authorities and advocating for the improvement of current conditions. You can contribute to protection in many ways:

- prioritizing the issue;
- understanding international protection instruments and local laws;
- doing a risk assessment;
- applying IFRC's policies and procedures;
- training staff and volunteers;
- integrating protection and safety into all programmes and services;
- monitoring with support[18].

It is essential to deliver humanitarian aid and services in a dignified way that supports vulnerable people, restores their dignity and helps rebuild local networks. It is often seen that the most effective social protection occurs when local people organize themselves to address threats, thereby creating a sense of empowerment and the possibility of sustainable protection mechanisms.[19]

Do no harm

The principle of 'do-no-harm' originates in emergency medicine. It reminds healthcare providers that they must consider the possible harm that any intervention might do to a patient. In humanitarian aid, it refers to the unintentional harm that may be caused to those who are supposed to benefit from an emergency intervention.[20]

Psychosocial action in emergencies can potentially cause harm because it deals with sensitive issues that are culturally specific. Humanitarian workers ideally should respect and adapt interventions to the culture, belief systems, established habits, attitudes, behaviour, and religion in the place where they work. They should possess the skills to communicate and work closely together with community leaders and representatives, as well as the skills to transfer knowledge and skills to community members or voluntary workers that are delivering many of the actual interventions.

The do-no-harm principle is closely connected to a human rights framework. Violation of human rights is often pervasive in emergencies, because there is a breakdown of social structures, erosion of traditional value systems, weak governance and lack of access to services. Humanitarian assistance helps people realize their rights and humanitarian workers are crucial in their role of advocating the rights and needs of the most vulnerable. At the same time it is the responsibility of humanitarian aid providers to identify and flag up harmful practices that may be acceptable in the local context.

Examples of reducing the risk of harm[21]:

- Participate in coordination groups to learn from others and to minimise duplication and gaps in response
- Design interventions on the basis of sufficient information
- Commit to evaluation, openness to scrutiny and external review
- Develop cultural sensitivity and competence
- Stay updated on the evidence base regarding effective practice
- Develop an understanding of universal human rights, power relations between outsiders and the emergency- affected people, and the value of participatory approaches.

Chapter 2: Getting started

This chapter describes some of the important tasks in getting started. It provides guidance on how to set up and structure initial activities after ERU deployment. A crucial element in this initial stage is cooperation with the hosting National Society and other entities working in PSS. On-going monitoring and reporting requirements are also detailed. The last part of the chapter provides guidance on how to deal with restoring family links and with violence. These are important and challenging areas that are common in emergencies and as such, you are likely to have to deal with these as a PS delegate.

Responsibilities of the psychosocial delegate

Your overall task as PS delegate is to plan and support basic psychosocial activities as part of the work of the ERU, together with the hosting National Society and/or local health authorities.[22] This entails the following tasks:

Logistics

- Set up the psychosocial component where possible and appropriate in the vicinity of the ERU
- Connect with ERU colleagues and agree on modes of collaboration and flow of patients through the clinic.

Management

- Establish the line of command and the reporting requirements together with the ERU team leader and the hospital administration
- Establish the budget for psychosocial activities.

Assessments

- Take part in health assessment activities with specific focus on psychosocial issues, mapping of local resources and identification of gaps
- Assess existing mental health and psychosocial resources and link up, where necessary and possible.

Recruitment and training of volunteers

- Interact with the Operating National Society to identify volunteers to assist in running psychosocial activities; follow screening policies and procedures
- Facilitate training of volunteers in psychological first aid and emotional support to affected groups and individuals, including creating safe environments, protection and handling disclosures
- Instruct volunteers on how to organize games and play activities for children.

Set up and implement PS activities

- Create safe environments, free of violence
- Launch psychosocial activities

- Organize outreach activities, e.g. community-awareness raising sessions and support groups
- Establish opportunities for mourning of the dead
- Continuously assess, monitor and evaluate needs and activities, follow up when necessary,

Cooperation, information sharing and coordination

- Inform ERU team members about psychosocial issues, including psychosomatic, grief and extreme stress reactions that can occur within the affected population
- Liaise with local health authorities, WHO, UNICEF and others regarding psychosocial interventions and mental health care at cluster meetings, if applicable
- Conduct short awareness-raising trainings on the need for psychosocial support and safe environments free of violence to people in leadership positions, for example in emergency response organizations, with camp committees or military personnel assisting the ERU.

Following a flood in Senegal some street children gravitated towards the psychosocial activity tent. After some time they began to take part in the daily activities which they greatly enjoyed. The psychosocial delegate observed that the street children also associated with the military personnel. They helped the military to clean the community after the flooding. After consulting with the ERU team leader and the head of the military, a brief presentation on child protection was given to military personnel.

Good communication skills enabling you to work closely with community leaders and representatives and good training skills for your work in orienting community volunteers are all essential in your task as a PS delegate. Your work should at all-time be based on the premise that culture, belief systems, established habits, attitudes, behavior and religion are to be respected and leveraged, in order to facilitate improvements in the health and general wellbeing of the public.

Setting up the psychosocial support component

As PS delegate in an ERU, you will be working in challenging and chaotic circumstances with limited access to resources. There will be situations where you will have to improvise to find the best possible solutions to many unforeseen challenges and problems. A timeline describing activities in relation to ERU deployment and the psychosocial support component is on page 26. All activities described in this and later chapters relate to this.

Once the ERU has been deployed and all delegates have arrived on the location for the ERU operation, the initial action is to identify a suitable site for setting up the psychosocial support component. As part of the health ERU, this may either be in the immediate vicinity of the Basic Health Care Unit or Referral Hospital. If a more

appropriate location is identified, for example, in connection with a spontaneous camp or a camp for internally displaced people (IDPs), the psychosocial support component may be set up here.

Checklist for setting up the psychosocial component

- Decide the appropriate spot for the tent of the psychosocial component
- Coordinate with ERU colleagues
- Do an initial assessment of needs and opportunities for activities
- Inform and liaise with other ERUs, NGOs and local authorities
- Establish a budget for activities, such as training, development, translation and printing of material etc.
- Establish how to coordinate with other PSS activities, local and international NGOs
- Establish attendance at cluster meetings

The ERU psychosocial support component can be housed in one or two tents. This is where most of the activities are coordinated and carried out, if space allows. Some interactions call for a quiet space for private, one-on-one communication. If needed this space can also be used, for example, to host a group mourning a dead relative.

Psychosocial programme in Meulaboh, Indonesia, in the aftermath of the tsunami, December 2004. © Ulrik Norup Jørgensen

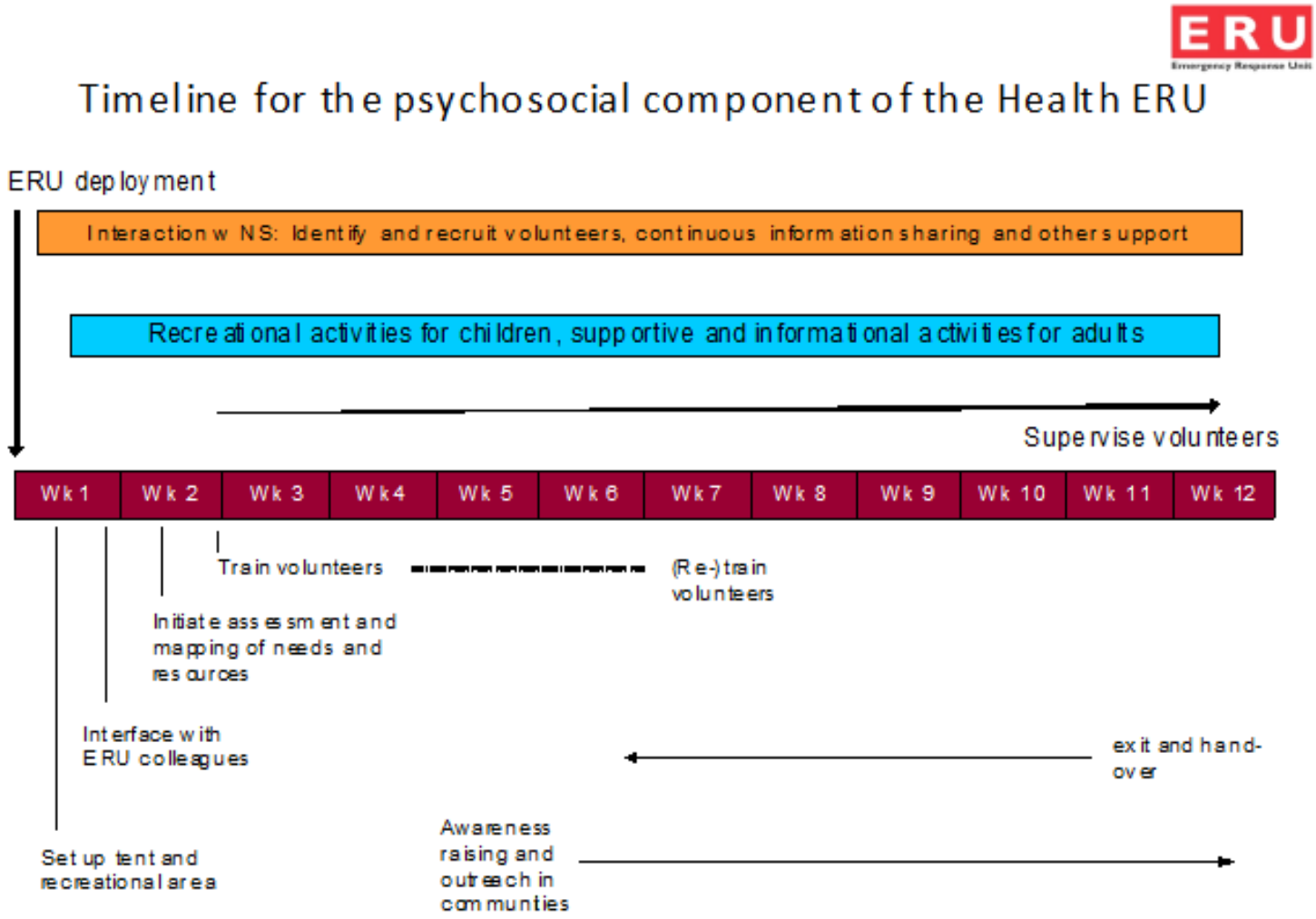
Other activities, such as support groups and awareness-raising sessions, are group activities that require more space and by nature are noisier, as they involve group discussions. When setting up the physical layout of the psychosocial support component, take into consideration the various activities that will take place here:

- Play activities in the tent for younger and older children
- Outdoor play activities for younger and older children
- Informational and supportive activities for adults, individuals or groups
- Information point or notice board
- Access points
- Training and facilitation for volunteers, ERU staff and members of the community
- Office and work space for the ERU psychosocial delegate and volunteers used for meetings, coordinating activities
- Relaxation or recreational area for the psychosocial volunteers.

Early on, it is important that the ERU team leader and delegates agree on how the psychosocial support component and its activities will be coordinated with the rest of the ERU. The ERU team may decide on a certain flow of patients through the clinic. If the psychosocial support component is set up in the immediate vicinity of the Basic Health Care Unit or Referral Hospital, children who are waiting for their treatment or their parents, can be invited to come to play. Adults who are in the clinic or hospital need to be made aware that they can access information and supportive activities in the psychosocial support component. If the psychosocial support component is based in an IDP camp, for example, it may function as an area for social interaction and support for camp residents.

When planning activities you will need to take existing resources into account. It may be necessary to allocate a budget for psychosocial activities, for example, to cover expenses for meals, transport, etc., for volunteers attending trainings.

Dual function: psychosocial support to the ERU and to the general public
The psychosocial component of the ERU has a dual function, as it serves the ERU and at the same time it serves the community. Regardless of its location, the psychosocial support component has the potential to become a hub for interacting with the surrounding community and a place from which to organize outreach activities. It is important to signal this dual function so that as many people as possible can access psychosocial support.


ERU
Timeline for the psychosocial component of the Health ERU
ERU deployment
Interaction w NS: Identify and recruit volunteers, continuous information sharing and others upport
Recreational activities for children, supportive and informational activities for adults
Supervise volunteers
Wk 1
Wk 2
Wk 3
Wk 4
Wk 5
Wk 6
Wk 7
Wk 8
Wk 9
Wk 10
Wk 11
Wk 12
Train volunteers
(Re-) train volunteers
Initiate assessment and mapping of needs and resources
Interface with ERU colleagues
exit and hand-over
Awareness raising and outreach in communties
Set up tent and recreational area

Interaction with the Operating National Society
An important next step is to approach the Red Cross Red Crescent National Society in the country of operation. Depending on the location of the ERU deployment, this may be at either headquarters or branch level. The decision for how and when to get in touch with the Operating National Society lies with the ERU team leader, as interaction must be coordinated.

The **primary purpose** of the visit is for you to explain the purpose of the ERU psychosocial support component and to request a number of volunteers to assist in carrying out the activities. The availability of volunteers is dependent on both the nature of the disaster that the ERU is responding to and the resources and capacity of the Operating National Society. If possible, try to arrange to have a contact person in the Operating National Society for the period of your deployment.

Checklist for interaction with Operating National Society

- Liaise with National Partner Society
- Establish contact with National Society or Local Branch
- Explain the purpose of psychosocial support and the activities
- Identify a contact person
- Screen and enrol volunteers
- Establish what support the local branch can offer the volunteers

An important **secondary aspect** of the visit is to get an initial impression of services that are already provided in the area of psychosocial support, by either the Operating National Society, local or international organizations, local support initiatives etc. It is essential to coordinate planning to avoid duplication, and so you should seek as much information as possible prior to initiating activities in the ERU psychosocial support component. If feasible, psychosocial support activities may be carried out in coordination or collaboration with already existing action or initiatives.

Establishing a profile of psychosocial needs - assessment
While planning the launch of ERU psychosocial activities, you must assess the context in which the psychosocial support activities will be implemented. This may be done either in connection with the general health assessment carried out by the ERU team or as a separate activity.

Establishing contact with local health authorities, organizations and stakeholders in the psychosocial field is an important first step. In most emergencies different groups, such as government departments, UN organizations and NGOs, will collect information on psychosocial and mental health issues. Psychosocial action must always be coordinated as much as possible with other entities.

Key information to be collected includes:

	Data collection
Relevant demographic and contextual information	Size of (sub) population Mortality rates and threats to mortality Access to basic physical needs (e.g. food, shelter, water and sanitation, health care) and education Human rights violations and protective frameworks Prevalence and incidence of interpersonal and self-directed violence Social, political, religious and economic structures and dynamics Changes in livelihood activities and daily community life Basic ethnographic information on cultural resources, norms, roles and attitudes Communication systems in place
Experience of the emergency	Local people's experiences of the emergency (perceptions of events and their importance, perceived causes, expected consequences)
Mental health and psychosocial problems	Signs of psychological and social distress, including behavioural and emotional problems Signs of impaired daily functioning Disruption of social solidarity and support mechanisms Information on people with severe mental disorders Reports on violence
Existing sources of psychosocial wellbeing and mental health	Ways people help themselves and others Ways in which the population may previously have dealt with adversity Types of social support and sources of community solidarity Types of safety measures people are using
Organizational capacities and activities	Structure, locations, staffing and resources for mental health care in the health sector (see WHO *Mental Health Atlas*) and the impact of the emergency on services Structure, locations, staffing and resources of psychosocial support programmes and violence prevention programmes in education and social services and the impact of the emergency on services Mapping psychosocial skills of community actors Mapping of potential partners and the extent and quality/content of previous MHPSS training Mapping of emergency MHPSS programmes
Programming needs and opportunities	Recommendations by stakeholders Extent to which key actions outlined in IASC guidelines are implemented Functionality of referral systems between and within health and other social, education, community and religious sectors

A **checklist** using the same format is in Annex 2 and is also available in the tools section of the ERU psychosocial support USB stick.

You will be collecting this information mainly through focus group discussions, key informant interviews, observations and site visits.[23] Statistical information, e.g. existing data about health systems, can also be helpful to complement the picture.[24]

Heavy rain was forecast in a disaster area. Many of the ERU volunteers were living in IDP camps nearby. Some of them asked the PS delegate if she could give them a tarpaulin and a blanket to help keep their families dry and warm. The PS delegate gently explained that the ERU needed to use these supplies for the hospital –they were not for personal use, even though she understood their needs and would have liked to have responded to them.

Recruiting and engaging volunteers

The PS delegate is dependent on local volunteers and staff to facilitate PS activities and to interact with both children and adults. It is usually not possible to estimate the number of volunteers who will be available for this task; this depends on both the capacity of the National Society as well as the nature of the emergency. Many volunteers may already be involved in relief activities or dispatched to assist other teams. However, when negotiating with the Operating National Society (branch or headquarters) leadership, the delegate should attempt to secure 15-20 volunteers to be attached to the psychosocial support component.

An information sheet has been developed on how best to support National Society volunteers. It is information sheet 3 (available in kit 3 - see chapter 4 for details). It explains how working as a volunteer in an emergency is often beneficial, but that it also puts pressure on because of the hectic and chaotic environment of emergency settings. The leaflet describes the responsibilities of the National Society in creating a supportive safe work environment for volunteers and the kinds of support mechanisms that should be in place, if at all possible. It may be used to advocate on behalf of volunteers when interacting with the Operating National Society.

