In a summer camp for child mine/ERW survivors, a psychosocial support session is facilitated by a psychologist, Davlatov Mahmadullo, who lives with a physical disability himself.

Chapter 5
Child-focused Victim Assistance

Section 5.4
Psychological and psychosocial support

Explanatory Note

THIS document is one of **eight** PDF documents that comprise the Guidance on Child-focused Victim Assistance. All are available in PDF at <http://www.unicef.org/publications/>. The full document is also available.

The first PDF contains the Acknowledgements, Foreword, Acronyms and Chapters 1 through 4:

Chapter 1. Introduction: The Need for Child-focused Victim Assistance Guidance
Chapter 2. Mine Action, UNICEF and Guidance on Child Victim Assistance
Chapter 3. Victim Assistance: Stakeholders and International Standards
Chapter 4. Principles, Coordination and Cross-cutting Aspects of Victim Assistance

This stand-alone document *Psychological and Psychosocial Support* is one of the six technical components of Child-focused Victim Assistance Guidance. Together, they comprise Chapter 5 Child-focused Victim Assistance. The other five parts (each of them in a PDF document) of Chapter 5 are:

Section 5.1 Data collection and analysis
Section 5.2 Emergency and continuing medical care
Section 5.3 Rehabilitation
Section 5.5 Social and economic inclusion
Section 5.6 Laws and policies

The eighth and final PDF document, Chapter 6, contains resources and references that users may find helpful.

BETWEEN 1999 and 2012, 88,331 people living in some 60 countries are known to have been killed or injured by landmines or explosive remnants of war (ERW). Of these, at least 15,868 were under the age of 18 at the time of the accident. Although progress has been made in reducing the threat of unexploded ordnance worldwide, some 1,000 children – 90 per cent of them boys or young male adolescents[1] – are still killed or injured annually.

Cluster munition remnants and improvised explosive devices (IEDs) are particularly deadly for children. Blast and fragmentation injuries often cause long-lasting impairments including limb amputations, loss of eyesight and hearing, severe injuries to genitals, internal organs, face and chest, brain damage and spinal cord damage.

These physical injuries are aggravated by the psychosocial, socio-economic and protection consequences of the traumatic event of a blast accident as the survivors confront lifelong difficulties accessing education, livelihood opportunities and, like many vulnerable children with disabilities, are subject to violence, abuse and exploitation.

This Guidance was developed in response to requests for support in developing child-focused victim assistance programming. It provides support for:

- Developing new policies and programmes (or adapting existing ones) that assist child mine/ERW victims that are age- and gender-appropriate and promote the rights of children and young people[2] with disabilities.
- Promoting access for children directly and indirectly affected by landmines and ERW to comprehensive support in emergency situations, directly or through their families, communities and service providers.
- Designing programming for mine/ERW injured children that is mainstreamed into wider disability, economic and social development, and poverty reduction efforts.
- Supporting stakeholders to meet the needs and enhance the quality of life of children and their families affected by landmines and ERW by advocating for and facilitating access to affordable health care, rehabilitation, psychosocial support, social and economic inclusion (education, livelihood support and social assistance, etc.).
- Encouraging stakeholders to facilitate the empowerment and participation of children affected by armed conflict and of children with disabilities.

This Guidance will be useful to Governmental and non-governmental entities and civil society organizations that provide services or influence policy and budgeting related to survivors and victims of landmines/ERW and persons with disabilities; UNICEF and other UN programme and policy staff at all levels; children and people with disabilities and their families and other care givers; Mine Action actors; Governmental and non-governmental entities and international organizations, including UN actors, providing services for survivors and victims of landmines/ERW and persons with disabilities; and researchers and academics.

Acronyms

AIDS	acquired immune deficiency syndrome
APMBC	Anti-Personnel Mine Ban Convention
C4D	communication for development
CBR	community-based rehabilitation
CCM	Convention on Cluster Munitions
CCW	Convention on Certain Conventional Weapons
CDC	Centers for Disease Control and Prevention (United States)
CMC	Cluster Munition Coalition
CRC	Convention on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
DFID	Department for International Development, Government of the United Kingdom of Great Britain and Northern Ireland
DPO	disabled people's organization
ERW	explosive remnants of war
GA	General Assembly (of the UN)
GICHD	Geneva International Centre for Humanitarian Demining
GMAP	Gender Mine Action Programme (A Swiss NGO)
HI	Handicap International
HIV	human immunodeficiency virus
ICBL	International Campaign to Ban Landmines
IDP	internally displaced persons
IED	improvised explosive device
IMAS	International Mine Action Standards
IMSMA	Information Management System for Mine Action
ISPO	International Society for Prosthetics and Orthotics
ISU	Implementation Support Unit (of the APMBC)
MA	mine action
MRE	mine risk education
NGO	non-governmental organization
NSA	non-state actor
PDR	People's Democratic Republic (as in Lao PDR)
PFA	psychological first aid

