IASC
Inter-Agency Standing Committee

IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

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Foreword

The Inter-Agency Standing Committee (IASC) issues these Guidelines to enable humanitarian actors to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psychosocial well-being in the midst of an emergency.

Populations affected by emergencies frequently experience enormous suffering. Humanitarian actors are increasingly active to protect and improve people's mental health and psychosocial well-being during and after emergencies. A significant gap, however, has been the absence of a multi-sectoral, inter-agency framework that enables effective coordination, identifies useful practices, flags potentially harmful practices and clarifies how different approaches to mental health and psychosocial support complement one another.

The Guidelines offer essential advice on how to facilitate an integrated approach to address the most urgent mental health and psychosocial issues in emergency situations.

I would like to thank the members of the IASC Task Force on Mental Health and Psychosocial Support in Emergency Settings and specifically the Task Force co-chairs, WHO and InterAction, for achieving inter-agency consensus on minimum responses in this important area of humanitarian aid.

I call upon all those who are involved in humanitarian assistance to implement these Guidelines.

Kasidis Rochanakorn

Chair, Inter-Agency Standing Committee Working Group
Director, OCHA Geneva

Acknowledgements

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CHAPTER 1

Introduction

Background

Armed conflicts and natural disasters cause significant psychological and social suffering to affected populations. The psychological and social impacts of emergencies may be acute in the short term, but they can also undermine the long-term mental health and psychosocial well-being of the affected population. These impacts may threaten peace, human rights and development. One of the priorities in emergencies is thus to protect and improve people's mental health and psychosocial well-being. Achieving this priority requires coordinated action among all government and non-government humanitarian actors.

A significant gap, however, has been the absence of a multi-sectoral, inter-agency framework that enables effective coordination, identifies useful practices and flags potentially harmful practices, and clarifies how different approaches to mental health and psychosocial support complement one another. This document aims to fill that gap.

These guidelines reflect the insights of practitioners from different geographic regions, disciplines and sectors, and reflect an emerging consensus on good practice among practitioners. The core idea behind them is that, in the early phase of an emergency, social supports are essential to protect and support mental health and psychosocial well-being. In addition, the guidelines recommend selected psychological and psychiatric interventions for specific problems.

The composite term *mental health and psychosocial support* is used in this document to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. Although the terms *mental health* and *psychosocial support* are closely related and overlap, for many aid workers they reflect different, yet complementary, approaches.

Aid agencies outside the health sector tend to speak of *supporting psychosocial well-being*. Health sector agencies tend to speak of mental health, yet historically have also used the terms *psychosocial rehabilitation* and *psychosocial treatment* to describe non-biological interventions for people with mental disorders. Exact definitions of these terms vary between and within aid organisations, disciplines and countries. As the current document covers intersectoral, inter-agency guidelines, the composite term *mental health and psychosocial support (MHPSS)* serves to unite as

broad a group of actors as possible and underscores the need for diverse, complementary approaches in providing appropriate supports.

Scientific evidence regarding the mental health and psychosocial supports that prove most effective in emergency settings is still thin. Most research in this area has been conducted months or years after the end of the acute emergency phase. As this emerging field develops, the research base will grow, as will the base of practitioners' field experience. To incorporate emerging insights, this publication should be updated periodically.

Mental health and psychosocial impact of emergencies

Problems

Emergencies create a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies erode normally protective supports, increase the risks of diverse problems and tend to amplify pre-existing problems of social injustice and inequality. For example, natural disasters such as floods typically have a disproportionate impact on poor people, who may be living in relatively dangerous places.

Mental health and psychosocial problems in emergencies are highly inter-connected, yet may be predominantly social or psychological in nature. Significant problems of a predominantly social nature include:

- Pre-existing (pre-emergency) social problems (e.g. extreme poverty; belonging to a group that is discriminated against or marginalised; political oppression);
- Emergency-induced social problems (e.g. family separation; disruption of social networks; destruction of community structures, resources and trust; increased gender-based violence); and
- Humanitarian aid-induced social problems (e.g. undermining of community structures or traditional support mechanisms).

Similarly, problems of a predominantly psychological nature include:

- Pre-existing problems (e.g. severe mental disorder; alcohol abuse);
- Emergency-induced problems (e.g. grief, non-pathological distress; depression and anxiety disorders, including post-traumatic stress disorder (PTSD)); and

- Humanitarian aid-related problems (e.g. anxiety due to a lack of information about food distribution).

Thus, mental health and psychosocial problems in emergencies encompass far more than the experience of PTSD.

People at increased risk of problems

In emergencies, not everyone has or develops significant psychological problems. Many people show resilience, that is the ability to cope relatively well in situations of adversity. There are numerous interacting social, psychological and biological factors that influence whether people develop psychological problems or exhibit resilience in the face of adversity.

Depending on the emergency context, particular groups of people are at increased risk of experiencing social and/or psychological problems. Although many key forms of support should be available to the emergency-affected population in general, good programming specifically includes the provision of relevant supports to the people at greatest risk, who need to be identified for each specific crisis (see Chapter 3, Action Sheet 2.1).

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:

- Women (e.g. pregnant women, mothers, single mothers, widows and, in some cultures, unmarried adult women and teenage girls);
- Men (e.g. ex-combatants, idle men who have lost the means to take care of their families, young men at risk of detention, abduction or being targets of violence);
- Children (from newborn infants to young people 18 years of age), such as separated or unaccompanied children (including orphans), children recruited or used by armed forces or groups, trafficked children, children in conflict with the law, children engaged in dangerous labour, children who live or work on the streets and undernourished/understimulated children;
- Elderly people (especially when they have lost family members who were care-givers);
- Extremely poor people;
- 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 (e.g. people who have lost close family members or their entire livelihoods, rape and torture survivors, witnesses of atrocities, etc.);
- People in the community with pre-existing, severe physical, neurological or mental disabilities or disorders;
- People in institutions (orphans, elderly people, people with neurological/mental disabilities or disorders);
- People experiencing severe social stigma (e.g. untouchables/dalit, commercial sex workers, people with severe mental disorders, survivors of sexual violence);
- 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).

It is important to recognise that:

- There is large diversity of risks, problems and resources within and across each of the groups mentioned above.
- Some individuals within an at-risk group may fare relatively well.
- Some groups (e.g. combatants) may be simultaneously at increased risk of some problems (e.g. substance abuse) and at reduced risk of other problems (e.g. starvation).
- Some groups may be at risk in one emergency, while being relatively privileged in another emergency.
- Where one group is at risk, other groups are often at risk as well (Sphere Project, 2004).

To identify people as 'at risk' is not to suggest that they are passive victims. Although at-risk people need support, they often have capacities and social networks that enable them to contribute to their families and to be active in social, religious and political life.

Resources

Affected groups have assets or resources that support mental health and psychosocial well-being. The nature and extent of the resources available and accessible may vary with age, gender, the socio-cultural context and the emergency environment. A common error in work on mental health and psychosocial well-being is to ignore these resources and to focus solely on deficits – the weaknesses, suffering and pathology – of the affected group.

Affected individuals have resources such as skills in problem-solving, communication, negotiation and earning a living. Examples of potentially supportive social resources include families, local government officers, community leaders, traditional healers (in many societies), community health workers, teachers, women's groups, youth clubs and community planning groups, among many others. Affected communities may have economic resources such as savings, land, crops and animals; educational resources such as schools and teachers; and health resources such as health posts and staff. Significant religious and spiritual resources include religious leaders, local healers, practices of prayer and worship, and cultural practices such as burial rites.

To plan an appropriate emergency response, it is important to know the nature of local resources, whether they are helpful or harmful, and the extent to which affected people can access them. Indeed, some local practices – ranging from particular traditional cultural practices to care in many existing custodial institutions – may be harmful and may violate human rights principles (see Action Sheets 5.3, 6.3 and 6.4).

The guidelines

Purpose of these guidelines

The primary purpose of these guidelines is to enable humanitarian actors and communities to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psychosocial well-being in the midst of an emergency. **The focus of the guidelines is on implementing minimum responses, which are essential, high-priority responses that should be implemented as soon as possible in an emergency.** Minimum responses are the first things that ought to be done; they are the essential first steps that lay the foundation for the more comprehensive efforts that may be needed (including during the stabilised phase and early reconstruction).

To complement the focus on minimum response, the guidelines also list concrete strategies for mental health and psychosocial support to be considered mainly before and after the acute emergency phase. These 'before' (emergency preparedness)

and 'after' (comprehensive response) steps establish a context for the minimum response and emphasise that the minimum response is only the starting point for more comprehensive supports (see Chapter 2).

Although the guidelines have been written for low- and middle-income countries (where Inter-Agency Standing Committee (IASC) member agencies tend to work), the overall framework and many parts of the guidelines apply also to large-scale emergencies in high-income countries.

Target audience

These guidelines were designed for use by all humanitarian actors, including community-based organisations, government authorities, United Nations organisations, non-government organisations (NGOs) and donors operating in emergency settings at local, national and international levels.

The orientation of these guidelines is not towards individual agencies or projects. **Implementation of the guidelines requires extensive collaboration among various humanitarian actors: no single community or agency is expected to have the capacity to implement all necessary minimum responses in the midst of an emergency.** The guidelines should be accessible to all humanitarian actors to organise collaboratively the necessary supports. Of particular importance is the active involvement at every stage of communities and local authorities, whose participation is essential for successful, coordinated action, the enhancement of local capacities and sustainability. To maximise the engagement of local actors, the guidelines should be translated into the relevant local language(s).

These guidelines are not intended solely for mental health and psychosocial workers. Numerous action sheets in the guidelines outline social supports relevant to the core humanitarian domains, such as disaster management, human rights, protection, general health, education, water and sanitation, food security and nutrition, shelter, camp management, community development and mass communication. Mental health professionals seldom work in these domains, but are encouraged to use this document to advocate with communities and colleagues from other disciplines to ensure that appropriate action is taken to address the social risk factors that affect mental health and psychosocial well-being. However, the clinical and specialised forms of psychological or psychiatric supports indicated in the guidelines should only be implemented under the leadership of mental health professionals.

An overview of the guidelines

The structure of these IASC Guidelines is consistent with two previous IASC documents: the *Guidelines for HIV/AIDS Interventions in Emergency Settings* (IASC, 2003) and the *Guidelines on Gender-Based Violence Interventions in Humanitarian Settings* (IASC, 2005). All three of these IASC documents include a matrix, which details actions for various actors during different stages of emergencies, and a set of action sheets that explain how to implement minimum response items identified in the middle column (Minimum Response) of the matrix. The current guidelines contain 25 such action sheets (see Chapter 3).

The matrix (displayed in Chapter 2) provides an overview of recommended key interventions and supports for protecting and improving mental health and psychosocial well-being. The three matrix columns outline the:

- Emergency preparedness steps to be taken before emergencies occur;

- Minimum responses to be implemented during the acute phase of the emergency; and

- Comprehensive responses to be implemented once the minimum responses have been implemented. Typically, this is during the stabilised and early reconstruction phases of the emergency.

The action sheets emphasise the importance of multi-sectoral, coordinated action. Each action sheet therefore includes (hyper-)links, indicated by turquoise text, relating to action sheets in other domains/sectors.

Each action sheet consists of a rationale/background; descriptions of key actions; selected sample process indicators; an example of good practice in previous emergencies; and a list of resource materials for further information. Almost all listed resource materials are available via the internet and are also included in the accompanying CD-ROM.

How to use this document

Reading the document from cover to cover may not be possible during an emergency. It may be read selectively, focusing on items that have the greatest relevance to the reader's responsibilities or capacities. **A good way to begin is to read the matrix,**

focusing on the centre column of minimum response, look for the items of greatest relevance and go directly to the corresponding action sheets. It is important to remember that no single agency is expected to implement every item in the guidelines.

The guidelines aim to strengthen the humanitarian response in emergencies by all actors, from pre-emergency preparedness through all steps of response programme planning, implementation and evaluation. They are especially useful as a tool for strengthening coordination and advocacy.

Coordination

In emergencies, coordination of aid is one of the most important and most challenging tasks. This document provides detailed guidance on coordination (see Action Sheet 1.1) and is a useful coordination tool in two other respects. First, it calls for a single, overarching coordination group on mental health and psychosocial support to be set up when an emergency response is first mobilised. The rationale for this is that mental health supports and psychosocial supports inside and outside the health sector are mutually enhancing and complementary (even though in the past they have often been organised separately by actors in the health and protection sectors respectively). Because each is vital for the other, it is essential to coordinate the two. If no coordination group exists or if there are separate mental health coordination and psychosocial coordination groups, the guidelines can be used to advocate for the establishment of one overarching group to coordinate MHPSS responses.

Second, the guidelines – and in particular the matrix – provide reference points that can be used to judge the extent to which minimum responses are being implemented in a given community. Any items listed in the matrix that are not being implemented may constitute gaps that need to be addressed. In this respect, the matrix offers the coordination group a useful guide.

Advocacy for improved supports

As an advocacy tool, the guidelines are useful in promoting the need for particular kinds of responses. Because they reflect inter-agency consensus and the insight of numerous practitioners worldwide, the guidelines have the support of many humanitarian agencies and actors. For this reason, they offer a useful advocacy tool in addressing gaps and also in promoting recommended responses – i.e. minimum, priority responses – even as the emergency occurs. For example, in a situation where non-participatory sectoral programmes are being established, the guidelines could be used to make the case with different stakeholders for why a more participatory approach would be beneficial. Similarly, if very young children are at risk and receiving no support, Action Sheet 5.4 could be used to advocate for the establishment of appropriate early child development supports.

Working with partners to develop appropriate mental health and psychosocial supports is an important part of advocacy. Dialogue with partners, whether NGO, government or UN staff, may help steer them, where needed, toward the kinds of practices outlined in this document. The guidelines may also be used for advocacy in other ways. For example, the inclusion of a comprehensive response column in the matrix facilitates advocacy for long-term planning (e.g. for the development of mental health services within the health system of the country concerned).

However, **these guidelines should not be used as a cookbook.** Although the matrix suggests actions that should be the minimum response in many emergencies, a local situation analysis should be conducted, to identify more precisely the greatest needs, specify priority actions and guide a socially and culturally appropriate response.

The guidelines do not give details for implementation, but rather contain a list of key actions with brief explanations and references to further resource materials regarding implementation.

Core principles

1. Human rights and equity

Humanitarian actors should promote the human rights of all affected persons and protect individuals and groups who are at heightened risk of human rights violations. Humanitarian actors should also promote equity and non-discrimination. That is, they should aim to *maximise fairness* in the availability and accessibility of mental health and psychosocial supports among affected populations, across gender, age groups, language groups, ethnic groups and localities, according to identified needs.

2. Participation

Humanitarian action should maximise the participation of local affected

populations in the humanitarian response. In most emergency situations, significant numbers of people exhibit sufficient resilience to participate in relief and reconstruction efforts. Many key mental health and psychosocial supports come from affected communities themselves rather than from outside agencies. Affected communities include both displaced and host populations and typically consist of multiple groups, which may compete with one another. Participation should enable different sub-groups of local people to retain or resume control over decisions that affect their lives, and to build the sense of local ownership that is important for achieving programme quality, equity and sustainability. From the earliest phase of an emergency, local people should be involved to the greatest extent possible in the assessment, design, implementation, monitoring and evaluation of assistance.

3. Do no harm

Humanitarian aid is an important means of helping people affected by emergencies, but aid can also cause unintentional harm (Anderson, 1999). Work on mental health and psychosocial support has the potential to cause harm because it deals with highly sensitive issues. Also, this work lacks the extensive scientific evidence that is available for some other disciplines. Humanitarian actors may reduce the risk of harm in various ways, such as:

- Participating in coordination groups to learn from others and to minimise duplication and gaps in response;
- Designing interventions on the basis of sufficient information (see Action Sheet 2.1);
- Committing to evaluation, openness to scrutiny and external review;
- Developing cultural sensitivity and competence in the areas in which they intervene/work;
- Staying updated on the evidence base regarding effective practices; and
- Developing an understanding of, and consistently reflecting on, universal human rights, power relations between outsiders and emergency-affected people, and the value of participatory approaches.

4. Building on available resources and capacities

As described above, all affected groups have assets or resources that support mental health and psychosocial well-being. A key principle – even in the early stages of an emergency – is building local capacities, supporting self-help and strengthening the resources already present. Externally driven and implemented programmes often lead to inappropriate MHPSS and frequently have limited sustainability. Where possible, it is important to build both government and civil society capacities. At each layer of the pyramid (see Figure 1), key tasks are to identify, mobilise and strengthen the skills and capacities of individuals, families, communities and society.

5. Integrated support systems

Activities and programming should be integrated as far as possible. The proliferation of stand-alone services, such as those dealing only with rape survivors or only with people with a specific diagnosis, such as PTSD, can create a highly fragmented care system. Activities that are integrated into wider systems (e.g. existing community support mechanisms, formal/non-formal school systems, general health services, general mental health services, social services, etc.) tend to reach more people, often are more sustainable, and tend to carry less stigma.

6. Multi-layered supports

In emergencies, people are affected in different ways and require different kinds of supports. A key to organising mental health and psychosocial support is to develop a layered system of complementary supports that meets the needs of different groups. This may be illustrated by a pyramid (see Figure 1). All layers of the pyramid are important and should ideally be implemented concurrently.

i. Basic services and security. The well-being 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). In most emergencies, specialists in sectors such as food, health and shelter provide basic services. An MHPSS response to the need for basic services and security may include: advocating that these services are put in place with responsible actors; documenting their impact on mental health and psychosocial well-being; and influencing humanitarian actors to deliver them in a way that promotes mental health and psychosocial well-being. These basic services should be established in participatory, safe and socially appropriate

Figure 1. Intervention pyramid for mental health and psychosocial support in emergencies. Each layer is described below.
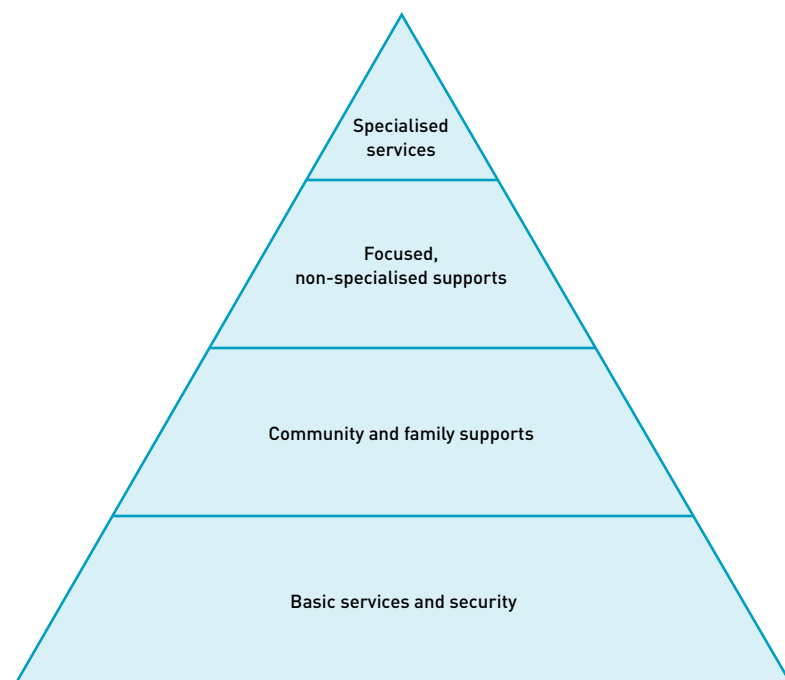
ways that protect local people's dignity, strengthen local social supports and mobilise community networks (see Action Sheet 5.1).

ii. 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 well-being if they receive help in accessing key community and family supports. In most emergencies, there are significant disruptions of family and community networks due to loss, displacement, family separation, community fears and distrust. Moreover, even when family and community networks remain intact, people in emergencies will benefit from help in accessing greater community and family supports. Useful responses in this

layer include family tracing and reunification, 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.

iii. Focused, non-specialised supports. The third layer represents the supports necessary for the still smaller number of people who additionally require more focused individual, family or group interventions by trained and supervised workers (but who may 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.

iv. Specialised 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. Although specialised services are needed only for a small percentage of the population, in most large emergencies this group amounts to thousands of individuals.

The uniqueness of each emergency and the diversity of cultures and socio-historic contexts makes it challenging to identify universal prescriptions of good practice. Nevertheless, experience from many different emergencies indicates that some actions are advisable, whereas others should typically be avoided. These are identified below as 'Do's' and 'Don'ts' respectively.

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 analyse 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.
Recognise that people are affected by emergencies in different ways. More resilient people may function well, whereas others may be severely affected and may need specialised 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.

Do's	Don'ts
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 services and, if available, in community mental health services.	Do not create parallel mental health services for specific sub-populations.
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.

Frequently asked questions

1. **What is meant by mental health and psychosocial support?**
   Mental health and psychosocial support (MHPSS) is a composite term used in these guidelines to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder.

2. **Why do the guidelines use the overlapping terms *mental health* and *psychosocial support*?**
   For many aid workers these closely-related terms reflect different, yet complementary, approaches. Agencies outside the health sector tend to speak of *supporting psychosocial well-being*. People working in the health sector tend to speak of *mental health*, but historically have also used the terms *psychosocial rehabilitation* and *psychosocial treatment* to describe non-biological interventions for people with mental disorders. Exact definitions of these terms vary between and within aid organisations, disciplines and countries.

3. **Are these guidelines for mental health professionals only?**
   No, this publication offers guidance on how a wide range of actors in diverse sectors can protect and improve mental health and psychosocial well-being. However, some action sheets cover clinical interventions that should be implemented only under the leadership of mental health professionals.