Ideally, volunteers recruited to assist with implementing ERU psychosocial activities should have a background in providing social support services. However it may be impossible to recruit volunteers who already have this kind of experience. In reality, you may have little say on the volunteers who come to work in the psychosocial support component. However you should try to recruit and screen volunteers with appropriate backgrounds, such as schoolteachers and social workers,

In a large-scale crisis, coordination of the distribution of aid had been very difficult and the volunteers involved had suffered many losses themselves. A support group was organized for the volunteers after working hours. This gave them an opportunity to address their own situation and enabled them to continue supporting others.

as well as people with previous experience of providing PSS. Remember these volunteers will be working with vulnerable people and it is the PS delegate's responsibility to ensure that the volunteers will not harm them.

Checklist for recruiting and engaging volunteers

- Draw up an initial plan for activities
- Recruit and screen volunteers
- Brief on IFRC Code of Conduct and have each volunteer sign it
- Conduct training of psychosocial volunteers on PFA and activities
- Establish a daily routine, roll call, working hours, meetings etc.
- Set up procedures for inclusion and exclusion of volunteers
- Ensure volunteer policy is in place

In this initial period, you will be busy planning the launch of activities and at the same time organizing and facilitating the initial volunteer training. (Chapter 5 covers volunteer training in detail.)

Volunteer training usually needs to be repeated during the period of ERU deployment. There are several reasons for this: The volunteers may not stay in the same team throughout the period of deployment. There is often an influx of people looking for work and new volunteers need to be trained, whenever they join the team. Sometimes more training is needed once the volunteers have got familiar with the activities. Once the team of volunteers is complete, it is good to instruct the people fielding requests for volunteer jobs (often guards or volunteers in post) to know how to turn people away in a respectful manner.

In most cases volunteers get an incentive or a per-diem – a small amount of money to cover daily expenses, for instance, when travelling to and from the ERU. Volunteers may not have any income in the emergency phase of a crisis situation. In this context, payment of expenses is important to enable people to volunteer. It is important to ensure the handover of money is done in a locally acceptable manner. Usually there is a roll call every day to register those present and payment is made at the end of the week.

You are responsible for supervising volunteers in their work. Make opportunities

Two psychosocial volunteers were no longer engaging in the work of the ERU and preferred chatting– or so it seemed - under a shady tree. The psychosocial delegate approached the volunteers and asked them how they were, what they thought about psychosocial support, etc. They told the PS delegate that there was a minor misunderstanding between the two and some of the other volunteers. The misunderstanding was rectified and they were then able to participate fully in their work.

to talk with volunteers regularly. If someone seems dispirited or doesn't seem to understand some aspect of psychosocial support, discuss how you can help. They may need more training or perhaps they would prefer to take part in other activities or do other tasks.

Launching psychosocial activities

During ERU deployment, you are responsible for planning, coordinating and overseeing the PS activities. Volunteers facilitate those activities. It is usual for you to spend more time closely supervising activities early on during deployment. As volunteers become familiar with facilitating activities and interacting with community members, you can then devote more time to other activities, such as organizing outreach activities in neighbouring communities, doing follow-up training for volunteers, linking up with local organizations and initiatives and gradually preparing for exit and handover.

The ERU psychosocial support component is an open space. For it to be used as a resource by the local community, it is important to communicate opening hours and advertise on-going activities and special events, such as awareness-raising sessions and support groups.

Children come to this kind of facility to play and adults come to socialize and to seek assistance and information about the emergency and possibilities for further assistance. Both children and adults may receive emotional and social support in dealing with the distress or grief they are experiencing. Some community members will come only once, and the intention is that they benefit from their visit, by being informed, being made aware of their own reactions or simply by having a pleasant time while playing or talking. Other community members will become part of a group of regulars and activities must be designed in a way that meets their needs as well.[25]

Depending on the context in which the ERU operates, the psychosocial support component may operate anywhere on a continuum, as shown below:

The timeframe of operation of health ERU deployment is usually up to three months. After this time, the contents of the ERU including the psychosocial support component will usually be handed over to the Operating National Society or other organization working in the area of operation. It is therefore important to have on-going contact and to coordinate with other psychosocial support action throughout the period of deployment. It may be that there will be interest to continue activities as part of a formalised psychosocial support programme at the end of this period.

Daily and weekly reporting requirements

In the first few weeks of an ERU deployment, there are daily verbal and written reporting requirements. Initially you will be expected to provide a daily verbal report to the team leader, head of ERU or to everyone at the daily staff meetings. Statistics are needed daily, as well as situational reporting to the head of the ERU.

Checklist of reports

- Daily verbal reports to team leader, head of ERU or at staff meetings
- Daily written statistics to the head of the ERU
- Daily situational report to the head of ERU
- Weekly reports and statistics to the ERU and IFRC PS Centre
- Occasional requests for reports to National Society, local administrations or cluster meetings

The format for the written documentation in the form of statistics and situational reports (Sitrep) will be supplied by the ERU. A weekly narrative report with statistics is done using the form in Annex 3 and in the 'tools' section of the ERU psychosocial support folder on the USB stick.

Other reports might be requested depending on the context. It may be the local hospital administration, requesting an update on the psychosocial activities or the National Society gathering information on all psychosocial activities in the area.

A few weeks into deployment, situational reports usually cover a period of two to three days and by the end of deployment, they will probably only be required once a week.

An example of a situational report after one month's deployment:

19 volunteers participated in the weekly activities and more than 100 beneficiaries were supported every day. During the week special attention was given to children and staff. Volunteers began planning the establishment of safe spaces for children. Individual psychosocial support was provided to volunteers to help ease their own pain and losses. PS delegates met with local hospital staff providing psychosocial support to discuss future areas of cooperation and exchange.

Monitoring

The PS delegate is responsible for monitoring the ERU psychosocial support component. This means:

- Monitoring and supervising volunteers
- Monitoring the PSS activities
- Monitoring the on-going needs of the community.

Right after a cyclone in Bangladesh the psychosocial delegate established a daily routine of gatherings with the volunteers:

- *in the morning for the roll call and planning of the day's activities;*
- *at lunch to follow up on the events of the morning and*
- *in the evening to talk about the work of the day.*

This allowed the delegate to monitor the activities and the wellbeing of the volunteers.

The PS delegate supervises all the volunteers and must make sure that volunteers interact with children and adults in an appropriate manner. You must also be aware of possible signs of stress and continuously assess the dynamics within the group of volunteers. The group composition may change over the period of ERU deployment and most likely the volunteer training will have to be repeated for new volunteers. All these changes must be recorded in monitoring reports.

The monitoring form in Annex 3 and the 'tools' section of the ERU psychosocial support folder can be used to monitor activities and numbers of people assisted on a daily and weekly basis. The psychosocial delegate should integrate their reporting of psychosocial action with reporting of other activities within the ERU, as agreed with the ERU team leader.

At the same time, you are also assessing psychosocial needs with the community and coordinating activities and information sharing with local and international organizations working in the field of mental health and psychosocial support. It should then be possible to adapt the activities carried out with the ERU psychosocial support component in line with the surrounding environment.

Please note: A new monitoring system enabling improved monitoring and evaluation of for the ERU PS component and the effect on beneficiaries is under development. This manual will be updated accordingly, when the new system in place.

Visibility and the media

Journalists are usually keen to find out about the impact of relief operations in emergencies. Psychosocial activities provide excellent media and photo opportunities

and as psychosocial work is relatively new, it is of interest to the media. Exposure is essential in mobilizing attention to the crisis situation and in fundraising for the relief operation. It is an opportunity to explain the need for psychosocial support and gives the world an impression of work in the ERU.
It is important to keep the goal of the ERU in mind when setting aside time for the media. The influx of reporters may get in the way of the work and may overwhelm the beneficiaries. As the PS delegate you must secure the agreement with the head of the ERU for interviews and if beneficiaries are portrayed, they need to give informed consent to interviews as well as photos.

Checklist for contact with the media

- Get permission from the head of the ERU for contacts with the media
- Secure informed consent from volunteers or beneficiaries for contact with the media

Psychosocial support and restoring family links (RFL)

The restoration of family links is important in so many ways. It can have an important psychological and emotional impact, as well as significant social and economic consequences on families.

Not knowing the fate of family members and loved ones causes great suffering to large numbers of people throughout the world. In emergencies, the need to know where and how relatives are – if they have survived, if they need help – is a priority. Beyond this immediate need in the acute phase of an emergency, the psychological, physical and social recovery of individuals and communities depends heavily on the family. For the majority of people affected by emergencies, family is perhaps the most essential coping mechanism of all. Not knowing the fate of one's family can ultimately lead to years of anguish.

What are RFL activities?
RFL is the generic term used to describe various activities that aim to prevent separation and disappearance, restore and maintain contact between family members, reunite families and clarify the fate of persons reported missing. These activities are often connected to the psychological, legal and material support provided to the families and persons affected, resettlement and reintegration programmes and social welfare services. Some 80 ICRC delegations and 188 National Red Cross and Red Crescent Societies around the world undertake RFL activities, whenever required and for as long as needed.

The distress of victims separated from their loved ones after emergencies highlights the importance of the Movement's RFL action. The mechanism for the rapid international RFL

deployment, called the **RFL pool of specialists**, was established in 2009 to strengthen the Movement's response in large-scale humanitarian crises. The RFL pool of specialists comprises 60 persons from 19 National Societies and ICRC and since its establishment, pool members have been deployed in all major emergencies worldwide.

Links between psychosocial support and RFL

As a psychosocial delegate you will often be faced with people in dire need of your support, because they have been separated from their families. Providing them with psychosocial support is crucial. Moreover, helping them to restore contact or finding out the whereabouts of their family members will contribute immensely to their psychological wellbeing. At the same time, your RFL colleagues will deal with a number of cases on a daily basis, trying to restore contact and reuniting loved ones. Providing psychosocial support to these families, on top of the RFL response, will help them deal with the agonizing pain of not knowing the fate of their relatives.

Whenever and wherever you are deployed, you can be sure there will be RFL teams on the spot – either from the National Society, the ICRC delegation or/and the RFL pool of specialists. Contact any of the team, as they are best placed to provide a wide spectrum of RFL services. They may also need your support in dealing with family separations.

Port-au-Prince, Haiti, 2010. After the worst earthquake in the country's history, an ICRC employee and a volunteer of the Haitian National Red Cross Society interview a woman: they are hoping to reunite her with her child. *Photo: CICR/KOKIC, Marko.*

What can PS delegates do about RFL?

- Establish contact with the RFL team on the ground (National Society, the ICRC delegation or the RFL pool of specialists)
- Ensure your team members, especially volunteers, as well as your Health ERU colleagues, are aware of RFL aspects
- Identify RFL needs among persons you are assisting, by asking if they have lost contact with family members, paying particular attention to children. Refer such cases to the RFL team.
- Be aware that medical evacuations and transfers in emergencies sometimes lead to secondary separations between injured persons and their families. Ensure with your Health ERU colleagues that such evacuations and transfers are registered and families duly notified.
- If for any reason you are not able to refer such cases to the RFL team, at least ensure access to means of communication for the persons you are assisting.
- In coordination with the RFL team, ensure they refer to you cases of the most vulnerable individuals, requiring psychosocial support and follow-up.
- Try to make your non-Movement PSS colleagues aware of the RFL services provided by the Movement and encourage referral of RFL cases.

Key messages about RFL and psychosocial support

RFL and psychosocial support services are closely related – often provided to the same persons who are in distress due to family separations.

The best psychosocial support for people who have lost their loved ones is to actually help them find their families.

Psychosocial support is crucial for people desperately searching for their disappeared family members.

A two-way referral system between RFL and psychosocial teams in the field is vital.

If you want to learn more about RFL activities in emergency situations, please consult RFL colleagues in your National Society. For further reading, please refer to "Restoring Family Links in Disasters: Field Manual" available with the RFL service of your National Society.

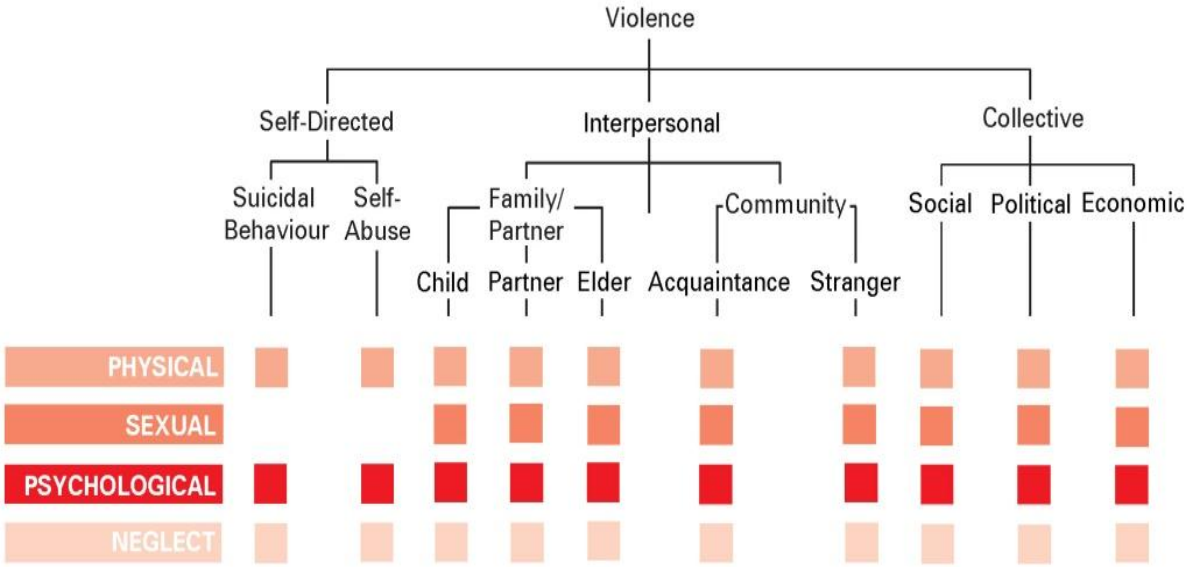
Violence in emergencies

What is violence and why is it important to consider in emergencies?
In emergencies the risk of violence – people hurting other people, or people hurting themselves – intensifies. Fragile, protective systems become strained or even collapse, stress levels soar, and people engage in harmful or exploitive behavior. Violence encompasses child abuse, family violence, gender-based violence, bullying and harassment, elder abuse, and community violence, such as gang violence.

For each act of interpersonal violence, there is a person inflicting violence, a target or victim/survivor of the violence, and often bystanders who watch, hear or know of the violence. Self-directed violence occurs when someone causes harm to themselves. This includes harm caused by the abuse of alcohol and other substances and by suicide.

WHO defines violence in three categories: self-directed, interpersonal and collective. Each of these categories has four different types of violence which are common to all: physical, sexual, psychological and neglect/deprivation. Most people are vulnerable to violence in emergencies, but some groups such as children are usually more vulnerable than others.

WHO categorization of violence[26]



Building on this WHO model, in November 2011 IFRC adopted and launched the Strategy on Violence Prevention, Mitigation and Response 2011 – 2020, with a focus on interpersonal and self-directed violence[27].

Gender-based violence (GBV) is violence that is inflicted on a person due to their gender, whether they are female, male or trans-gendered. Gender is one of the root causes of violence. It can include all types of violence – physical, sexual, psychological, deprivation - and violators can be individuals, groups and/or societies. It can be identified as either inter-personal or collective violence, with sexual gender-based violence during conflict now identified as a war crime. Gender also is a social determinant for types of self-harm.

'Sexual and gender-based violence' (SGBV) is an umbrella term for harmful acts based on 'socially ascribed differences of genders'. This means that differences depend on the culture, social setting and ethnic context in which the violence occurs. SGBV includes acts that inflict physical, mental, or sexual harm or suffering; threats such as coercion; and other deprivations of liberty[28].

Some agencies in emergency settings might use SGBV mainly to describe violence against women. However it is important to acknowledge that men are also victims of SGBV, specifically when it is used as a weapon of war in armed conflicts. When men are targeted, they are often victims of sexual torture or forced to commit violent or sexual acts on family members or strangers. (More information about men as subjects of SGBV can be found in "Shattered Lives" published by MSF[29]).

In emergencies, the risk of interpersonal and self-directed violence needs to be monitored and responded to with the same urgency, attention and resources as other preventable public health emergencies and psychosocial issues. As a PS delegate with multiple roles - assessor, educator, programme implementer, listener and supporter - you have a crucial responsibility too in preventing, mitigating and responding to violence.

What are the causes and risk factors of violence in emergencies?
Violence is a complex issue with root causes identified within individuals, relationships, communities and societies. While there are many variables that increase the risk of violence during an emergency, common underlying risk factors include:

- the collapse of protective systems;
- crowded and insecure environments;
- a stress-filled context;
- separation of family members;
- gender and age based inequalities and discrimination;
- social isolation and exclusion;
- harmful use of alcohol and other substances;
- income inequality;
- pre-existing vulnerabilities such as domestic violence, child abuse; and
- misuse of power.

What is the impact of interpersonal and self-directed violence during emergencies?
Violence within emergencies means there are 'disasters within disasters' that take an additional toll on individuals, communities, societies and the recovery process. Some of these impacts are:

- **Physical:** bruises, fractures, abrasions, injuries, delayed development, chronic diseases, addictions, death
- **Sexual:** unwanted pregnancies or abortions, vaginal fistulas, sexually transmitted diseases including HIV/AIDS
- **Psychological**: PTSD, depression, helplessness, hopelessness, inability to trust, fear, stigmatization, low self-esteem, loss of liberty
- **Community**: fear, loss of productivity, poverty, stigmatization, changed community identity
- **Society**: costs to health, education, social, legal and justice systems
- **Emergency recovery**: recovery is slowed because people feel unsafe even as they try to get their basic needs met; psychosocial needs are heightened.