P&O	prosthetics and orthotics
UN	United Nations
UNDG	United Nations Development Group
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNMAS	United Nations Mine Action Service
UXO	unexploded ordnance
VA	victim assistance
WASH	water and sanitation and hygiene
WHO	World Health Organization

Boxes

Box 15:	Life After the Bomb: A Psychosocial Study of Child Survivors of Unexploded Ordnance Accidents in Lao People's Democratic Republic
Box 16:	Peer-to-peer Support in El Salvador
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Figure 2:	Mental Health and Psychosocial Support, the Intervention Pyramid

5.4 Psychological and psychosocial support

Introduction

PSYCHOLOGICAL care aims to prevent or treat mental disorder while *psychosocial support* has been defined as any type of local or outside support that aims to protect or promote psychosocial well-being. 'Psycho' refers to the psyche or the 'soul' of a person. It has to do with the inner world – with feelings, thoughts, desires, beliefs and values and how we perceive ourselves and others. 'Social' refers to the relationships and environment of an individual. It includes not only the material world but also the social and cultural context in which people live, ranging from the intricate network of their relationships to manifold cultural expressions to the community and the state. The inner world (psycho) and the outer world (social) influence each other. In short, 'psychosocial' deals with the well-being of individuals in relation to their environment.[3]

People who experience a violent injury from a blast explosion suffer a trauma, which is a Greek word that means wound. Survivors may suffer a *physical trauma* – an amputation of a limb or limbs, blindness or deafness – as well as a *mental trauma*. A landmine or explosive remnant of war (ERW) accident is traumatic both for those who are injured and for those who witness it but are left unharmed. Although everyone is affected in some way, individual reactions vary greatly. Many people may feel overwhelmed, confused, guilty and very uncertain about what is happening, especially children. Some feel very fearful or anxious; others display numbness and detachment. Some people may have mild reactions, whereas others may have more severe reactions. How someone reacts depends on many factors including age – and children of different age groups react differently.

Traumatic processes change not only the individuals directly affected, but also their environs. Living as a person with a disability often creates additional stress resulting from discrimination, mockery and bullying, but also from over-protection and pity instead of empathy. Prejudice against and stigmatization of persons with disabilities may lead to exclusion and a low self-esteem in children and adults. Women and girls with disabilities can face greater discrimination within their communities. Exclusion from school, from play, from community and for adolescents from economic life has particularly dire consequences for the recovery of children and young people. Many young people with disabilities are often incorrectly believed to be sexually inactive, unlikely to use substances and at less risk of violence and abuse than their peers without disabilities.

An indicator of the high level of anxiety felt by child survivors is seen in their strong attachment to their parents. The majority of child survivors say they are afraid to be without their parents. Several parents also mentioned over-attachment immediately after the accident.

"After coming back from the hospital, he could not be separated from me for 3 months: he was afraid to be alone."

Handicap International/Lao Youth Union/UNICEF (2004), Life after the Bomb: A Psychosocial Study of Child Survivors of UXO Accidents in Lao PDR, *Vientiane, p. 13*

Psychosocial support must address both the direct victims and their families and close friends. Loved ones, be they spouse or parents, brothers and sisters or close friends usually are the first ones who have to come to terms with how best to deal with this difficult and stressful situation. They can play a very important support role but they may also 'panic' and make the coping process more difficult. Too often, the new realities of life after such a trauma result in the break-up of marriages or long-term relationships as people with disabilities often confront discrimination.

The first year after the accident is often described as the most difficult: suicidal intentions, anger, grief, deep sadness, anxiety, guilt, and psychosomatic illnesses are common. Leaving the 'safe environment' of the hospital, sometimes months after the incident, is a difficult step in the adaptation process to learn to accept the new reality of being a person with a disability. The survivors return to their home (unless their family has become displaced in the meantime) and face their friends, neighbours, other relatives, and school mates.

In the immediate aftermath of the traumatizing event, psychosocial attention has to focus on the suffering and shock (traumatic reaction). Long term psychosocial approaches should focus on the coping mechanisms and strengthening the resilience of the individual and the surrounding family and community (traumatic process). Everyone has experienced more or less traumatizing events in his/her lifetime and developed coping mechanisms. These need to be identified and understood. What has helped in the past can also help in the present.

Goal

Landmine/ERW victims and survivors including children have access to psychological and psychosocial support that allows them to better understand and cope with the consequences of the traumatic accident.