4. **Why do these guidelines cover sectors that are not within the traditional concern or expertise of mental health professionals?**
   There is increasing inter-agency consensus that psychosocial concerns involve all sectors of humanitarian work, because the manner in which aid is implemented (e.g. with/without concern for people's dignity) affects psychosocial well-being. A parallel may be drawn with multi-sectoral efforts to control mortality. Mortality rates are affected not only by vaccination campaigns and health care but also by actions in the water and sanitation, nutrition, food security and shelter sectors. Similarly, psychosocial well-being is affected when shelters are overcrowded and sanitation facilities put women at risk of sexual violence.

5. **The guidelines focus on minimum responses in the midst of emergencies, but what is an *emergency* and what is a *minimum response*?**
   The annual IASC Consolidated Appeal Process (CAP) documents (www.reliefweb. int) provide useful examples of the situations that the IASC considers to be *emergencies*. These include situations arising from armed conflicts and natural disasters (including food crises) in which large segments of populations are at *acute* risk of dying, immense suffering and/or losing their dignity.
       Minimum responses are essential, high-priority responses that should be implemented as soon as possible in an emergency. Comprehensive responses should only be implemented after ascertaining that the population has access to at least the minimum response.

6. **These guidelines are overwhelming. How can any one humanitarian actor (agency, community) do everything? Do all the action sheets have to be implemented in every emergency?**
   No single community or agency is expected to have the capacity to implement all necessary minimum response interventions in the midst of an emergency. The orientation of the guidelines is not towards individual agencies or projects. Because these guidelines are *inter-agency*, they require coordinated action by different actors to implement their various elements. Furthermore, the actions described as minimum response in the guidelines are likely to be *minimum responses* in most, but not all, emergencies. Local situation analyses are essential to determine what specific actions are priorities in the local context and at different points in time.

7. **Why is there no timeline for when to implement actions?**
   Although the humanitarian aftermath of some disasters (e.g. earthquakes, cyclones) is predictable to some extent, many emergencies, such as those which arise from armed conflict, are unpredictable and defy a linear timeline. Also, most complex emergencies persist for years.

8. **What is the role of emergency-affected individuals, groups or communities in implementing these guidelines?**
   Although the document is written by aid organisations in the language of humanitarian aid, affected populations should be involved to the greatest extent

possible in the design and implementation of all aid, and should play a lead role insofar as this is possible (see Action Sheets 5.1 and 5.2). For this reason, the guidelines should be translated into relevant local languages.

9. **Why do the guidelines not focus on traumatic stress and post-traumatic stress disorder (PTSD)?**

The types of social and psychological problems that people may experience in emergencies are extremely diverse (see the section on 'Problems' on page 2). An exclusive focus on traumatic stress may lead to neglect of many other key mental health and psychosocial issues. There is a wide range of opinion among agencies and experts on the positive and negative aspects of focusing on traumatic stress. The present guidelines aim to provide a balanced approach of recommended minimum actions in the midst of emergencies. The guidelines include (a) psychological first aid for people in acute trauma-induced distress by a variety of community workers (see Action Sheets 4.3, 4.4, 5.2 and 6.1) and (b) care for people with severe mental disorders, including severe PTSD, by trained and supervised health staff only (see Action Sheet 6.2).

10. **Does this document aim to set standards? What is the relationship between these guidelines and the Sphere Handbook?**

This document outlines *guidelines* for minimum responses but does not set *standards* for minimum response. This document is nevertheless consistent with Sphere Project (2004) standards. Implementing the guidelines is likely to contribute to achieving relevant Sphere standards, including the standard on Mental and Social Aspects of Health.

11. **How do these IASC intersectoral guidelines relate to the IASC Cluster approach?**

The IASC Cluster Approach is a new IASC mechanism intended to improve the coordination and overall performance of sectors. Whenever necessary in an emergency, Clusters are instituted to fill gaps in aid (see http://www. humanitarianinfo.org/iasc/content/Cluster). The following IASC Clusters have relevance to these mental health and psychosocial support guidelines: Camp Coordination and Camp Management; Early Recovery; Education; Emergency Shelter; Health; Nutrition; Protection; and Water, Hygiene and Sanitation.

During an emergency, each Cluster should take responsibility for implementing the interventions covered in these guidelines that are relevant to

its own domain of work. Moreover, in any large emergency, one intersectoral, inter-agency mental health and psychosocial support coordination group should be established and should aim to secure compliance with guidelines such as those outlined in this document (see Action Sheet 1.1 on coordination).

12. **What is the IASC?**

The Inter-Agency Standing Committee (IASC), established by the United Nations General Assembly, is an inter-agency forum for coordination, policy development and decision-making by the executive heads of key humanitarian agencies (UN agencies, Red Cross and Red Crescent societies, and consortia of non-government humanitarian organisations. See http://www.humanitarianinfo.org/iasc/content/about/default.asp.

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4. Sphere Project (2004). Humanitarian Charter and Minimum Standards in Disaster Response. Geneva: Sphere Project. http://www.sphereproject.org/handbook/

Matrix of Interventions

This chapter provides a matrix (shown on the following pages, and also available in poster format), which provides guidelines on key actions for protecting and promoting mental health and psychosocial support in emergency settings. The matrix contains 11 rows that describe the relevant functions and domains of humanitarian action. For purposes of coherence and readability, the matrix rows are grouped into cross-cutting functions, core mental health and psychosocial support domains, and social considerations in specific sectors. In addition, the matrix contains three columns that explain the types of response:

1. Emergency Preparedness

The left-hand column of the matrix summarises key recommended actions for emergency preparedness. Taking these actions should enable rapid implementation of minimum responses.

2. Minimum Response

Interventions to be conducted in the midst of emergencies are described in the middle column of the matrix. Minimum responses are defined as high-priority responses that should be implemented as soon as possible in an emergency. These responses may be seen as providing the *minimum* supports to which affected populations are entitled. For each action listed in this middle column, there is a corresponding Action Sheet in Chapter 3, which details the actions that in many emergencies comprise the minimum response.

3. Comprehensive Response

The right-hand column in the matrix outlines a summary of recommended key interventions that form part of a comprehensive response. These interventions should be considered only once it is clear that the vast majority of communities are engaged in/are receiving the locally defined minimum response. These interventions are most often implemented during the stabilised phase and early reconstruction period following an emergency.

Mental Health And Psychosocial Support (MHPSS)
In Emergency Settings: Matrix of Interventions

Function or Domain	Emergency Preparedness	Minimum Response *(to be conducted even in the midst of an emergency, but also as part of a comprehensive response)*	Comprehensive Response *(potential additional response for stabilised phase and early reconstruction)*
Part A. Common functions across domains			
1 Coordination	• Identify qualified organisations and resource persons • Develop agency and inter-agency national policies and plans for MHPSS emergency response • Determine coordination mechanisms, roles and responsibilities at local, regional, national and international levels • Identify MHPSS focal points for emergencies in each region and from various agencies • Fundraise for MHPSS, including for MHPSS coordination • Integrate MHPSS considerations into all sectoral emergency preparedness plans • Advocate for MHPSS at all stages of humanitarian action	1.1 Establish coordination of intersectoral mental health and psychosocial support	• Develop sustainable coordination structures, including government and civil society stakeholders • Develop inter-agency strategic plans and promote joint MHPSS programming and fundraising • Enhance information sharing among humanitarian actors • Link MHPSS emergency activities with development activities • Integrate MHPSS activities into national policies, plans and programmes and ensure that programmes utilise existing policies, plans and capacities
2 Assessment, monitoring and evaluation	• Build capacity in MHPSS assessment, monitoring and evaluation • Review and generate information on capacities and vulnerabilities of communities • Assess emergency MHPSS response capacity of organisations • Develop inter-agency, culturally appropriate, rapid assessment plans and tools for emergencies • Collate and disseminate assessment information and tools • Develop or adapt strategies, indicators and tools for monitoring and evaluation • Review previous MHPSS responses and identify good practices, challenges and gaps	2.1 Conduct assessments of mental health and psychosocial issues 2.2 Initiate participatory systems for monitoring and evaluation	• Conduct regular assessments and implement further in-depth situation analyses as appropriate • Monitor and evaluate programmes in relation to planned activities with pre-defined indicators • Monitor and evaluate MHPSS activities in relation to these guidelines • Disseminate results and lessons from assessment, monitoring and evaluation activities • Develop inter-agency indicators for MHPSS work in the transition phase
3 Protection and human rights standards	• Promote human rights, international humanitarian law and related good practices • Review existing policies and laws related to protection • Develop mechanisms to monitor, report and seek redress for human rights violations • Work with people at risk to identify priorities and develop capacities and strategies for protection and security • Train armed forces on international protection standards • Implement strategies to prevent violence, including gender-based violence	3.1 Apply a human rights framework through mental health and psychosocial support 3.2 Identify, monitor, prevent and respond to protection threats and failures through social protection 3.3 Identify, monitor, prevent and respond to protection threats and abuses through legal protection	• Strengthen national capacity to create awareness of, monitor, report, prevent and seek redress for violations of human rights and humanitarian law • Strengthen accountability for human rights violations • Strengthen capacities for social protection • Review data and address gaps in services for people with specific needs (at-risk groups) • Institutionalise training on protection for workers across all sectors, including armed forces and the justice system

Function or Domain	Emergency Preparedness	Minimum Response (to be conducted even in the midst of an emergency, but also as part of a comprehensive response)	Comprehensive Response (potential additional response for stabilised phase and early reconstruction)
	• In the case of political violence, facilitate externally monitored agreements between opposing parties to protect civilians • Promote ratification and support implementation of international human rights/humanitarian law instruments • Promote the adoption and implementation of national legislation that supports human rights/humanitarian standards		• Support safe community reintegration for people affected by all forms of violence • Limit easy access to alcohol in camp settings • Take steps to prevent human trafficking • Provide appropiate psychological, social, economic, educational and medical support to survivors of rights violations and their families, and to witnesses, including trial witnesses • Assist justice systems to implement laws according to international standards
4 Human resources	• Map existing human resource capacity and training resources, including within the local population • Build awareness of need for workers who understand local culture and language • Train all workers on international protection standards and codes of conduct • Train workers in different sectors on how to integrate MHPSS into emergency work following these guidelines • Expand the pool of available emergency workers trained in MHPSS • Encourage educational institutions to incorporate MHPSS training into professional programmes • Expand MHPSS in emergency preparation courses worldwide • Develop organisational policies and plans for the prevention and management of MHPSS problems in humanitarian workers • Develop organisational policies to maximise worker security and safety in the field	4.1 Identify and recruit staff and engage volunteers who understand local culture 4.2 Enforce staff codes of conduct and ethical guidelines 4.3 Organise orientation and training of aid workers in mental health and psychosocial support 4.4 Prevent and manage problems in mental health and psychosocial well-being among staff and volunteers	• Develop a description of essential worker competencies that is locally relevant • Institutionalise, monitor and enforce codes of conduct and ethical standards, strengthening them as needed • Map the distribution and extent of training and supervision received • Scale up training and supervision and build sustainable capacity by institutionalising training • Review response to MHPSS issues in workers and adhere to organisations' MHPSS policies for staff and volunteers

Part B. Core mental health and psychosocial support domains

Function or Domain	Emergency Preparedness	Minimum Response	Comprehensive Response
5 Community mobilisation and support	• Conduct participatory mapping and context analysis of local communities (current situation, resources, divisions, services and practices) • Conduct risk analysis, develop a community response plan, including an early warning system, and strengthen local capacity to implement such plans • Develop mechanisms for mobilisation of internal MHPSS resources and integration of external resources • Train and supervise existing community workers on how to provide appropriate emergency MHPSS support • Develop community-owned and -managed social support activities • Develop community plans on protecting and supporting early childhood development in emergencies	5.1 Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors 5.2 Facilitate community self-help and social support 5.3 Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices 5.4 Facilitate support for young children (0–8 years) and their care-givers	• Facilitate strengthening of community ownership of response • Strengthen livelihoods and support implementation of community and economic development initiatives • Provide the space for victims and survivors to discuss issues of reparation (economic, judicial, symbolic) to be addressed by responsible parties • Facilitate recording of historical memory of how the community has dealt with the emergency • Review mobilisation of community resources and facilitate expansion and improvement of quality of community social supports and self-help • Strengthen the MHPSS system, including referral mechanisms • Explore possibilities to deinstitutionalise orphanages and custodial homes and facilitate alternative community-based care • Develop conflict resolution and peace-building programmes

Function or Domain	Emergency Preparedness	Minimum Response *(to be conducted even in the midst of an emergency, but also as part of a comprehensive response)*	Comprehensive Response *(potential additional response for stabilised phase and early reconstruction)*
			• Facilitate community-based reintegration of children recruited or used by armed forces or groups • Exhume mass graves in a culturally appropriate manner, supporting relatives and friends • Organise discussions on helpful and harmful traditional practices • Build capacities to provide quality care for young children and their care-givers
6 Health services	• Strengthen the national capacity of health systems for providing MHPSS in emergencies • Map existing formal and non-formal resources and practices • Promote gender- and age-disaggregated health information systems that cover essential mental health data • Train staff in culturally appropriate clinical care of survivors of gender-based and other violence • Orient health staff in psychological first aid • Bring the national essential drug list in line with the WHO Model Essential Drug List and prepare emergency stocks of essential psychotropic medications • Develop emergency preparedness plans for institutions • Implement strategies for reducing discrimination and stigma of people with mental illness and/or mental disability • Develop capacity to prevent and address harm related to alcohol and other substance use	6.1 Include specific psychological and social considerations in provision of general health care 6.2 Provide access to care for people with severe mental disorders 6.3 Protect and care for people with severe mental disorders and other mental and neurological disabilities living in institutions 6.4 Learn about and, where appropriate, collaborate with local, indigenous and traditional health systems 6.5 Minimise harm related to alcohol and other substance use	• Initiate updating of mental health policy and legislation, as appropriate • Develop the availability of mental health care for a broad range of emergency-related and pre-existing mental disorders through general health care and community-based mental health services • Work to ensure the sustainability of newly established mental health services • Continue to foster collaborative relationships with local healing systems, as appropriate • For people in psychiatric institutions, facilitate community-based care and appropriate alternative living arrangements • Conduct regular assessments of the accessibility and quality of mental health care • Expand efforts to prevent harm related to alcohol and other substance use
7 Education	• Map existing resources for formal and non-formal educational practices • Determine levels of education and vocational options for girls, boys and adults who may have missed out on education • Using participatory methods, train and supervise teachers in basic psychosocial support, children's rights, participatory methods, positive discipline and codes of conduct • Strengthen the capacity of national education systems for school-based MHPSS in emergencies • Establish general and psychosocial crisis plans for schools • Strengthen emergency education capacities, addressing prominent protection issues in the curriculum	7.1 Strengthen access to safe and supportive education	• Expand educational opportunities for adolescent girls and boys, including vocational training, and start adult literacy courses • Ensure that education curricula are sensitive to culture, diversity and gender issues • Monitor and improve the quality of education • Expand educational opportunities for girls and boys and start adult literacy courses • Provide livelihood and other necessary supports to enable participation in education and prevent drop-out • Expand capacities for psychosocial support within formal and non-formal education settings • Strengthen prevention of and response to violence and other forms of abuse and exploitation in schools • Integrate peace-building and life skills into education

Function or Domain	Emergency Preparedness	Minimum Response *(to be conducted even in the midst of an emergency, but also as part of a comprehensive response)*	Comprehensive Response *(potential additional response for stabilised phase and early reconstruction)*
8 Dissemination of information	• Map existing information-related resources and gaps in resources • Educate staff on ethical aspects of information gathering • Make information accessible to different target audiences • Prepare a 'risk communication' strategy for disseminating essential information during emergencies • Distribute information on how to prevent problems such as family separation in emergencies • Advocate against media use of harmful images and the distribution of inappropriate information • Involve key stakeholders in developing, pilot-testing and distributing information on positive coping	8.1 Provide information to the affected population on the emergency, relief efforts and their legal rights 8.2 Provide access to information about positive coping methods	• Support reliable and accessible systems of accurate dissemination of information • Strengthen community participation in validating and disseminating information • Provide continuous access to information on the availability of assistance • Conduct information campaigns on supporting people with mental health and psychosocial problems • Monitor and evaluate use of communication materials

Part C. Social considerations in sectoral domains

Function or Domain	Emergency Preparedness	Minimum Response	Comprehensive Response
9 Food security and nutrition	• Assess the population's pre-existing food preparation habits, beliefs and main staples • Monitor access to key micronutrients known to influence child psychological development • Plan and develop equitable distribution according to needs	9.1 Include specific social and psychological considerations (safe aid for all in dignity, considering cultural practices and household roles) in the provision of food and nutritional support	• Review and organise regular assessments on social and psychological considerations in provision of food security and nutrition • Encourage and support food self-sufficiency
10 Shelter and site planning	• Map social dimensions of existing resources, gaps, practices and at-risk groups regarding shelter and site planning • Conduct participatory assessments on safety and appropriateness of potential sites • Plan to provide emergency shelter for all people (with appropriate targeting of people at risk) in a manner that supports safety, dignity, privacy and empowerment • Plan to prevent people being placed in camps long-term • Plan for the heating of shelters (in emergencies involving cold climates)	10.1 Include specific social considerations (safe, dignified, culturally and socially appropriate assistance) in site planning and shelter provision, in a coordinated manner	• Review and organise regular assessments of social considerations in shelter and site planning • Address equity issues in distributing land and in legislation on land rights • Build community and government capacities for integrating social considerations into longer-term shelter and site planning
11 Water and sanitation	• Map social dimensions of existing resources, gaps and at-risk groups regarding water and sanitation • Plan to provide water and sanitation for all people (with appropriate targeting of people at risk) in a manner that supports safety, dignity, privacy and non-violent problem solving	11.1 Include specific social considerations (safe and culturally appropriate access for all in dignity) in the provision of water and sanitation	• Review and organise regular assessments of social considerations in the provision of water and sanitation • Build community and government capacities for integrating social considerations into longer-term water and sanitation supports

This chapter contains the Action Sheets for minimum response. There is one Action Sheet for each action covered in the middle (Minimum Response) column of the matrix provided in Chapter 2.

CHAPTER 3

Action Sheets for Minimum Response

Function or Domain	Title of Action Sheet
A. Common functions across domains	
1 **Coordination**	1.1 Establish coordination of intersectoral mental health and psychosocial support
2 **Assessment, monitoring and evaluation**	2.1 Conduct assessments of mental health and psychosocial issues
	2.2 Initiate participatory systems for monitoring and evaluation
3 **Protection and human rights standards**	3.1 Apply a human rights framework through mental health and psychosocial support
	3.2 Identify, monitor, prevent and respond to protection threats and failures through social protection
	3.3 Identify, monitor, prevent and respond to protection threats and abuses through legal protection
4 **Human resources**	4.1 Identify and recruit staff and engage volunteers who understand local culture
	4.2 Enforce staff codes of conduct and ethical guidelines
	4.3 Organise orientation and training of aid workers in mental health and psychosocial support
	4.4 Prevent and manage problems in mental health and psychosocial well-being among staff and volunteers
B. Core mental health and psychosocial support domains	
5 **Community mobilisation and support**	5.1 Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors
	5.2 Facilitate community self-help and social support
	5.3 Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices

Function or Domain	Title of Action Sheet
	5.4 Facilitate support for young children (0–8 years) and their care-givers
6 Health services	6.1 Include specific psychological and social considerations in provision of general health care
	6.2 Provide access to care for people with severe mental disorders
	6.3 Protect and care for people with severe mental disorders and other mental and neurological disabilities living in institutions
	6.4 Learn about and, where appropriate, collaborate with local, indigenous and traditional health systems
	6.5 Minimise harm related to alcohol and other substance use
7 Education	7.1 Strengthen access to safe and supportive education
8 Dissemination of information	8.1 Provide information to the affected population on the emergency, relief efforts and their legal rights
	8.2 Provide access to information about positive coping methods

C. Social considerations in sectoral domains

9 Food security and nutrition	9.1 Include specific social and psychological considerations (safe aid for all in dignity, considering cultural practices and household roles) in the provision of food and nutritional support
10 Shelter and site planning	10.1 Include specific social considerations (safe, dignified, culturally and socially appropriate assistance) in site planning and shelter provision, in a coordinated manner
11 Water and sanitation	11.1 Include specific social considerations (safe and culturally appropriate access for all in dignity) in the provision of water and sanitation

Action Sheet 1.1
Establish coordination of intersectoral mental health and psychosocial support

Function: Coordination
Phase: Minimum Response

Background

Effective mental health and psychosocial support (MHPSS) programming requires intersectoral coordination among diverse actors, as all participants in the humanitarian response have responsibilities to promote mental health and psychosocial well-being. MHPSS coordination must include health, education, protection and social services, and representatives of affected communities. It must also engage with the food, security, shelter, and water and sanitation sectors.

Coordination helps to ensure that (a) all aspects of the humanitarian response are implemented in a way that promotes mental health/psychosocial well-being; (b) specific mental health and psychosocial supports are included in the humanitarian response. In order to do this, MHPSS actors must agree on an overall strategy and division of labour that equitably support emergency-affected communities. Poor coordination can lead to ineffective, inefficient, inappropriate or even harmful programming.

A number of key difficulties exist in ensuring appropriate coordination. Bridging the gap between 'mental health' and 'psychosocial' programming (often associated, respectively, with the health and protection sectors) is a key challenge in many emergencies. Coordination has been especially challenging in high-profile emergencies involving large numbers of actors. Affected populations can be overwhelmed by outsiders, and local contributions to mental health and psychosocial support are easily marginalised or undermined. Building common understandings among actors with diverse views on MHPSS (for instance, national governments, donors, international organisations, local communities and NGOs) and ensuring timely resolution of shared problems are key to effective coordination.