Who is at increased risk of violence during emergencies?
All people are at risk, but some are more at risk than others depending on the context, pre-existing risks, separation and presence of protective systems:

- Children
- Adolescents/youth
- Women
- People with disabilities
- Older people
- Men.

What is the role of the PS delegate in violence prevention?

Pre-deployment

- Know the international protection conventions such as the Convention on the Rights of the Child, Convention on Eliminating Discrimination against Women, Convention on People with Disabilities
- Know the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, the Sphere Guidelines and the Children's Charter for Disaster Risk Reduction
- Know the IFRC Strategy on Violence Prevention, Mitigation and Response and the IFRC Gender Strategy
- Know 'Ten Steps to Creating Safe Environments' (Canadian Red Cross)
- Know the IFRC advocacy report, 'Predictable, Preventable: Best practices for addressing interpersonal and self-directed violence during and after disasters'
- Know the child protection laws of the country where you are being deployed.

Set-up phase:

Assessments

- Include questions on violence in your assessment
- Define community-based programmes, resources and referrals for violence prevention – both informal and formal - and identify gaps
- Identify violence prevention programmes supported by Movement partners and other humanitarian agencies
- Identify potential at-risk groups
- Liaise with Operating National Societies (ONS) on screening of volunteers and staff, and current and historical violence prevention programmes and services.

Planning

- Develop standards of practice to ensure safe environments including a safety plan
- Set up safe spaces for PS activities with access points being able to be monitored
- Educate your staff and volunteers on violence prevention, protection (especially of children) and creating/maintaining safe environments
- Ensure that codes of conduct have been understood and signed
- Set –up referral systems (informal and formal) within communities and with other agencies, both local and international
- Collaborate with communities; have in place a system specifically for responding to children who are experiencing violence
- Conduct a risk assessment on your own programmes and activities
- Collaborate with other groups working on the same issues.

Implementation phase:

- Inform beneficiaries that they have a right to be safe and free of violence. Explain how they might prevent and lessen violence and how and where they can report any incidences.
- Indicate where information and resources about violence prevention are available, both locally and online (where accessible).
- Monitor the implementation of your own programmes and activities for safety and identify on-going risks.
- Respond to both verbal and non-verbal disclosure of violence:
    - Listen – use open-ended questions; do not interview; do not make promises; do not keep secrets
    - Refer/report – according to situation, context, need, legal requirements, policies, age of person disclosing. Inform your manager
    - Document – record accurately and specifically; store confidential information securely.

Handover phase:

- Review your safety plan.

- Review your referral base.
- Make recommendations for maintaining safe environments free of violence.
- Liaise with your manager on the handover of confidential files.
- Know you have made a big difference in people's lives in both creating safe environments for them and being able to respond to their disclosures.

Taking action and dealing with survivors of violence is a very delicate matter. In some cultures, people who have experienced sexual violence are likely to experience traumatic stigmatization or even rejection from the local community, if violence is disclosed. The following 'do no harm' principles (similar to the ones used in psychological first aid) are therefore important to know:

Do:	Do not:
Do listen: Say, "I can listen."	**Do not** ask leading questions: "Why…?" "What…?" "Who…?" etc.
Do use open-ended statements: Say, "Tell me about it."	**Do not** draw conclusions: "Have you been beaten?"
Do affirm their action: Say, "It takes a lot of courage to talk about this."	**Do not** analyze: "You must hate your husband for doing this."
Do inform them of their rights: Say, "You have a right to be safe."	**Do not** make promises: "Everything will be alright if you report this."
Do tell them of next steps: Say, "We need to get some help with this."	**Do not** become a part of the secret: "Don't worry, I won't tell anyone."

After the initial phase

All ERU deployments differ and the timeline will vary according to the circumstances. It is easy for PS delegates to get caught up in the running of the day-to-day activities, but it is important for you to build the capacity of the local branch to sustain psychosocial activities once the ERU mission is over.

Checklist for the early recovery phase

- Adjust the approach of volunteers to fit the early recovery phase
- Assess the needs for training of volunteers
- Build capacity of National Society
- Integrate psychosocial support in other programmes
- Collaborate with other organizations offering psychosocial support

Setting up a meeting with the local branch is a good way for you to assist in the planning of future psychosocial efforts in the community. Depending on the rotation you are deployed to, you might find that the operation has entered a recovery phase and so the activities may need to be adjusted accordingly. Psychosocial interventions may of

course end, when the emergency phase is over. But, if you have the time, try to assess whether recovery and/or long-term development programmes would be relevant. They can help prevent further harm and promote resilience and psychosocial wellbeing. Often these kinds of programmes evolve naturally, but planning ahead helps avoid gaps in delivery of PS services. This assessment should always be done with the agreement of the donor National Society and the hosting National Society.

PSS programmes can be stand-alone or integrated into programmes. If it is a stand-alone PSS programme, it will usually have its own budget and management and be implemented independently. If it is integrated, it will be part of a bigger, sectorial programme (such as health, social support, education, livelihood or life-skills programmes) and managed and implemented in conjunction with these activities.

The IFRC PS Centre is at your disposal with technical support and offers a variety of tools for assessment and implementation, including:

- Psychosocial interventions: A handbook
- The Children's Resilience Program: Psychosocial support in and out of schools
- Caring for Volunteers – A Psychosocial Support toolkit
- Life-skills handbook (available March 2012)
- Sports and physical activities in PSS (available in 2013)

These handbooks provide guidance on how to develop both stand-alone and integrated PSS programmes, trainings and supervision of volunteers in a recovery and development setting, and how to link PSS into other sectors and fields.

As a PS ERU delegate – no matter at which phase of the emergency – it is important that you keep a **strategic view**, as well as responding to the immediate needs of an emergency. You will then be ready to move from a PS emergency response into something more recovery and development-oriented when the situation allows. This is the only way to ensure that the PSS work conducted within the ERU becomes sustainable in the longer term.

Ending the ERU mission

An ERU mission usually lasts up to three months, though sometimes this period may be extended depending on the nature of the emergency. The handover and exit strategy are usually planned in advance. It is your responsibility to write a handover report for the head of the ERU and to organize the practical handover for whatever programmes and activities have been on-going. Your report will include summaries of plans or recommendations made in conjunction with the local branch about psychosocial support in the community and will indicate who will be responsible for future programmes. Adequate training should be done well in advance to prepare those volunteers who are carrying on the activities of the next phase, together with the coordinator from the National Society. This is a good point at which the efforts of the volunteers are celebrated in a formal farewell ceremony.

Chapter 3: Activities for children

This chapter deals with providing support to children after emergencies and describes safe standards of care and the benefits of play for children. The contents of PS ERU play kits 1 and 2 are also listed here with details of each item.

Supporting children after emergencies

Children are a particularly vulnerable group during and after emergencies. Children's wellbeing can be affected if their parents or caregivers are overwhelmed or exhausted or depressed, and therefore physically or emotionally unable to provide care, routine and support.

Safe standards of practice

In setting up child friendly spaces, it is critical to provide an environment that is safe for the children and protects them from harm. This is the first priority. This means that there is a safety plan that includes screening, training and monitoring of volunteers and staff. Personnel need to know best standards and practices regarding:

Working with Children	Safe Standards of Practice
Touching	Only touch children on their hands, arms, shoulders and head – with their permission
Alone with child	Never be alone with a child: can be out of hearing but not out of sight
Bullying between children	Bullying should not be allowed even if it is labelled as "teasing". Need to deal with person who is bullying, the person who has been targeted and the bystanders
Working with disabled children	Understand their disability, adjust to their care, always have two adults for any personal care
Personal care of young children, such as toileting	Always have two adults or two children with one adult: rule – 2:1
Contact with children outside work	Contact with children is during work, not outside, unless they are family members or you have known them previously
Access to children	When children are in your care, always know who is with them and if these people have been screened

	Check who in the family or community can pick up the child from activities
Disclosures of abuse/violence: **Non-verbal – you become suspicious of patterns of physical and behavioural signs** **Verbal – children tell you they are being harmed either physically, sexually, emotionally, and/or neglected**	Know your safety plan and local child protection legislation Listen: do not interview; no promises; no secrets Tell the child you are worried and want to make sure he/she is safe Discuss with your supervisor Report/refer according to your safety plan and child protection legislation Document specifics: store in secure place Follow up according to safety plan.

One of the most difficult experiences is when you know a child is being harmed and a community referral system and safety plan are not in place. Therefore it is important to plan for this scenario before "opening up for business". If child protection legislation is in place, it will guide the next steps; if not there needs to be a community/Host National Society /NGO safety plan.

The benefits of play

The ERU psychosocial support component contains materials for play and recreational activities. Play is one aspect of children's wellbeing - once children are safe, they should play as much as they wish. Stimulation and opportunities to play and for education are often interrupted during crises and emergency situations. It is very important to re-establish such opportunities as soon as possible. Children also benefit from having routines in their daily lives, as far as this can be achieved.

Why conduct play activities?
The purpose of conducting play and recreational activities is to enable a positive social and physical environment where children find opportunities for stimulation, skills-building and socialisation.

Play is very important - children develop their understanding of the world around them through play. They realise their potential and develop physically, intellectually, emotionally and socially. Early childhood activities should provide stimulation, facilitate basic nutrition in situations of food shortage, enable protection and promote bonding between children and their caregivers.[30]

Skills development falls within several categories,[31] as listed in the table below:

Skills	Description
Cognitive skills	Involve mental processes in learning, understanding, reasoning, decision making, remembering and problem solving
Sensory skills	Encompass hearing (auditory skills), seeing (visual skills), touching (tactile skills), tasting, smelling and sensing body/muscles and balance (kinaesthetic skills).
Hand-eye coordination skills	Refer to the control of eye movement and hand movements as well as the processing of visual input to guide bodily movement. Training of hand-eye coordination happens in e.g. handwriting, drawing, games and sports activities.
Social and language skills	Deal with the interaction of children with other people through communication and cooperation. Encompass the ability to express and respond to feelings in a respectful way, to engage in relationships, to cooperate and solve conflicts. Language skills include understanding what others say, as well as developing a differentiated language through expansion of the vocabulary.
Motor skills	Gross motor skills deal with large muscle movements, i.e. using the large muscle groups through physical movement i.e. when jumping, running or kicking. Fine motor skills deal with small muscle movement when using the mouth, hands or fingers i.e. when sewing, eating with utensils or writing.

A week into a natural disaster, the main activities had been training volunteers, offering psychological first aid, establishing play activities for children and setting up an information board for adults. The volunteers were gathered for an afternoon of planning forthcoming activities. The volunteers spent time working on how to integrate local plays, songs and rituals into the activities for children and adults.

PS ERU play kits

There are two play kits – play kit 1 is for children up to six years old and play kit 2 is for children aged six to 18 years old. The kits have been specially designed and assembled for the different age groups of children.

> It is important to note that the purpose of the kits is to provide something to start with in the initial phase of an emergency. Not all items will be useful in all kinds of settings, for example due to cultural or hygiene reasons.

As PS delegate, please remind volunteers and staff that the play kits are start-up kits which can be added to with locally made toys and games etc.
They should adapt games and activities to the local culture and introduce activities that are known and accepted locally[32]. The toys and games and equipment should be looked after carefully to make them last as long as possible.

A. PLAY KIT 1 FOR CHILDREN UP TO SIX YEARS

This section describes each item in play kit 1, together with some suggestions for how they can be used. The list is an extended version of the overview in the *complete items overview catalogue*. Suggestions for additional activities and games can be found in the ERU psychosocial support folder on the USB stick, under 'List of additional games, play and relaxation activities for children.'

Four transportation boxes with padlock

The play kit comes in boxes that can be locked to keep the contents secure. The boxes are made of aluminium and have handles for easy transport.

Materials for instructors (BOX 1A)
1A-1: Drawing paper **1A-2: Adhesive tape** **1A-3: Pens** **1A-4: Pencils** **1A-5: Exercise notebooks** **1A-6: Glue sticks** **1A-7: Erasers** **1A-8: Sharpeners** **1A-9: Soap**
In order to maintain hygiene in a place where potentially many children stay and use the same toys, soap (for washing hands) is included in the play kit. All children coming to participate in activities should be shown how to wash their hands before engaging in activities. These items are mainly for 'instructors' i.e. the people conducting games and activities with the children:

- Adhesive tape can be used to put drawings or posters on walls or when making things for homemade games etc.
- These pens and pencils are generally not appropriate for children up to six years old. The children themselves should use large crayons when drawing, which are better suited to their stage of development.
- The drawing paper (called sugar paper) is for children's drawing activities. It has a slightly rough surface making it well suited for drawing on, as the colour attaches more easily. Please note there is a **limited amount of paper** available in the boxes. Instructors should use the paper wisely for specific drawing activities, so as not to waste this limited resource.

Toys and materials for activities

1B-1: Rattle
Age 0 months+
The bell inside of the rattle gives a pleasant and interesting sound when the rattle is shaken. When babies are a couple of months old, the rattle is relatively easy to grab and hold onto by themselves.

Transportation BOX 1B	
1B-1: Rattle	**(3 pieces)**
1B-2: Trix manipulation toy	**(2 pieces)**
1B-3: Stacking ring	**(1 piece)**
1B-4: Toy bricks, wood	**(2 pieces)**
1B-5: Shape sorter	**(1 piece)**
1B-6: Foam ball	**(3 pieces)**
1B-7: Soap bubble kit	**(3 pieces)**

1B-1: Trix manipulation toy
Age 6 months+
The trix toy is a manipulative toy consisting of small coloured pieces of wood put together with an elastic band. Playing with the toy stimulates the child's fine motor skills and colour recognition.

1B-3: Stacking ring
Age 1 years+
The stacking ring helps children learn about sequencing and supports hand-eye coordination when the rings are placed on the rod. Children can experiment with placing the rings either in sequence or out of sequence. The rings are coloured and thus present an opportunity to deal with colour recognition.

1B-4: Toy blocks, wood, coloured
Age 1 year+
Blocks are used for building simple structures and, in the case of younger children, for putting one on top of the other. This supports the development of manipulative skills, fine motor skills and the use of imagination when constructing. Large blocks are well suited for the smallest children, as they are big and easier to grip for little hands. They do not stick together like **Plus Plus** (see below), and are easy and fun to build into towers and knock down again.

1B-5: Shape sorter, plastic

Age 1 to 3 years
The shape sorter is a container with different shaped holes. Inside there are blocks that correspond to the shaped holes. The blocks are put into the container through the holes and so the child learns how to identify different shapes and sizes of objects by posting the blocks through the right holes.

1B-6: Foam ball, diameter 10 cm
Age 1+ years
The small sponge balls are used for simple throw and catch games involving one, two or more children. The balls may also be rolled across the floor between players and the game may simply consist of giving and receiving, time and again, between the child and the adult. Sponge balls are easy to grip for small hands and are not hard or heavy to play with.

1B-7: Soap bubble kit
Age: 3 months+
For children, soap bubbles are almost magical, as they reflect all the different colours of the rainbow while floating through the air. The soap bubbles can be used for initiating contact and playing together with younger children. Dip the loop into the bubble mix and blow gently against the soap film. Since young children may put the bubbles into their mouth, they must be closely supervised by adults.

Toys from the ERU psychosocial component play kit. Photo by Carina Sorensen / PS Centre

Transportation BOX 1C

1C-1: Hammer peg	**(1 piece)**
1C-2: Plus Plus puzzle blocks	**(1 piece)**
1C-3: Crayons, normal size	**(10 packages)**
1C-4: Crayons, jumbo size	**(10 packages)**
1C-5: Scissors, for children	**(pack of 2, 5 packages)**
1C-6: Clothespins	**(50 pieces)**

1C-1: Hammer peg
Age 2 years+
The hammer peg supports hand-eye coordination, motor skills and muscle performance. The physical action involved in hammering releases energy.

1C-2: Plus plus blocks, light foam material
Age 3 years+
Plus plus blocks are used for construction at any level. This aids the development of manipulative skills, fine motor skills, hand-eye coordination and social skills, in terms of learning to cooperate when two or more children build something together. Playing with Plus plus blocks also teach the children about cause and effect, spatial relations, the concepts of part/whole, proportions and problem solving.

1C-3: Crayons normal size, coloured, wax
Depending on the individual child's preference and motor skills, they may start using crayons of normal size by the age of 3.

1C-4: Crayons, jumbo size, coloured, wax
9 months+
The jumbo size crayons are suited to younger children, as they are easy to grip for small hands.

Caution: Jumbo and normal size crayons may break into small pieces which small children may put in their mouth, eat or choke on. Therefore, drawing activities with small children should always be supervised.

1C-5: Scissors for children, plastic, "safe ones"
Age 5+ years
Children aged five years and over may use these scissors when doing creative activities with paper. The scissors are safety scissors with blunt tips. Children of this age range do not yet have full command of their motor functions and may hurt themselves or others if playing with ordinary scissors.

1C-6: Clothes pins
Clothespins and string can be used to display children´s drawings and other papers e.g. information sheets for parents. The artwork can be changed daily, weekly, or even hourly. Multiple pieces can be displayed at one time, and then stored undamaged.