The role of psychological and psychosocial support in child-focused victim assistance

The role of psychological and psychosocial support in child-focused victim assistance is to promote the mental health and the psychosocial well-being of child survivors and family members of injured or killed children and adults.

Key concepts

Psychosocial support

Psychosocial support addresses the psychological and emotional well-being of persons directly and indirectly affected from traumatic events and circumstances. These events include violent deaths or injuries from conflict-related events such as landmine/ERW accidents and from torture, sexual violence, trafficking, and natural disasters such as earthquakes or landslides. How a person reacts to such a distressing event differs widely and is associated to his or her individual resilience, which often depends on previous traumatic experiences, their social support structures, and coping mechanisms. The process of the trauma continues in a healing or destructive way after the war, direct violence and persecution have come to an end. It is usually not difficult to determine when a traumatic process began, but often difficult to know when it has stopped.

From a psychosocial perspective, three key social processes correspond to certain mental processes: threat and fear; destruction and trauma; loss and grief. Landmines were designed to create a threat and to leave soldiers and civilians in constant fear of getting maimed or killed. The victims thus do not only have to deal with their own fear reaction to their terrible experience, but also with being a symbol of the destructive power of the mines and therefore potentially being rejected or marginalized by others. Destruction and trauma are always present for the victims, many of whom experience feelings of total helplessness and the terrible images of destruction that, like a nightmare, stay in the vivid memory and are difficult to overcome. Finally, the experiences always imply loss – the violent injury of a blast explosion implies death or the loss of one or several limbs, eyesight or hearing. Assisting others to grieve, to mourn, is a key component of psychosocial support. Loss of loved ones and the difficulties of grieving during acute conflict are evident. One amputee in Angola said he wished he could have buried his leg that had been cut off but that it had been dumped in the hospital garbage. Burying the remains of his leg would have been one way for him to grieve.[4]

Medical staff, preoccupied with treating physical trauma, are often not sensitive to survivors' psychological needs. A comprehensive psychosocial approach should address the fundamental needs of an affected person, usually through psychological first aid or professional counselling if available. Only in rare cases is it necessary to refer a survivor to clinical management of severe mental conditions. Psychosocial support needs to be specific to the stage of the child's life cycle, for example, to address the anxiety of female adolescents about their suitability for marriage or the fears of adolescent boys who sustained injuries to their genital area. It is equally critical for young children, especially those under five, whose communication skills are less developed.
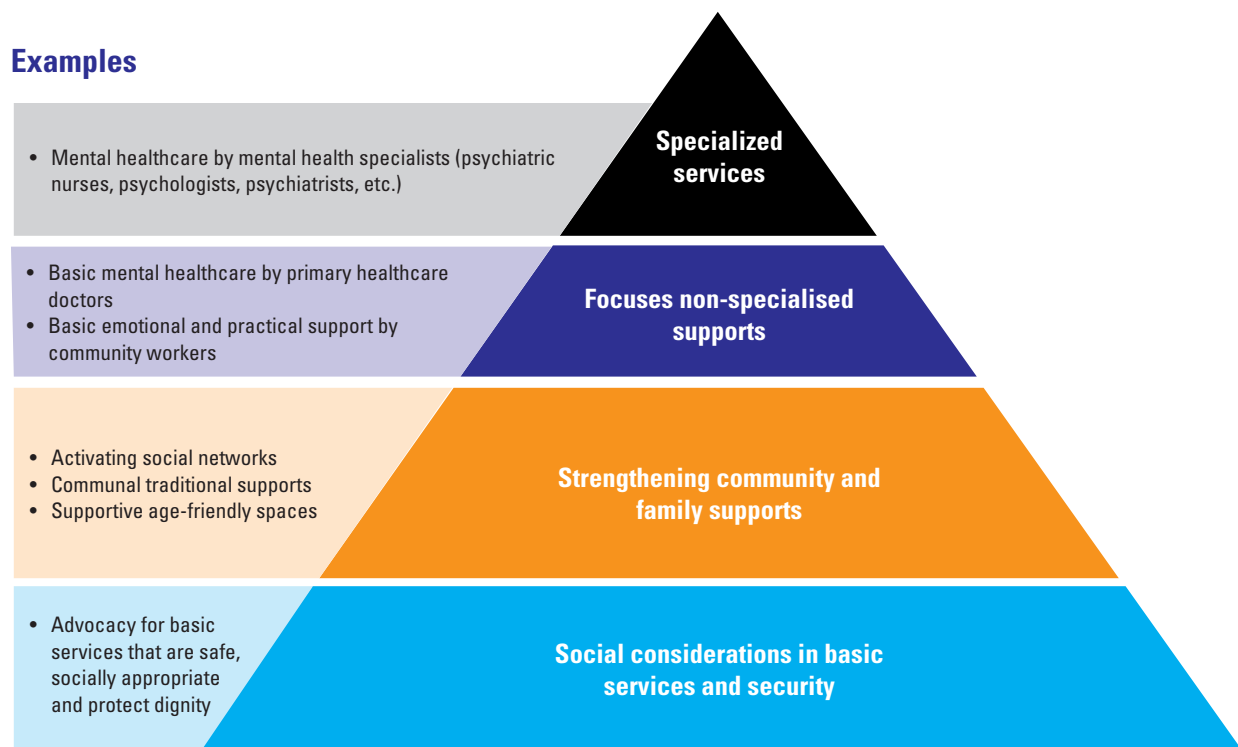
Psychosocial support includes ensuring access to shelter, food, health, water, sanitation, hygiene, and safety and offering these services in a way that respects the dignity of the people affected. It includes organizing support from family and neighbours. It encompasses organizing support from persons trained in basic psychosocial support, such as community workers, child protection and health care staff, and if needed, referral to clinical specialists. Meeting basic needs can go a long way in allaying anxiety. Building supportive networks helps to build individual resilience and to reweave the broken social fabric.