Key actions

1. Activate or establish an intersectoral MHPSS coordination group.

- Form a group to coordinate MHPSS action and jointly develop a plan stating what will be done and by whom. Forming a single intersectoral MHPSS coordination group, including actors traditionally associated with both the health and protection

sectors, is recommended. This is the most effective way to reduce fragmentation and to ensure that all aspects of MHPSS, from community-based social support to treatment for severe mental disorders, are addressed in an integrated manner. However, it can be helpful to establish sub-groups to address specific issues (e.g. psychosocial support in schools, mental health care in health services). The MHPSS coordination group should coordinate with all relevant sectors or IASC Clusters to ensure that their activities are conducted in a way that promotes mental health and psychosocial well-being and that relevant MHPSS actions are undertaken in these Clusters.

- Include in the MHPSS coordination group representatives from key government ministries (such as ministries of health, social welfare and education), UN agencies and NGOs. Participants from other organisations, such as government ministries, professional associations and universities, religious or community-based organisations and Red Cross/Red Crescent movements, should be included when they are active in MHPSS. Community consultation and input should be actively encouraged at all levels of coordination.

- Use existing coordination groups if available. If not, ad hoc groups should be established. The MHPSS coordination group should coordinate with the Protection and Health Clusters and, where appropriate, with any additional national coordinating mechanisms, including relevant websites (e.g. the Humanitarian Information Centre, www.humanitarianinfo.org).

- Establish MHPSS coordination groups at the sub-national and/or national level. In addition, encourage information exchange between organisations at the international level. There must be communication between national and sub-national coordination groups, with clear definition of their respective roles.

- MHPSS coordination groups should be led where possible by one or more national organisation(s), with appropriate technical support from international organisations. Lead organisations should be knowledgeable in MHPSS and skilled in inclusive coordination processes (e.g. avoiding dominance by a particular approach/sector or, in situations of armed conflict, perceived as impartial by key actors).

- Work to reduce power differences between members of the coordination group and to facilitate the participation of under-represented or less powerful groups (e.g. by using local languages and considering the structure and location of meetings).

- All organisations have a responsibility to coordinate their responses (provided this

is not contradictory to the principle of 'do no harm'). Organisations should make efforts to ensure that their representatives have the authority, knowledge and skills to participate effectively in coordination.

2. Coordinate programme planning and implementation.

- The coordination group is responsible for coordinating programme planning and implementation in relation to these guidelines. This includes ensuring that minimum MHPSS actions are carried out as appropriate in the local situation and that they reach emergency-affected communities equitably and in a timely manner.

- Facilitation of the process of intersectoral, inter-agency MHPSS strategic planning includes:

  - Coordinating assessments and communicating findings (see Action Sheet 2.1);
  - Establishing agreed programming and geographical priorities;
  - Identifying and working to fill gaps in responses;
  - Ensuring a functional division of labour amongst actors;
  - Facilitating inter-agency cooperation on joint actions (such as referral mechanisms or joint trainings);
  - Coordinating the dissemination of information about the emergency, relief efforts, legal rights and self-care amongst the affected population (see Action Sheets 8.1 and 8.2);
  - Documenting and sharing information on agency approaches, materials and lessons learned;
  - Monitoring and evaluation and communicating findings (see Action Sheet 2.2).

  If appropriate, an inter-agency strategic plan should be developed.

3. Develop and disseminate guidelines and coordinate advocacy.

- The MHPSS coordination group should lead the process of adapting these and other relevant guidelines to the local context. It should develop additional MHPSS guidelines/policies when needed. This process should be as inclusive as possible. Mechanisms to ensure broad awareness of and commitment to guidelines and policies need to be developed (e.g. formal adoption by national authorities and organisations working on MHPSS).

- The group should coordinate advocacy for MHPSS. Key minimum actions are: (1) agree upon key advocacy issues by determining which factors have the greatest impact on MHPSS and which are most likely to be changed through advocacy; (2) identify key stakeholders such as government, armed groups, media, donors, NGOs, policy-makers and other coordinating bodies, and develop targeted key messages for each; and (3) determine roles and responsibilities for advocacy by different organisations.

4. Mobilise resources.

- Coordination of fundraising includes ensuring that MHPSS is appropriately included in any Consolidated Appeals Process, as well as identifying and mobilising funds for coordination activities and joint advocacy to donors.

Key resources

1. Inter-Agency Working Group on Separated and Unaccompanied Children (2005). *Psychosocial Care and Protection of Tsunami Affected Children: Inter-Agency Guiding Principles.* http://www.iicrd.org/cap/node/view/383

2. The Mangrove: Psychosocial Support and Coordination Unit, Batticaloa, Sri Lanka. http://www.themangrove.blogspot.com/

3. Psychosocial/Mental Health Coordination. Inter-governmental Meeting of Experts Final Report, Annex V, Jakarta, 4-5 April 2005. http://www.who.int/mental_health/emergencies/mh_key_res/en/index.html

4. Palestinian Code of Conduct for Psycho-Social Interventions, 4 October 2001. http://www.who.int/mental_health/emergencies/mh_key_res/en/index.html

5. World Health Organization (2003). *Mental Health in Emergencies: Mental and Social Aspects of Health in Populations Exposed to Extreme Stressors.* Geneva: WHO. http://www.who.int/mental_health/media/en/640.pdf

Sample process indicator

- An MHPSS coordination group is established at the local and/or national level, integrating actors from various sectors, including health, protection and education.

Example: Aceh, Indonesia, 2005

- During the humanitarian operations following the December 2004 tsunami, the province's health authorities were collaboratively assisted by two UN organisations in coordinating all efforts related to mental health and psychosocial support.

- An Aceh Inter-Agency Psychosocial Working Group was established. More than 60 agencies working in the social, health and protection sectors participated in weekly meetings. The psychosocial group reported to both health and child protection coordination groups.

- The Aceh Inter-Agency Psychosocial Working Group drafted the 'Psychosocial Programme Principles for Aceh, Indonesia', which were widely promoted and used.

Action Sheet 2.1
Conduct assessments of mental health and psychosocial issues

Function: Assessment, monitoring and evaluation

Phase: Minimum Response

Background

Mental health and psychosocial support (MHPSS) assessments in emergencies provide (a) an understanding of the emergency situation; (b) an analysis of threats to and capacities for mental health and psychosocial well-being; and (c) an analysis of relevant resources to determine, in consultation with stakeholders, whether a response is required and, if so, the nature of the response.[1]

An assessment should include documenting people's experiences of the emergency, how they react to it and how this affects their mental health/psychosocial well-being. It should include how individuals, communities and organisations respond to the emergency. It must assess resources, as well as needs and problems. Resources include individual coping/life skills, social support mechanisms, community action and government and NGO capacities. Understanding how to support affected populations to more constructively address MHPSS needs is essential. An assessment must also be part of an ongoing process of collecting and analysing data in collaboration with key stakeholders, especially the affected community, for the purposes of improved programming.

Key actions

1. Ensure that assessments are coordinated.

- Coordinate assessments with other organisations that are assessing psychosocial/mental health issues. Coordinating assessments is essential to ensure efficient use of resources, achieve the most accurate and comprehensive understanding of the MHPSS situation and avoid burdening a population unnecessarily with duplicated assessments.

- Organisations should first determine what assessments have been done and should review available information (e.g. conduct a desk review, interview other organisations, review existing information on the country, such as relevant pre-existing ethnographic literature and data on the mental health system). They should design further field assessments only if they are necessary.

[1] Definition adapted from the Sphere Handbook (2004).

- Organisations should inform the coordination group (see Action Sheet 1.1) on which issues they are conducting assessments, as well as where and how, and should be prepared to adapt their assessments if necessary and to share information.

- In most emergencies, different groups (government departments, UN organisations, NGOs, etc.) will collect information on different aspects of MHPSS (as outlined in the table on pages 40-41) in a range of geographical areas. The coordination group should help to identify which organisations will collect which kinds of information, and where, and ensure as far as possible that all the information outlined in the table is available for the affected area. It should support organisations to do this in an appropriate and coordinated manner (e.g. by standardising key tools). This assessment information should be regularly collated, analysed and shared among the various organisations involved.

- Specific social considerations should be included in assessments carried out by all sectors, including community services, protection, health, education, shelter, food, and water and sanitation (see relevant Action Sheets for each sector/domain).

2. Collect and analyse key information relevant to mental health and psychosocial support.

The table overleaf outlines the main information that needs to be available to organisations working on MHPSS (note that individual organisations will focus on specific aspects particularly relevant to their work).

- The assessment should collect information disaggregated by age, sex and location whenever possible. This includes identifying at-risk groups in the community and their particular needs/capacities. Groups commonly at risk are described in Chapter 1.

- Address both the needs and resources of different sections of the affected population, from distressed people who are functioning well to those who are not functioning because of severe mental disorder.

Type of information	Including
Relevant demographic and contextual information	• Population size and size (and, where relevant, location) of relevant sub-groups of the population who may be at particular risk (see Chapter 1) • 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 (see Action Sheets 3.1, 3.2 and 3.3) • Social, political, religious and economic structures and dynamics (e.g. security and conflict issues, including ethnic, religious, class and gender divisions within communities) • Changes in livelihood activities and daily community life • Basic ethnographic information on cultural resources, norms, roles and attitudes (e.g. mourning practices, attitudes towards mental disorder and gender-based violence, help-seeking behaviour)
Experience of the emergency	• 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 (e.g. aggression, social withdrawal, sleep problems) and local indicators of distress • Signs of impaired daily functioning • Disruption of social solidarity and support mechanisms (e.g. disruption of social support patterns, familial conflicts, violence, undermining of shared values) • Information on people with severe mental disorders (e.g. through health services information systems) (see Action Sheet 6.2 for details)
Existing sources of psychosocial well-being and mental health	• Ways people help themselves and others i.e. ways of coping/healing (e.g. religious or political beliefs, seeking support from family/friends) • Ways in which the population may previously have dealt with adversity

Type of information	Including
	• Types of social support (identifying skilled and trusted helpers in a community) and sources of community solidarity (e.g. continuation of normal community activities, inclusive decision-making, inter-generational dialogue/respect, support for marginalised or at-risk groups)
Organisational capacities and activities	• Structure, locations, staffing and resources of psychosocial support programmes in education and social services and the impact of the emergency on services • Structure, locations, staffing and resources for mental health care in the health sector (including policies, availability of medications, role of primary health care and mental hospitals etc. – see WHO *Mental Health Atlas* for baseline data on 192 countries) and the impact of the emergency on services • Mapping psychosocial skills of community actors (e.g. community workers, religious leaders or counsellors) • 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 different stakeholders • Extent to which different key actions outlined in these IASC guidelines are implemented • Functionality of referral systems between and within health, social, education, community and religious sectors

3. Conduct assessments in an ethical and appropriately participatory manner.

• **Participation** Assessments must, as far as is possible, be a participatory and collaborative process with the relevant stakeholders, including governments, NGOs and community and religious organisations, as well as affected populations. Participatory assessment is the first step in a dialogue with affected populations, which, if done well, not only provides information but may also help people to take control of their situation by collaboratively identifying problems, resources and potential solutions (see Action Sheets 5.1 and 5.2). Feedback on the results and process of the assessment should be sought from participants. The affected population should also be involved in defining well-being and distress.

- **Inclusiveness** The assessment must involve diverse sections of the affected population, including children, youth, women, men, elderly people and different religious, cultural and socio-economic groups. It should aim to include community leaders, educators and health and community workers and to correct, not reinforce, patterns of exclusion.

- **Analysis** Assessments should analyse the situation with a focus on identifying priorities for action, rather than merely collecting and reporting information.

- **Attention to conflict** When operating in situations of conflict, assessors must be aware of the parties involved in the conflict and of their dynamics. Care must be taken to maintain impartiality and independence and to avoid inflaming social tensions/conflict or endangering community members or staff. Participatory assessments may not be advisable in some situations, where asking questions may endanger interviewers or interviewees.

- **Cultural appropriateness** Assessment methodologies (including indicators and instruments) should be culturally and contextually sensitive and relevant. The assessment team should include individuals familiar with the local context, who are – as far as is known – not distrusted by interviewees, and should respect local cultural traditions and practices. Assessments should aim to avoid using terminology that in the local cultural context could contribute to stigmatisation.

- **Ethical principles** Privacy, confidentiality and the best interests of the interviewees must be respected. In line with the principle of 'do no harm', care must be taken to avoid raising unrealistic expectations during assessments (e.g. interviewees should understand that assessors may not return if they do not receive funding). Intrusive questioning should be avoided. Organisations must make every effort to ensure that the participation of community members in the assessment is genuinely voluntary. Persons interviewing children or other groups with particular needs (such as survivors of gender-based violence) should possess appropriate skills and experience. Whenever possible, support must be given to respondents in need to access available MHPSS services.

- **Assessment teams** Assessors should be trained in the ethical principles mentioned above and should possess basic interviewing and good interpersonal skills. Assessment teams should have an appropriate gender balance and should be knowledgeable both in MHPSS and the local context.

- **Data collection methods** Relevant qualitative methods of data collection include literature review, group activities (e.g. focus group discussions), key informant interviews, observations and site visits. Quantitative methods, such as short questionnaires and reviews of existing data in health systems, can also be helpful. As far as is possible, multiple sources of data should be used to cross-check and validate information/analysis. Surveys that seek to assess the distribution of rates of emergency-induced mental disorders (psychiatric epidemiological surveys) tend to be challenging, resource-intensive and, too frequently, controversial – and, as such, they are beyond minimum response (see page 45). Using existing data from the literature to make approximate projections can be a useful alternative (see Action Sheet 6.2 for an example of such projections).

- **Dynamism and timeliness** Assessments should be sufficiently rapid for their results to be used effectively in the planning of emergency programming. It is often appropriate to have a dynamic, phased assessment process consisting, for instance, of two phases:

  1. *Initial ('rapid') assessment* focusing mostly on understanding the experiences and the current situation of the affected population, together with community and organisational capacities and programming gaps. This should normally be conducted within 1–2 weeks.

  2. *Detailed assessments*: more rigorously conducted assessments addressing the various issues outlined in the table above are conducted as the emergency unfolds.

4. Collate and disseminate assessment results.

- Organisations should share the results of their assessments in a timely and accessible manner with the community, the coordination group and with other relevant organisations. Information that is private, that could identify individuals or particular communities, or that could endanger members of the affected population or staff members should not be disclosed publicly. Such information should be shared only in the interest of protecting affected people or staff members, and then only with relevant actors.

- The coordination group should document, collate, review and disseminate assessment results to all stakeholders (e.g. post assessments on the internet and conduct feedback sessions with communities).

- MHPSS actors must use assessments as a resource and guide for planning, monitoring and evaluating programming (see Action Sheet 2.2).

Key resources

1. Action by Churches Together (ACT) Alliance, Lutherhjalpen, Norwegian Church Aid and Presbyterian Disaster Services (2005). *Community Assessment of Psychosocial Support Needs.* Chapter 6, Community Based Psychosocial Services: A Facilitator's Guide.
http://www.svenskakyrkan.se/tcrot/lutherhjalpen/psychosocialservices/pdf/psychosocialservices.pdf

2. Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) (2003). *Participation of Crisis-Affected Populations in Humanitarian Action: A Handbook for Practitioners.* Assessments, Chapter 3. http://www.odi.org.uk/ALNAP/publications/gs_handbook/gs_handbook.pdf

3. Bolton P. (2001). Cross-Cultural Assessment of Trauma-Related Mental Illness (Phase II). CERTI, Johns Hopkins University, World Vision.
http://www.certi.org/publications/policy/ugandafinahreport.htm

4. Médecins Sans Frontières (2005). Field Assessments. Chapter 1, Part III, *Mental Health Guidelines: A Handbook for Implementing Mental Health Programmes in Areas of Mass Violence.*
http://www.msf.org/source/mentalhealth/guidelines/MSF_mentalhealthguidelines.pdf

5. Silove D., Manicavasagar V., Baker K., Mausiri M., Soares M., de Carvalho F., Soares A. and Fonseca Amiral Z. (2004). 'Indices of social risk among first attenders of an emergency mental health service in post-conflict East Timor: an exploratory investigation'. *Australian and New Zealand Journal of Psychiatry.* 38:929-32. http://www.who.int/mental_health/emergencies/mh_key_res/en/index.html

6. Sphere Project (2004). *Humanitarian Charter and Minimum Standards in Disaster Response.* Initial Assessment, pp.29-33. http://www.sphereproject.org/handbook/

7. UNICEF East Asia and Pacific Office and Regional Emergency Psychosocial Support Network (2005). *Handbook of Psychosocial Assessment for Children and Communities in Emergencies.*
http://www.crin.org/docs/Handbook%20new%20update.pdf

8. World Health Organization (2005). *Mental Health Atlas.*
http://www.who.int/mental_health/evidence/atlas/

Sample process indicators

- Organisations design their assessments taking into account and building upon the psychosocial/mental health information already collected by other organisations.
- Assessment information on MHPSS issues from various organisations (as outlined in the table pages 40-41) is collated and disseminated (e.g. by the coordination group).

Epidemiological surveys of mental disorder and distress

Epidemiological surveys in the general population can (a) provide population-level rates of different mental disorders and signs of distress and (b) identify associated risk factors (e.g. being female), protective factors (e.g. having work), service utilisation rates and factors affecting help-seeking. Such surveys, if well conducted, can be used for programme planning, advocacy, developing an improved evidence base for programmes and advancing scientific knowledge. Moreover, if repeated, they can monitor whether natural recovery (spontaneous recovery without planned intervention) is occurring for many people in the population.

However, there are many challenges in conducting useful and valid epidemiological surveys in emergencies. To date, the vast majority of such surveys have been unsuccessful in distinguishing between mental disorders and non-pathological distress. The instruments used in such surveys have usually been validated only outside emergency situations in help-seeking, clinical populations, for whom distress is more likely a sign of psychopathology than it would be for the average person in the community in an emergency. As a consequence, many surveys of this type appear to have overestimated rates of mental disorder, suggesting incorrectly that substantial proportions of the population would benefit from clinical psychological or psychiatric care. Similarly, the instruments used in the vast majority of past surveys have not been validated for the culture in which they have been applied, which creates further uncertainty over how to interpret results.

Experience has shown that it requires considerable expertise to conduct sound psychiatric surveys in a sufficiently rapid manner to substantially influence programmes in the midst of an emergency. Although well-conducted psychiatric surveys may be part of a *comprehensive response*, such surveys go beyond *minimum responses*, which are defined in these guidelines as essential, high-priority responses that should be implemented as soon as possible in an emergency (see Chapter 1).

If psychiatric epidemiological surveys are conducted in emergency-affected contexts, special attention should be given to (a) validating the instruments for the local situation (see Key resource 3 above) and (b) including assessment of indicators that are potentially related to severe mental health problems (e.g. suicidal tendencies; inability to provide life-sustaining care of self/family; bizarre behaviour; dangerousness to others; and locally defined indicators of severely impaired daily functioning: see Key resource 5).

Initiate participatory systems for monitoring and evaluation

Function: Assessment, monitoring and evaluation
Phase: Minimum Response

Background

Assessment, planning, monitoring and evaluation are part of the same programme cycle. Monitoring in emergencies is the systematic process of collecting and analysing information to inform humanitarian decision-making related to ongoing or potential new activities. Evaluation includes the analysis of the relevance and effectiveness of ongoing or completed activities. In short, the aim of monitoring and evaluation (M&E) in emergencies is to improve humanitarian action by collecting information on the implementation and impact of aid and using it to guide programme improvements in a changing context.

M&E should preferably be based on participatory approaches (see Key resources below). This means that affected communities should participate to the maximum extent possible in all aspects of the M&E process, including the discussion of results and their implications (see Action Sheet 5.1 for a description of different levels of community involvement).

Action Sheet 2.1 focuses on assessment and describes the kinds of data to be collected as part of an initial assessment. This Action Sheet focuses on subsequent monitoring and evaluation activities.

Key actions

1. Define a set of indicators for monitoring, according to defined objectives and activities.

- The exact choice of indicators depends on the goals of the programme and on what is important and feasible in the emergency situation.

- Process, satisfaction and outcome indicators should be formulated consistent with pre-defined objectives.

  - **Process indicators** describe activities and cover the quality, quantity, coverage and utilisation of services and programmes (e.g. number of self-help meetings).

  - **Satisfaction indicators** describe the satisfaction of the affected population with the activity (e.g. the number of people expressing a negative, neutral or positive opinion of a programme). Satisfaction indicators may be seen as a sub-type

of process indicators.

  - **Outcome indicators** describe changes in the lives of the population according to pre-defined objectives. These indicators aim to describe the extent to which the intervention was a success or a failure. Although certain outcome indicators are likely to be meaningful in most contexts (e.g. level of daily functioning), deciding what is understood by 'success' in a psychosocial programme should form part of participatory discussions with the affected population.

Although process and satisfaction indicators are useful tools for learning from experience, outcome indicators provide the strongest data for informed action.

- Collecting data on indicators in the midst of emergencies provides baseline information not only for minimum responses (such as those outlined in this document) but also for long-term, comprehensive humanitarian action.

- Indicators should be SMART (Specific, Measurable, Achievable, Relevant and Time-bound).

- Typically, only a few indicators can feasibly be monitored over time. Indicators should therefore be chosen on the principle of 'few but powerful'. They should be defined in such a way that they can be easily assessed, without interfering with the daily work of the team or the community.

- Data on indicators should be disaggregated by age, gender and location whenever possible.

2. Conduct assessments in an ethical and appropriately participatory manner.

- For monitoring and evaluation, the same measurement principles apply as for assessment. See Key action 3 of Action Sheet 2.1 for a detailed discussion of issues related to participation, inclusiveness, analysis, conflict situations, cultural appropriateness, ethical principles, assessment teams and data collection methods, including psychiatric epidemiology.