Transportation BOX 1D

1D-1: Mirror (plastic)	**(2 pieces)**
1D-2: Puzzle with knobs	**(1 piece)**
1D-3: Puzzle, 6 puzzles in one	**(1 piece)**
1D-4: Puzzle, floor	**(1 piece)**
1D-5: Memory game	**(1 piece)**
1D-6: Picture lottery	**(1 piece)**
1D-7: Dolls, knitted, to give away	**(50 pieces)**
1D-8: Clown's nose	**(2 pieces)**
1D-9: Finger puppet	**(1 piece)**
1D-10:Hand puppet	**(1 piece)**

1D-1: Mirror
Age: 6 months+
The mirror can be used for imitation and self-recognition games with younger children. Older children can use it to play the "take care game" when placed in a box (as shown in the PS Centre film, "Rebuilding hope").

1D-2: Puzzle with knobs on the pieces
Age: 2 years+
This has a number of different shaped pieces which fit into corresponding shaped holes in the puzzle. Each piece has a knob on it and is suitable for the smallest children who enjoy placing the pieces in and taking them out again. Through trial and error, children will slowly realise that shape and position matters, and after a while, with some adult guidance, the process of comparing the hole, the piece and its position begin to solidify.

1D-3: Puzzle (six puzzles of 4-9 pieces each)
Age: 3 years+
At this age children can move onto assembling puzzle pieces to form a picture. The process of making a puzzle helps hand-eye coordination, concentration, problem solving, spatial awareness and coordination of thoughts and actions. For example, the pincer grip, used to hold a puzzle piece, is the same kind of grip for holding a pencil. Social skills such as cooperation and compromise are also practised, if two or more children are doing a puzzle together.

1D-4: Puzzle (of 18-35 pieces)
Age: 5 years+
Please see description above.

1D-5: Memory game, bingo and dominoes (in one package)
Age: 3 years+
Board games are useful for learning social skills such as waiting your turn, following rules and accepting that sometimes you win, and sometimes you lose. These three games are specifically designed for younger children, and have big colourful pieces. They should all be played under the guidance and supervision of an instructor. (For all three, please see the English language instructions in the games.)

Instructors can also make their own memory games. Make paired sets of cards based on numbers, signs or pictures. The game can be made more challenging by pairing objects which are not the exactly the same but are connected in some way, such as pencil and eraser, book and school bag, shirt and trousers.

1D-6: Lottery
Age: 2+
Picture lottery is a memory game with pictures of animals and objects. The game is aimed at younger children, but older children might also enjoy it.

1D-7: Dolls, knitted, or smaller stuffed animals, to give away and for using the Huggy-Puppy intervention
Age: 2 years+
The knitted dolls or stuffed animals can be used as gifts for children in stressful situations and for using the Huggy-Puppy intervention (see the description below).

Research shows that a high level of attachment to a stuffed animal can reduce stress. This intervention may be appropriate, for example, when children are hospitalized or in temporary shelters.

1D-8: Clown´s nose
Age: 1+
The clown's nose is used for playing and interacting with children.

1D-9: Finger puppets
Age: 6 months+
This set includes a group of finger puppets that can interact, for example an animal family. Each finger puppet is placed on one finger to animate it. The set can be used for storytelling with more than one character. Younger children should not be left alone with small puppets, as they may put them in their mouths.

The Huggy-Puppy intervention
Children between the ages of 2-7 who were living in a sheltered camp during the Israel-Lebanon war (2006) were assessed with regard to war exposure and stress reactions. In addition to standard care, some of the affected children received a stuffed animal and a brief intervention encouraging them to care for a needy Huggy-Puppy doll; the Huggy-Puppy intervention.
During the intervention, each child is introduced to a Huggy-Puppy doll. The child is told a short story about Huggy, usually being a very happy puppy. Right now, Huggy is looking a little sad and scared. The child is asked to guess why Huggy might be sad. After the child replies, the story continues: “He is sad because he is very far away from his home and he does not have any good friends.” The child is asked if she/he can be the puppy´s good friend, take care of the puppy, hug him a lot, and take him to bed when they go to sleep. After the story is finished, the caregiver of the child is encouraged to maintain the child´s interest in the doll and to remind the child of the responsibility to care for the puppy.
In the follow-up period, 71 % of the children in the intervention group were symptom-free (e.g. not presenting with any severe stress symptoms) compared to only 39 % in the control group. A higher level of attachment and involvement with the doll was associated with better outcomes.

[16] A.Sadeh et al: Young children´s reactions to war-related stress: A survey and assessment of an innovative intervention. Pediatrics Vol 121, Number 1, January 2008.

1D-10: Hand puppets
Age: 6 months+
The hand puppet set has two puppets that can interact with one another, for example, a king and a queen, or two animals. The puppets are manipulated by the instructor and need some practice before use. When telling stories or performing plays with the hand puppets, use other "performing objects" to bring the story to life, like snow made from torn paper.

Additional games and activities: For suggestions of games and play activities for children up to six years, please refer to the list of additional games, play and relaxation activities for children on the ERU psychosocial support USB stick.

B. PLAY KIT 2 – FOR CHILDREN AGED SIX TO 18 YEARS

This section describes each item in play kit 2, together with some suggestions for how they can be used. The list is an extended version of the overview in the *complete items overview catalogue*. Suggestions for additional activities and games can be found in the ERU psychosocial support folder on the USB stick, under 'List of additional games, play and relaxation activities for children.'

Eight transportation boxes with padlock

The play kit comes in boxes that can be locked to keep the contents secure. Each box is made of aluminium and has handles for easy tranport.

Materials for instructors (BOX 2A)	
2A-1: Drawing paper A4	**(500 pieces, 5 packages)**
2A-2: Adhesive tape	**(8 pieces, 1 package)**
2A-3: Pens	**(12 pieces, 4 packages)**
2A-4: Pencils	**(1 pair)**
2A-5: Scissors (for adults)	**(1 pair)**
2A-6: Glue sticks	**(1 package)**
2A-7: Erasers	**(pack of 20, 1 package)**
2A-8: Pencil sharpeners	**(2 pieces)**
2A-9: Soap	**(pack of 3 pieces, 6 packages)**

In order to maintain hygiene in a place where potentially many children stay and use the same toys, soap (for washing hands) is included in the play kit. All children coming to participate in activities should be shown how to wash their hands before engaging in activities.

These items are mainly for 'instructors' i.e. the people conducting games and activities with the children:

- Adhesive tape can be used to put drawings or posters on walls or when making things for homemade games etc.
- These pens and pencils are generally not appropriate for children up to six years old. The children themselves should use large crayons when drawing, which are better suited to their stage of development.

The drawing paper, also called sugar paper, is for children's drawing activities. It has a slightly rough surface making it well suited for drawing on, as the colour attaches more easily. Please note there is a **limited amount of paper** available in the boxes. Ask instructors to use the paper wisely for specific drawing activities, so as not to waste this limited resource.

Arts activities

Transportation BOX 2B

2B-1: Carton, coloured	**(various size and colours)**
2B-2: Pencil sharpeners	**(6 pieces)**
2B-3: Crayons, normal	**(pack of 24, 10 packages)**
2B-4: Colour pencils	**(box with 12, 10 boxes)**
2B-5: Clipboard	**(7 pieces)**
2B-6: Ready-made sewing kit	**(6 pieces)**

2B-1: Carton, coloured
Used for drawing and decorating.

2B-2: Pencil sharpeners
Sharpeners are used to sharpen colour pencils.

2B-3: Crayons, normal
Used for drawing and writing.

2B-4: Colour pencils
From approximately the age of four to five, children are able to use pencils for drawing, as their fine motor skills are more developed.

2B-5: Clipboards
The clipboards can be used for writing and drawing; e.g. allowing immobilized children to draw in bed.

2B-6: Ready-made sewing kit
Age: 8+
The sewing kit should only be used when the children are under supervision, since it contains needles. The kit is suitable for the children who are able to and want to concentrate on a small sewing or repair project.

Sports activities

Physical and sports-oriented activities are beneficial for both children and adults. While sports activities provide exercise, physical movement is also helpful to improve social and psychological wellbeing.

Transportation BOX 2C

2C-1:	**Volleyball net**	**(1 piece)**
2C-2:	**Volleyballs**	**(5 pieces)**
2C-3:	**Rope**	**(1 piece)**
2C-4:	**Round bat**	**(2 pieces)**
2C-5:	**Brown paper roll**	**(2 pieces)**
2C-6:	**Skipping rope**	**(6 pieces)**
2C-7:	**Sponge balls**	**(6 pieces)**
2C-8:	**Inflating pump**	**(1 piece)**
2C-9:	**Frisbee**	**(1 package of 4, and 8 loose)**
2C-10:	**Referee's whistle**	**(1 package of 12 pieces)**
2C-11:	**Footballs**	**(5 pieces)**
2C-12:	**junior footballs**	**(5 pieces)**
2C-13:	**Cricket balls**	**(3 pieces)**
2C-14:	**Tennis balls**	**(5 pieces)**

2C-1: Volleyball net
Posts and nets for volleyball are mounted as shown in the volleyball post instructions.

2C-2: Volleyballs
Volleyballs are used for volleyball and for training skills used in volleyball, such as underhand serve, overhand serve, underarm pass, overhand pass, floater, smash, blockade and many more. Children can practise these skills in pairs, throwing the ball and catching it between them. If lots of children are to participate, they can line up in two lines opposite each other, with the first pair practising throwing and catching and then going to the back of the line to give the next pair their turn.

2C-3: Rope, hemp, 10 m
Rope can be used for 'tug-of-war'. Participants are split into two groups consisting of an equal number of players. There may be any number of players on the teams. The teams choose an end which is theirs and stand behind each other on either side of the middle of the rope. A line is drawn on the ground between the two opposing teams. The aim of the game is to try to pull the opposing team over the marked line on the ground.

The rope can also be used to mark the outline of a pitch for a ball game.

2C-4: Round bat
The bat is used to strike the ball when playing a game.

2C-5: Paper roll, brown
The paper can be used for drawing activities. It can be used in long pieces either placed on a row of tables or on the floor. It may also be hung in one long piece on the wall at a

suitable height for the children to stand beside each other and draw. The paper roll is used when the drawing activity is a shared activity, such as when a group of children draw a big picture together, like a town, a zoo, or a forest with animals.

2C-6: Skipping rope, one-person
One-person skipping ropes are used for individual skipping. The ropes may be tied together for skipping in groups. Two children turn the rope for the rest of the group to skip. Instructors should agree rules with the children about taking turns in skipping and turning the rope.

2C-7: Sponge ball
Sponge balls can be used when playing with younger children or more generally with children who feel uncomfortable playing with the ordinary balls because of their weight and the force with which they can be thrown or kicked. Sponge balls are not suitable for ordinary ball games, but may be used in throw and catch games, in games where the players hit each other with the ball and in singing games involving throwing an item between participants as part of the game.

2C-8: Inflating kit
The kit is used to inflate footballs and volleyballs.

2C-9: Frisbee
Frisbees can be thrown and caught by multiple players. The frisbee is held in a horizontal position and thrown by a twist of the hand towards the catcher so that the frisbee floats on the air while travelling between the players.

Frisbees can also be used to play ‘frisbee golf’. A course of numbered pickets or other markers is laid out with some distance in between. The players try to throw the frisbee so that it touches the first picket of the course, then the second, the third and so on. Players take turns throwing and have one throw each. If a player’s frisbee hits the intended picket, he or she gets an extra throw. The player who finishes the whole course first has won.

2C-10: Referee’s whistle
The whistle is used by the referee when playing ball games and may also be used to call to attention participants of other games. It can also be used (like sounding a bell) to make it known to children that the play area is now open or closed.

2C-11: Football, size 5
Footballs are used for playing a game of football/soccer or kicking a ball. For training purposes, different kinds of skills may be practiced, e.g. different kinds of kicks, dribble, curbing, tackling, heading etc. Also tactical elements may be practiced when playing together, rehearsing positioning in the field. Football size 5 is the usual size for adolescents and adults.

2C-12: Football, size 3
Football size 3 is used as described above, but is smaller and therefore suited for younger children.

2C-13: Cricket balls
Age: 10+
Cricket is a bat-and-ball game played between two teams of 11 players played on a field, with a rectangular pitch in the middle. One team bats, trying to score as many runs as possible, while the other team bowls and fields, trying to dismiss the batsmen and thus limit the runs scored by the batting team. A run is scored by the striking batsman hitting the ball with his bat, running to the opposite end of the pitch and then touching the crease without being dismissed. The teams switch between batting and fielding at the end of 'an innings'.

It is helpful if some players are familiar with the game. Or the rules can be simplified so that new players do not get confused when they start to play.

2C-14: Tennis balls
Tennis balls can be used for various ball games and for throwing and catching games. They may also be used for juggling with two or more balls in the air or against a wall.

In addition to the transportation boxes, the play kit also includes the following items:

1: Flipchart stand
2: Flipchart paper
3: Volleyball net
4: Hoola hoop

1: Flipchart stand

2: Flipchart paper

3: Posts for volleyball net
Posts and nets for volleyball are mounted as shown in the volleyball post instructions.

4: Hoola hoop
Firstly the hoola hoop rings must be assembled, as they are packed in pieces to fit the play kit box. Bigger (eight pieces) or smaller hoops (six pieces) can be made.

Hoola hoops are used mainly for the game in keeping the hoop circulating around your waist for as long as possible. The hoola hoop can also be twirled around your arms or

legs or thrown/caught between two or more persons. Hoola hoops may also be placed on the ground to mark a play area or for jumping from one hoola hoop to the next.

Board games

Board games support the development of social skills, e.g. having to wait your turn, learning about winning and losing, accepting rules and decisions and learning to cooperate.

Transportation BOX 2D

2D-1: Chess	**(2 pieces)**
2D-2: Mikado	**(2 pieces)**
2D-3: Dice	**(1 set of 12 pieces)**
2D-4: Uno	**(3 pieces)**
2D-5: Playing cards	**(6 pieces)**
2D-6: Dominoes	**(1 piece)**
2D-7: Snake & Ladders game	**(1 piece)**
2D-8: Go-On game	**(1 piece)**
2D-9: Drum	**(1 piece)**
2D-10: Tambourines	**(4 pieces)**
2D-11: Xylophone	**(1 piece)**
2D-12: Maracas	**(2 pieces)**

2D-1: Chess

Age: 10 years+

The game of chess is played by two people, each having a little army of sixteen chess pieces on a chessboard divided into sixty-four squares. Each player has eight superior pieces or officers, and eight minor ones called pawns. The two sets of chess pieces are different colours (usually black and white). See the rules inside the box.

Though the strategies of the game are complicated, the rules are simple. Relatively young children can therefore play chess. However, please note a game takes some time to finish and ideally players need a quiet place to play.

2D-2: Mikado

Age: 7 years+

2 or more players

The game of Mikado or Spillikins consists of a number of sticks. The game begins by one of the players holding all sticks in one hand upright over a table or on the ground, and then letting them fall at random. Taking turns the players now try to remove the sticks one by one without moving any other stick, other than the one they are trying to remove. If another stick moves, it is the next player's turn to try. Whenever a player has succeeded in removing a stick without any other sticks moving, she keeps the stick in

front of her. The person, who has removed the most sticks, when all sticks are taken, has won the game.

2D-3: Dice
Age: 3+
Dice are used in lots of different games to decide who will be first to start a game,, or do an activity. They are also used in specific dice games such as Craps or Yahtzee.

2D-4: UNO
Age: 7 years+
Game for two to ten players.
Please see the English language instructions for the game.

2D-5: Playing cards
Playing cards are used for lots of different games (see two examples below)..

One easy game is “Snap”: Divide the cards evenly between the players. Players hold them face down and take turns to flip the card over onto the centre of the table. If the new card and the previous card are the same (e.g. two queens), the first player to shout “snap” wins the cards on the table and adds them to his/her own.[33]

Another easy game is “War” which is played by two players. The cards are divided equally between the two players. Players hold their cards face down and both flips the top card in their stack of cards over onto the centre of the table. The player whose card is the most valuable wins both cards and adds them to their own, putting them at the bottom of their stack of cards. The player who ends up having all cards has won.

Playing cards may also be used for building houses of cards, which trains fine motor skills and concentration. This activity can be organized as a competition. Each player gets 10 or 15 cards each and has to try to build the tallest tower possible. The player whose tower is the tallest is the winner.

2D-6: Dominoes
Age: 5 years+
Game for two to four players.
Please see the English language instructions for the game.

2D-7: Snake & Ladders game
Age: 6+
Snakes and Ladders (or Chutes and Ladders) is an ancient Indian board game regarded today as a worldwide classic. It is played between two or more players on a board with numbered squares. The object of the game is to navigate the board from the start to the finish, but when you land on a snake you go down and when you land on a ladder you go up the board. The game is a simple race and is popular with young children.

D2-8: Go-On game
Age: 5+
The game is designed for children who have been affected by a crisis event. It can be played by two to 12 players. The purpose of the game is to put your own and the others' feelings into focus and to become confident in receiving and providing help. The game encourages children to help each other and enables the children to feel a sense of normality in an abnormal situation. The game combines creativity, learning and play and provides a gathering point for a common positive experience.

Music, song and dance

All instruments in the kit are percussion instruments and are used to mark rhythm. Rhythmical instruments may be used by instructors and children when making music, singing and dancing. Please note that the instruments should be used for specific music activities – not for ordinary playtime, as the instruments need to be handled with care and will make too much noise, if just played at any time in the play area.