Mental health

Mental health is a state of well-being in which a person realizes his/her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his/her community. The term 'Mental health' is also used when referring to the work of specialists and includes psychological and psychosocial support. These terms are therefore often used interchangeably. Mental health specialists are usually asked to intervene for patients diagnosed with a severe mental disorder, usually not more than 3-5 per cent out of a group that is faced by severely distressing events (See Figure 2, The Intervention Pyramid).

Mental health is among the least understood areas among the VA components: Trauma is sometimes perceived as an illness that needs to be 'overcome'[5] or 'cured'. It is helpful to understand the experience of trauma, as a process that may manifest itself from time to time, sometimes triggered years after the initial most violent traumatic event. Trauma goes through different stages, in which the immediate

Figure 2: Mental Health and Psychosocial Support, the Intervention Pyramid

Examples

• Mental healthcare by mental health specialists (psychiatric nurses, psychologists, psychiatrists, etc.)	**Specialized services**
• Basic mental healthcare by primary healthcare doctors • Basic emotional and practical support by community workers	**Focuses non-specialised supports**
• Activating social networks • Communal traditional supports • Supportive age-friendly spaces	**Strengthening community and family supports**
• Advocacy for basic services that are safe, socially appropriate and protect dignity	**Social considerations in basic services and security**

Note: This Intervention Pyramid shows four main types of mental health/psychosocial support interventions to a population under distress. The pyramid resembles the total group requiring multi-layered support. The smallest group, at the top of the pyramid requires support by mental health specialists while the largest group gets the highest mental relief from living in security and safety and by having basic services guaranteed. All layers of the pyramid are important and should ideally be implemented at the same time.

Source: Minimum standards in child protection (2012), after Inter-Agency Standing Committee (IASC) (2007), Guidelines on Mental Health and Psychosocial Support in Emergency Settings, Geneva

environment of the survivors plays an important role. The initial traumatic shock reaction often subsides rather quickly, but then begins the long phase of getting used to the new life, of facing difficulties and experiencing social rejection, of anger, pain and depression. In order to mobilize their strength and resilience, victims need to come to terms with loss and the adverse life changes they experience. By identifying and addressing feelings of helplessness and despair, survivors and victims can develop their resilience and make better use of their own capacities and resources. Furthermore, whether traumatic symptoms appear or reappear will depend in large part on how the social environment reacts to the issue, not only in the immediate aftermath but also many years later.

Barriers to psychosocial support

Psychosocial support in child-focused VA needs to address the needs of both children and their care givers. The capacities of parents, caregivers and other members of the family should be recognized and strengthened to provide emotional support for survivors and victims. Interviews with parents of child survivors indicate that parents also experience stress, anxiety and depression, which can reduce their capacity to provide care and support. Family members and caregivers of persons with disabilities must also be provided with psychosocial support and ways to provide adequate support to their child.

In some cases, the family can be an obstacle to inclusion because family members are ashamed, because they want to overprotect the child, or they do not have enough information or understanding to be inclusive. The stigma of having a family member with a disability is often a source of fear and pain for family members. This may lead parents to keep these children, especially daughters, out of sight. Girl survivors in some cultural contexts are seen as 'useless' by their parents because they assume the girl cannot contribute to the household and cannot get married. A child with disability may be seen as an additional 'burden' that increases the cost of living and leads to lost income-earning opportunities as a result of time spent for specific care. It is essential to create a supporting environment within the family first, and to do so through a contextual approach that builds on and respects positive cultural traditions and coping mechanisms.