- For monitoring and evaluating interventions, indicators need to be measured first *before* and then *after* the intervention to see if there has been any change. However, a much more rigorous design would be required to determine whether the intervention has *caused* the change. Such designs tend to go beyond minimum response, which in this document is defined as essential, high-priority responses that should be implemented as soon as possible in an emergency.

- Quantitative data should be complemented with relevant qualitative data (e.g. testimonials of people's experiences of the intervention).

3. Use monitoring for reflection, learning and change.

- Data on selected indicators may be collected periodically, starting during an emergency, with ongoing follow-up in subsequent months or years. For instance, if a specific type of assessment and analysis is conducted in the midst of an emergency, the same process can be repeated at later intervals (e.g. at six, 12 and 18 months) to investigate changes and to help stakeholders rethink actions as necessary.

- Key conclusions from monitoring and evaluation should be distributed to all relevant stakeholders, including the government, coordination bodies and the affected population. Information for the affected population should be distributed in an accessible form (e.g. in local languages and intelligible to people with low levels of literacy).

- To facilitate reflection, learning and change, participatory dialogues are useful as a means of stepping back and reflecting on what the data mean and how to adjust activities in light of what has been learned.

Key resources

1. Action Aid International. *Participatory Vulnerability Analysis: A step-by-step guide for field staff.* http://www.actionaid.org.uk/wps/content/documents/PVA%20final.pdf

2. Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP). Chapter 6: 'Monitoring'; Chapter 7: 'Evaluation'. In *Participation by Crisis-Affected Populations in Humanitarian Action: A Handbook for Practitioners*, pp.193-227. http://www.globalstudyparticipation.org/index.htm

3. Bolton P. and Tang A.M. (2002). 'An alternative approach to cross-cultural function assessment'. *Social Psychiatry and Psychiatric Epidemiology.* 37:537-43. http://www.who.int/mental_health/emergencies/mh_key_res/en/index.html

4. Bragin M. (2005). 'The community participatory evaluation tool for psychosocial programmes: A guide to implementation'. *Intervention: International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict* 3, 3-24. http://www.interventionjournal.com/downloads/31pdf/03_24%20Bragin%20.pdf

5. Cohen R.N. (2004). *Introducing Tracer Studies: Guidelines for Implementing Tracer Studies in Early Childhood Programmes* (available in English and Spanish). Bernard van Leer Foundation.

http://www.bernardvanleer.org/publications/Browse_by_series/publications_results?getSerie=Books%20and%20Monographs

6. International Institute for Environment and Development (IIED). *Participatory Learning and Action (PLA Notes).* http://www.iied.org/NR/agbioliv/pla_notes/backissues.html (see specifically notes 31 and 42, which cover PRA monitoring and evaluations)

7. Psychosocial Working Group (2005). *Reflections on Identifying Objectives and Indicators for Psychosocial Programming.* http://www.forcedmigration.org/psychosocial/papers/PWG_OI_.pdf

8. Perez-Sales P. (2006). 'Repensar Experiencas. Evaluación de programas psicosociales y de salud mental. Metodologías y técnicas'. *Ed Popular.* (www.psicosocial.net) ('Rethinking experiences. Assessment of mental health and psychosocial programmes. Methods and techniques', in Spanish)

Sample process indicators

- SMART process and outcome indicators are defined for mental health and psychosocial support programmes.

- Indicators are regularly assessed, as appropriate.

- Key stakeholders, including the affected population, are involved in all aspects of the M&E process, including the discussion of results and their implications.

Example: El Salvador, 2001

- Local authorities and a psychosocial community team from a local university and an international NGO set up an M&E system in a camp of 12,000 people affected by an earthquake.

- The system gathered quantitative and qualitative data on mutual support, solidarity, security, leadership, decision-making processes, access to updated information, perception of authorities, employment, normalising activities, perception of community cohesion and perception of the future. The system involved a baseline survey with regular three-month follow-ups in a random sample of 75 tents. On each occasion, data were collected within a 24-hour period by five volunteers.

- After three months, the M&E system detected a substantial decrease in perceived mutual support and solidarity. Appropriate measures were taken (e.g. rearrangement of the distribution of tents and cooking facilities, group activities). Three months later the survey showed an increase in confidence in leadership and decision-making processes, indicating that the trend had been reversed.

Apply a human rights framework through mental health and psychosocial support

Function: Protection and human rights standards
Phase: Minimum Response

Background

Human rights violations are pervasive in most emergencies. Many of the defining features of emergencies – displacement, breakdown in family and social structures, lack of humanitarian access, erosion of traditional value systems, a culture of violence, weak governance, absence of accountability and a lack of access to health services – entail violations of human rights. The disregard of international human rights standards is often among the root causes and consequences of armed conflict. Also, human rights violations and poor governance can exacerbate the impact of natural disasters. Groups who may be at particular risk in emergencies are outlined in Chapter 1 and include people who are under threat for political reasons. Such people are more likely to suffer rights violations and to face increased risks of emotional distress, psychosocial problems and mental disorder.

In emergency situations, an intimate relationship exists between the promotion of mental health and psychosocial well-being and the protection and promotion of human rights. Advocating for the implementation of human rights standards such as the rights to health, education or freedom from discrimination contributes to the creation of a protective environment and supports social protection (see Action Sheet 3.2) and legal protection (see Action Sheet 3.3). Promoting international human rights standards lays the ground for accountability and the introduction of measures to end discrimination, ill treatment or violence. Taking steps to promote and protect human rights will reduce the risks to those affected by the emergency.

At the same time, humanitarian assistance helps people to realise numerous rights and can reduce human rights violations. Enabling at-risk groups, for example, to access housing or water and sanitation increases their chances of being included in food distributions, improves their health and reduces their risks of discrimination and abuse. Also, providing psychosocial support, including life skills and livelihoods support, to women and girls may reduce their risk of having to adopt survival strategies such as prostitution that expose them to additional risks of human rights violations. Care must be taken, however, to avoid stigmatising vulnerable groups by targeting aid only at them.

Because promoting human rights goes hand-in-hand with promoting mental health and psychosocial well-being, mental health and psychosocial workers have a dual responsibility. First, as indicated in key actions 1–3 below, they should ensure that mental health and psychosocial programmes support human rights. Second, as indicated in actions 4–5 below, they should accept the responsibilities of all humanitarian workers, regardless of sector, to promote human rights and to protect at-risk people from abuse and exploitation.

Key actions

1. Advocate for compliance with international human rights standards in all forms of mental health and psychosocial support in emergencies.

- Promote inclusive and non-discriminatory service delivery, avoid unnecessary institutionalisation of people with mental disorders, and respect freedom of thought, conscience and religion in mental health and psychosocial care.

- Help recipients of mental health and psychosocial support to understand their rights.

- Respect at all times the right of survivors to confidentiality and to informed consent, including the right to refuse treatment.

- Protect survivors of human rights violations from the risk of stigmatisation by including them in broader programmes.

2. Implement mental health and psychosocial supports that promote and protect human rights.

- Make human rights an integral dimension of the design, implementation, monitoring and evaluation of mental health and psychosocial programmes in emergencies, especially for people judged to be at risk. Include human rights sensitisation in psychosocial programmes.

- Work with stakeholders at different levels (family, community, local and national NGOs and government) to ensure that they understand their responsibilities.

- Where appropriate, consider using discussions of human rights as a means of mobilising communities to assert their rights and to strengthen community social support (see example on page 54).

- Analyse the impact of programmes on current or (potential) future human rights violations.

- Consider, where appropriate, sharing information from these programmes with human rights organisations. This could include sharing voluntary and anonymous testimonies of survivors for advocacy purposes. It is essential to consider the risks for beneficiaries and for local and international staff, and to adhere to strict standards of privacy, data protection, confidentiality and informed consent.

3. **Include a focus on human rights and protection in the training of all relevant workers.**

- Provide training to local and international humanitarian workers in all sectors and to health and social services staff working in pre-existing services, as well as to government officials, including police and military.

- Make the fundamental rights of the affected population core components of staff training on codes of conduct (see Action Sheet 4.2).

- Promote the inclusion of the psychosocial impact of human rights violations on survivors in training for staff of human rights organisations and for government officials. Emphasise the need for appropriate interview techniques that respect survivors and consider the psychological impact of events.

- Advocate with human rights organisations on the need for psychosocial support for survivors and provide them with information on available support structures.

4. **Establish – within the context of humanitarian and pre-existing services – mechanisms for the monitoring and reporting of abuse and exploitation.**
- Give particular attention to those people most at risk.
- See Action Sheet 4.2 for guidance.

5. **Advocate and provide specific advice to states on bringing relevant national legislation, policies and programmes into line with international standards and on enhancing compliance with these standards by government bodies (institutions, police, army, etc.).**

Advocacy should begin as soon as possible in the emergency and should take into account the need for measures to prevent violence and abuse and to ensure accountability for rights violations. Policies that favour the right to truth, justice and reparation should be promoted. Possible points for advocacy are:

- Ending attacks on hospitals, schools and marketplaces;

- Ending discrimination against minority groups;

- Preventing child recruitment into armed forces or armed groups;

- Releasing children from armed groups or illegal detention;

- Preventing and responding to sexual violence (including sexual exploitation and trafficking);

- Facilitating humanitarian access for support and rehabilitation.

Consider how best to respond to non-compliance or to serious violations by raising the issue with the parties involved, at the international level or through the media, balancing the potential impact of any intervention with the risks for beneficiaries and for local and international staff.

Key resources

Relevant universal human rights instruments

1. A detailed overview of the universal human rights instruments, including the full texts and information on their status of ratification, can be found at: http://www.ohchr.org/english/law/index.htm. The website contains the:

- UN International Covenant on Economic, Social and Cultural Rights (1966)

- UN International Covenant on Civil and Political Rights (1966)

- General Comment 14 on the right to the highest attainable standard of health adopted by the Committee on Economic, Social and Cultural Rights in May 2000 (E/C.12/2000/4, CESCR dated 4 July 2000)

- UN Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (1991)

- Geneva Conventions (1949) and the additional Protocols to the Conventions (ICRC, 1977)

- Rome Statute of the International Criminal Court (1998)

- UN Convention on the Rights of the Child (1989) and the Optional Protocols to the Convention (2000)

- UN Convention Relating to the Status of Refugees (1951)

- UN Convention for the Elimination of all Forms of Racial Discrimination (1965)

- UN Convention on the Elimination of All Forms of Discrimination against Women (1979) and the Optional Protocol to the Convention (1999).

Guidelines and manuals

2. Amnesty International, International Human Rights Standards and Organisations, in *Campaigning Manual*, Chapter 6, www.amnesty.org/resources/pdf/campaigning-manual/chapter6.pdf.
(To access the full manual: http://web.amnesty.org/pages/campaigning-manual-eng).

3. Health and Human Rights Info. http://www.hhri.org

4. OCHA (forthcoming). *Developing a Humanitarian Advocacy Strategy and Action Plan: A Step-by-Step Manual*.

5. Slim H. and Bonwick A. (2005). *Protection: An ALNAP Guide for Humanitarian Agencies*. http://www.odi.org.uk/ALNAP/publications/protection/alnap_protection_guide.pdf

6. Tearfund. *Setting the Standard: A common approach for child protection in NGOs*. http://tilz.tearfund.org/webdocs/Tilz/Topics/Child%20Protection%20Policy.pdf

7. UN Guiding Principles on Internal Displacement (1998). http://www.unhchr.ch/html/menu2/7/b/principles.htm

8. UNICEF and the Coalition to Stop the Use of Child Soldiers (2003). *Guide to the Optional Protocol on Children in Armed Conflict*. http://www.unicef.org/publications/files/option_protocol_conflict.pdf

9. UNICEF. *A Principled Approach to Humanitarian Action,* e-learning course. www.unicef.org/path

Sample process indicators

• Mental health and psychosocial programmes comply with international human rights standards and are designed with a view to protecting the population against violence, abuse and exploitation.

• Training for staff of psychosocial and mental health programmes contains a focus on human rights.

• Appropriate mechanisms for the monitoring and reporting of instances of abuse and exploitation of civilians are established.

Example: Occupied Palestinian territory, 2000

• A UN agency supported workshops where adolescents discussed their roles in the community, against a background of ongoing conflict that was undermining their rights to education, health, participation and protection from violence, among other rights.

• Many adolescents felt hopeless and some thought that violence was the only option, while others argued for non-violent ways to protect their rights.

• Adolescents agreed to use an adolescents' forum to advocate for their rights with Palestinian decision-makers; to use the media to explain their situation, rights and views on what should be done; to work as trained volunteers in health facilities; to conduct recreational activities for younger children; and to establish a peer-to-peer support system.

• By providing concrete options for youth to contribute to their community and to assert their rights, these programmes provided a sense of purpose, built solidarity and hope, and engaged adolescents as constructive, respected role models in the community.

Action Sheet 3.2

Identify, monitor, prevent and respond to protection threats and failures through social protection

Function: Protection and human rights standards
Phase: Minimum Response

Background

In emergencies, a complex interplay occurs between protection threats and mental health and psychosocial well-being. Survivors often report that their greatest stress arises from threats such as attack and persecution, forced displacement, gender-based violence, separation from or abduction of family members, extreme poverty and exploitation and ill treatment. Such protection problems produce immediate suffering and may interfere with the rebuilding of social networks and a sense of community, both of which support psychosocial well-being. Emergencies may also exacerbate differences in power within the affected population, increasing the vulnerability of already marginalised people.

Without attention to protection issues, MHPSS can become focused on consequences while ignoring underlying and ongoing causes. Promoting a protective environment, then, is an integral part of psychosocial support. Psychosocial and mental health issues can also contribute to protection threats. For example, children who have lost their families and who are extremely distressed face increased risks of living on the streets, being exploited or, in some emergencies, joining armed groups. In addition, people with severe mental disabilities may wander, exposing themselves to hazards that most other people can avoid.

Protection requires both legal and social mechanisms. Legal protection entails applying international human rights instruments (see Action Sheet 3.1), and international and national laws (see Action Sheet 3.3). Social protection, the focus of this Action Sheet, occurs largely through activating and strengthening social networks and community mechanisms that reduce risks and meet immediate needs. Protection is a collective responsibility of states, affected populations and the humanitarian community (see *Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief*).

Humanitarian workers, whether they are from the affected population or outside agencies or both, can contribute to protection in numerous ways. An essential step is to deliver aid in various key sectors (see Action Sheets 9.1, 10.1 and 11.1) in a way that supports vulnerable people, restores dignity and helps to rebuild social networks. Much of the most effective social protection occurs as local people organise

themselves to address protection threats, thereby building a sense of empowerment and the possibility of sustainable mechanisms for protection. Complementing this non-specialist work is work conducted by protection specialists. For example, experienced child protection workers should address the special vulnerabilities of children, and specialised protection workers are also needed to build local capacities for protection. This Action Sheet is aimed at both non-specialists and specialists.

Key actions

1. Learn from specialised protection assessments whether, when and how to collect information on protection threats.

Many protection assessment activities should be carried out by protection specialists who have technical expertise and who understand the local context. Non-specialists should avoid conducting assessments on sensitive issues such as rape, torture or detention. However, there is a role for non-specialist work. For example, educators must learn about protection risks to children and how to make education safe. To succeed, non-specialist work must build upon the work of protection specialists by:

- Learning what protection threats have been identified;
- Talking with protection specialists before initiating social protection activities;
- Learning what channels exist for reporting protection issues;
- Assessing any dangers (for interviewers, interviewees, aid workers, the local population) related to asking questions. Ask trusted key informants from different sub-groups or factions:
  - What is permissible to ask safely?
  - When and where is it safe to ask questions?
  - How to avoid causing harm.

Before interviewing torture survivors, ask whether doing so will endanger other members of their families; who could conduct interviews safely; where and when to conduct interviews; and what the risks are of post-interview retaliation against survivors.

2. Conduct a multi-sectoral participatory assessment of protection threats and capacities.

- Conduct a situation analysis of protection concerns:

  - See Action sheet 2.1 for guidance on conducting assessments in an ethical and appropriately participatory manner.

  - Include in the team members of the affected group who are trained and supported, provided they are viewed as impartial and it is safe for all involved.

  - Determine whether it is acceptable to discuss sensitive protection issues either with people individually or in group settings.

  - Identify in a range of settings (e.g. camps, routes followed by people collecting water or firewood, non-formal education sites, markets) protection threats such as gender-based violence (GBV), attacks on civilians, forced displacement, abduction, recruitment of minors, trafficking, exploitation, hazardous labour, landmines, exposure to HIV/AIDS and neglect of people in institutions. However, avoid using a checklist approach, which may 'blind' assessors to other or emerging protection threats.

- Taking care to avoid causing harm, ask questions such as:

  - What factors cause the violence and who are the perpetrators?

  - Are the perpetrators still present and are they intimidating local people or those who would offer protection?

  - Has family separation occurred? Is it still happening?

  - Where are separated or unaccompanied children?

  - What has happened to elderly/disabled people?

  - What has happened to those living in institutions and hospitals?

  - What are the current safety/security concerns?

- Analyse local capacities for protection, asking questions such as:

  - In the past, how did groups in the community handle protection threats such as those present now, and what are people doing at present?

  - How has the crisis affected protection systems and coping mechanisms that were previously active?

  - Where are those who would normally provide protection?

  - Are some of the presumed protective resources – such as police, soldiers or peacekeepers, or schools – creating protection threats?

- Collect age- and gender-disaggregated data whenever possible.

- Establish protocols/guidance relating to informed consent and to the documentation, storage and sharing of confidential information.

- Alert all sectoral and intersectoral assessment teams and coordination mechanisms to identified protection concerns.

3. Activate or establish social protection mechanisms, building local protection capacities where needed.

- As appropriate in the context, mobilise people who have or who previously had a role in organising community-level care or protection, ensuring that women and other key at-risk groups are represented.

- Raise local awareness about how to report protection violations.

- Establish, where feasible, a protection working group (PWG) that builds on existing initiatives whenever possible, incorporates diverse actors (including human rights organisations) and serves as a coordination body regarding protection for humanitarian actors. PWGs help to monitor and respond to protection issues and may be set up for villages, camps or wider geographic areas. They should have defined roles, such as filling protection gaps and sharing best practices.

- Organise training by protection specialists to build the capacity of the PWG if necessary, including material on the risks faced by people with mental disabilities.

- Wherever possible, link the PWG with other protection mechanisms in neighbouring areas, forming regional protection networks that exchange information on threats.

- Provide access to education as a protection measure (see Action Sheet 7.1), ensuring that education personnel understand how to make education safe.

4. Monitor protection threats, sharing information with relevant agencies and protection stakeholders.

- Track protection threats and changes in their nature, intensity, pattern and focus at different venues such as schools and marketplaces.

- Via the PWGs and organisations active on protection issues, regularly share information with protection stakeholders, creating wherever possible a central database accessible by different agencies and offering data disaggregated by age

and gender.

- Establish places for information exchange (see Action Sheet 8.1) relevant to protection threats and security issues through which members of the affected population and agency workers can provide information, thereby reducing the spread of rumours.

- Protect confidentiality and share information, following guidelines established by the PWG.

5. Respond to protection threats by taking appropriate, community-guided action.

- Ensure that interventions are based on consultation with and, whenever possible, participation of affected communities.

- Learn from and build on community-level successes in responding to threats and, where appropriate, disseminate the strategies that the community (or a relevant segment of the community) has developed to protect itself.

- Organise appropriate social protection responses, such as:

  - Organising safe spaces (see Action Sheet 5.1) where children can play and adults can meet to discuss steps to increase protection and well-being;

  - Establishing systems for the identification, documentation, tracing, reunification and temporary care arrangements of separated children (see *Inter-Agency Guiding Principles on Unaccompanied and Separated Children* in the Key resources below);

  - Providing emergency support at safe spaces, centres or designated areas for extremely vulnerable individuals/families;

  - Activating local processes of dispute resolution;

  - Activating local processes for helping people at greatest risk (see Action Sheet 5.2);

  - Providing small grants, where appropriate, to alleviate economic threats to well-being;

  - Supporting local action to decrease the risks posed by landmines, unexploded ordnance and uncovered wells;

  - Preventing external groups from taking away orphans, young single women or other individuals at risk.

- Organise support for survivors of abuse who are in severe psychological distress (see Action Sheets 5.2 and 6.1).

- Avoid singling out or targeting specific sub-groups for assistance, unless this is critical to prevent further harm. Integrated support helps to reduce discrimination and may build social connectedness. Consider, for example, providing women's groups rather than groups for women who have been raped.

- Integrate protection into all sectors of humanitarian assistance, including:

  - Post-distribution monitoring of food aid to ensure that it reaches children and others in need;

  - Monitoring shelter programmes to ensure that those who may need special assistance receive support in obtaining adequate shelter;

  - Ensuring that sanitation facilities are close to people's living quarters, and that they are well lit and safe for women and children;

  - Developing an intersectoral strategy regarding GBV, where appropriate.

6. Prevent protection threats through a combination of programming and advocacy.

- Enforce codes of conduct for humanitarian workers that protect children and prevent sexual exploitation and abuse (see Action Sheet 4.2).

- Develop an advocacy strategy in collaboration with local people and relevant coordination groups, addressing key issues such as:

  - Measures to protect the physical safety and security of local people;

  - The need for flexible, long-term funding to respond to complex, changing threats;

  - Appropriate care arrangements for children placed in orphanages and institutions.

- Establish procedures concerning media access to at-risk people, recognising that media attention can lead to (a) reprisal attacks against former child soldiers or rape survivors; (b) distress related to violations of confidentiality, multiple interviews or use of inappropriate questions; and (c) stigma on account of being singled out.

- Provide information in ways that people can understand, enabling them to make informed decisions about key protection issues (see Action Sheet 8.1).