Severe flooding in Sindh, Pakistan, meant that children had left their homes and were living in harsh circumstances in IDP camps. Many had infections. Together with the Community Health Module team, the psychosocial delegates and volunteers in the ERU for Basic Health Care came up with a way of addressing the situation: They invited the children to make up a song about the importance of washing your hands with soap. The children picked a local tune and when hygiene kits were distributed, the song was sung with a hygiene-promoting message.

2D-9: Drum
Flat drums are played by holding the drum in one hand and beating the drum with the mallet which is held in the other hand. The drums can also be placed on a flat surface and played with the hands or the mallet. The wooden block drum is played by hitting the drum with the mallet, holding the drum in one hand and the mallet in the other.

2D-10: Tambourine
The tambourine is held in one hand grasping the wooden frame and holding the tambourine in the air. It is shaken in rhythm so that the bells on the side of the tambourine sound. It can also be hit with the palm of the hand to produce a drum sound.

2D-11: Xylophone and mallets
Playing the xylophone is not complicated. Children learn that each bar plays a different note and can practise playing a sequence of notes to play a tune. The instructor or children can playing the xylophone to accompany song and dance activities.

2D-12: Maracas
Maracas are shaken in rhythm with the music. Maracas can also be hit against the body, usually a hand or leg, to create a different, more mellow sound.

Additional games and activities
For suggestions of games and play activities for children from approximately six years and up, please refer to the list of additional games, play and relaxation activities for children on the ERU psychosocial support USB stick.

Equipment for volunteers

The play kit also contains equipment for the volunteers including ID cards, vests, trolleys, bags and water bottles.

Chapter 4: Activities for adults

This chapter deals with providing psychosocial support to adults who are affected by emergencies or crisis events. As PS delegate you will be responsible for assessing the needs and resources of adults, as well as training volunteers for their roles with adults in the ERU psychosocial support component.

Social support and self-help for individuals and communities

All communities contain psychosocial support structures and sources of coping and resilience. These may be partially or totally disrupted due to an emergency or crisis situation. The ERU psychosocial support component will play a crucial role both in providing immediate support in lieu of the disrupted structures, and be instrumental in restoring social support and self-help mechanisms in communities.[34]

The psychosocial support component is a resource space where a number of different activities take place. Adults may come here after initial triage in the health ERU or directly because they have heard about this service within their community or the setting where they live.

Purpose of psychosocial component

The purpose of the ERU psychosocial support component is to enable a positive social and physical environment, through provision of relevant and culturally appropriate activities that respect the independence, dignity and coping mechanisms of individuals and communities. In the longer term, psychosocial support promotes the restoration of social cohesion and infrastructure within communities that have lived through disasters or crisis situations.

The services available in the ERU psychosocial support component include:

- Provision of information, assistance or practical help to community members, e.g. about local resources and places to seek help
- Emotional and social support to individuals and groups. This is done through supportive listening, providing psychological first aid, and constructive dialogue
- Organization of relevant activities with the aim of supporting the psychosocial wellbeing of individuals and groups.

Interaction is facilitated through volunteers who have been trained to provide different types of support. However psychosocial support activities for adults within the ERU deployment context should first and foremost support the needs of existing initiatives within a community.

As part of the initial assessment of psychosocial needs and resources, your task as the PS delegate is to identify people and groups that will be helpful in providing information on community resources and thus in facilitating psychosocial activities. Examples of such resources are community leaders (including government officials), significant elders, religious leaders or groups, local health practitioners, traditional healers, teachers, social workers, youth and women's groups, neighbourhood groups. A useful

strategy in locating resources is to ask which community member people - either themselves or others - normally turn to for support in times of crisis.

In addition, a range of activities may be undertaken, depending on the context and needs identified during assessment. The following suggestions are by no means exclusive:[35]

- Family tracing and reunification for all age groups
- Re-establishment of normal cultural and religious events for all
- Access to information about what is happening, services, missing persons, security, etc.
- Activities that facilitate the inclusion of isolated individuals, such as orphans, widows, widowers, elderly people, people with severe mental disorders or disabilities or those without their families into social networks
- Women's support and activity groups, where appropriate
- Supportive parenting programmes
- Activities that promote non-violent handling of conflict as discussions, drama and songs, joint activities by members of opposing sides, etc.
- Community child protection committees that identify at-risk children, monitor risks, intervene when possible and refer cases to protection authorities or community services, when appropriate
- Protection of street children and children previously associated with fighting forces and armed groups, and their integration into the community
- Organizing structured and monitored foster care rather than orphanages for separated children, whenever possible
- Group discussions on how the community may help at-risk groups identified in the assessment as needing protection and support
- Communal healing practices
- Other activities that help community members gain or regain control over their lives.

Facilitating community psychosocial support requires sensitivity and critical thinking, as communities often include diverse and competing sub-groups with different agendas and levels of power. When assessing, planning and implementing activities, it is essential to avoid strengthening particular sub-groups at the cost of others, and to promote the inclusion of people who are usually invisible or left out of activities or discussions.

Some of the suggested activities take place within the ERU psychosocial support component, whereas others naturally take place outside at relevant locations within the local community. It is important that the approach applied by both the psychosocial delegate and volunteers who assist in facilitating activities is based on the needs identified and remain flexible. Post-emergency settings are by nature dynamic, and an activity that is relevant at one point may not be needed a few weeks later.

When designing the physical layout of the psychosocial support component, it is important to consider the need for space for different types of interaction and activities that are taking place Some interaction requires one-on-one communication and a relatively quiet space to create a sense of privacy. Other activities such as support groups and awareness-raising sessions are group activities that require more space and by nature are noisier as they involve group discussions.

Printed materials

You will be training the volunteers in providing emotional and social support to individuals who are experiencing distress or grief following the emergency or crisis situation (see chapter 5 of this manual). Volunteers will be trained so that those seeking support are comforted, informed, made aware of own reactions or simply benefit from having talked to and interacted with someone. A set of printed materials is available in kit 3 and can be used in the training as well as to provide information on a number of different topics to humanitarian workers, parents, teachers etc.:

No	Title	Type	Target group	Content
1	**Coping with stress and crisis**	Brochure	Beneficiaries and patients	Helps adults to understand their reactions to extreme events and what they can to help themselves and others
2	**Children's stress and how to support**	Brochure	Beneficiaries: parents, teachers and adults in general	Provides information on children's reactions to crisis situations and how adult may help them cope
3	**Working in stressful situations**	Brochure	Red Cross Red Crescent volunteers, ERU staff and humanitarian staff in general	Provides information on work-related stress and useful action for how to deal with stress
4	**Psychological first aid**	Brochure	Red Cross Red Crescent volunteers, ERU staff and humanitarian staff in general	Provides information on the benefits of psychological first aid and describes basic elements

5	**Supporting volunteers**	Information sheet	Operating National Society	Informs National Societies on how to support and care for their volunteers, and how to keep them safe
6	**Common reaction of persons affected by disasters**	Information sheet	ERU staff and other humanitarian staff	Information on common reactions of persons affected by disasters
7	**All children deserve to be safe**	Information sheet	Volunteers, ERU and humanitarian staff, parents, teachers	One-page information sheet with pictures about violence against children

Brochures number 1 and 2 will be especially helpful in explaining the kind of normal reactions of adults or children can expect to crisis events and what can be done to get through a difficult time. It is recommended you spend time during the training with the volunteers going through these materials and making sure that volunteers are comfortable with this information. .

All brochures are available in Word format on the ERU psychosocial support USB stick for translation into local languages.

Group activities
Groups of people with similar problems or life situations – for instance, those who have experienced the same crisis situation - benefit from meeting together. In the context of the ERU psychosocial support component, establishing a support group may be an effective way of empowering participants, helping them to support one another and learning that they can make a difference to the group members. It is, however, important that support groups are not used to replace professional help when that is needed.

Volunteers who have received basic training in psychosocial support can assist in facilitating support groups. Very often people who have learned to cope with a certain problem can

After a cholera outbreak in Chad, the PS delegate met with the ERU volunteers to explain what cholera was and to discuss how the affected population could be supported with appropriate information and hygiene promotion. A volunteer explained that some people might see cholera as a curse from God and making them listen to advice on hygiene promotion might be difficult. The PS delegate explained that their role was not to convince people to change their worldview, but rather to develop good hygiene habits and encourage people to seek medical treatment if presenting with symptoms of cholera.

themselves become good role models and are good facilitators when starting a group. The idea is that over time, the group should be self-sustaining with a self-selected group-leader or facilitator.

Reaching specific groups

Various factors determine the type and extent of vulnerability that individuals face after an emergency, among them are the age and gender of the affected person (see matrix in Chapter 1, page 14). The characteristics of the vulnerabilities and suggestions for psychosocial activities for specific groups are listed below. Interventions should not exclude a focus on other equally vulnerable groups.

Mothers with infants and young children
Children are affected by the wellbeing of their caretakers. Mothers of infants or young children bear responsibility for the wellbeing of not only themselves, but also usually of their children. The ERU psychosocial support component aims to address the needs of both children and mothers.

The children may be engaged in the ERU psychosocial support component play activities while their mothers attend support groups. The aim of these support groups is to provide care for caregivers, have a space to share problem-solving, address issues (for example in mother and child health or nutrition), and in supporting one another in caring for their children. It is also possible for the mothers to come and play with their children, using the toys and play items in the kits. Here, the volunteers may be role models for mothers of young children, demonstrating positive interaction and stimulation.[36]

Men
In families where men earn a significant income for the household, a disaster may lead to men losing their position of being the provider for their family. This may not always be the case – this naturally depends on the characteristics and extent of the disaster. However losing one's usual socially ascribed position (for example, of being the provider of the family) may be an additional stressor to a stressful situation.

In armed conflicts, men are also at greater risk of being exposed to GBV, of being abducted or of being stigmatized in the local community because they been ex-combatants. These factors add to the personal distress that a disaster may entail.

When you conduct the psychosocial assessment in connection with the ERU psychosocial support component and plan activities, it will be important to specifically consider the role and needs of men in the given context. It is common for men to be involved in clean-up or reconstruction activities, but we always need to consider that different activities are helpful in different contexts, both for women and for men.

Older people
Older men and women are some of the most vulnerable people in disasters and conflicts[37]. A global ageing population means more and more will be affected.
By 2050, older people will start to outnumber children under 14. Over 80% of the world's older people will be living in developing countries (compared to 60% today).

Older people are particularly vulnerable and face specific threats in emergencies. Their needs are very different from those of other groups, with serious consequences resulting from:

- Restricted mobility and increased vulnerability
- Inappropriate food
- Inadequate healthcare
- Trauma and isolation
- Loss of livelihoods (including little access to micro-credit or pensions)

It is important too to remember that older people contribute immeasurably to their families and communities in various roles. These may become even more important in crisis situations.

Young people
Today we have the largest generation of young people the world has ever known. Children and adolescents (under 18) represent approximately 47% of UNHCR's "persons of concern" (11% of these under five years of age) (UNHCR statistical yearbook 2010).

However adolescents are not a homogeneous group. There is a tendency in programming to group all young people together, but activities that are specific to age and gender and targeting needs should be planned where possible. For example, the needs of younger adolescents (10-14) are different from older adolescents (15-19).

Young people may have increased vulnerabilities because of such issues as:

- Breakdown of social and cultural systems
- Exposure to violence and chaos
- Personal traumas, such as the loss of family members, loss of protection mechanisms
- Lack of basic information on sexual and reproductive health
- Substance abuse and boredom
- Disruption of school and friendships
- Absence of role models[38].

What has been shown to work well includes:

- *Multi-sectoral* approaches, looking at young people's needs more holistically
- *Using a life-cycle lens* i.e. looking at evolving capabilities and needs as a young person grows up
- *Inter-generational* approaches – working with parents, caregivers, community members[39]

Chapter 5: Training

This chapter details the organization and facilitation of trainings for volunteers and orientation sessions for ERU staff and staff of other humanitarian organizations. These are key tasks for the PS delegate in the PS Health ERU.

You are expected to train staff or volunteers using different approaches throughout the period of the ERU deployment. It is therefore desirable that you have prior experience in this field and is able to apply this when facilitating trainings and practice-based teaching for individuals and groups.

This chapter describes two different trainings that the delegate will be responsible for:

- A one-day training for volunteers attached to the ERU psychosocial support component and
- A short (30 minutes to one hour) briefing session for ERU colleagues on psychosocial issues and the work that goes on in the psychosocial support component.

It is important that you continuously assess training needs and look for opportunities for trainings and the transfer of knowledge and skills. This can take place in the classroom and/or wherever activities are going on and may involve members of the affected community as well as volunteers, ERU colleagues and other humanitarian staff.

Refresher training with volunteers is done on a continuous basis and introductory training may be repeated with ERU staff, volunteers and other humanitarian workers, as there is usually a high turnover.

Training kit 3

The items in kit 3 (listed below and in the ‘complete items overview’ catalogue) are principally provided for you for the trainings and other sessions you will be doing with volunteers, community members and ERU colleagues. The items are mostly not for community members, but rather to facilitate the work of the volunteers and others involved in the work of the ERU psychosocial support component.

Two transportation boxes with padlock
The training kit comes in boxes that can be locked to secure the contents. The boxes are made of aluminium and have handles for easy transport. The kit includes:

Flipchart stand, foldable

Flipchart paper

Markers for flipchart

All the above items are for your use as the ERU PS delegate, or another person designated by you during training and facilitation sessions. These items may also be used by participants in the training sessions, during group exercises or when presenting the outcome of group discussions.

Exercise books and pens
The exercise books and pens are for volunteers and others who attend the trainings facilitated in the ERU psychosocial support component. Training participants use the notebooks during the training and keep it afterwards as a source of reference and for further notes.

Printed information materials
The brochures and information sheets described in chapter 4 are also in kit 3, plus extra copies of this manual and the *Handbook for volunteers*. In addition, all these materials are available in electronic format on the ERU psychosocial support USB stick.

Facilitating training

The trainings described in this manual are very practical and hands-on, with lots of interaction between the trainer and participants and amongst the participants. The use of pre-prepared presentations and power points[40] are kept to a minimum.

When facilitating trainings, be prepared to plan and adapt the resources provided here according to the circumstances, background knowledge and experience of your participants and the overall aims of the training. Resources include:

- The training notes in this chapter for the one day volunteers' training and for the briefing session on PS issues
- The brochures and information sheets provided in kit 3
- Additional resources on the ERU psychosocial support USB stick.

The USB stick has lots more information and tips about facilitating training from the *Trainer's book* of the *Community-based psychosocial support training kit*[41].The introductory sections of the *Trainer's book* deal with how to plan psychosocial support trainings, the learning process in a psychosocial context, and preparing and conducting a workshop in psychosocial support. The book also provides useful insights and tips on how to organize trainings.

A. Volunteer training

This training for volunteers provides a brief, basic introduction to psychosocial support and to the tasks that the volunteers will carry out. Participants are likely to come from a variety of backgrounds and will not necessarily have experience in health, mental health or social welfare.

After the training, participants will:

- Have some knowledge of what an ERU is
- Understand the importance of setting up safe environments free of violence and know how to maintain them
- Know how to respond to disclosures of violence
- Understand what kind of activities go on in the ERU psychosocial support component
- Be able to support another person using psychological first aid and supportive listening
- Have been introduced to the play kits and know how to interact with children and adults respectively
- Be aware of the possible stress of their work as volunteers and how to take care of themselves.

The identification and selection of volunteers for the ERU psychosocial support component is done in collaboration with the Operating National Society. The process of establishing contact with the Operating National Society is described in Chapter 2.

As soon as a group of volunteers has been identified and screened, the initial training should be planned and carried out, preferably within the first or second week of ERU deployment. In order to facilitate the planning, a checklist has been developed, listing some practical considerations. It is included as Annex 5 in this manual and is also available in electronic format on the ERU psychosocial support USB stick.

The training programme

The volunteer training lasts for one day. The programme is summarized below. It can of course be adjusted according to the situation you are working in, and the needs of the affected population.

An extended version of the programme is included in Annex 6 and in electronic format on the ERU psychosocial support USB memory stick. The full programme is helpful for planning, having full instructions and information on what materials are needed for each session of the training.

Time	Topic	Activities
08.00 – 09.00 **Session 1**	Welcome Participants' introductions Training programme and goals of training	Welcome by trainer/RCRC branch chairperson/ERU team leader Round of introductions Presentation of programme and goals of training
09.00 – 09.30 **Session 2**	What is an Emergency Response Unit (ERU) for Health? What is the psychosocial support component of the health ERU?	Presentation by trainer
09.30 – 10.00 **Session 3**	Introduction to psychological first aid	Presentation by trainer Activity
10.00 – 10.15	BREAK	
10.15 – 12.00	Psychological first aid – continued Violence: risk factors, vulnerable populations How to support a person in distress	Presentation, group work, role plays
12.00 – 13.00 **Session 4**	The psychosocial support component – an introduction	Look through the items in the kits Group exercise and presentation
13.00 – 14.00	**LUNCH**	
14.00 – 15.00 **Session 5**	Psychosocial support to children through play and recreational activities Setting up safe environments free of violence	Interactive play Group work and discussion
15.00 – 15.15	**BREAK**	
15.15 – 15.45 **Session 6**	What to do if someone is being hurt or not treated right? Handling disclosures of violence	Interactive session / brainstorm
15.45 – 17.15 **Session 7**	Stress management and self-care for volunteers working in emergency settings	Presentation, group work and plenary discussion on issues related to work-induced stress
17.15 – 17.30	Wrap-up and final comments	

Training notes
These training notes describe each session in turn and provide suggestions for the content and structure of the training.