Box 15: Life After the Bomb: A Psychosocial Study of Child Survivors of Unexploded Ordnance Accidents in Lao People's Democratic Republic

A total of 162 child survivors in 23 districts were interviewed using a questionnaire and an additional 24 children participated in open interviews. Boys made up 76 per cent of child survivors interviewed. A total of 158 parents of child survivors were interviewed, the overwhelming majority of whom were rural farmers.

Very few child survivors had received specialist medical care after the accident. About one in ten had accessed rehabilitation services at the National Rehabilitation Centre in Vientiane.

Despite frequent vision and hearing impairments, none reported undergoing medical examinations to ascertain whether or not treatment, surgery or special rehabilitation aids such as eye glasses or hearing aids could improve their remaining vision or hearing. Most child survivors and their families were not aware that specialist services exist.

The cost of medical treatment for child survivors ranged widely. Some families spent the equivalent of a few US dollars, while several paid more than US$1,000. A significant proportion of health care expenditure is accounted for by the cost of transportation to hospital. The mean average expenditure on transport to hospital was US$43, but in some cases transport to hospital cost families a few hundred dollars.

None of the child survivors had received psychological support. The small Mental Health Unit located in Mahasot Hospital in Vientiane provides the only psychological care and support service in the country. There are no mental health services at the provincial or district level, nor any community-based mental health care services.

Traditional healing practices were often sought. They are not limited to the treatment of physical injury and pain, but also address emotional suffering. This is significant given the total lack of mental health services outside the capital city. Traditional healing practices therefore have an essential role in the psychological rehabilitation of child survivors and their families. Healing practices also have a broader therapeutic function. By bringing together the injured child, parents, the extended family and other members of the community, they serve to reinforce social relationships, help to re-integrate the child into the community and provide an opportunity for family and community members to provide moral and material support. The overwhelming majority of parents (88 per cent) said that their child's recovery was assisted by a ceremony of some sort. The most common healing ceremonies involved calling and strengthening souls. Ceremonies involving offerings to spirits and at the temple were less common. Suk Khouane (soul strengthening) and Ern Khouane (soul calling) ceremonies are deemed necessary in light of the force of a UXO explosion, the resulting pain and the strong emotional impact which can severely weaken a person's soul and may even cause one or more souls to become detached from the body [One person has multiple souls according to local beliefs]. Recovery is considered to be impossible without a full complement of strong souls.

Source: Handicap International (Belgium), Lao Youth Union, UNICEF (2004), *Life After the Bomb*, … Vientiane, pp. 16-19

Peer support

Peer support refers to support from a person who has knowledge of a condition drawn from their own experiences. For victim assistance, peer support typically comes from a landmine or ERW survivor.[6] Meeting people who face the same problems as I do helps to realize that I am not alone and that there are solutions that might also work for me. Peer support reduces isolation and can lead to providing longer term mutual support, for example in self-help groups or in Disabled People's Organizations. 'If they can, so can I' is a powerful motivator. The turning point in recovery for many is seeing other survivors leading productive, fulfilling lives. Peer counsellors need to be trained both in trauma recovery and confidence building as well as in socio-economic

> **"After I returned from hospital we went back to the site of the accident to call back the souls that I lost … Not all the souls have come back yet."**
> — *Child landmine survivor from Lao PDR*

empowerment through referrals and advocacy.

Peer support extends also to mixed groups of persons with and without disabilities. Peer support of classmates for fellow students with disabilities has shown very successful results. Seeing the capacities of persons with disabilities changes the prevailing perceptions among persons without disabilities. (See Box 16 on Peer Support in El Salvador.)

Social exclusion

Social exclusion is the process of being shut out from the social, economic, political and cultural systems that contribute to the inclusion of a person into the community. Exclusion of persons with disabilities in conflict or post-conflict societies is also an expression of the fragmentation and destruction of the collective social structure, of the social fabric. Without addressing the past and without addressing the context in which most mine/ERW victims live – in poverty where social injustice is common – progress to improve individuals' and communities' mental health may be modest. Stigma against people with disabilities is widespread regardless of whether it is a congenital or acquired disability. Family members are also subject to limited understanding, prejudiced attitudes and discriminatory behaviour. Stigmatization may lead to self-stigma, internalizing negative attitudes, leading to self-blame, a low self-image and low self-esteem.