Key resources

1. Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP)
(2005). *Protection: An ALNAP Guide for Humanitarian Agencies.*
http://www.alnap.org/publications/protection/index.htm

2. IASC (2002). *Growing the Sheltering Tree: Protecting Rights Through Humanitarian Action.*
http://www.icva.ch/files/gstree.pdf

3. IASC (2005). *Guidelines on Gender-Based Violence Interventions in Humanitarian Settings.* Geneva:
IASC. http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/gbv.asp

4. IASC (2006). *Protecting Persons Affected By Natural Disasters: IASC Operational Guidelines on Human
Rights and Natural Disasters.* http://www.humanitarianinfo.org/iasc/content/products/docs/IASC%20O
perational%20Guidelines%20final.pdf

5. ICRC, IRC, Save the Children UK, UNICEF, UNHCR and World Vision (2004). *Inter-Agency Guiding
Principles on Unaccompanied and Separated Children.* Save the Children UK.
http://www.unhcr.org/cgi-bin/texis/vtx/protect/opendoc.pdf?tbl=PROTECTION&id=4098b3172

6. IFRC and ICRC (1994). *The Code of Conduct for the International Red Cross and Red Crescent
Movement and Non-Governmental Organizations (NGOs) in Disaster Relief.*
http://www.ifrc.org/publicat/conduct/index.asp

7. InterAction (2004). *Making Protection a Priority: Integrating Protection and Humanitarian Assistance.*
http://www.interaction.org/campaign/protection_paper.html

8. OCHA (forthcoming). *Developing a Humanitarian Advocacy Strategy and Action Plan:
A Step-by-Step Manual.*

9. UNHCR. *Operational Protection in Camps and Settlements: A reference guide of good practices in the
protection of refugees and other persons of concern.*
http://www.unhcr.org/cgi-bin/texis/vtx/publ/opendoc.pdf?tbl=PUBL&id=448d6c122

10. UNICEF. *Ethical Guidelines for Journalists.* www.unicef.org/ceecis/media_1482.html

Sample process indicators

- Humanitarian workers know they are responsible for reporting violations
  and know how to report violations.

- In camps, villages or settlement areas, there is a local protection group or
  mechanism that engages in protection monitoring, reporting and action.

- Steps are taken to protect the most vulnerable people, including those with
  chronic mental disabilities.

Example: Sierra Leone, 2002

- Following a decade of internal war, girls who had been abducted and sexually
  exploited by armed groups often experienced stigmatisation, harassment and
  attack on their return to villages.

- An international NGO organised community dialogues to help local people
  understand that the girls had been forced to do bad things and had themselves
  suffered extensively during the war.

- Local villages organised Girls' Well-Being Committees that defined and imposed
  fines for harassment and mistreatment of the girls.

- This community protection mechanism sharply reduced abuses of the girls and
  supported their reintegration into civilian life.

Action Sheet 3.3

Identify, monitor, prevent and respond to protection threats and abuses through legal protection

Function: Protection and human rights standards
Phase: Minimum Response

Background

The breakdown in law and order that occurs in many emergencies increases people's vulnerability to violations of the rights and safeguards afforded by international and national legal systems. In armed conflict, where human rights violations are often widespread and committed with impunity, people may be too afraid to report crimes or may experience retaliation if they do. These conditions rob people of their dignity and respect, as well as their sense of control over their lives and environment. Legal protection is therefore essential in promoting mental health and psychosocial well-being.

Legal protection refers to the application of international humanitarian and human rights laws, which delineate the rights to which all people are entitled, with special protection measures for at-risk groups (see Chapter 1). Under international law, states bear the primary responsibility for protecting people on their territories. As such, national statutory and customary laws should be used as the basis for legal protection, when they are consistent with international legal standards. When protection under national law is weak or is not feasible, efforts should be made to provide legal protection in accordance with established international standards, recognising that these are the minimum applicable standards to which the international community should adhere in an emergency. Legal protection activities must begin at the earliest stages of an emergency, and those involved must understand the sensitivity that such work may require and the need to weigh carefully the relative risks and benefits.

Safety, dignity and integrity are fundamental concepts to both international humanitarian/human rights law and to a psychosocial approach to humanitarian action. Legal protection promotes mental health and psychosocial well-being by shielding people from harm, promoting a sense of dignity, self-worth and safety, and strengthening social responsibility and accountability for actions. However, legal protection efforts may cause harm when they ignore psychosocial considerations. For instance, survivors of crimes such as torture or rape often feel blamed or stigmatised as a result of legal proceedings. It is important to implement legal protection in a way that promotes psychosocial well-being.

To achieve legal protection, there needs to be collaboration at local, national, regional and international levels. In this partnership approach, many different actors play vital roles. While much legal protection work is the work of specialists, all people involved in humanitarian aid have a responsibility to support appropriate legal protection.

Key actions

1. Identify the main protection threats and the status of existing protection mechanisms, especially for people at heightened risk.

- Conduct participatory assessments (see Action Sheet 2.1) with people at increased risk (see Chapter 1) to identify: the main protection risks; people's skills and capacity to prevent and respond to the risks; whether local protection mechanisms are available and how well or how poorly they protect different groups; and what additional support should be provided (see also Action Sheet 3.2).

- Consider the potential harm of such assessments to the population, analysing the potential risks and benefits.

2. Increase affected people's awareness of their legal rights and their ability to assert these rights in the safest possible way, using culturally appropriate communication methods (see Action Sheet 8.1).

Actions may include:

- Working with community leaders and relevant local authorities (such as lawyers, camp leaders, police, etc.) to mobilise and educate members of their community about legal rights and how to achieve these rights in a safe manner. Priority issues may include rights of access to humanitarian aid, special protection for at-risk groups, mechanisms for reporting and their potential risks, etc. Actions may include:

  - Organising group dialogues in socially acceptable ways (i.e. considering age and gender roles, and appropriate communication tools) to discuss rights.

  - Providing age- and gender-appropriate information in public places such as food distribution sites, health clinics, schools, etc.

- Facilitating the use of legal mechanisms to ensure access to humanitarian services and goods, ensuring that there are systems in place for lodging complaints about violations of rights to free and safe access to services and goods.

3. Support mechanisms for monitoring, reporting and acting on violations of legal standards.

- Identify when and how it is appropriate to report violations. Recognise that in some situations, official mechanisms such as police are appropriate venues for reporting, whereas in other situations reporting to police can create risk of harm.

- Humanitarian actors should report denials of rights, such as access to humanitarian assistance, to the appropriate body (such as Human Rights Commissions or the Protection Cluster) and seek its assistance in identifying possible actions.

- Information sharing must respect confidentiality and minimise risks of retribution or stigmatisation.

- Utilising national and/or international mechanisms (for example, Security Council Resolution 1612 regarding children affected by armed conflict) may be appropriate.

4. Advocate for compliance with international law, and with national and customary laws consistent with international standards.

Actions might include:

- Identifying and disseminating information on the national and international legal frameworks (see Action Sheet 4.2) that protect people at risk;

- Participating in or supporting public education campaigns to end specific abuses such as illegal detentions, *refoulement*, gender-based violence or recruitment of children;

- Orienting national and local legal structures to provide adequate legal protection through capacity-building efforts with, for example, police, judicial and military personnel;

- Conducting legal advocacy against commonly known inappropriate responses in emergencies that can degrade the social fabric of affected populations, such as adoption in emergencies, institutionalisation of vulnerable persons and trafficking of children and women.

5. Implement legal protection in a manner that promotes psychosocial well-being, dignity and respect.

Important steps include:

- Assisting survivors who choose to report violations, and who are seeking protection or redress, to fully understand the implications of their actions, so that they are carried out with informed consent;

- Avoiding causing marginalisation by drawing attention to particular survivors, especially when their experiences are likely to attract social stigma;

- Identifying and supporting mechanisms that end impunity and hold perpetrators accountable for their acts. This includes recognising that punitive justice does not always allow for community-level healing or support community-based restorative justice systems that are consistent with international legal standards and that will lead to forgiveness and reconciliation (e.g. safe release of child and other vulnerable combatants, tracing and reunification, and promoting initial steps in the reintegration process);

- Orienting those working within the legal system – e.g. lawyers, judges, paralegals and court advocates – on how their work affects psychosocial well-being. Key topics may include:

  - The potential positive and negative impacts on psychosocial well-being that judicial proceedings may have on survivors, emphasising approaches that promote safety, dignity and integrity;

  - Sensitive and appropriate techniques for interviewing witnesses and survivors, taking into consideration age, gender and the psychosocial impact of their experiences;

  - The importance of confidentiality in protecting the safety and well-being of survivors (i.e. information storage and management, closed courtroom sessions, etc.);

  - The significance of key legal protection issues in relation to the psychosocial well-being of different groups. Topics may include:

    - Legal processes to determine the fate of disappeared persons, which are particularly important for grieving processes;

    - Ensuring that customary law processes of accountability are followed, as these may be essential to communities' acceptance of children recruited by armed forces;

    - How inheritance and land rights provide essential economic support for widows and children, encouraging self-reliance and resilience;

- Diversion of people with severe mental disorders from the legal system to appropriate social and health services.

• Conducting advocacy in a way that respects confidentiality, dignity and integrity, and which avoids further distress. Public display of survivors' faces, even to communicate information about humanitarian efforts, can be degrading. Avoid images that display overwhelming and obvious suffering, or which reinforce survivors' sense of victimisation (see Action Sheet 8.1).

6. Provide psychosocial support and legal protection services in a complementary fashion.

Useful steps are to:

• Identify appropriate psychosocial supports for witnesses and people who wish to report violations or seek legal redress.

• Orient social support workers on how to assist survivors through the judicial and accompanying processes (i.e. medical examinations, exhumations, identification of dead, etc.).

• Establish support groups and child care options for witnesses, defendants and others involved in legal processes.

• Identify how to make referrals to specialised mental health and psychosocial supports and services, if needed.

• Recognise the need for legal protection referral for persons encountered in psychosocial and mental health services. For example, survivors of sexual violence often receive medical and psychosocial support, but may continue to be or feel in danger and be unable to fully heal if they know that the perpetrator will not be punished.

• Include essential information on legal protection in orientations and training on mental health and psychosocial support (see Action Sheet 4.1), helping workers to understand what to do, or not to do, when they encounter people who need legal protection, including appropriate referrals.

Key resources

Guidelines and manuals

1. ActionAid (2001). *Learning About Rights – Module three: law and rights in emergencies.*
http://www.reliefweb.int/library/library/actionaid-rights-2001.htm

2. Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) (2005). *Protection: An ALNAP Guide for Humanitarian Emergencies.*
www.odi.org.uk/alnap/publications/protection/index.htm

3. IRIN (2006). *Justice for a Lawless World: Rights and Reconciliation in a New Era of International Law (Parts I and II).* http://www.irinnews.org/webspecials/RightsAndReconciliation/default.asp

4. Keeping Children Safe (2006). 'Setting the international standards for child protection'.
http://www.keepingchildrensafe.org.uk/

5. UNICEF (2003). *Technical Notes: Special Considerations for Programming in Unstable Situations.*
http://www.unicef.org/protection/files/Tech_Notes_chap_14_Psychosocial_Dev.pdf

Human rights monitoring and action groups

Amnesty International
http://www.amnesty.org

Human Rights Watch
http://www.hrw.org

Inter-American Commission on Human Rights
http://www.cidh.org/DefaultE.htm

Key international legal instruments

For a list of key international legal instruments, see Action Sheet 3.1.

Sample process indicators

• Key legal protection gaps are identified and action plans are developed to address these appropriately.

• Psychosocial, mental health and orientations/trainings for legal protection workers include information on legal protection and psychosocial well-being, and on the link between the two.

• Survivors of human rights abuses receive complementary support from legal protection workers and from people skilled in providing mental health and psychosocial support.

Action Sheet 4.1
Identify and recruit staff and engage volunteers who understand local culture

Function: Human resources
Phase: Minimum Response

Background

International staff and volunteers may come from different geographic, economic and cultural backgrounds than the affected population in the host country and may have different views and values. Nevertheless, they should have the capacity to respect local cultures and values and to adapt their skills to suit local conditions. The distress of the affected population may be worsened by an influx of humanitarian workers if the latter are not technically competent or if they are unable to handle the predictable stresses of emergency aid work. Local staff and volunteers may be well acquainted with local cultures and traditions, but there can still be large socio-cultural differences, for example between urban and rural populations and between ethnic groups.

People in Aid's *Code of Good Practice in the Management and Support of Aid Personnel* provides overall guiding principles for the management and support of staff working in humanitarian and development agencies. As described in the *Code of Good Practice*, the objective of recruitment is to get the right people (staff and volunteers) to the right place at the right time. In most emergencies this is an enormous challenge, and competition for local staff is common. The key actions described below give specific guidance relevant to recruiting workers to protect and support the mental health and well-being of emergency-affected populations in crisis situations.

Key actions

1. Designate knowledgeable and accountable personnel to undertake recruitment. Such personnel should:

• Be trained in human resource management (according to the People in Aid *Code of Good Practice*);

• Be knowledgeable about the predictable stresses of humanitarian aid work and the policies and practices needed to mitigate them (see Action Sheet 4.4);

• Understand minimum health and mental health requirements for high-risk and high-stress assignments (based on the organisation's own experience and that of similar agencies);

- Depending on context, be aware of potential conflict based on ethnic, racial or national identity.

2. Apply recruitment and selection principles. The selection process must be fair, transparent and consistent to ensure that the most appropriate and capable personnel are appointed.

- Follow written recruitment procedures that outline in detail how staff and volunteers are recruited and selected.
- Aim to attract the widest pool possible of suitably qualified candidates.
- Reduce 'brain drain' from local to international organisations. International agencies should a) collaborate with local agencies to carry out essential relief tasks, reducing the need to hire large numbers of staff from international organisations and b) avoid offering exceptionally high wages that draw local staff away from organisations already working in the area.
- Maintain appropriate documentation and inform candidates whether or not they have been selected. Feedback should be given to candidates if requested.

3. Balance gender in the recruitment process and include representatives of key cultural and ethnic groups. Mental health and psychosocial support programmes require community input and participation. Women and men in the community often have different needs. To assess these differences, men and women typically need to be interviewed separately by male and female workers. This enables gender-specific and personal issues to be discussed more openly. Similarly, recruiting representatives from key cultural and ethnic groups facilitates inputs from, and the participation of, those groups.

4. Establish terms and conditions for volunteer work. Organisations that work with volunteers to deliver psychosocial support should make clear their expectations of volunteers' roles. Similarly, they should make clear policies on reimbursement, entitlements, training, supervision and management of/support for volunteers. Where possible, volunteers should be recruited and supported by organisations that have experience in managing volunteers.

5. Check references and professional qualifications when recruiting national and international staff, including short-term consultants, translators, interns and volunteers.

- Contact referees to identify/check:
  - The candidate's strengths and weaknesses;
  - The candidate's ability to tolerate high-stress situations;
  - Whether the candidate has presented himself or herself honestly;
  - The candidate's ability to adapt to and respect local culture;
  - That the candidate has no record whatsoever of child abuse (especially relevant when recruiting for work that involves contact with children).
- When hiring professionals, check formal qualifications (proof of completion of professional training, membership of a professional organisation, as appropriate).
- If time allows, check for criminal records. Consider the following:
  - In situations of political repression, people may have a record of having been arrested without having committed any crime.
  - Do not hire persons who have a history of perpetrating any type of violence. A deliberate exception may be made in the case of former soldiers, with the aim of promoting their reintegration into society.

6. Aim to hire staff who have knowledge of, and insight into, the local culture and appropriate modes of behaviour. Clinical or any other interpersonal psychosocial support tasks should be performed mainly by local staff who speak the local language and who have a thorough understanding of social and cultural responses to the emergency situation.

7. Carefully evaluate offers of help from individual (non-affiliated) foreign mental health professionals. Well-intending foreign mental health professionals (who are not affiliated to any organisation) should be discouraged from travelling to disaster-affected regions unless they meet the following criteria:

- They have previously worked in emergency settings.
- They have previously worked outside their own socio-cultural setting.

- They have basic competence in some of the interventions covered in these guidelines.

- They have an understanding of either community psychology or public health principles.

- They have a written invitation from a national or established international organisation to work in the country.

- They are invited to work as part of an organisation that is likely to maintain a sustained community presence in the emergency area.

- They do not focus their work on implementing interventions themselves (e.g. clinical work), but rather provide support to programmes on a general level, including the transfer of skills to local staff, so that interventions and supports are implemented by local staff.

Key resources

1. Antares Foundation (2005). *Managing Stress in Humanitarian Workers: Guidelines for Good Practice*.
http://www.antaresfoundation.org/download/Managing%20Stress%20in%20Humanitarian%20Aid%20Workers%20-%20Guidelines%20for%20Good%20Practice.pdf

2. IASC (2005). *Guidelines on Gender-Based Violence Interventions in Humanitarian Settings*, Action Sheet 4.1: Recruit staff in a manner that will discourage sexual exploitation and abuse, pp.50-52. Geneva: IASC. http://www.humanitarianinfo.org/iasc/content/products/docs/tfgender_GBVGuidelines2005.pdf.

3. IFRC (1999). *Volunteering Policy: Implementation Guide*. Geneva: IFRC.
http://www.ifrc.org/cgi/pdf_pubsvol.pl?volpol_impl.pdf

4. Oxfam (2004). *Recruitment in Humanitarian Work*.
http://www.oxfam.org.uk/what_we_do/issues/gender/links/0404humanitarian.htm

5. People in Aid (2003). *Code of Good Practice in the Management and Support of Aid Personnel*.
http://www.peopleinaid.org/pool/files/code/code-en.pdf

Sample process indicators

- Organisations apply a written human resource policy that specifies steps relating to recruitment procedures and terms of employment.

- Organisations achieve balanced recruitment in terms of men/women and minority groups.

- Agencies decline help offered by foreign mental health professionals who do not meet the key criteria outlined above.

- Clinical or other interpersonal psychosocial support tasks are provided primarily by national staff who are familiar with the local culture.

Example: Sri Lanka, 2005

- After the December 2004 tsunami, national Red Cross and Red Crescent societies from numerous countries worked with the Sri Lankan Red Cross Society, making extensive use of local volunteers.

- The national Red Cross/Red Crescent societies collaborated to develop a common psychosocial support framework for the Sri Lankan Red Cross Society.

- All relevant staff and volunteers engaged by the movement were trained according to similar principles, including training in working with cultural resources to provide community support. Because resources were invested in hiring and training staff and volunteers, there is now an enhanced understanding in the country of the positive effects of community-based psychosocial work.

Action Sheet 4.2
Enforce staff codes of conduct and ethical guidelines

Function: Human resources
Phase: Minimum Response

Background

During emergencies, large numbers of people rely on humanitarian actors to meet basic needs. This reliance, together with disrupted or destroyed protection systems (e.g. family networks), contributes to inherently unequal power relationships between those delivering services and those receiving them. Accordingly, the potential for abuse or exploitation of the affected population is high; at the same time, the opportunities for detection and reporting of such abuse tend to diminish. The potential for humanitarian actors to cause harm, either by abusing positions of power or as an unintended consequence of an intervention, must be explicitly recognised, considered and addressed by all humanitarian agencies.

To reduce harm, humanitarian workers should adhere to agreed standards for staff conduct, particularly the *Secretary-General's Bulletin on Special Measures for Protection from Sexual Exploitation and Sexual Abuse*. This bulletin applies to all UN staff, including separately administered organs and programmes, to peacekeeping personnel and to personnel of all organisations entering into cooperative arrangements with the UN. Donors increasingly require aid organisations to enforce these measures.

In addition, the *Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief* outlines the approaches and standards of behaviour that promote the independence, effectiveness and impact to which humanitarian NGOs and the International Red Cross and Red Crescent Movement aspire. As of 2007, this *Code of Conduct* had been agreed by 405 organisations.

Wider issues of ethical standards that guide the behaviour expected of workers need to be agreed, made explicit and enforced, sector by sector. In all interventions, the potential for causing harm as an unintended, but nonetheless real, consequence must be considered and weighed from the outset. A critical example is the collection of data, which is essential for the design and development of effective services but which also requires the careful weighing of benefits and risks to individuals and communities. Consideration of how not to raise expectations, how to minimise harm, how to obtain informed consent, how to handle and store confidential data and how to provide additional safeguards when working with at-risk populations (such as children and

youth) is an essential minimum first step in any assessment, monitoring or research.

The existence of a code of conduct or agreed ethical standards does not in itself prevent abuse or exploitation. Accountability requires that all staff and communities are informed of the standards and that they understand their relevance and application. There must be an organisational culture that supports and protects 'whistle-blowers' and complaints mechanisms that are accessible and trusted through which people, including those who are most isolated and/or most vulnerable (and thus often most at risk of abuse), can report concerns confidentially.

There need to be investigation procedures in place and staff who have been trained to investigate in a sensitive but rigorous manner. Systems also need to be in place that advise when legal action is safe and appropriate and that support individuals who take legal action against alleged perpetrators. Throughout, systems need to take into account the safety and protection needs of everyone concerned in such incidents: victims, complainants, witnesses, investigators and the subject(s) of the complaint, the alleged perpetrator(s).

Key actions

1. Establish within each organisation a code of conduct that embodies widely accepted standards of conduct for humanitarian workers.

2. Inform and regularly remind all humanitarian workers, both current and newly recruited workers, about the agreed minimum required standards of behaviour, based on explicit codes of conduct and ethical guidelines. This applies to all workers, international and national staff, volunteers and consultants, and to those recruited from the affected population. Informing workers of their responsibilities should not be done solely in writing but also through person-to-person dialogue that ensures understanding and allows workers to ask questions.