Session 1 – Welcome (one hour)

- **Formal welcome**

Someone other than the ERU psychosocial delegate, e.g. a senior official from the Operating National Society, the branch chairperson or the ERU team leader, should open the volunteers training if at all possible. The presence of outside senior staff will increase the ownership and contribute to a sense of belonging for the volunteers. Senior speakers from the outside should emphasize the value of what the volunteers bring to the ERU psychosocial support component and how their contribution will make a difference.

- **The training programme**

After the formal opening, describe the purpose of the training and go through the programme for the day. Individual copies of the programme may be handed to participants or written on a piece of flipchart paper.

Give each participant a copy of the *Handbook for volunteers* and give a brief overview of the contents.

- **Getting to know one another**

It is important to start the day on a positive note, by making sure all participants feel comfortable, and that they get to know each other as soon as possible. Use an icebreaker to enable the group to engage with one another. Here are some examples of useful icebreakers:

Name of icebreaker	Description
Unique characteristics	Even if the participants already know each other, the trainer must get to know them. The trainer divides the group into pairs and gives participants a few minutes to interview each other. Then, each participant introduces their partner by name and shares at least two unique characteristics about them. Characteristics to be presented should be agreed upon before they are shared with the large group.
Time machine	Participants are divided in pairs and the trainer asks them to take turns in a time machine. They strap themselves in, set the dial to after the workshop ends, and push the button. They feel a vibration and wonder if the machine is working. Then they look out the window and see themselves at work. They realize that they are watching themselves in the future. Then they open the door to the time machine and tell their partner how they see themselves

	working and what they do differently after the training.
Your favourite …	The trainer prepares a list of topics on a flipchart, e.g. favourite TV programme, ideal holiday, secret ambition, etc. The chairs are arranged in two rows, facing each other. When people are seated, ring a bell and ask half the group to spend one minute talking with the person opposite them on the topic given. Every time the trainer rings the bell, each person moves on one place, clockwise. They then spend one minute talking to another person on topic two, and so it goes on. The trainer keeps this going until everyone is back in their original place, or stops at an appropriate time.
Three questions	Participants write down three questions and find someone in the room they do not know well. Each participant then asks questions of the other. The participants then introduce their partners to the group by sharing both the questions and the answers.

Session 2 – What is an Emergency Response Unit? (30 minutes)

Give a description of what an Emergency Response Unit is and why it has been deployed in this situation. Try to use non-technical language and use examples and pictures from previous deployments, if possible.

The session can be extended, e.g. during a break, to include a walk through the ERU area, to give the volunteers an idea of the activities that take place.

Session 3 – (1) Psychological first aid (2) Violence (135 minutes)

1. **Psychological first aid**

- **Background**

Begin the session with a brief description of psychosocial support. For materials on psychosocial support within the ERU context, please refer to Chapter 6, 'Linking research and practice.'

Psychological First Aid (PFA) is recommended in the IASC guidelines (action sheet 6.1), and the 2011 Sphere project handbook (p. 335). Although the model of PFA needs to be researched systematically, but there is consensus that the components that are currently used provide effective ways to help survivors manage post-disaster distress and adversities, and to identify those who may need additional services.[42]

- **What is PFA?**

PFA is a kind of method or tool for providing a humane, supportive response for people who have experienced severe stress. Providers of PFA do not ask intrusive questions about feelings and the event, unlike psychological debriefing which involves a discussion of the event that caused the distress. PFA stresses listening in a non-judgmental manner, identifying and assisting with practical needs, discouraging

negative ways of coping and linking people with their loved ones and others who can provide needed social support.

Guidelines for delivering Psychological First Aid

- Politely observe; don´t intrude. Then ask simple respectful questions to determine how you may help.
- Speak calmly. Be patient, responsive, and sensitive.
- If survivors want to talk, be prepared to listen. When you listen, focus on hearing what they want to tell you, and how you can be of help.
- Acknowledge the positive features of what the survivor has done to keep safe.
- Give information that is accurate and age-appropriate.
- When communicating through a translator or interpreter, look at and talk to the person you are addressing, not at the translator or interpreter.
- Maintain confidentiality as appropriate.
- Do not make assumptions about what survivors are experiencing or what they have been through.
- Do not assume that everyone exposed to a disaster will be traumatized.
- Do not speculate or offer possibly inaccurate information. If you cannot answer a survivor´s question, do your best to learn the facts.
- Know how to handle disclosures of violence.
- Do not make assumptions based only on physical appearance or age, for example, that a confused elder have irreversible problems with memory, reasoning, or judgement. Reasons for apparent confusion may include: disaster-related disorientation due to change in surroundings; poor vision or hearing; poor nutrition or dehydration; sleep deprivation; a medical condition or problems with medications; social isolation; and feeling helpless and vulnerable.
- Remember that the goal of Psychological First Aid is to reduce stress, assist with current needs, and promote adaptive functioning, not to elicit details of traumatic experiences and losses.
- Pay attention to your own emotional and physical reactions, and practice self-care.

Brymer M, Jacobs A, Layne C, Pynoos R, Ruzek J, Steinberg A, Vernberg, E, Watson P, (National Child Traumatic Stress Network and National Center for PTSD), Psychological First Aid: Field Operations Guide, 2nd Edition. July 2006. Available on: www.nctsn.org and www.ncptsd.va.gov.

What material is available for training in Psychological First Aid?

A PowerPoint presentation is available on the ERU psychosocial support USB memory stick. The presentation comes from the *Community-based psychosocial support training*

kit[43] - A set of additional role plays to practice psychological first aid skills are also found on the USB memory stick[44].

The printed materials brochure 1: Stress and coping, brochure 2: Children's stress and how to support, and brochure 4: Psychological first aid can be used as reference materials by the participants during this session.

Where can I as a PS delegate learn more about PFA and access specialized materials?

- **Resources**

Where you have access to online resources, the following two guides provide detailed information about PFA. If you have no access, use the information in the box above. The summary below – **look, listen, link** – from the WHO Guide is also helpful.

1) Psychological First Aid, Field Operations Guide 2nd Edition. National Child Traumatic Stress Network, National Center for PTSD. (2006) Available on: www.nctsn.org and www.ncptsd.va.gov.

This material describes an advanced form of PFA and gives an in-depth understanding of its core elements. It includes basic information-gathering techniques to help providers make rapid assessments of survivors' immediate concerns and needs, and to implement supportive activities in a flexible manner. It relies on field-tested, evidence-informed strategies that can be provided in a variety of disaster settings. The material emphasizes developmentally and culturally appropriate interventions for survivors of various ages and backgrounds.

Each chapter explains a core action of PFA and how it can be addressed in a disaster setting. It also includes handouts with advice for different groups e.g. survivors, parents and helpers. This material is suitable for professionals within psychosocial support who want an in-depth understanding of PFA, its essence and core elements.

2) Psychological first aid: Guide for field workers. World Health Organization, War Trauma Foundation and World Vision International (2011). Available on: www.who.int/publications

This guide was developed in order to have a toolkit for widely agreed interventions available for use in low and middle-income countries. It contains an overview of core elements in PFA, case scenarios and sample conversations. This material does not require previous training in psychosocial support.

PFA principles are summed up as:

- **Look** (Check for safety, people with urgent basic needs and people with serious distress reactions).

- **Listen** (Approach people who may need support, ask about needs and concerns, listen and help people feel calm).
- **Link** (Help people address basic needs and access services, help people cope with problems, give information and connect people with loved ones and social support).

2. Violence and the role of the volunteers

In this session participants are introduced to why violence is important to consider in emergencies, which types of violence exist and the impact of violence on people's lives. This is followed by exercises and presentations on how to prevent violence.

- **Background**

It is important that the volunteers understand how emergencies can lead to a scale-up of violence in the community, and how PSS can both prevent and lessen violence. You can use the section on 'Violence in emergencies' in chapter 2 and 'Safe standards of practice' in chapter 3 for input here.

- **Exercises**

Give participants time to do some exercises on how to work on violence prevention and mitigation and how the safe spaces around PSS activities can be set-up to mitigate its occurrence. Details are in the full programme on the ERU psychosocial USB stick.

- **Presentations**

Ask volunteers to briefly present feedback on the exercises they did together.

Session 4 – The psychosocial support component – an introduction (one hour)

In this session, participants start familiarizing themselves with the contents of play kits 1 and 2, containing toys and play items for children aged zero to six years and six to 18 years respectively.

As the play kits are a core feature of the ERU psychosocial support component, it is crucial that the volunteers understand the purpose of the toys and play items and how they are used.

Divide participants into small groups and give each group a number of items from the play kits. Ask them to unpack the items and give them a try. Ask each group to work out:

- what the items are
- how they are used, and
- how they, as instructors, will facilitate play sessions with children by using these items.

Give each group access to the complete items overview catalogue as a reference guide during this session.

Session 5 – Psychosocial support to children through play and recreational activities (1 hour)

This session follows directly from the previous one and focuses on games and play activities that are conducted either using the play kit items, or with games that are played locally or that are described on the ERU psychosocial support USB stick.

- **Playing games together**

Play one or more game with the participants (either in a big group or smaller ones) and after each game, as a group reflect on the benefits of playing that particular game or activity.

Stimulate discussion about (i) the importance of safe environments/spaces and (ii) what kind of activities children in this particular location normally engage in. Think through with volunteers some ideas of how to adapt local materials and resources for use in the ERU psychosocial support component.[45]

Brochure 2: Children's stress and how to support is a key resource here to guide discussion about ERU psychosocial work.

Session 6 – What to do if someone is being hurt or not treated right (30 minutes)

Using *information sheet 7*: *All children deserve to be safe*, the aim of this session is to generate discussion about how best to protect children after crisis events and what can be done if someone suspects that a child is suffering from abuse or maltreatment.

Session 7 – Self-care and stress management for volunteers (30 minutes)

The session covers a familiar but often forgotten topic in emergency settings: that relief work is highly demanding on those involved. Volunteers and other humanitarian workers are likely to be subjected to stress, and should know how to avoid stress and how to care for themselves and others.

A PowerPoint presentation is available in the training resources section of the ERU psychosocial support USB stick[46]. Towards the end of the presentation there are some breathing and relaxation exercises. Instructions on how to facilitate these exercises are also found on the USB stick.

Brochure 3: Working in stressful situations can be used as reference materials for the volunteers during this session.

Wrap-up (15 minutes)

The day ends with a recap of the major topics and an informal evaluation of the day's programme.

B. Briefing session on psychosocial issues

This section presents a short briefing session (30 minutes to one hour) for ERU colleagues and other humanitarian staff working in the same area. The overall objective of this session is to raise awareness about the possible psychosocial impacts on people affected by the emergency. This is an opportunity for you as the PS delegate to explain how all sectors of an emergency response actually affect people's psychosocial wellbeing.

Many humanitarian workers do not think that armed conflicts, violence or natural disasters cause psychological and social suffering to the affected communities. They do not always realize that psychosocial actions may significantly influence people's abilities to adopt positive coping mechanisms to handle their situation. Humanitarian staff involved in general health care, camp management or water and sanitation, for example, may also not be overtly aware of how they, as part of their work, may support the resilience and coping mechanisms of people affected by disasters or crisis situations.

A PowerPoint presentation is available on the ERU psychosocial support USB stick for use during this session. The brochures and information sheets in kit 3 will also be useful during this session.

The training notes here highlight main points in relation to **general health care, shelter and site planning, and water and sanitation.** You can shape this session to fit the specific setting you are working in to make it relevant to your colleagues. Whatever topics you choose, use the session to stimulate discussion on the significance of psychosocial issues in crisis situations and draw on real life examples to illustrate the importance of psychosocial wellbeing in people's lives.

A relief worker and a PS delegate were approached by a journalist from a large news agency. The journalist wanted to do a story on the work in the ERU. The relief worker told the journalist that psychosocial support was "cute" and "made for good photos", but wasn´t about "any real ways of helping people like in my area of expertise". The psychosocial delegate approached the relief worker and their team leader after the incident and explained what psychosocial support actually meant.
This kind of advocacy is a crucial part of psychosocial support. The PS delegate found that there was very limited understanding of psychosocial support and how it promotes resilience and coping.

Training notes

1. General health care

General health care settings, such as the health ERU, are often **entry points** for supporting people with mental health and psychosocial problems. Health care providers frequently encounter psychosocial issues when treating diseases and injuries. For

example, they invariably will be treating injuries from some type of violence. The strong connections between social, mental and physical aspects of health are commonly ignored in the rush to organize and provide health services.

General health care providers may benefit from learning the principles of **psychological first aid and violence prevention**. You could use some of the materials from the session on PFA and violence prevention from the volunteers' training, if this is relevant in the current situation.

.

Stress the importance of meeting and treating affected people with respect for their dignity, and provide basic information about the **mental health and psychosocial impact** of crisis events, violence and situations. It is crucial to give information about local understandings of and responses to crisis, as these may be very different from what health care workers are used to.

Explain that health care providers should use **communication methods** that encourage positive coping. Highlight the importance of talking with individuals, families and communities about the ways in which most people tend to react to crisis events or situations. This will enable the community members to more effectively acknowledge their own psychosocial needs, as well as those of others. If possible, have relevant brochures and information sheets available on communicating with patients.[47]

Present the findings of your **initial assessment**, and indicate where local resources are and what social support and protection structures are in place, as these may be helpful in the overall implementation of ERU activities. Importantly, all ERU health personnel need to know about **local referral mechanisms** and a safety plan for **child protection.**

Advocating for the **needs of affected children** is another crucial area. Stress and pain experienced by young children and infants are often overlooked in health care settings. The reason is often that children´s signs of stress may be subtle (an infant may sleep, even though she or he is experiencing pain) and that myths, for example that infants can´t feel pain, are still around.. Most importantly, evidence highlights the importance of maintaining close contact between children and their caregivers when children are hospitalized.

Because the health ERU is the entry point for everyone, there will be a **range of patients** suffering from normal psychosocial distress and those with mental disorders requiring clinical treatment or referral. With this understanding, colleagues may avoid inappropriate medical treatment. You can also explain your role in assisting with information on local referral mechanisms for people with mental disorders and indicate that, patients with mental disorders may also benefit from taking part in the activities organized in the ERU psychosocial support component.

Reducing children´s stress in health care settings – Examples from the field

The PS delegate has an important role providing support and raising awareness on children´s stress and needs in health care settings after disasters. Here are some examples:

- Sharing information and bringing attention to children´s need of stress-reducing interventions and prevention of additional stress, e.g. children´s need for adequate pain relief (including infants and very young children) and age-appropriate information.

- Promoting close contact between children and their caregivers, when children are hospitalized (for newborns skin-to-skin contact is of great importance and should be encouraged whenever possible).

- Reducing stress in the hospital environment by arranging as much routine and predictability as possible in the situation.

- Making the hospital environment less frightening, e.g. decorating with drawings.

- Providing recreational activities such as arranging music and singing in the hospital setting for children and their caregivers.

- Supporting caregivers of hospitalized children, providing them with information on common reactions, giving practical assistance and emotional support.

2. Shelter and site planning

There are a number of relevant psychosocial points about **organizing shelter**. The provision of safe and adequate shelter in crisis situations saves lives, reduces morbidity and enables people to live in dignity without excessive distress.

There are psychosocial benefits of **involving people** affected by an emergency in decisions regarding shelter and site planning. It reduces helplessness and promotes wellbeing. The participation of displaced people also promotes self-reliance, builds community spirit and encourages local management of facilities.

Some additional important aspects relating to shelter are mentioned here:[48]

- Focus on **cultural requirements** for shelter; where cooking is done and, if inside, how ventilation is provided. Privacy issues and proximity to neighbours, accessibility to safe latrines for those with restricted mobility; how much light is required if income-generating activities are to be carried out inside; etc.

- Organize **support** for people who are unable to build their own shelters.

- Consult **women** in particular about privacy and security, including safe, ready access to local resources (e.g. firewood) for cooking and heating and the

location, lightening, locks and pathways to the latrines.[49] If centralised cooking facilities are provided, they should be located close to the shelters.

- Select and design sites that enable ready and safe access to **communal services**, e.g. health facilities, food distribution points, water points, markets, schools, places of worship, community centres, fuel sources, recreational areas and solid waste. Include communal safe space in site design and implementation.

- Distribute shelter and allocate land in a **non-discriminatory manner.**

- Whenever possible, **avoid separating people** who wish to be together with members of their family, village, or religious or ethnic group.

3. Water and sanitation

Providing access to clean drinking water and safe and culturally appropriate hygiene and sanitation facilities are high priorities, both for survival and to restore a sense of dignity. **The manner in which such humanitarian assistance** is provided has significant psychosocial impact on the affected population. Water and sanitation (Watsan) support can either improve or be harmful to mental health and psychosocial wellbeing.

Watsan specialists may or may not be aware of the important **human consequences** of how services are organized and provided. Look for ways to generate discussion about this, if an opportunity arises. In emergencies poorly lit and unlocked latrines often become sites of violence, including rape. Conflict at water sources can also be a significant source of distress.

In many countries, strict **cultural norms and taboos** influence the usage of latrines and the disposal of human excreta. Inattention to cultural norms can lead to the construction of latrines or water points that are never used. In some cases, water points or latrines are not utilized because they may have been used to dispose of dead bodies. Attention to social and cultural norms will help to minimise the distress of adjusting to unfamiliar surroundings and different ways of performing daily tasks.

Other **psychosocial actions in relation to watsan** include:[50]

- **Involve** members of the affected population, especially women, people with disabilities and elderly people, in decisions on the location and design of latrines and, if possible, of water points and bathing shelters. This may not always be possible due to the speed with which facilities have to be provided, but community consultation should be the norm rather than the exception.