Empowerment

Empowerment is at the core of the psychosocial approach. It includes empowerment of the individual, including improved self-esteem, and empowerment of marginalized communities by overcoming social injustice and seeking inclusive development. To seek empowerment, we need to understand the factors that result in disempowerment.[7] One of these factors is pity. While feeling empathy is good, pity implies labelling the other as deficient. Also, with children, it is important to understand that they may be angry and frustrated with their situation, and that anger in this context is not only a difficulty but may actually be a positive yet temporary force that helps them survive and struggle for a better life. Many mine/ERW casualties in children are the result of their natural and healthy curiosity, which should not be destroyed in the aftermath of the experience of destruction.

Desirable outcomes

- Landmine and ERW victims including children have access to psychological and to psychosocial support.
- Mental health workers, community workers, teachers and other education professionals, peer-supporters and others who work with children, are adequately trained in psychosocial support including on specificities regarding both female and male children and adolescents.
- Families, caregivers and communities are trained and mobilized to provide support to children and their families or care takers.
- Child survivors and children with disabilities are valued as members of their families. They are encouraged and supported to contribute their

skills and resources to the development of their communities.
- Sport and leisure activities provide an opportunity for boys and girls to better accept their changed bodies and to be included in school and the community.
- Awareness campaigns and social mobilization promote positive knowledge, attitudes and practices to help reduce stigma and discrimination towards people with disabilities and alleviate mental health problems. Bullying of children with disabilities in schools is reduced.
- People with disabilities and conflict victims make their own decisions and take responsibilities for changing their lives and improving their communities.

Suggested activities

In general, activities intended to provide direct and indirect psychosocial support should reconnect children with family members, friends and neighbours. They should foster social connections and interactions especially in situations where children are separated from their family or community of origin. Activities should normalize daily life; promote a sense of competence and restoration of control over one's life; and build on and encourage children's and community's innate resilience to crisis. Finally, they should provide for identifying, referring and treating children with severe mental conditions. Specific activities may include the following:

Promote psychosocial support

- ✓ Promote training in psychosocial support that addresses the specific needs of children. Include mine action actors in training opportunities in psychological first aid. (Psychological first aid or PFA, despite its name, covers both social and psychological support.)
- ✓ Be aware that all staff, not only 'professionals', dealing with mine/ERW victims need special psychosocial

Chan, 17 years old, lost three friends in an ERW incident that left him blind in one eye and caused his right arm to be amputated. To help defray the high expenses of his treatment, he dropped out of school and is working as a car washer. His two younger sisters also dropped out of school and work in Thailand in the garment industry.

training in order to manage their own difficulties and potential hate that can result from fear, helplessness, and difficulties in accepting that victims do not need to be grateful for the help they are getting.
- ✓ Create opportunities for 'non-focused specialized care' (such as PFA) for child survivors and victims of mines/ERW.
- ✓ Value and incorporate traditional medicine and local ceremonies offering support for acceptance of a traumatic event or change in life.
- ✓ Merge mine/ERW risk education messages and Child Protection psychosocial support messages in awareness-raising campaigns.
- ✓ A risk education session provided to a community recently traumatized by a victim-activated explosion can be considered both as a psychosocial intervention and a prevention strategy (e.g. to discuss the accident and to identify ways to prevent future accidents).

Promote mental health
- ✓ Train and build the capacity of psychosocial and mental health care providers to identify children who may require more specialized psychosocial or mental health care/attention.
- ✓ Promote clinical mental health providers to be able to provide psychiatric care to treat severe mental conditions, including to children, when required.
- ✓ Train clinical mental health providers in the psychosocial approach.

Overcome stigma and discrimination
- ✓ Support awareness campaigns and long-term values-based communication efforts to promote positive attitudes and social norms to overcome stigma and discrimination.
- ✓ Address common myths, prejudices and discrimination at family and at community levels (for example, through schools/parents committees, religious leaders, community-based organizations, village committees and in the workplace).
- ✓ Mobilize community support groups of children, adolescents, women and men.
- ✓ Develop the capacity of mine action staff, Child Protection staff, Community-based Rehabilitation (CBR)-workers and others on disability issues and services and how to undertake awareness campaigns/Communication for Development strategies.
- ✓ Promote activities that foster mutual support, such as peer support and self-help groups, for both children and their parents/family members.

Support the recovery process
- ✓ Facilitate access to appropriate medical care, to social support, to livelihood opportunities, to community life, and to psychological support as needed.

Support family members

- ✓ Promote assistance to the caregivers of survivors (mostly for mothers and/or eldest sisters), including education on proper health care and health promotion and the psychosocial impact of trauma.
- ✓ Provide life skills training for parents and other caregivers.