3. Establish an agreed inter-agency mechanism (e.g. Focal Point Network proposed by the United Nations Secretary-General) to ensure compliance beyond simply having a code of conduct. This mechanism should:

- Share information and lessons learned, to improve the functioning of individual systems;
- Jointly disseminate information about codes of conduct to communities;

- Coordinate other activities, including staff training, monitoring mechanisms, investigation procedures, etc. to prevent and respond to sexual exploitation and abuse;

- Establish systems that respond appropriately when an allegation of misconduct concerns staff from a number of different organisations, or where the individual and/or organisation cannot be identified immediately.

4. Establish accessible, safe and trusted complaints mechanisms that:

- Demonstrate commitment to confidentiality;

- Are age-, gender-, and culture-sensitive;

- Take into account the safety and well-being of the survivor as the paramount consideration;

- Refer the victim/survivor to appropriate, confidential services, including medical and legal services and psychosocial supports;

- Preserve the complainant's confidentiality.

5. Inform communities about the standards and ethical guidelines, and of how and to whom they can raise concerns confidentially.

6. Ensure that all staff understand that they must report all concerns as soon as they are raised. Their obligation is to report possible violations, not to investigate the allegation.

7. Use investigation protocols that comply with an agreed standard, such as the IASC Model Complaints and Investigations Procedures (see Key resources).

8. Take appropriate disciplinary action against staff for confirmed violations of the code of conduct or ethical guidelines.

9. Establish an agreed response in cases in which the alleged behaviour constitutes a criminal act in either the host country or the home country of the alleged perpetrator. As a minimum, this requires that no administrative action is taken that jeopardises legal proceedings, other than those instances in which fair or humane proceedings are very unlikely.

10. Maintain written records of workers who have been found to have violated codes of conduct, to increase the effectiveness of subsequent referral/recruitment checks.

Key resources

1. Horizons, Population Council, Impact, Family Health International (2005). *Ethical Approaches to Gathering Information from Children and Adolescents in International Settings.* www.popcouncil.org/pdfs/horizons/childrenethics.pdf

2. IASC (2004). Model Complaints Referral Form (Sexual Exploitation and Abuse). http://www.icva.ch/cgibin/browse.pl?doc=doc00001187

3. IASC (2004). Model Information Sheet for Communities. http://www.icva.ch/cgi-bin/browse.pl?doc=doc00001186

4. IASC (2004). Terms of Reference for In-Country Focal Points on Sexual Exploitation and Abuse. http://www.icva.ch/cgi-bin/browse.pl?doc=doc00001185

5. IASC (2004). Terms of Reference for In-Country Networks on Sexual Exploitation and Abuse. http://www.icva.ch/cgi-bin/browse.pl?doc=doc00001184

6. International Council of Voluntary Agencies (forthcoming). *Building Safer Organisations.* Geneva: ICVA.

7. IFRC, *Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief.* www.IFRC.org/PUBLICAT/conduct/code.asp

8. Keeping Children Safe (2006). 'Setting the international standards for child protection'. http://www.keepingchildrensafe.org.uk/

9. United Nations (2003). *Secretary-General's Bulletin: Special Measures for Protection from Sexual Exploitation and Sexual Abuse* (ST/SGB/2003/13). http://www.humanitarianinfo.org/iasc/content/products/docs/SGBulletin.pdf

10. United Nations (2004). *Special Measures for Protection from Sexual Exploitation and Sexual Abuse: Report of the Secretary-General* (A/58/777). http://www.un.org/Docs/journal/asp/ws.asp?m=A/58/777

Sample process indicators

- Each organisation has systems in place to inform all staff of the minimum standards of behaviour expected.

- Communities being served by humanitarian actors are informed about the standards and about ways in which they can safely raise concerns about possible violations.

- Agencies have staff trained and available to undertake investigations of alleged violations, within a reasonable timeframe.

Example: Kenya, 2003

- Agencies working in Kakuma agreed to a common code of conduct that applied to all workers.
- Communities received information about the standards through a range of channels, including video.
- Inter-agency training was conducted on how to investigate allegations of misconduct.

Organise orientation and training of aid workers in mental health and psychosocial support

Function: Human resources
Phase: Minimum Response

Background

National and international aid workers play a key role in the provision of mental health and psychosocial support (MHPSS) in emergencies. To be prepared to do so requires that all workers have the necessary knowledge and skills. Training should prepare workers to provide those emergency responses identified as priorities in needs assessments (see Action Sheets 1.1 and 2.1).

Though training content will have some similarities across emergencies, it must be modified for the culture, context, needs and capacities of each situation, and cannot be transferred automatically from one emergency to another. Decisions about who participates in training and about the mode, content and methodology of learning vary according to the conditions of the emergency and the capacities of the workers. Inadequately oriented and trained workers without the appropriate attitudes and motivation can be harmful to populations they seek to assist.

Essential teaching may be organised through **brief orientation and training seminars followed by ongoing support and supervision.** Seminars should accentuate practical instruction and focus on the essential skills, knowledge, ethics and guidelines needed for emergency response. Seminars should be participatory, should be adapted to the local culture and context and should utilise learning models in which participants are both learners and educators.

Key actions

1. Prepare a strategic, comprehensive, timely and realistic plan for training.
All partner organisations involved in MHPSS must have such plans. Plans must be coordinated and integrated between partners and should follow the guidelines established in the overall rapid assessments of problems and resources (see Action Sheets 1.1 and 2.1).

2. Select competent, motivated trainers.
Local trainers or co-trainers with prior experience and/or knowledge of the affected location are preferred when they have the necessary knowledge and skills. Important selection criteria for trainers include:

- Cultural sensitivity and basic knowledge about local cultural attitudes and practices and systems of social support;
- Emotional stability;
- Good knowledge about MHPSS emergency response, including understanding the value of integrated and collaborative responses;
- Practical field-based experience in providing psychosocial support in previous emergencies;
- Good knowledge of teaching, leading to immediate and practical MHPSS interventions.

3. Utilise learning methodologies that facilitate the immediate and practical application of learning.
- Use a participatory teaching style (e.g. role play, dialogue, drama, group problem solving, etc.) that engages active trainee participation.
- Utilise learning models in which participants are both learners and educators.
- Train participants in local languages or, when this is not possible, provide translation.
- Use audio/visual/reference materials adapted to local conditions (e.g. avoid PowerPoint presentations if electricity is unavailable).
- Use classrooms for theoretical learning and initial practice of skills (e.g. role plays, among other techniques).
- Use hands-on field-based training to practise skills in locations that are in or resemble the emergency-affected area.
- Distribute written reference materials in accessible language, including manuals with specific operational guidelines (if available).
- Complete immediate evaluations of training (by trainers, trainees and assisted populations) to benefit from lessons learned.

4. Match trainees' learning needs with appropriate modes of learning.
Brief orientation seminars (half or full-day seminars) should provide immediate basic, essential, functional knowledge and skills relating to psychosocial needs, problems and available resources to everyone working at each level of response. Orientation

seminars should preferably be organised before workers begin their missions.

Possible participants include all aid workers in all sectors (particularly from social services, health, education, protection and emergency response divisions). This includes paid and unpaid, national and international workers from humanitarian organisations and from government. Depending on the situation, orientation seminars can also include elected or volunteer male, female and youth community leaders, including clan, religious, tribal and ethnic group leaders.

Training seminars. More extensive knowledge and skills are recommended for those working on focused and specialised MHPSS (see top two layers of the pyramid in Figure 1, Chapter 1).
- The length and content of training seminars vary according to trainees' needs and capacities. Inexperienced staff will require longer periods of training.
- The timing of seminars must not interfere with the provision of emergency response.
- The use of short, consecutive modules for cumulative learning is recommended, because (a) this limits the need to remove staff from their duties for extended periods and (b) it allows staff to practise skills between training sessions. Each short module lasts only a few hours or days (according to the situation) and is followed by practice in the field with support and supervision, before the next new module is introduced in a few days' or weeks' time.
- Training seminars should always be followed up with field-based support and/or supervision (see key action 7 below).

5. Prepare orientation and training seminar content directly related to the expected emergency response.
The contents of **brief orientation seminars** may include:
- Review of safety and security procedures;
- Methods for workers to cope with work-related problems (see Action Sheet 4.4);
- Codes of conduct and other ethical considerations (see Action Sheet 4.2);
- Human rights and rights-based approaches to humanitarian assistance (see the Sphere Project's Humanitarian Charter and Action Sheet 3.1);
- Importance of empowerment and of involving the local population in relief activities (see Action Sheet 5.1);

- Basic knowledge on the impact of emergencies on mental health and psychosocial well-being of populations (see Chapter 1);

- Techniques for psychological first aid (see Action Sheet 6.1);

- Methods to promote the dignity of the affected population, using lessons learned from previous emergencies;

- Knowledge about local socio-cultural and historical context, including:

  - Basic knowledge about the crisis and the world view(s) of the affected populations;

  - Basic information about cultural attitudes, practices and systems of social organisation, as well as both effective and detrimental traditional practices, rituals and coping strategies;

  - Basic information on workers' behaviours that might be offensive to the local culture;

- Information about available sources of referral (e.g. tracing, health and protection services, traditional community supports, legal services, etc.);

- Information on how and where to participate in relevant inter-agency coordination.

The content of **training seminars** may include:
- All information covered in the orientation seminars;

- Emergency individual, family and community psychosocial and mental health assessment skills;

- Emergency psychosocial and mental health response techniques that can be taught quickly, that are based on the existing capacities, contexts and cultures of the trainees and that are known to be effective in related contexts;

- Knowledge and skills necessary for implementing interventions that are (a) part of the minimum response and (b) identified as necessary through assessment (see Action Sheet 2.1). This applies to training of:

  - Health workers (see Action Sheets 5.4, 6.1, 6.2, 6.3, 6.4 and 6.5)

  - Protection workers (see Action Sheets 3.2, 3.3 and 5.4)

  - Formal and non-formal community workers (see Action Sheets 5.1, 5.2, 5.3 and 5.4)

- Teachers (see Action Sheet 7.1).

6. Consider establishing Training of Trainers (ToT) programmes to prepare trainers prior to training.

ToT programmes educate future trainers so that they can competently train others. Trainers of brief orientation and training seminars can be prepared via a ToT. Skilful ToT programmes can also prepare trainers to transfer information to large groups of people. However, ToT must only be done with careful planning and be taught by experienced and skilled master trainers. Poorly prepared ToTs – in particular those that involve (a) future trainers without any previous experience in training or (b) future trainers with limited experience in the training content – tend to fail and may lead to poor or even harmful MHPSS outcomes. Thus, after a ToT, follow-up support should be provided to the future trainers and to their trainees, to achieve accuracy of training and quality of the aid response.

7. After any training, establish a follow-up system for monitoring, support, feedback and supervision of all trainees, as appropriate to the situation.

Supervision is important to try to ensure that training is actually put into practice. Many training efforts fail because of insufficient follow-up. All training seminars should be followed by continuing monitoring and follow-up training, field-based support, feedback and/or supervision. These follow-up activities should be properly planned before the start of any training. Follow-up can be provided by trainers or alternatively by experienced professionals, well-trained colleagues, a collegial network of peers or related professional institutions (as available). Close supervision is particularly essential for new field staff.

8. Document and evaluate orientation and training to identify lessons learned, to be shared with partners and to enhance future responses.

Key resources

1. Baron N. (2006). 'The "TOT": A global approach for the Training of Trainers for psychosocial and mental health interventions in countries affected by war, violence and natural disasters'. *Intervention: International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict*, 4, 109-126. http://www.interventionjournal.com/index1.html

2. Jensen S.B. and Baron N. (2003). 'Training programs for building competence in early intervention skills'. In: *Reconstructing Early Intervention After Trauma*. Editors: Ørner R. and Schnyder U. Oxford: Oxford University Press. http://www.who.int/mental_health/emergencies/mh_key_res/en/index.html

3. Psychosocial Working Group (2006). CD of training manuals from numerous organisations. http://www.forcedmigration.org/psychosocial/

4. Sphere Project (2004). The Humanitarian Charter. *Humanitarian Charter and Minimum Standards in Disaster Response*. Geneva: Sphere Project. http://www.sphereproject.org/handbook/index.htm

5. Van der Veer G. (2006). 'Training trainers for counsellors and psychosocial workers in areas of armed conflict: some basic principles'. *Intervention: International Journal of Mental Health, Psychosocial Work and Counselling in Areas of Armed Conflict*, 4, 97-108. http://www.interventionjournal.com/index1.html

6. Weine S. et al. (2002). *Guidelines for International Training in Mental Health and Psychosocial Interventions for Trauma Exposed Populations in Clinical and Community Settings.* http://www.who.int/mental_health/resources/training_guidelines_for_trauma_interventions.pdf

Sample process indicators

• Content of training seminars is based on needs assessment.

• Aid workers in all sectors can participate in brief and relevant orientation seminars providing essential functional knowledge and skills about mental health and psychosocial support.

• Trainers have prior knowledge and skills in related work.

• Training is followed up by field-based support and supervision.

Example: Sri Lanka, 2005

• A local NGO with a long history of providing psychosocial support to war-affected populations temporarily refocused its work to support tsunami survivors.

• The NGO organised short action-oriented seminars to teach existing psychosocial field staff essential skills to better support people with specific tsunami-induced mental health and psychosocial problems, together with practical methods of intervention.

• After the seminars, follow-up was provided through the NGO's existing system of weekly supervision.

Action Sheet 4.4
Prevent and manage problems in mental health and psychosocial well-being among staff and volunteers

Function: Human resources
Phase: Minimum Response

Background

Staff members working in emergency settings tend to work many hours under pressure and within difficult security constraints. Many aid workers experience insufficient managerial and organisational support, and they tend to report this as their biggest stressor. Moreover, confrontations with horror, danger and human misery are emotionally demanding and potentially affect the mental health and well-being of both paid and volunteer aid workers, whether they come from the country concerned or from abroad.

The provision of support to mitigate the possible psychosocial consequences of work in crisis situations is a moral obligation and a responsibility of organisations exposing staff to extremes. For organisations to be effective, managers need to keep their staff healthy. A systemic and integrated approach to staff care is required at all phases of employment – including in emergencies – and at all levels of the organisation to maintain staff well-being and organisational efficiency.

The word 'staff' in this action sheet refers to paid and volunteer, national and international workers, including drivers and translators, affiliated with an aid organisation. Support measures should in principle be equal for national and international staff. However, some structural differences exist between the two.

For example, national staff are often recruited from the crisis area and are more likely to have been exposed to extremely stressful events or conditions. In addition, they and their families are often unable to leave the crisis area if the security situation worsens, in contrast with international aid workers, who tend to have good access to evacuation operations. For international workers, on the other hand, particular stressors include separation from their support base, culture shock and adjustment to difficult living conditions. These and other differences are often forgotten or left unaddressed in staff support systems. Humanitarian organisations should work to improve their performance in staff support and to reduce differential support practices for national and international staff.

Key actions
1. Ensure the availability of a concrete plan to protect and promote staff well-being for the specific emergency.

- While most agencies have a general *policy* on staff welfare in emergencies, for each specific emergency they should also have a concrete *plan* for proactive staff support. The activities within the plan should be part of the overall emergency budget, and should be consistent with the points outlined below.

2. Prepare staff for their jobs and for the emergency context.
- Ensure that national and international staff receive information on (a) their jobs (see key action 4 below) and (b) the prevailing environmental and security conditions and possible future changes in these conditions. Provide to international staff (and, when appropriate, to national staff) information on the local socio-cultural and historical context, including:
  - Basic knowledge of the crisis and the world view(s) of the affected population;
  - Basic information on local cultural attitudes and practices and systems of social organisation;
  - Basic information on staff behaviours that may cause offence in the local socio-cultural context.
- Ensure that all staff receive adequate training on safety and security.
- Ensure that all staff are briefed on a spectrum of stress identification (including but not restricted to traumatic stress) and stress management techniques and on any existing organisational policy for psychosocial support to staff.
- Ensure that experienced field management staff are available.

3. Facilitate a healthy working environment.
- Implement the organisation's staff support policy, including a rest and recuperation (R&R) provision. When the environment provides no opportunities for non-work-related activities, then consider organising a higher frequency of R&R opportunities.
- Ensure appropriate food and hygiene for staff, taking into account their religion and culture.
- Address excessive, unhealthy living practices, such as heavy alcohol use by workers.
- Facilitate some privacy in accommodation (e.g. if possible, provide separate work and living places).

- Define working hours and monitor overtime. Aim to divide the workload among staff. If a 24-hour, seven-days-a-week work pattern is essential in the first weeks of an emergency, then consider rotating staff in shifts. Eight-hour shifts are preferable, but if that is not possible, shifts should be no longer than 12 hours. Twelve hours on and 12 hours off is tolerable for a week or two during emergency situations, but it would be helpful to have an extra half-day added to rest schedules about every five days. The hotter or colder an environment, or the more intense the stress, the more breaks are required.
- Facilitate communication between staff and their families and other pre-existing support mechanisms.

4. Address potential work-related stressors.
- Ensure clear and updated job descriptions:
  - Define objectives and activities;
  - Confirm with staff that their roles and tasks are clear;
  - Ensure clear lines of management and communication.
- Evaluate daily the security context and other potential sources of stress arising from the situation.
- Ensure sufficient supplies for staff security (bullet-proof vests, communication equipment, etc.).
- Ensure equality between staff (national, international, lower and higher management) in the personal decision to accept security risks. Do not force national staff to take risks that international staff are not allowed or not willing to take.
- Organise regular staff or team meeting and briefings.
- Ensure adequate and culturally sensitive technical supervision (e.g. clinical supervision) for mental health and psychosocial support staff (see also Action Sheet 4.3).
- Build teams, facilitate integration between national and international staff and address intra-team conflict and other negative team dynamics.
- Ensure appropriate logistical back-up and supply lines of materials.
- Ensure that members of senior management visit field projects regularly.

5. Ensure access to health care and psychosocial support for staff.

• Train some staff in providing peer support, including general stress management and basic psychological first aid (PFA) (for a description of basic PFA, see Action Sheet 6.1).

• For national staff who may be unable to leave the emergency area, organise access to culturally appropriate mental health (including psychiatric) and psychosocial support and physical health care.

• Ensure stand-by, specialist back-up for urgent psychiatric complaints in staff (such as suicidal feelings, psychoses, severe depression and acute anxiety reactions affecting daily functioning, significant loss of emotional control, etc.). Consider the impact of stigma on the willingness of staff to access mental health assistance and adjust back-up support accordingly (e.g. international staff may be fearful that they will be sent home if they seek assistance).

• Ensure that staff are provided with prophylactics such as vaccinations and anti-malarials, condoms and (when appropriate) access to post-exposure prophylactics, and ensure adequate availability of medicines for common physical diseases amongst staff.

• Ensure that medical (including mental health) evacuation or referral procedures are in place, including appropriate medically trained staff to accompany evacuees.

6. Provide support to staff who have experienced or witnessed extreme events (critical incidents, potentially traumatic events).

• For all critical incident survivors, make basic psychological first aid (PFA) *immediately* available (for a description of basic PFA, see Action Sheet 6.1). As part of PFA, assess and address the basic needs and concerns of survivors. Although natural opportunities should be provided for sharing among survivors, they should not be pushed to describe events in detail nor should they be pushed to share or listen to details of other survivors' experiences. Existing (positive and negative) coping methods should be discussed, and use of alcohol and drugs as a way of coping should be explicitly discouraged, as survivors are often at increased risk of developing addiction.

• Make available appropriate self-care materials (see Action Sheet 8.2 for guidance on developing culture-appropriate materials). The materials should include contact information for a staff welfare officer/mental health professional in case survivors wish to seek help for any level of distress.

• When survivors' acute distress is so severe that it limits their *basic* functioning (or that they are judged to be a risk to themselves or others), they must stop working and receive immediate care by a mental health professional trained in evidence-based treatment of acute traumatic stress. An accompanied medical evacuation may be necessary.

• Ensure that a mental health professional contacts all national and international staff members (including translators, drivers, volunteers, etc.) who have survived a critical incident one to three months following the event. The professional should assess how the survivor is functioning and feeling and make referral to clinical treatment for those with substantial problems that have not healed over time.

7. Make support available after the mission/employment.

• Staff members should receive a technical debriefing and job evaluation from senior office staff.

• Staff members should obtain an overall health check-up, including a stress review and assessment.

• Staff support mechanisms should be made available upon request.

• Brief informational materials should be provided to help people understand and manage stress. This material should include an updated referral list of mental health professionals as well as opportunities for peer support.

Key resources

1. Action Without Borders/Idealist.org (2004). Website with resources on stress management for aid workers, managers and workers' families. http://www.psychosocial.org

2. Antares Foundation (2005). *Managing Stress in Humanitarian Workers. Guidelines for Good Practice.* Amsterdam: Antares Foundation. www.antaresfoundation.org

3. Headington Institute (2005). Various resources and free online training modules on understanding and coping with the stress associated with humanitarian work. http://www.headington-institute.org

4. McFarlane C. (2004). 'Adjustment of humanitarian aid workers'. *Australasian Journal of Disaster and Trauma Studies.* ISSN: 1174-4707, Volume 2004-1.
http://www.massey.ac.nz/~trauma/issues/2004-1/mcfarlane.htm

5. National Child Traumatic Stress Network and National Center for PTSD (2006). *Psychological First Aid: Field Operations Guide* (Second edition). http://www.ncptsd.va.gov/ncmain/ncdocs/manuals/PFA_2ndEditionwithappendices.pdf (A potential limitation of this resource is that it was specifically developed for Western disaster settings. The guide describes an advanced form of psychological first aid because it was developed for use by previously trained mental health professionals.)

6. People in Aid (2003). *Code of Good Practice in the Management and Support of Aid Personnel.* http://www.peopleinaid.org/pool/files/code/code-en.pdf.

Sample process indicators

- The organisation has funded plans to protect and promote staff well-being for the emergency.

- Workers who survive a critical incident have immediate access to psychological first aid.

- Workers who survive a critical incident are systematically screened for mental health problems one to three months following the incident, and appropriate support is arranged when necessary.