- Ensure that adequate water points are close to and **accessible to all households**, including those of vulnerable people such as those with restricted mobility.

- Ensure that all latrines and bathing areas are **secure and, if possible, well lit**. Providing male and female guards and torches or lamps, locks on doors and whistles are simple ways of improving security.

- Ensure that latrines and bathing shelters are **private and culturally acceptable** and that wells are covered and pose **no risk to children**.

- When there is an influx of displaced people, take steps to **avoid the reduction of water supplies** available to host communities and the resulting strain on resources.

- Encourage community clean-up campaigns and communication about basic hygiene.

Chapter 6: Linking research and practice

As a newly deployed PS ERU Delegate, it is important for you to know how PSS and the activities you will be responsible for works. This chapter presents a summary of how research links with practice, indicating the benefits of some of the key interventions described in this manual.

The references for this chapter and further reading on early PSS interventions are in Annex 7.

Introduction
Earthquakes, severe flooding, epidemic outbreaks or other disasters can cause significant psychological and social suffering to affected populations. The past decade has seen immense development when it comes to what we understand about early psychological reactions and what kind of immediate psychosocial support we should give to children, adults and those who receive aid.

> A large part of the world´s population will be exposed to potentially traumatic events in the course of their lifespan. Recent research documents that in most situations natural recovery will occur for many survivors, if opportunities are provided for affected people to make use of their own resources.
>
> It has been estimated that in emergencies, on average, the percentage of people with mild to moderate mental disorders, such as post-traumatic stress disorder, (PTSD), may increase by 5-10 per cent above an estimated baseline of 10 per cent.
> IASC MHPSS, 2007

It looks like the development of mental disorders is rare, but stress reactions are relatively common amongst survivors and relatives. Early negative psychological reactions can be understood as signs of distress, fear, and helplessness – without being seen as signs that people need individual counselling or clinical treatment. It seems that most people are most likely to need support and provision of resources to resume a balance in their lives, rather than receive psychological treatment.

The shift in early interventions
Early psychosocial support interventions have shifted from a focus on talking and emotional processing to interventions known for promoting stress-resistant and resilient outcomes following exposure to extreme stress. These kinds of PS interventions would be providing practical and social support. PFA is an example of this approach.

ERU staff and volunteers should therefore not be asking intrusive questions or forcing individuals to talk about their experiences shortly after they have been exposed to

severe stress, as this may cause further stress. The added stress may disturb the body´s natural healing process at a point in time where it is essential to restore balance and calm down. Interventions in the acute phase of disasters that are not evidence-based may be harmful.

Recommendations for early psychosocial support interventions
Any early intervention approach should be based on an accurate and current assessment of needs prior to intervention. The interventions themselves should be culturally sensitive, related to a local formulation of problems and ways of coping[9].

WHO identified key principles to guide the kind of support which should be provided in the immediate and mid-term phases of potentially traumatic events affecting many people. This means from the immediate hours a crisis event hits to several months after the event. These five guiding principles have been identified as promoting resilience following exposure to extreme stress:

1. A sense of safety
2. Calming
3. A sense of self- and community efficacy
4. Connectedness
5. Hope

In the context where the ERU Psychosocial component operates, the work is about meeting basic needs of large groups of children and adults – in other words providing community-based psychosocial support interventions aimed at reducing stress and strengthening social support for affected children and adults. In addition, some of the interventions used are linked to restoring dignity and human rights[51]. The next section highlights more specifically the linkages between the ERU PS component and the five guiding principles.

The five guiding principles and linkages to the tasks of the PS ERU delegate
Here is an overview of the guiding principles (from Hobfoll et al,2007) with examples of the kinds of tasks PS delegates in the PSS ERU can undertake:

Guiding principle	*Example of tasks in the ERU Psychosocial component*
Promote a sense of safety	Setting up the psychosocial component at an appropriate and **safe** site. Teaching coping skills and grounding techniques. Encouraging individuals to limit intake of news media that cause distress. Educating media to cover safety and resilience rather than imminent threat. Restoration of family links.
Promote calming	Involvements in activities that help people solve their immediate practical needs and concerns. Informing ERU team members on psychosocial issues and stress reactions. Stress-reducing interventions for children and adults receiving medical care. Providing opportunities for children and adults to engage in everyday physical activities. Providing information about possible reactions, self-help, and further support. Liaising with local health authorities and others regarding psychosocial resources and support available/needed.
Promote a sense of self-efficacy and collective efficacy	Promoting the individual and community as experts; focus on activities implemented by the community itself. Identifying and making resources available for a restoration of normalcy and dignity, e.g. school activities. Collaboration with and awareness-raising on psychological reactions and resilience in other areas of disaster response. Involving children and adolescents in appropriate community activities.
Promote connectedness	Establishing safe areas where children and families can play, interact, and engage in recreational activities. Helping patients and survivors connect with their loved ones. Identifying and mobilizing resources for Restoration of Family Links.

	Promoting support through community volunteers.
Promote hope	Involving and encouraging the affected population to be active. Memorializing and meaning-making. Advocating for and communicating appropriate interventions, including the power of human resilience and people´s right to have their dignity restored.

The ERU Psychosocial component is a Red Cross Red Crescent community-based PSS tool for addressing the stress and total disruption of normalcy that children and adults may experience following disasters. Most of the affected population will not need psychological treatment for their reactions. It is important to note that this is why PS delegates do not need to have a background as psychologists – they can have backgrounds in teaching, pedagogics, anthropology, nursing, social sciences etc.

When do you make a referral to professional help?
If initial stress reactions are diminishing, the affected person is likely to heal without any need for professional psychological support. However, if reactions are persisting, increasing or hindering in everyday life, it is likely that the person may need further review and/or referral to professional (psychological or medical) help.

PTSD is the most widely recognized post-traumatic disorder, but is not the only one. Other negative post trauma reactions include depression, anxiety, incident-specific fears, somatization, traumatic grief, sleep disturbances and substance abuse[52]. However keep in mind that the reason behind people´s reactions in disaster settings can be many: disaster-related disorientation due to sudden change in surroundings, poor nutrition and dehydration, medical conditions or problems with medications[53]. It could also be due to the increase in inter-personal violence after disasters[54].

Final points
The past decade has seen immense development when it comes to what we understand about early psychological reactions and needs following disasters. Today we know that most initial negative psychological reactions are normal and are signs of stress, fear and helplessness. Most people will not develop psychological disorders. They are likely to recover with the help of empathic, practical and social support.

No one specific intervention can be recommended for everyone exposed to a potential trauma. Initial interventions should focus on a non-intrusive care; assessing needs and concerns, establishing safe environments free of violence; ensuring that basic needs are met, restoring and strengthening social support and protection from further harm.

Chapter 7: Policies and guidelines

The final chapter provides a brief overview of relevant global policies and guidelines related to PSS in humanitarian settings. You should familiarise yourself with them, as they guide the overall actions of all humanitarian workers engaged in PSS. This manual has also been written in line with the basic principles of the policies and guidelines listed below.

- Sphere Project Handbook, 2011
- IFRC Psychological Support Policy, 2003
- IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, 2007
- IASC Checklist for Field Use, 2007

All documents are available on the PS Centre webpage

1. The Sphere guidelines – PSS as a cross-cutting/inter-sectorial concern

As the PS delegate you may from time to time hear references by humanitarian colleagues in the field to 'the Sphere.' This is the general global policy framework guiding all humanitarian responses including RCRC interventions. This section sets out four protection principles from the handbook and explains how they relate to PSS interventions in humanitarian settings.

The aim of the Sphere Project is to improve the quality of multi- and cross-sectorial humanitarian response, and to increase the accountability of the humanitarian sector.

The most recent Sphere Handbook (2011) treats psychosocial support as a cross-cutting theme. This means it is seen as relevant to every aspect of humanitarian response. In each humanitarian sector, the manner in which aid is managed has a psychosocial impact that may either support or cause harm to affected people. Aid should therefore be delivered in a compassionate manner that promotes dignity, enables self-efficacy via meaningful participation, respect and in acknowledging the importance of religious and cultural practices of the affected population[1].

[1] Sphere project handbook 2011, p.17

The Sphere 2011 - key protection principles related to PSS

Principle 1 - Avoid causing further harm.

Principle 2 - Ensure access to impartial assistance. Ensure that PSS is available to all those in need, particularly those who are most vulnerable or who face exclusion.

Principle 3 - Protect people from violence. This principle is concerned with protection from violence and protection from being forced or induced to act against one's will, e.g. to take up arms, to be forcibly removed from a place or to be prevented from moving, or to be subjected to degrading treatment or punishment. It is concerned with preventing or mitigating physical and psychological harm, including the spread of fear and deliberate creation of terror or panic.

Principle 4 - Assist with rights claims, access to remedies and recovery from abuse. This refers to the role of humanitarian agencies in helping affected people claim their entitlements and access remedies such as helping people overcome the effects of rape and, more generally, with helping people recover from the effects of abuse – physical and psychological, social and economic.

The four protection principles related to PSS listed in the box above aim to help protect disaster-affected populations, but the roles and responsibilities of humanitarian actors in this context are generally *secondary* ones. This means that the work of humanitarian agencies must be seen in relation to the *primary* duty of the state or other relevant authorities, e.g. parties to a conflict who control or occupy territory etc.

Nevertheless, the principles reflect universal humanitarian concerns which should guide our action at all times. A number of humanitarian agencies have protection mandates or specific roles concerning vulnerable groups. Several of these agencies carry out protection activities as stand-alone programmes or projects. In 2011, the Global Protection Cluster included coordination structures with focal points for particular areas of concern, including child protection, gender-based violence etc.

Within the RCRC movement, the ICRC usually has the mandate related to protection and events related to violent conflicts. The IFRC has the mandate to "promote cultures of non-violence and peace," as outlined in Strategy 2020 and the IFRC Strategy on Violence Prevention, Mitigation and Response which addresses self-directed and interpersonal violence.

This means IFRC is responsible to provide safe and protected environments in all their work. However, it is not the ERU PS delegate's primary role and responsibility, but is part of the institutional mandate of the IFRC that also includes the ERU PS delegate. In a natural disaster or other emergency, you may refer to ICRC colleagues in the field if you are confronted with issues related to protection, restoring family links, interpersonal and self-directed violence, child protection and trafficking etc.

2. IFRC Psychological Support Policy

The IFRC psychological support policy establishes a basis for Red Cross Red Crescent actions in emergency response operations, as well as in the implementation of long-term development programmes. It applies to any type of psychological support activity carried out by an individual, National Society or any of its branches, staff or volunteers or by the International Federation as a collective entity.

Psychosocial support is an integral part of the IFRC's emergency response. It aims to help individuals and communities to heal the psychological wounds and rebuild social structures after an emergency. The key objective of the policy is to ensure early and adequate PSS aimed at preventing distress and suffering from developing into something more severe and help people better cope. This is done by integrating PSS into emergency, recovery and development interventions. The PS component of the Health ERU is an example of the IFRC's integration of PSS into emergency responses.

3. The IASC MHPSS Guidelines - DO´s and DON´TS

The IASC Guidelines for MHPSS in Emergencies were developed in order for humanitarian actors to plan, establish and coordinate a set of minimum multi-sectorial responses to protect and improve people´s mental health and psychosocial wellbeing in the midst of an emergency. The checklist for field-use provides a valuable practical list that is worthwhile familiarizing yourself with and applying in the field.

Experiences from different emergencies indicate that some activities are advisable, whereas others should typically be avoided. These activities are identified in the IASC MHPSS guidelines and are summarized below as ´Do´s and ´Don´ts´.[55] Not all of the listed activities relate directly to work of PS ERU Delegate, but are a set of good practices for all humanitarian actors working in the field of PSS:

Do's	Don'ts
Establish one overall coordination group on mental health and psychosocial support.	Do not create separate groups on mental health or on psychosocial support that do not talk or coordinate with one another.
Support a coordinated response, participating in coordination meetings and adding value by complementing the work of others.	Do not work in isolation or without thinking how one's own work fits with that of others.
Collect and analyze information to determine whether a response is needed and, if so, what kind of response.	Do not conduct duplicate assessments or accept preliminary data in an uncritical manner.

Tailor assessment tools to the local context.	Do not use assessment tools not validated in the local, emergency-affected context.
Recognize that people are affected by emergencies in different ways. More resilient people may function well, whereas others may be severely affected and may need specialized supports.	Do not assume that everyone in an emergency is traumatised, or that people who appear resilient need no support.
Ask questions in the local language(s) and in a safe, supportive manner that respects confidentiality.	Do not duplicate assessments or ask very distressing questions without providing follow-up support.
Pay attention to gender differences.	Do not assume that emergencies affect men and women (or boys and girls) in exactly the same way, or that programmes designed for men will be of equal help or accessibility for women.
Check references in recruiting staff and volunteers and build the capacity of new personnel from the local and/or affected community.	Do not use recruiting practices that severely weaken existing local structures.
After trainings on mental health and psychosocial support, provide follow-up supervision and monitoring to ensure that interventions are implemented correctly.	Do not use one-time, stand-alone trainings or very short trainings without follow-up if preparing people to perform complex psychological interventions.
Facilitate the development of community-owned, managed and run programmes.	Do not use a charity model that treats people in the community mainly as beneficiaries of services.
Build local capacities, supporting self-help and strengthening the resources already present in affected groups.	Do not organise supports that undermine or ignore local responsibilities and capacities.
Learn about and, where appropriate, use local cultural practices to support local people.	Do not assume that all local cultural practices are helpful or that all local people are supportive of particular practices.
Use methods from outside the culture where it is appropriate to do so.	Do not assume that methods from abroad are necessarily better or impose them on local people in ways that marginalise local supportive practices and beliefs.
Build government capacities and integrate mental health care for emergency survivors in general health	Do not create parallel mental health services for specific sub-populations.

services and, if available, in community mental health services.	
Organise access to a range of supports, including psychological first aid, to people in acute distress after exposure to an extreme stressor.	Do not provide one-off, single-session psychological debriefing for people in the general population as an early intervention after exposure to conflict or natural disaster.
Train and supervise primary/general health care workers in good prescription practices and in basic psychological support.	Do not provide psychotropic medication or psychological support without training and supervision.
Use generic medications that are on the essential drug list of the country.	Do not introduce new, branded medications in contexts where such medications are not widely used.
Establish effective systems for referring and supporting severely affected people.	Do not establish screening for people with mental disorders without having in place appropriate and accessible services to care for identified persons.
Develop locally appropriate care solutions for people at risk of being institutionalised.	Do not institutionalise people (unless an institution is temporarily an indisputable last resort for basic care and protection).
Use agency communication officers to promote two-way communication with the affected population, as well as with the outside world.	Do not use agency communication officers to communicate only with the outside world.
Use channels, such as the media to provide accurate information that reduces stress and enables people to access humanitarian services.	Do not create or show media images that sensationalise people's suffering or put people at risk.
Seek to integrate psychosocial considerations as relevant into all sectors of humanitarian assistance.	Do not focus solely on clinical activities in the absence of a multi-sectoral response.

Annex 1: Job description

International Federation of Red Cross and Red Crescent Societies
Job Description – Emergency Response Unit

POSITION TITLE: **Psychosocial Delegate** – Basic Health Care and Field Hospital Emergency Response Unit (ERU) –
REPORTING TO: ERU Team leader
PURPOSE: The PS Delegate works to facilitate the resilience, emotional and psychosocial wellbeing of the affected population, in collaboration with the host NS, the local health authorities and ERU colleagues.

DUTIES: Applicable to All

1. Work towards the achievement of Federation goals in the country/region of operation through effective managerial and lateral relations and teamwork
2. Ensure understanding of roles, responsibilities, lateral relationships and accountabilities
3. Perform other work related duties and responsibilities, as may be assigned by the supervisor.

Specific duties, responsibilities and accountabilities

These are the duties and accountabilities applicable to the ERU team members, within the ERU deployed in a Federation coordinated operation, and are complimentary to the specific tasks elaborated in the ERU deployment Order / Terms of Reference.

Standard Operating Procedures for Emergency Response Units as agreed to by the deploying National Society apply.

- Undertake professional duties under direction of the ERU team leader
- Plan and support basic psychosocial activities as part of the work of the ERU, together with the host National Society and/or local health authorities. This may include:
- Set up and maintain safe environments including a safety plan for children who need protection
- Set up the psychosocial component where appropriate in the vicinity of the ERU
- Interface with ERU colleagues, agree on modes of collaboration and flow of patients through the clinic
- Take part in health assessment activities with specific focus on psychosocial issues, mapping of resources and identification of gaps

- Assess existing mental health/psychosocial resources and link up where necessary and possible
- Interact with host National Society to identify volunteers to assist in running psychosocial activities
- Facilitate training of volunteers in psychological first aid and emotional support to affected groups and individuals
- Instruct volunteers on how to organise games and play activities for children
- Launch psychosocial activities
- Organise outreach activities, e.g. community awareness-raising sessions and establishment of support groups
- Inform ERU team members on psychosocial issues, including psychosomatic, grief and extreme stress reactions that can occur within the affected population
- Liaise with local health authorities, WHO, UNICEF and others regarding psychosocial interventions and mental health care at e.g. cluster meetings if applicable
- Set up local and NGO referral systems and know how to handle disclosures of inter-personal and self-directed violence
- Continuously assess, monitor and evaluate needs and activities, follow up when necessary
- Provide regular and timely reports to the ERU team leader
- Work according of the SOP, to the Ministry of Health / WHO guidelines and meet standards as stated in the IASC MHPSS 2007 document.
- Support the capacity of the host National Society and develop skills where possible.
- Interact and, if necessary, advocate with local authorities concerned in matters of mental health and psychosocial support

Lateral Relationships

1. Establish and ensure effective working relationships with the other ERUs and RC partners.
2. Ensure effective working relationships with National Society counterparts and leadership.
3. Ensure effective working relationships with technical and service departments at regional and Geneva Secretariat level.