Contribute to the empowerment process

- ✓ Ensure that child survivors and victims of mines/ERW are able to access and participate in support activities for children in the community.
- ✓ Promote art, sport and leisure activities both as activities for people with disabilities only (amputee football, wheelchair basketball, cycling, swimming, athletics, etc.) and as inclusive events. Sport and leisure activities can help survivors accept the new body image and improve self-esteem. Invite parents to design sports and cultural programmes that include children with disabilities, especially girls.
- ✓ Provide support to caregivers to better care for child survivors of mines/ERW, to deal with their own distress and to link them to basic services.
- ✓ Include support for child survivors and victims of mines/ERW in work to strengthen pre-existing community networks to provide psychosocial support to children and their families.

Box 16: Peer-to-peer Support in El Salvador

To address issues of social exclusion and extreme poverty of persons with disabilities and their families, including survivors of armed conflict, the *Fundación Red de Sobrevivientes y Personas con Discapacidad* (Foundation Network of Survivors and Persons with Disabilities) developed a peer-to-peer support programme.

Its three major components are:

1. **Access to Health:** promotion of mental health (self-esteem and self-management), rehabilitation (mobility devices), and prevention (nutrition, preventing infectious disease);
2. **Support for Decent Work:** business training and seed capital;
3. **Promotion of Social Empowerment:** training on disability and human rights, leadership, advocacy and legal frameworks; strengthening of community-based organizations and awareness-raising at national level.

The Red has a team of field workers with disabilities who visit other persons with disabilities to understand their needs and define a personal plan of action in accordance with the person's priorities, potential and environment.

The Red notes that although peer-to-peer support contributes to improving mental health, it should not be seen as a substitute for professional psychological support.

About 700 persons with disabilities have been trained annually by peers on health, human rights and business management. Another 100 persons with disabilities received support to start self-employment projects. In 2012, 160 persons received mobility devices. Evidence indicates that a larger number actually benefits from support provided to persons with disabilities, including their family members and friends.

This peer-to-peer model has been successful in improving psychological and socio-economic wellbeing. It promotes sustainability in three ways:

1. Persons with disabilities themselves are trained and improve their own knowledge and capacities, and share them with their peers;
2. Persons with disabilities can use peer-to-peer support with the main goal of promoting self-esteem and psychological well-being, and also as a methodology to provide support in a specific sector (e.g. employment or health);
3. Collective empowerment is strengthened via local associations of persons with disabilities for advocacy and awareness campaigns.

Donors to this programme are the Government of Norway, InterAmerican Foundations and Provictimis Foundation.

Source: Handicap International (2013), VA Factsheet 'Psychological & Psycho-social Support'

Box 17: Mpila's emergency experience about trauma counselling and risk education – Brazzaville, Congo

Poster and leaflet used during joint UXO Risk Education-psychosocial support activities in Mpila, Brazzaville

On 4 March 2012, ammunition stores exploded in the neighbourhood of Mpila, in Brazzaville, the capital of the Republic of the Congo. The blast killed at least 300 persons and injured another 2,500. It destroyed homes and buildings, including public infrastructures. It forced 200,000 citizens to live in camps or with friends or families. After this tragedy, many people, mostly children and adults living around the epicentre of the explosion, were traumatized. Some lost relatives, many lost their homes and belongings and some of them believed they would die.

In response, the UNICEF Country Office developed several activities. In the camps, Child Friendly Spaces were established and recreational activities organized. Teams of psychologists were deployed to alert the public and take care of traumatized people. Unexploded Ordnance (UXO) risk education activities were developed and implemented inside and outside the camps. (Indeed, a large perimeter around the epicentre of the blast had been contaminated by potentially dangerous devices.) Scouts undertook door-to-door awareness, supported by the association Tchikaya U'Tamsi which staged plays about the risk education. Communication supports, such as flyers, were disseminated all over the city. The Scouts and members of Tchikaya U'Tamsi learned how to recognize the signs of a traumatized person: being afraid to be hurt or to die (for oneself or family), inability to attend or participate in favourite activities, feelings of guilt, feeling to be a burden for the family, feeling of being isolated and detached from social activities. If a person exhibited some of these symptoms, teams in the field or relatives were asked to refer him or her to psychologists in spaces established to provide psychosocial support and trauma counselling.

This approach proved to be successful. As of early 2014, UNICEF and its partners are pursuing risk education activities in Pointe-Noire and Brazzaville, reaching out to teachers, youth representatives, military and police. The psychological approach has been integrated with the risk education component, which includes a specific component on the psychological impacts after an exposure to an explosion caused by ammunitions.

Source: UNICEF Brazzaville, Congo, January 2014

Technical Resources

Documents are listed in *inverse chronological order*, starting with the most recent ones.