Example: unspecified country, 1999

- After a violent hostage situation involving staff of an international NGO, all national and international staff received an operational debriefing and information on how and where to receive support from a national or foreign doctor or mental health worker at any time it was needed.

- In the days following the incident, a staff counsellor organised two meetings to discuss with staff how they were doing. Care (and medical evacuation) was organised for a person with severe anxiety problems.

- One month later, a trained volunteer contacted all national and international staff individually to check their well-being and organised support as necessary.

Action Sheet 5.1
Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors
Domain: Community mobilisation and support
Phase: Minimum Response

Background

The process of response to an emergency should be owned and controlled as much as possible by the affected population, and should make use of their own support structures, including local government structures. In these guidelines, the term 'community mobilisation' 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 the discussions, decisions and actions that affect them and their future. As people become more involved, they are likely to become more hopeful, more 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.

There are varying degrees of community participation:

- The community to a large extent controls the aid process and decides on aid responses, with government and non-government organisations providing direct advocacy and support.

- The community or its representative members have an equal partner role in all major decisions and activities undertaken in partnership with various government and non-government organisations and community actors.

- The community or its representative members are consulted on all major decisions.

- The community acts as an implementing partner (e.g. supporting food distribution or self-help activities), while major decisions are made by government and non-government organisations.

- Community members are not involved in designing and only minimally involved in implementing relief activities.

It is important to note that communities tend to include multiple sub-groups that have different needs and which often compete for influence and power. Facilitating genuine community participation requires understanding the local power structure and patterns of community conflict, working with different sub-groups and avoiding the privileging of particular groups.

The political and emergency aspects of the situation determine the extent of participation that is most appropriate. In very urgent or dangerous situations, it may be necessary to provide services with few community inputs. Community involvement when there is inadvertent mingling of perpetrators and victims can also lead to terror and killings (as occurred, for example in the Great Lakes crisis in 1994). However, in most circumstances, higher levels of participation are both possible and desirable. Past experience suggests that significant numbers of community members are likely to function well enough to take leading roles in organising relief tasks and that the vast majority may help with implementing relief activities. Although outside aid agencies often say that they have no time to talk to the population, they have a responsibility to talk with and learn from local people, and usually there is enough time for this process.

Nevertheless, a critical approach is necessary. External processes often induce communities to adapt to the agenda of aid organisations. This is a problem, especially

when outside agencies work in an uncoordinated manner. For example, a year after the 2004 tsunami in southeast Asia, a community of 50 families in northern Sri Lanka, questioned in a door-to-door psychosocial survey, identified 27 different NGOs offering or providing help. One interviewee stated: 'We never had leaders here. Most people are relatives. When someone faced a problem, neighbours came to help. But now some people act as if they are leaders, to negotiate donations. Relatives do not help each other any more.'

As this example indicates, it can be damaging if higher degrees of community participation are facilitated by agencies with their own agendas offering help, but lacking deep bonds with or understanding of the community. It is particularly important to facilitate the conditions in which communities organise aid responses themselves, rather than forcing the community to adhere to an outside agenda.

Key actions

1. Coordinate efforts to mobilise communities.

- Actively identify, and coordinate with, existing processes of community mobilisation (see Action Sheet 1.1). Local people often have formal and non-formal leaders and also community structures that may be helpful in coordination, although care should be taken to ensure that these do not exclude particular people.

- It is important to work in partnership with local government, where supportive government services are present.

2. Assess the political, social and security environment at the earliest possible stage.
In addition to reviewing and gathering general information on the context (see Action Sheet 2.1):

- Observe and talk informally with numerous people representative of the affected community;

- Identify and talk with male and female key informants (such as leaders, teachers, healers, etc.) who can share information about (a) issues of power, organisation and decision-making processes in the community, (b) what cultural rules to follow, and (c) what difficulties and dangers to be aware of in community mobilisation.

3. Talk with a variety of key informants and formal and informal groups, learning how local people are organising 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. Often it is useful to meet separately with sub-groups defined along lines of religion or ethnicity, political affinity, gender and age, or caste and socio-economic class. Ask groups questions such as:

- In previous emergencies, how have local people confronted the crisis?
- 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?

4. Facilitate the participation of marginalised people.
- Be aware of issues of power and social injustice.
- Include marginalised people in the planning and delivery of aid.
- Initiate discussions about ways that empower marginalised groups and prevent or reduce stigmatisation or discrimination.
- Ensure, if possible, that such discussions take note of existing authority structures, including local government structures.
- Engage youth, who are often viewed as a problem but who can be a valuable resource for emergency response, as they are often able to adapt quickly and creatively to rapidly changing situations.

5. Establish safe and sufficient spaces early on to support planning discussions and the dissemination of information.
Safe spaces, which can be either covered or open, allow groups to meet to plan how to participate in the emergency response and to conduct self-help activities (see Action Sheet 5.2) or religious and cultural activities (see Action Sheet 5.3). Safe spaces can

also be used for protecting and supporting children (see Action Sheets 3.2 and 5.4), for learning activities (see Action Sheet 7.1), and for communicating key information to community members (see Action Sheets 8.1 and 8.2).

6. Promote community mobilisation processes.
- Security conditions permitting, organise discussions regarding the social, political and economic context and the causes of the crisis. Providing a sense of purpose and meaning can be a powerful source of psychosocial support.
- Facilitate the conditions for a collective reflection process involving key actors, community groups or the community as a whole regarding:
  - Vulnerabilities to be addressed at present and vulnerabilities that can be expected in the future;
  - Capacities, and abilities to activate and build on these;
  - Potential sources of resilience identified by the group;
  - Mechanisms that have helped community members in the past to cope with tragedy, violence and loss;
  - Organisations (e.g. local women's groups, youth groups or professional, labour or political organisations) that could be involved in the process of bringing aid;
  - How other communities have responded successfully during crises.
- One of the core activities of a participatory mobilisation process is to help people to make connections between what the community had previously, where its members are now, where they want to go, and the ways and means of achieving that. Facilitation of this process means creating the conditions for people to achieve their goals in a manner that is non-directive and as non-intrusive as possible. If needed, it may be useful to organise activities (e.g. based on popular education methodologies) that facilitate productive dialogue and exchange. This reflective process should be recorded, if resources permit, for dissemination to other organisations working on community mobilisation.
- The above process should lead to a discussion of emergency 'action plans' that coordinate activities and distribute duties and responsibilities, taking into account agreed priorities and the feasibility of the actions. Planning could also foresee longer-term scenarios and identify potentially fruitful actions in advance. It should be clearly understood whether the action is the responsibility of the community itself or of external agents (such as the state). If the responsibility is with the

community, a community action plan may be developed. If the responsibility is with external agents, then a community advocacy plan could be put in place.

Key resources

1. Action on the Rights of the Child. *Community Mobilisation*.
http://www.savethechildren.net/arc/files/f_commmob.pdf

2. Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) (2003). *Participation by Crisis-Affected Populations in Humanitarian Action: A Handbook for Practitioners.*
http://www.odi.org.uk/ALNAP/publications/gs_handbook/gs_handbook.pdf (English); http://www.psicosocial.net (Spanish)

3. Donahue J. and Williamson J. (1999). *Community Mobilization to Mitigate the Impacts of HIV/AIDS*. Displaced Children and Orphans Fund. http://pdf.dec.org/pdf_docs/pnacj024.pdf

4. Norwegian Refugee Council/Camp Management Project (2004, revised 2007). *Camp Management Toolkit*. http://www.flyktninghjelpen.no/?did=9072071

5. Regional Psychosocial Support Initiative (REPSSI) (2006). *Journey of Life – A Community Workshop to Support Children*. http://www.repssi.org/home.asp?pid=43

6. Segerström E. (2001). 'Community Participation' in *The Refugee Experience*, Oxford Refugee Studies Centre. http://earlybird.qeh.ox.ac.uk/rfgexp/rsp_tre/student/commpart/com_int.htm

7. Sphere Project (2004). *Humanitarian Charter and Minimum Standards in Disaster Response*, Common standard 1: participation, pp.28-29. Geneva: Sphere Project.
http://www.sphereproject.org/handbook/index.htm

8. UNHCR (2002). *Guide for Shelter Planning* (chapters on Community Participation and Community Organising). http://www.unhcr.org/cgi-bin/texis/vtx/home/opendoc.pdf?tbl=PARTNERS&id=3c4595a64 (English); http://www.acnur.org/index.php?id_pag=792 (Spanish)

9. UNHCR (2006). Tool for Participatory Assessment in Operations.
http://www.unhcr.org/publ/PUBL/450e963f2.html

Sample process indicators

- Safe spaces have been established and are used for planning meetings and information sharing.
- Local people conduct regular meetings on how to organise and implement the emergency response.
- Local men, women, and youth – including those from marginalised groups – are involved in making key decisions in the emergency.

Example: Mexico, 1985

- In 1985, following a devastating earthquake in Mexico City – where there were strong, pre-existing community organisations – people from the local community organised the emergency relief efforts.
- Local people did most of the clean-up work, distributed food and other supplies, organised temporary shelters and designed new living quarters.
- The local emergency response developed into a social movement that assisted people for a period of five years.
- Studies conducted three and five years after the earthquake reported no increase in the prevalence of mental health problems.

Facilitate community self-help and social support

Domain: Community mobilisation and support
Phase: Minimum Response

Background

All communities contain effective, naturally occurring psychosocial supports and sources of coping and resilience. Nearly all groups of people affected by an emergency include helpers to whom people turn for psychosocial support in times of need. In families and communities, steps should be taken at the earliest opportunity to activate and strengthen local supports and to encourage a spirit of community self-help.

A self-help approach is vital, because having a measure of control over some aspects of their lives promotes people's mental health and psychosocial well-being following overwhelming experiences. Affected groups of people typically have formal and informal structures through which they organise themselves to meet collective needs. Even if these structures have been disrupted, they can be reactivated and supported as part of the process of enabling an effective emergency response. Strengthening and building on existing local support systems and structures will enable locally owned, sustainable and culturally appropriate community responses. In such an approach, the role of outside agencies is less to provide direct services than to facilitate psychosocial supports that build the capacities of locally available resources.

Facilitating community social support and self-help requires sensitivity and critical thinking. Communities often include diverse and competing sub-groups with different agendas and levels of power. It is essential to avoid strengthening particular sub-groups while marginalising others, and to promote the inclusion of people who are usually invisible or left out of group activities.

Key actions

1. Identify human resources in the local community.

Examples of such resources are significant elders, community leaders (including local government leaders), traditional healers, religious leaders/groups, teachers, health and mental health workers, social workers, youth and women's groups, neighbourhood groups, union leaders and business leaders. A valuable strategy is to map local resources (see also Action Sheet 2.1) by asking community members about the people they turn to for support at times of crisis. Particular names or groups of people are likely to be reported repeatedly, indicating potential helpers within the affected population.

- Meet and talk with identified potential helpers, including those from marginalised groups, and ask whether they are in a position to help.
- Identify social groups or mechanisms that functioned prior to the emergency and that could be revived to help meet immediate needs. These might include collective work groups, self-help groups, rotating savings and credit groups, burial societies and youth and women's groups.

2. Facilitate the process of community identification of priority actions through participatory rural appraisal and other participatory methods.

- Identify available non-professional or professional supports that could be activated immediately or strengthened.
- Promote a collective process of reflection about people's past, present and future that enables planning. By taking stock of supports that were present in the past but which have been disrupted in the emergency, people can choose to reactivate useful supports. By reflecting on where they want to be in several years' time, they can envision their future and take steps to achieve their vision.
- Discuss with key actors or community groups:
  - Organisations that were once working to confront crisis and that may be useful to reactivate;
  - Mechanisms (rituals, festivals, women's discussion groups, etc.) that have helped community members in the past to cope with tragedy, violence or loss;
  - How the current situation has disrupted social networks and coping mechanisms;
  - How people have been affected by the crisis;
  - What priorities people should address in moving towards their vision of the future;
  - What actions would make it possible for people to achieve their priority goals;
  - What successful experiences of organisations have been seen in their and neighbouring communities.
- Share results of this identification process with the coordination group (see Action Sheets 1.1 and 2.1).

3. Support community initiatives, actively encouraging those that promote family and community support for all emergency-affected community members, including people at greatest risk.

- Determine what members of the affected population are already doing to help themselves and each other, and look for ways to reinforce their efforts. For example, if local people are organising educational activities but need basic resources such as paper and writing instruments, support their activities by helping to provide the materials needed (while recognising the possible problem of creating dependency). Ask regularly what can be done to support local efforts.
- Support community initiatives suggested by community members during the participatory assessment, as appropriate.
- Encourage when appropriate the formation of groups, particularly ones that build on pre-existing groups, to conduct various activities of self-support and planning.

4. Encourage and support additional activities that promote family and community support for all emergency-affected community members and, specifically, for people at greatest risk.

In addition to supporting the community's own initiatives, a range of additional relevant initiatives may be considered. Facilitate community inputs in (a) selecting which activities to support, (b) designing, implementing and monitoring the selected activities, and (c) supporting and facilitating referral processes. Examples of potentially relevant activities are provided in the box below.

Examples of activities that promote family and community support for emergency-affected community members and, specifically, for people at greatest risk

- Group discussions on how the community may help at-risk groups identified in the assessment as needing protection and support (see Action Sheet 2.1);
- 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 (see Action Sheet 3.2);
- Organising structured and monitored foster care rather than orphanages for separated children, whenever possible (see Action Sheet 3.2);
- Family tracing and reunification for all age groups (see Action Sheet 3.2);

- Protection of street children and children previously associated with fighting forces and armed groups, and their integration into the community;
- Activities that facilitate the inclusion of isolated individuals (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;
- Sports and youth clubs and other recreational activities, e.g. for adolescents at risk of substance abuse or of other social and behavioural problems;
- Re-establishment of normal cultural and religious events for all (see Action Sheet 5.3);
- Ongoing group discussion about community members' mental health and psychosocial well-being;
- Building networks that link affected communities with aid agencies, government and various services;
- Communal healing practices (see Action Sheet 5.3);
- Other activities that help community members gain or regain control over their lives;
- Activities that promote non-violent handling of conflict e.g. discussions, drama and songs, joint activities by members of opposing sides, etc.;
- Structured activities for children and youth (including non-formal education, as in child-friendly spaces: see Action Sheet 7.1);
- Organising access to information about what is happening, services, missing persons, security, etc. (see Action Sheet 8.1);
- Organising access to shelter and basic services (see Action Sheets 9.1, 10.1 and 11.1).

5. Provide short, participatory training sessions where appropriate (see Action Sheet 4.3), coupled with follow-up support.

Where local support systems are incomplete or are too weak to achieve particular goals, it may be useful to train community workers, including volunteers, to perform tasks such as:

- Identifying and responding to the special needs of community members who are not functioning well;
- Developing and providing supports in a culturally appropriate way;
- Providing basic support, i.e. psychological first aid, for those acutely distressed after exposure to extreme stressors (see Action Sheet 6.1);
- Creating mother-child groups for discussion and to provide stimulation for smaller children (see Action Sheet 5.4);
- Assisting families, where appropriate, with problem-solving strategies and knowledge about child rearing;
- Identifying, protecting and ensuring care for separated children;
- Including people with disabilities in various activities;
- Supporting survivors of gender-based violence;
- Facilitating release and integration of boys and girls associated with fighting forces and armed groups;
- Setting up self-help groups;
- Engaging youth e.g. in positive leadership, organising youth clubs, sports activities, conflict resolution dialogue, education on reproductive health and other life skills training;
- Involving adults and adolescents in concrete, purposeful, common interest activities e.g. constructing/organising shelter, organising family tracing, distributing food, cooking, sanitation, organising vaccinations, teaching children;
- Referring affected people to relevant legal, health, livelihood, nutrition and social services, if appropriate and if available.

6. When necessary, advocate within the community and beyond on behalf of marginalised and at-risk people.
Typically, those who were already marginalised before the start of a crisis receive scant attention and remain invisible and unsupported, both during and after the crisis. Humanitarian workers may address this problem by linking their work to social justice, speaking out on behalf of people who may otherwise be overlooked and enabling marginalised people to speak out effectively for themselves.

Key resources

1. IASC (2005). *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings*. Geneva: IASC. http://www.humanitarianinfo.org/iasc/content/products/docs/tfgender_GBVGuidelines2005.pdf

2. IFRC (2003). 'Promoting community self-help', in *Community-based Psychological Support: A Training Manual*, pp.57-65. Geneva: International Federation of the Red Cross and Red Crescent Societies. Available in English, Arabic, French and Spanish at: http://psp.drk.dk/sw2995.asp

3. Norwegian Refugee Council/Camp Management Project (2004, revised 2007). *Camp Management Toolkit*. http://www.flyktninghjelpen.no/?did=9072071

4. Pretty J.N. and Vodouhê D.S. (1997). 'Using rapid or participatory rural appraisal'. FAO: New York. http://www.fao.org/docrep/W5830E/w5830e08.htm

5. Refugee Studies Centre and UNICEF (2002). 'Addressing the needs of children, their families and communities', in *Working with Children in Unstable Situations – Principles and Concepts for Psycho-social Interventions* (draft), pp.47-79. http://psp.drk.dk/graphics/2003referencecenter/Doc-man/Documents/1Disaster-general/WorkWithChild.UnstableSitua.pdf

6. Regional Psychosocial Support Initiative (REPSSI) (2006). *The Journey of Life* (awareness and action workshops). http://www.repssi.org/

7. Save the Children (1996). *Promoting Psychosocial Well-Being Among Children Affected by Armed Conflict and Displacement: Principles and approaches*. http://www.savethechildren.org/publications/technical-resources/emergencies-protection/psychsocwellbeing2.pdf

Sample process indicators

- Steps have been taken to identify, activate and strengthen local resources that support mental health and psychosocial well-being.
- Community processes and initiatives include and support the people at greatest risk.
- When necessary, brief training is provided to build the capacity of local supports.

Example: Bosnia, 1990s

- In Bosnia, following the wars of the 1990s, many women in rural areas who had survived rape and losses needed psychosocial support, but did not want to talk with psychologists or psychiatrists because they felt shame and stigma.
- Following a practice that existed before the war, women gathered in knitting groups to knit, drink coffee and also to support each other.
- Outside agencies played a facilitating role by providing small funds for wool and by developing referral supports.

Action Sheet 5.3

Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices

Domain: Community mobilisation and support

Phase: Minimum Response

Background

In emergencies, people may experience collective cultural, spiritual and religious stresses that may require immediate attention. Providers of aid from outside a local culture commonly think in terms of individual symptoms and reactions, such as depression and traumatic stress, but many survivors, particularly in non-Western societies, experience suffering in spiritual, religious, family or community terms.

Survivors might feel significant stress due to their inability to perform culturally appropriate burial rituals, in situations where the bodies of the deceased are not available for burial or where there is a lack of financial resources or private spaces needed to conduct such rituals. Similarly, people might experience intense stress if they are unable to engage in normal religious, spiritual or cultural practices. This action sheet concerns general communal religious and cultural (including spiritual) supports for groups of people who may not necessarily seek care, while Action Sheet 6.4 covers traditional care for individuals and families seeking help.

Collective stresses of this nature can frequently be addressed by enabling the conduct of appropriate cultural, spiritual and religious practices. The conduct of death or burial rituals can ease distress and enable mourning and grief. In some settings, cleansing and healing ceremonies contribute to recovery and reintegration. For devout populations, faith or practices such as praying provide support and meaning in difficult circumstances. Understanding and, as appropriate, enabling or supporting cultural healing practices can increase psychosocial well-being for many survivors. Ignoring such healing practices, on the other hand, can prolong distress and potentially cause harm by marginalising helpful cultural ways of coping. In many contexts, working with religious leaders and resources is an essential part of emergency psychosocial support.

Engaging with local religion or culture often challenges non-local relief workers to consider world views very different from their own. Because some local practices cause harm (for example, in contexts where spirituality and religion are politicised), humanitarian workers should think critically and support local practices and resources only if they fit with international standards of human rights.

Key actions

1. Approach local religious and spiritual leaders and other cultural guides to learn their views on how people have been affected and on practices that would support the affected population.

Useful steps are to:

- Review existing assessments (see Action Sheet 2.1) to avoid the risk of repetitive questioning;

- Approach local religious and spiritual leaders, preferably by means of an interviewer of the same ethnic or religious group, to learn more about their views (see key action 3 below). Since different groups and orientations may be present in the affected population, it is important to approach all key religious groups or orientations. The act of asking helps to highlight spiritual and religious issues, and what is learned can guide the use of aid to support local resources that improve well-being.

2. Exercise ethical sensitivity.

Using a skilled translator if necessary, work in the local language, asking questions that a cultural guide (person knowledgeable about local culture) has indicated are appropriate. It may be difficult for survivors to share information about their religion or spirituality with outsiders, particularly in situations of genocide and armed conflict where their religious beliefs and/or ethnic identities have been assaulted.

Experience indicates that it is possible for humanitarian workers to talk with religious and spiritual leaders if they demonstrate respect and communicate that their purpose is to learn how best to support the affected people and avoid damaging practices. In many emergencies, religious and spiritual leaders have been key partners in educating humanitarian workers about how to support affected people. Ethical sensitivity is needed also because some spiritual, cultural and religious practices (e.g. the practice of widow immolation) cause harm. It is important to maintain a critical perspective, supporting cultural, religious and spiritual practices only if they fit with human rights standards. Media coverage of local practices can be problematic, and should be permitted only with the full consent of involved community members.

3. Learn about cultural, religious and spiritual supports and coping mechanisms.

Once rapport has been established, ask questions such as:

- What do you believe are the spiritual causes and effects of the emergency?

- How have people been affected culturally or spiritually?

- What should properly happen when people have died?