Person specification	Required	Preferred
General		
In good mental & physical health	X	
Qualifications		
Basic delegates training course or equivalent	X	
Professional qualification as a psychologist, social worker, nurse or teachers – multiple years of field experience	X	
In addition, delegate needs a strong public health background with *skills of training, diplomacy, cultural awareness and practical approach.* Must possess both the communication skills necessary to enable him/her to work closely with community leaders and representatives, as well as the training skills to transfer knowledge/skills to community volunteers that will actually conduct most of the activities. The delegate must have a holistic public health-oriented approach to health in emergencies and related sectors with the view that culture, belief systems, established habits, attitudes, behaviour, and religion are to be respected and leveraged to facilitate improvements in the health of the public.	X	
Basic technical ERU training (health)	X	
Experience		
Experience of managing & supporting staff		X
Experience of working for the Red Cross/Red Crescent		X
Experience of planning and managing budgets		X
Experience of writing narrative & financial reports		X
Skills		
Skills in training and developing staff	X	
Self-supporting in computers: Windows, spread sheets, word-processing	X	
Valid international driving licence: Manual gears	X	
Languages: Intermediate Berlitz level 6 English	X	
Core competencies - a high degree of competence in:		

Person specification	Required	Preferred
Commitment to the International Red Cross & Red Crescent Movement; integrity & personal conduct; sensitivity to diversity; flexibility & adaptability; proactivity; solution-focused approaches; decisiveness; accountability; teamwork; interpersonal skills; resilience.	X	
Management competencies - a high degree of competence in:		
Management of strategy; management of change; leadership; planning; management of budgets; management of resources; monitoring; supervision and control; reporting; communication; networking; management of self; management of others; inspiring others; forming vision; organisation building.		X

Annex 2: Collecting information and mapping resources on psychosocial issues

Type of information
The table below is a guide for collecting information on psychosocial issues for an initial assessment after an emergency or crisis event.[56]

Type of information	Including
Relevant demographic and contextual information	Size of (sub) population Mortality and threats to mortality Access to basic physical needs (e.g. food, shelter, water and sanitation, health care) and education Human rights violations and protective frameworks Social, political, religious and economic structures and dynamics Changes in livelihood activities and daily community life Basic ethnographic information on cultural resources, norms, roles and attitudes Prevalence and incidence of self-directed and inter-personal violence
Experience of the emergency	Local people's experiences of the emergency (perceptions of events and their importance, perceived causes, expected consequences)
Mental health and psychosocial problems	Signs of psychological and social distress, including behavioural and emotional problems Signs of impaired daily functioning Disruption of social solidarity and support mechanisms Information on people with severe mental disorders
Existing sources of psychosocial well-being and mental health	Ways people help themselves and others Ways in which the population may previously have dealt with adversity Types of social support and sources of community solidarity
Organizational capacities and activities	Structure, locations, staffing and resources for mental health care in the health sector (see WHO *Mental Health Atlas*) and the impact of the emergency on services Structure, locations, staffing and resources of psychosocial support programmes in education and social services and the impact of the emergency on services Mapping psychosocial skills of community actors; formal and informal Mapping of potential partners and the extent and quality/content of previous MHPSS training Mapping of emergency MHPSS programmes

Programming needs and opportunities	Recommendations by stakeholders Extent to which key actions outlined in IASC guidelines are implemented Functionality of referral systems between and within health and other social, education, community and religious sectors

Key informants and groups

In addition to collecting the above information, as the PS delegate, plan to talk with a variety of key informants and formal and informal groups. Key informants are people who are in a position to know their community or have a specific area of interest or expertise in the community. These discussions will help you learn how local people are organising themselves and how different agencies can participate in the relief effort.

Communities include sub-groups that differ in interests and power, and these different sub-groups should be considered in all phases of community mobilisation. It may be appropriate to meet separately with sub-groups defined along lines of religion or ethnicity, political affinity, gender and age, or caste and socio-economic class.

The questions below may be used to guide discussion:[57]

Question	Answer
In previous emergencies, how have local people confronted the crisis?	
In times of crisis, who do people normally turn to for support?	

In what ways are people helping each other now?	
How can people here participate in the emergency response?	
Who are the key people or groups who could help organise health supports, shelter supports, etc.?	
How can each area of a camp or village ‘personalise’ its space?	
Would it be helpful to activate pre-existing structures and decision-making processes? If yes, what can be done to enable people in a camp setting to group themselves (e.g. by village or clan)?	

If there are conflicts over resources or facilities, how could the community reduce these? What is the process for settling differences?	

Annex 3: Daily and weekly monitoring form

1. Daily reporting form – information collected on: (Date)

Children aged under 5 years: Male Female Sub-total:
Children aged over 5 years: Male Female Sub-total:

Totals for the above categories:

Number of first-time visitors:
Number of returning visitors:

Number of volunteers: Male Female
Total:

Summarizes week dates xx to xx

2. Weekly reporting form covering the dates to

Narrative section

1a. Provide a general overview of activities that took place this week, describing types of interaction: Play activities for children (specify) Social and supportive activities for adults (specify) Training or workshops (specify) Disclosures/complaints Other (specify)

1b. Specific follow-up action required based on the current week's activities

2a. Rate the ability of volunteers to interact with children Very good 4 3 2 1 Not good
Describe needed follow-up action

2b. Rate the ability of volunteers to interact with adults Very good 4 3 2 1 Not good
Describe needed follow-up action

3. Reflecting on this week's activities, what should be the focus in the following week?

Annex 4: Reading on violence in emergencies

- Overcoming the challenges of violence Published by IFRC/Canadian Red Cross, 2012.

- Guidelines for gender-based violence interventions in humanitarian settings, focusing on prevention of and response to sexual violence in emergencies. *Published by the Inter-Agency Standing Committee, 2005.*

- IFRC Strategy on Violence Prevention, Mitigation and Response: 2011 – 2020. *Published by IFRC.*

- Ten steps to creating safe environments: How organisations and communities can prevent, mitigate and respond to interpersonal violence. *Published by the Canadian Red Cross and the International Federation of the Red Cross and Red Crescent societies, 2011.*

- Eliminating Violence against Children, *Published by UNICEF, 2007.*

- Shattered lives: Immediate Medical Care Vital for Sexual Violence Vict*Sans Frontier2009.*
  This manual gives a good insight to SGBV targeted at meIASC Guidelines on Mental Health and Psychosocial Support*The Inter-Agency Standing Committee, 200*

Annex 5: Checklist for organizing trainings

The following list is a starting point for organising trainings sessions for volunteers. It is not exhaustive; additional items to be remembered may be added in the blank spaces.

Things to consider	Own notes/comments
Selection of participants (equal representation among men and women?)	
Issue invitations	
Identify and secure venue	
Is a per diem paid – how much?	
Do participants have transport? If not how will they get to the training?	
Is there a curfew to be observed?	
Lunch and snacks during breaks	
Branch chairperson (or other official) to hold opening speech/welcome	
Is an interpreter necessary?	
Have the kits available at the venue	
Practical issues around the training	

Things to consider	Own notes/comments

Annex 6: One-day volunteer training programme

For ERU psychosocial support component

Date: Venue: Trainer:

Time	Topic	Activities	Participants Material	Trainers Material/Notes
08.00 – 09.00 Session 1	Welcome Participant introductions Training programme and goals of training Film on psychosocial support	Welcome by trainer and/or RC/RC branch chairperson and/or ERU team leader Round of introductions Presentation of programme and goals of training	Programme for the day	 Name game or ice-breaker Training programme notes Film
09.00 – 09.30 Session 2	What is an Emergency Response Unit (ERU) for Health? What is the psychosocial support component of the Health ERU?	Presentation by trainer		Short overview of what is an ERU, what goes on in general and in the psychosocial support component specifically Film on ERU available on USB
09.30 – 10.00 Session 3	Introduction to psychological first aid	Presentation by trainer Activity		PowerPoint presentation
10.00 – 10.15	**BREAK**			
10.15 – 12.00	Psychological first aid - continued How to support a person in distress	Presentation Group work/role plays	Brochure 1: Stress and coping Brochure 2: Children's stress and how to support Brochure 4:	PowerPoint presentation Group work/Role play notes

Time	Topic	Activities	Participants Material	Trainers Material/Notes
			Psychological first aid	
12.00 – 13.00 Session 4	The psychosocial support component – an introduction	Group exercise using play kits and presentation	Complete items overview of all three kits Kits 1 and 2	In small groups, ask participants to familiarise themselves with a items from the kit and present to the rest of the group
13.00 – 14.00	**LUNCH**			
14.00 – 15.00 Session 5	Psychosocial support to children through play and recreational activities	Interactive play Group work and discussion	Handbook for volunteers Brochure 2: Children's stress and how to support	Play one or two games with participants Group work on ideas for local games and toys. Plenary discussion how to organise activities
15.00 – 15.15	**BREAK**			
15.15 – 15.45 Session 6	What to do if someone is being hurt or not treated right	Discussion	Information sheet 7: All children deserve to be safe	Discussion on how to act if abuse is observed or detected
15.45 – 17.15 Session 7	Stress management and self care for volunteers working in disaster settings: what may be stressful, how to avoid stress, how to help yourself and others	Presentation, group work and plenary discussion on issues related to work-induced stress	Brochure 3: Working in stressful situations	PowerPoint presentation
17.15 – 17.30	Wrap-up and final comments			

Annex 7: Further reading

Early interventions

- Hobfoll, S, Watson, P, Bell, C, Bryant, R, Brymer, M, Friedman, M, et al. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. *Psychiatry 70* (4): 283-315.

- International Society for Traumatic Stress Studies (ISTSS) Treatment Guidelines. This is available on: http://www.istss.org/TreatmentGuidelines.htm

    - Guideline 1 gives an overview of recommended early interventions. Other international practice guidelines are available via the ISTSS web site.

- IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings and Psychosocial Support in Humanitarian Emergencies: What Should Humanitarian Health Actors Know?

- World Health Organization: Mental Health in Emergencies: Mental Health and Social Aspects of Health of Populations Exposed to Extreme Stressors. This is available on: http://www.who.int/mental_health/media/en/640.pdf

- World Health Organization: Single-session Psychological Debriefing: Not Recommended. This is available on: http://www.who.int/hac/techguidance/pht/13643.pdf

    - This technical communication note from the WHO Dept. of Mental Health and Substance Abuse explains why psychological debriefing is not recommended and provides a short, field-friendly overview of current knowledge.

Resilience and early psychological reactions

- Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely adverse events? *American Psychologist, 59*, 20-28.

- Seery, M. D., Silver, R. C., Holman, E. A., Ence, W. A., & Chu, T. Q. (2008). Expressing thoughts and feelings following a collective trauma: Immediate responses to 9/11 predict negative outcomes in a national sample. *Journal of Consulting and Clinical Psychology, 76,* 657-667.

Endnotes

1 Community Health Activities within ERUs, 23 Nov 2006, 2nd draft.

2 Inter-Agency Guidelines for Mental Health and Psychosocial Support in Emergency Settings (IASC MHPSS). Geneva 2007.

3 A. Sumathipula et al: Management of Patients with Medically Unexplained Symptoms – a Practical Guide (2006).

4 Adapted from IASC Guidelines on MHPSS in Emergency Settings.

5 IASC Guidelines on MHPSS: The issue of assessing existing assets and resources, as well as identifying gaps, is covered in chapter 2.

6 The topic of psychological first aid is covered in chapter 5 of this manual.

7 Van Ommeren, M. et al: Mental and social health during and after acute emergencies:

emerging consensus? Bulletin of WHO, January 2005, 83 (1).

8 Technical Assessment of the International Federation's ERU Deployment in Sri Lanka and Indonesia following the Tsunami Disaster. International Federation Health & Care Department, Geneva (2006).

9 For a manual on creating child friendly spaces, consult the manual by Save the Children, available online: http://www.scslat.org/web/uploads/files/emergencias/Handbook-Child_Friendly_Spaces_in_Emergencies.pdf

10 Ten Steps to Creating Safe Environments, IFRC/CRC (2011).

11 Save the Children: Child Friendly Spaces in Emergencies: A Handbook for Save the Children Staff (2008).

12 Public Health in Crisis-Affected Populations. A Practical Guide for Decision-Makers. HPN Network Paper 61 (2007).

13 See IASC MHPSS Action Sheets 6.2 and 6.3.

14 IASC MHPSS.

15 Ibid Figure 1, p 12.

16 Nancy Baron: Community-based psychosocial and mental health interventions for Southern Sudanese refugees living in long term exile in Uganda. In: J. de Jong (ed.) War and Violence: Public Mental Health in the Socio-cultural Context. New York: Plenum Press, 2001.

17 IASC MHPSS.

18 Ibid Ten Steps.

19 Ibid

20 Mary B. Anderson (Ed.), Do No Harm: How Aid Can Support Peace or War. Lynne Rienner Publishers, Boulder/London, (1999).

21 IASC Guidelines on MHPSS, p 10.

22 As described in the job description for the psychosocial delegate position (see Annex 1).

23 Two useful resources on how to initiate and facilitate participatory data collection in communities are available on the ERU psychosocial support USB memory stick: IFRC's Vulnerability and Capacity Assessment (VCA) Toolbox and the Feinstein International Centre's Participatory Impact Assessment – A practitioners guide.

24 Please refer to IASC MHPSS Action Sheet 2.1 for detailed information related to psychosocial assessment.

25 The issue of establishing support groups is dealt with in Chapter 4.

26 Ibid

27 IFRC Strategy on Violence Prevention, Mitigation and Response (2011).

28 Ten Steps to Creating Safe Environments, IFRC/CRC 2011.

29 Shattered Lives: Immediate Medical Care Vital for Sexual Violence Victims. Published by Medecins Sans Frontieres, 2009.

30 IASC MHPSS Action Sheet 5.4.

31 The Handbook for volunteers provides more information on child development and the purpose of establishing psychosocial activities for children in crisis situations.

32 Annex 2 of the UNICEF ECD Manual available on the ERU psychosocial support USB memory stick shows examples of toys and play materials that can be made using local materials.

33 Courtesy of ECPAT International.

34 IASC MHPSS Action Sheet 5.2.

35 Adapted from IASC MHPSS Action Sheet 5.2.

36 Annex 2 of the UNICEF ECD Manual is on the ERU psychosocial support USB memory stick, showing examples of toys and play materials that can be made using local materials.

37 HelpAge International is an international organization working to meet the needs, uphold the rights and recognize the capacities of older people in humanitarian crises. See www.helpage.org/

38 Adolescents and Young People in Emergency and Transition Settings. Cecile Mazzacurati, UNFPA, Humanitarian Response Branch 21 February 2012.

39 Ibid.

40 The PS delegate cannot be certain of having a power point projector at their disposal during trainings.

41 International Federation Reference Centre for Psychosocial Support, (2009).

42 Brymer M, Jacobs A, Layne C, Pynoos R, Ruzek J, Steinberg A, Vernberg, E, Watson P, (National Child Traumatic Stress Network and National Center for PTSD), Psychological First Aid: Field Operations Guide, 2nd Edition. July 2006. Available on:www.nctsn.org and www.ncptsd.va.gov.

43 International Federation Reference Centre for Psychosocial Support 2009; the full version of this training programme is available in the 'additional training resources' section of the Laptop and USB stick.

44 Adapted from the International Federation's psychosocial programme in Bangladesh and used here with permission.

45 Annex 2 of the UNICEF ECD Manual available on the ERU psychosocial support USB stick shows examples of toys and play materials that may can be made using local materials.

46 The slides were initially developed in connection with the American Red Cross psychosocial intervention in the Maldives following the Indian Ocean tsunami and subsequently in the International Federation's psychosocial programme following cyclone Sidr in Bangladesh. They are used here with permission.

47 Refer to action sheets 6.1 and 8.2 of IASC MHPSS for further details on the issues covered in this section.

48 Refer to action sheet 10.1 of IASC MHPSS for further details on the issues covered in this section.

49 For guidance see IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings available on the ERU psychosocial support USB stick.

50 Refer to action sheet 11.1 of IASC MHPSS for further details on the issues covered in this section.

51 Convention on the Rights of the Child.

52 Brymer M, Jacobs A, Layne C, Pynoos R, Ruzek J, Steinberg A, Vernberg, E, Watson P, (National Child Traumatic Stress Network and National Center for PTSD), Psychological First Aid: Field Operations Guide, 2nd Edition. July, 2006. Available on:www.nctsn.org and www.ncptsd.va.gov.

The panel identified five empirically supported intervention principles presented in the article: Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence.

54 Predictable, Preventable: Best Practices for Introducing Interpersonal and Self-Directed Violence During and After Disasters, IFRC/CRC, (2012).

55 From IASC MHPSS Checklist for field use.

56 Please refer to IASC MHPSS Action sheet 2.1 for more information on psychosocial assessment.

57 Please refer to IASC MHPSS Action sheets 5.1 and 5.2 for more on how to facilitate community mobilization.