Psychological and psychosocial support

Rutherford, Ken and Cameron Macauley (CISR) (2013), 'The Power of Peers: Rethinking Victim Assistance', *The Journal of ERW and Mine Action*, V.17.3, Fall 2013 [Focus Survivor Assistance]. Harrisonburg, VA, pp. 6-9, <http://www.jmu.edu/cisr/journal/17.3/173.pdf>

Child Protection Working Group (2012), 'Standard 10 Psychosocial distress and mental disorders', in *Minimum standards for child protection in humanitarian action,* pp. 97-102, <http://cpwg.net/minimum-standards/>

WHO/War Trauma Foundation/World Vision International (2011), *Psychological first aid: Guide for field workers,* Geneva, <http://www.who.int/mental_health/publications/guide_field_workers/en/>

WHO/UNESCO/ILO/IDDC (2010), 'CBR and mental health', in 'Supplementary booklet', *Community-Based Rehabilitation: CBR Guidelines,* Geneva, pp. 3-20 [see also 'Empowerment component' and 'Social component'] <http://www.who.int/disabilities/cbr/guidelines/en/>

International Federation of Red Cross and Red Crescent Societies (2009), *Psychosocial interventions: A handbook,* IFRC Reference Centre for Psychosocial Support, Copenhagen [Note: the 'Psychosocial Centre' states that it collaborates with UNICEF, WHO etc., <http://psp.drk.dk/sw2955.asp], <http://www.medbox.org/preview/5255d859-89d8-4908-b860-15880e695ecc/doc.pdf>

Inter-Agency Standing Committee (IASC) (2007), *Guidelines on Mental Health and Psychosocial Support in Emergency Settings,* Geneva, <http://www.who.int/hac/network/interagency/news/mental_health_guidelines/en/>

Becker, David and Weyermann, Barbara (2006), *Gender, Conflict Transformation & the Psychosocial Approach, Toolkit,* SDC Bern, <http://www.deza.admin.ch/ressources/resource_en_91135.pdf>

UNICEF East Asia and Pacific Regional Office/Regional Emergency Psychosocial Support Network (2004), *Handbook on Psychosocial Assessment of Children and Communities in Emergencies,* Bangkok, Quezon City, <http://www.unicef.org/eapro/Handbook.pdf>

Handicap International (Belgium)/Lao Youth Union/UNICEF (2004), *Life After the Bomb: A Psychosocial Study of Child Survivors of UXO Accidents in Lao PDR,* Vientiane

Sperber Richie, Beth, et al. (2003), 'Resilience in Survivors of Traumatic Limb Loss', Landmine Survivors Network, *Disability Studies Quarterly* Vol 23, No 2, 2003, pp. 29-41

Walsh, Nicolas E. and Walsh, Wendy S. (2003), 'Rehabilitation of landmine victims – the ultimate challenge', *Bulletin of the World Health Organization* 2003, 81 (9), pp. 665-670, <http://www.who.int/bulletin/volumes/81/9/Walsh.pdf>

Endnotes

1   A "child" is defined in the Convention on the Rights of the Child as a person younger than 18 years of age. "Adolescents" are generally defined to be between 10 and 18 years old. Some definitions of "young people" go up to 24 years.

2   "A system providing proper fit and alignment based on sound biomechanical principles [that] suits the needs of the individual and can be sustained by the country at the most economical and affordable price." Day, H.J.B., J. Hughes & N. Jacobs (eds.), *Report of ISPO Consensus Conference on Appropriate Orthopaedic Technology for Developing Countries*, ISPO, Phnom Penh, Cambodia, 5-10 June 1995, ISPO/USAID/WHO, Brussels 1996.

3   Becker, David and Weyermann, Barbara (2006), *Gender, Conflict Transformation & the Psychosocial Approach, Toolkit,* SDC Bern; here: Work Sheet 2, *The psychosocial approach: conceptual framework*. <http://www.deza.admin.ch/ressources/resource_en_91135.pdf>

4   As recounted to the author by a survivor in Luena, Angola.

5   For example: "[T]he States Parties have increased their understanding of the importance and cross-cutting nature of psychological support, including peer support, and the need to raise the profile of this component to assist mine survivors and the families of those killed or injured **to overcome the psychological trauma** of a landmine explosion and promote their social well-being." (Highlighted by the author). APMBC (2010), 'Part II: Review of the operation and status of the Convention on the prohibition of the use, stockpiling, production and transfer of anti-personnel mines and on their destruction: 2005-2009', Cartagena, in Final Report of the Second Review Conference, APLC/CONF/2009/9, 17 June 2010, p. 49, para 119.