- Are there rituals or cultural practices that could be conducted, and what would be the appropriate timing for them?

- Who can best provide guidance on how to conduct these rituals and handle the burial of bodies?

- Who in the community would greatly benefit from specific cleansing or healing rituals and why?

- Are you willing to advise international workers present in this area on how to support people spiritually and how to avoid spiritual harm?

If feasible, make repeated visits to build trust and learn more about religious and cultural practices. Also, if possible, confirm the information collected by discussing it with local anthropologists or other cultural guides who have extensive knowledge of local culture and practices.

4. Disseminate the information collected among humanitarian actors at sector and coordination meetings.
Share the information collected with colleagues in different sectors, including at inter-sectoral MHPSS coordination meetings and at other venues, to raise awareness about cultural and religious issues and practices. Point out the potential harm done by e.g. unceremonious mass burials or delivery of food or other materials deemed to be offensive for religious reasons.

5. Facilitate conditions for appropriate healing practices.
The role of humanitarian workers is to facilitate the use of practices that are important to affected people and that are compatible with international human rights standards. Key steps are to:

- Work with selected leaders to identify how to enable appropriate practices;

- Identify obstacles (e.g. lack of resources) to the conduct of these practices;

- Remove the obstacles (e.g. provide space for rituals and resources such as food for funeral guests and materials for burials);

- Accept existing mixed practices (e.g. local and Westernised) where appropriate.

Key resources

1. PAHO/WHO (2004). 'Sociocultural aspects'. In: *Management of Dead Bodies in Disaster Situations*, pp.85-106. Washington: PAHO.
http://www.paho.org/English/DD/PED/DeadBodiesBook.pdf

2. Psychosocial Working Group (2003). *Psychosocial Intervention in Complex Emergencies: A Conceptual Framework*.
http://www.forcedmigration.org/psychosocial/papers/Conceptual%20Framework.pdf

3. Sphere Project (2004). *Humanitarian Charter and Minimum Standards in Disaster Response*. Mental and social aspects of health, pp.291-293. Geneva: Sphere Project.
http://www.sphereproject.org/handbook/index.htm

Sample process indicators

- Local cultural, religious and spiritual supports have been identified, and the information is shared with humanitarian workers.

- Obstacles to the conduct of appropriate practices have been identified and removed or reduced.

- Steps have been taken to enable the use of practices that are valued by the affected people and consistent with international human rights standards.

Example: Angola, 1996

- A former boy soldier said he felt stressed and fearful because the spirit of a man he had killed visited him at night. The problem was communal since his family and community viewed him as contaminated and feared retaliation by the spirit if he was not cleansed.

- Humanitarian workers consulted local healers, who said that they could expel the angry spirit by conducting a cleansing ritual, which the boy said he needed.

- An international NGO provided the necessary food and animals offered as a sacrifice, and the healer conducted a ritual believed to purify the boy and protect the community. Afterwards, the boy and people in the community reported increased well-being.

Facilitate support for young children (0–8 years) and their care-givers

Domain: Community mobilisation and support
Phase: Minimum Response

Background

Early childhood (0–8 years) is the most important period in human life for physical, cognitive, emotional and social development. During this period, critical brain development occurs rapidly and depends on adequate protection, stimulation and effective care. Early losses (e.g. the death of a parent), witnessing physical or sexual violence, and other distressing events can disrupt bonding and undermine healthy long-term social and emotional development. However, most children recover from such experiences, especially if they are given appropriate care and support.

In emergencies, the well-being of young children depends to a large extent on their family and community situations. Their well-being may suffer if they have overwhelmed, exhausted or depressed mothers or care-givers who are physically or emotionally unable to provide effective care, routine and support. Children who have been separated from their parents may be placed in temporary care that is unsatisfactory. In the community, both parents and children may be at risk due to disrupted medical services, inadequate nutrition and a range of protection threats.

In emergencies, early childhood programmes should be coordinated (see Action Sheet 1.1) and informed by appropriate assessments (see Action Sheet 2.1), including data estimating the number and ages of children under eight years old, the number of pregnant women and the number of women with newborns. Early childhood programmes should support the care of young children by their families and other care-givers. Early childhood activities should provide stimulation, facilitate basic nutrition (in situations of extreme food shortage), enable protection and promote bonding between infants and care-givers. Such activities aim to meet children's core needs and help to reduce emergency-induced distress in safe, protected and structured settings, while providing relief and support to care-givers.

Key actions

1. Keep children with their mothers, fathers, family or other familiar care-givers.

(a) Prevent separation. In emergencies where population movement is likely, support communities and families in developing culturally acceptable and appropriate methods to avoid separation.

- Prioritise keeping breastfeeding mothers and children together.
- Teach older children songs that include their family name, village and contact information.
- Tag children to minimise separation.

(b) Reunify children and parents (see Action Sheet 3.2). If children are separated:

- Contact the proper reunification organisation.
- Facilitate tracing and reunification. Record the date and place whenever separated children are found, and collect information from children themselves, using age-appropriate methods such as having them draw where they lived or tell about themselves.
- Keep clothing with the child, as one of the key means of identifying and reunifying separated children with their parents.

(c) Facilitate alternative care arrangements. In crises and emergencies where other options of care are not available, it may be necessary to organise temporary centres to protect separated children until a long-term solution is identified. While waiting to be reunited with their families, separated children may be fostered with an individual or a family who can provide appropriate care and protection. Orphanages should be viewed as a last resort, as they usually do not provide appropriate support.

- Decide on care arrangements according to *what is in the best interest of the child within the local cultural context*.
- Keep the child within the extended family and/or community whenever possible and avoid separating siblings from one another.
- Wherever possible, arrange for one continuous foster family, avoiding multiple foster families.
- For newborns who have lost their mother or who have been separated from their parents, meet basic needs for food, warmth and care, remembering that in some cultures female children may be at greater risk of neglect.

If children have already been placed in orphanages or other institutions, there should be a rapid assessment to identify their condition and guide possible steps to promote early childhood development (ECD) activities.

2. Promote the continuation of breastfeeding.
Breastfeeding is optimal for the physical, psychosocial and cognitive well-being of

infants and toddlers. Breastfeeding supports the child's cognitive development, comforts the child, is likely to strengthen the mother-child bond and is easy to prepare, free and usually very safe (regarding caveats on safety, see UNICEF (2002) under Key resources for guidance on breastfeeding and HIV/AIDS).

- Encourage breastfeeding through individual support and community dialogues.
- Counsel mothers of newborns (and relatives) in newborn care, with regard to exclusive breastfeeding, wrapping and warming their baby, deferred bathing and hygiene.
- Avoid routine distribution of milk formulas as they discourage breastfeeding.
- Make supplemental feeding for pregnant and lactating women a high priority.
- Avoid excessive pressure on mothers to breastfeed. Mothers who refuse to breastfeed, who find it very difficult or who cannot breastfeed should receive proper support.

3. Facilitate play, nurturing care and social support.
A variety of ECD activities should be provided during emergencies. These activities could include parent education, home visits, shared child care and communal play groups, 'safe spaces', toy libraries and informal parent gatherings in safe spaces (see Action Sheet 5.1).

- Organise locally appropriate opportunities for active play, stimulation and socialisation. These may help to mitigate the negative psychosocial impact of crisis situations.
- Tailor the activities to the children's age, gender and culture. To minimise distress, children require a sense of routine and participation in normalising activities, which should reflect their usual daily activities (e.g. a child from a nomadic background who has never been in school may find formal education neither normalising nor comforting). In programme planning and implementation, use culturally relevant developmental milestones such as rites of passage rituals, which may be more appropriate than Western developmental models.
- Include in safe spaces (see Action Sheets 5.1 and 7.1) activities that specifically support very young children. If conditions permit, organise activity groups roughly according to children's age/stage of development: 0–12/18 months (pre-verbal, not ambulatory), 12/18 months to three years, and 3–6 years. (Activities for 6–8-year-

olds are addressed in Action Sheet 7.1). Train parents, siblings, grandparents and youth to work with available staff, and also to take learning home to their families on how they can assist in the healthy development of young children. Consider engaging trusted older women and female youth as volunteers in safe spaces.

- Consider using known games, songs and dances and also home-made toys, since these are most practical in an emergency.
- Include an area for care-giver/child play and interaction in all services for younger children, such as therapeutic feeding programmes, hospitals and clinics, as well as in areas for distribution of food and non-food items.
- Facilitate activities for young children that promote social community-building and non-violence in violence-affected communities.
- Include children with special needs in care activities, games and social support at the community level.
- For specific guidance on stimulating young children in food crises, see the WHO (2006) reference under Key resources.

4. Care for care-givers.
In emergencies, it is important to organise meetings at which care-givers of young children can discuss the past, present and future, share problem-solving and support one another in caring effectively for their children.

- In safe spaces (see Action Sheets 5.1 and 7.1), organise support groups in which parents/mothers can talk about their own suffering.
- Advise parents not to talk about the details of horrific events in front of or with their children.
- During small group activities for families and their young children, parents have the opportunity to learn from the interactions of others with their children. When positive parent-child interaction occurs, point this out and encourage other parents to interact with their own children in a similar manner.
- Help parents and care-givers to understand the changes they see in their children following a crisis. Explain that behaviour such as heightened fear of others and withdrawal, or increased fighting with other children, are common reactions to stress and reflect no failure on the care-giver's part.

- Share information with parents and care-givers on how to identify problems and support the psychosocial health of their children, including how to control, regulate and modify aggressive behaviour by children through consistent discipline and limit-setting.

- Identify harmful responses to a child's stress, such as beating, abandonment or stigmatisation, and suggest alternative strategies to parents and community leaders.

- Parents who have difficulties in caring for their children because of severe mental health problems should be referred to receive appropriate support from health services staff (if trained in mental health care; see Action Sheet 6.2). In particular, severe depression may interfere with the ability to care for children.

Key resources

1. Bernard van Leer Foundation (2005). *Early Childhood Matters. Volume 104: Responding to young children in post-emergency situations*. http://www.bernardvanleer.org/publication_store/publication_store_publications/Early_Childhood_Matters_104/file

2. Consultative Group on Early Childhood Care and Development (1996). *Children as Zones of Peace: Working with Children Affected by Armed Violence*. http://www.ecdgroup.com/docs/Children_as_Zones_of_Peace;_Working_with_Children_Affected_by_Armed_Violence-13_05_2001-13_53_24.pdf

3. Emergency Nutrition Network Online (2006). *Infant Feeding in Emergencies*. http://www.ennonline.net/ife/index.html

4. Human Sciences Research Council of South Africa (HSRC). Psychosocial Support Resources: Davids D. (Hesperian Foundation), *Emotional Behaviour Book*. http://www.hsrc.ac.za/research/programmes/CYFD/unicef/other_resources.html

5. ICRC, IRC, Save the Children UK, UNICEF, UNHCR and World Vision (2004). *Inter-Agency Guiding Principles on Unaccompanied and Separated Children*. Save the Children UK. http://www.unhcr.org/cgi-bin/texis/vtx/protect/opendoc.pdf?tbl=PROTECTION&id=4098b3172

6. INFO Reports/Johns Hopkins Bloomberg School of Public Health (2006). *Breastfeeding Questions Answered: A Guide for Providers*. http://www.infoforhealth.org/inforeports/breastfeeding/inforpt5.pdf

7. Save the Children UK (2006). *ECD Guidelines for Emergencies – the Balkans*. http://www.savethechildren.org.uk/scuk/jsp/resources/details.jsp?id=4174&group=resources&section=policy&subsection=details&pagelang=en

8. UNESCO and IIEP (2006). *Guidebook for Planning Education in Emergencies and Reconstruction*. http://www.unesco.org/iiep/eng/focus/emergency/guidebook.htm

9. UNICEF and Macksoud M. (2000). *Helping Children Cope with the Stresses of War: A Manual for Parents and Teachers*. http://www.unicef.org/publications/files/Helping_Children_Cope_with_the_Stresses_of_War.pdf

10. UNICEF (2002). *HIV and Infant Feeding*. http://www.unicef.org/publications/files/pub_hiv_infantfeeding_en.pdf

11. WHO (2006). *Mental health and psychosocial well-being among children in severe food shortage situations*. Geneva: WHO. http://www.who.int/nmh/publications/msd_MHChildFSS9.pdf

12. Women's Commission for Refugee Women and Children (2005). *Field-friendly Guide to Integrate Emergency Obstetric Care in Humanitarian Programs*. http://www.womenscommission.org/pdf/EmOC_ffg.pdf

Sample process indicators

- The *Inter-Agency Guiding Principles on Unaccompanied and Separated Children* are implemented.

- Early childhood development (ECD) activities are organised for young girls and boys (0–8 years) and their care-givers.

- Breastfeeding is promoted.

- Care-givers meet in safe spaces to discuss challenges and to support each other.

Example: Angola, 1999–2000

- Young children in IDP camps had few activities available, and parents spent little time interacting with young children.

- Having identified adults whom local people sought out for advice and help with young children, an international NGO provided training on how to organise age- and gender-appropriate activities that provided stimulation and promoted positive social interaction.

- Although there were no schools or other centres, local participants conducted activities under the shade of trees, engaged mothers in the activities and made referrals for children needing special assistance. These activities benefited several thousand mothers and children.

Action Sheet 6.1

Include specific psychological and social considerations in provision of general health care

Domain: Health services
Phase: Minimum Response

Background

There is a gap in most emergencies between mental health and psychosocial supports (MHPSS) and general health care. However, the way in which health care is provided often affects the psychosocial well-being of people living through an emergency. Compassionate, emotionally supportive care protects the well-being of survivors, whereas disrespectful treatment or poor communication threatens dignity, deters people from seeking health care and undermines adherence to treatment regimes, including for life-threatening diseases such as HIV/AIDS. Physical and mental health problems frequently co-occur, especially among survivors of emergencies. However, strong inter-relationships between social, mental and physical aspects of health are commonly ignored in the rush to organise and provide health care.

Often general health care settings – such as primary health care (PHC) settings – offer the first point of contact for helping people with mental health and psychosocial problems. General health care providers frequently encounter survivors' emotional issues in treating diseases and injuries, especially in treating the health consequences of human rights violations such as torture and rape. Some forms of psychological support (i.e. very basic psychological first aid) for people in acute psychological distress do not require advanced knowledge and can easily be taught to workers who have no previous training in mental health.

This action sheet covers psychological and social considerations in the overall provision of general health care in emergencies. Action Sheet 6.2 describes the management of severe mental disorder in emergencies. The actions below apply to both pre-existing and emergency-related health services.

Key actions

1. Include specific social considerations in providing general health care.
Develop equitable, appropriate and accessible health care consistent with the Sphere minimum standards on health to preserve life with dignity. The following social considerations apply:

- Maximise participation of the affected male and female population in the design, implementation, monitoring and evaluation of any emergency health services (for guidance, see ALNAP reference under Key resources and Action Sheets 2.1, 2.2 and 5.1).

- Maximise access to health care by locating any new services within safe walking distance of communities. Aim to balance gender and include representatives of key minority and language groups among health staff to maximise survivors' access to health services. Use translators if necessary.

- Protect and promote patients' rights to:
  - Informed consent (for both sexes) before medical and surgical procedures (clear explanations of procedures are especially necessary when emergency health care is provided by international staff, who may approach medicine differently);
  - Privacy (as much as possible – e.g. put a curtain around the consultation area);
  - Confidentiality of information related to health status of patients. Caution is especially needed for data related to human rights violations (e.g. torture, rape).

- Use essential drugs consistent with the *WHO Model List of Essential Medicines* to facilitate affordable and thus sustainable care. Use locally available, generic medicines as far as possible.

- Record and analyse sex- and age-disaggregated data in health information systems.

- Communicate important emergency-related health information to the affected population (see Action Sheet 8.1).

2. Provide birth and death certificates (if needed).

Death certification is important for claims (including inheritance claims) by surviving family members. Birth certification is often essential for identification and citizenship claims and thus for access to government services (e.g. education) and for protection against illegal adoption, forced recruitment and trafficking. If regular authorities are not able to provide these documents, health care workers should provide them.

3. Facilitate referral to key resources outside the health system, including to:

- Locally available social services and supports and protection mechanisms in the community (see Action Sheets 3.2, 3.3 and 5.2);

- Legal support and/or testimony services for survivors of human rights violations, as feasible and appropriate;

- Tracing agencies for those who are unable to locate missing relatives.

4. Orient general health staff and mental health staff in psychological components of emergency health care.

See also Action Sheet 4.3 for guidance on organising orientations. Provide half-day or, preferably, one-day orientation seminars to national and international health staff. Consider the following contents:

- Psycho-education and general information, including:

  - The importance of treating disaster survivors with respect to protect their dignity;

  - Basic information on what is known about the mental health and psychosocial impact of emergencies (see Chapter 1), including understanding of local psychosocial responses to an emergency;

  - Key conclusions drawn from local mental health and psychosocial support assessments (see Action Sheet 2.1);

  - Avoiding inappropriate pathologising/medicalisation (i.e. distinguishing non-pathological distress from mental disorders requiring clinical treatment and/or referral);

  - Knowledge of any available mental health care in the region to enable appropriate referral for people with severe mental disorders (see Action Sheet 6.2);

  - Knowledge of locally available social supports and protection mechanisms in the community to enable appropriate referrals (see Action Sheets 5.2 and 3.2);

- Communicating to patients, giving clear and accurate information on their health status and on relevant services such as family tracing. A refresher on communicating in a supportive manner could include:

  - Active listening;

  - Basic knowledge on how to deliver bad news in a supportive manner;

  - Basic knowledge on how to deal with angry, very anxious, suicidal, psychotic or withdrawn patients;

  - Basic knowledge on how to respond to the sharing of extremely private and emotional events, such as sexual violence;

- How to support problem management and empowerment by helping people to clarify their problems, brainstorming together on ways of coping, identifying

choices and evaluating the value and consequences of choices;

- Basic stress management techniques, including local (traditional) relaxation techniques;

- Non-pharmacological management and referral of medically unexplained somatic complaints, after exclusion of physical causes (see Forum for Research and Development reference under Key resources).

5. Make available psychological support for survivors of extreme stressors (also known as traumatic stressors).

- Most individuals experiencing acute mental distress following exposure to extremely stressful events are best supported without medication. All aid workers, and especially health workers, should be able to provide very basic psychological first aid (PFA). PFA is often mistakenly seen as a clinical or emergency psychiatric intervention. Rather, it is a description of a humane, supportive response to a fellow human being who is suffering and who may need support. PFA is very different from psychological debriefing in that it does not necessarily involve a discussion of the event that caused the distress. PFA encompasses:

  - Protecting from further harm (in rare situations, very distressed persons may take decisions that put them at further risk of harm). Where appropriate, inform distressed survivors of their right to refuse to discuss the events with (other) aid workers or with journalists;

  - Providing the opportunity for survivors to talk about the events, but without pressure. Respect the wish not to talk and avoid pushing for more information than the person may be ready to give;

  - Listening patiently in an accepting and non-judgemental manner;

  - Conveying genuine compassion;

  - Identifying basic practical needs and ensuring that these are met;

  - Asking for people's concerns and trying to address these;

  - Discouraging negative ways of coping (specifically discouraging coping through use of alcohol and other substances, explaining that people in severe distress are at much higher risk of developing substance use problems);

  - Encouraging participation in normal daily routines (if possible) and use of positive means of coping (e.g. culturally appropriate relaxation methods,

accessing helpful cultural and spiritual supports);

- • Encouraging, but not forcing, company from one or more family member or friends;

- • As appropriate, offering the possibility to return for further support;

- • As appropriate, referring to locally available support mechanisms (see Action Sheet 5.2) or to trained clinicians.

- In a minority of cases, when severe acute distress limits basic functioning, clinical treatment will probably be needed (for guidance, see *Where There is No Psychiatrist* under Key resources). If possible, refer the patient to a clinician trained and supervised in helping people with mental disorders (see Action Sheet 6.2). Clinical treatment should be provided in combination with (other) formal or non-formal supports (see Action Sheet 5.2).

- With regards to clinical treatment of acute distress, benzodiazepines are greatly over-prescribed in most emergencies. However, this medication may be appropriately prescribed for a very short time for certain specific clinical problems (e.g. severe insomnia). Nevertheless, caution is required as use of benzodiazepines may sometimes quickly lead to dependence, especially among very distressed persons. Also, various experts have argued that benzodiazepines may slow down the recovery process after exposure to extreme stressors.

- In most cases, acute distress will decrease naturally, without outside intervention, over time. However, in a minority of cases, a chronic mood or anxiety disorder (including severe post-traumatic stress disorder) will develop. If the disorder is severe, then it should be treated by a trained clinician as part of the minimum emergency response (see Action Sheet 6.2). If the disorder is not severe (e.g. the person is able to function and tolerate the suffering), then the person should receive appropriate care as part of a more comprehensive aid response. Where appropriate, support for these cases may be given by trained and clinically supervised community health workers (e.g. social workers, counsellors) attached to health services.

6. Collect data on mental health in PHC settings.

All PHC staff should document mental health problems in their morbidity data using simple, self-explanatory categories (see Action Sheet 6.2, key action 1 for more detailed guidance).

Key resources

1. Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) (2003). Participation and health programmes. In: *Participation by Crisis-Affected Populations in Humanitarian Action: A Handbook for Practitioners*, pp.315-330.
http://www.globalstudyparticipation.org/index.htm

2. Forum for Research and Development (2006). *Management of Patients with Medically Unexplained Symptoms: Guidelines Poster*. Colombo: Forum for Research and Development.
http://www.irdsrilanka.org/joomla/

3. Médecins Sans Frontières (2005). *Mental Health Guidelines*. Amsterdam: MSF.
http://www.msf.org/source/mentalhealth/guidelines/MSF_mentalhealthguidelines.pdf

4. National Child Traumatic Stress Network and National Center for PTSD (2006). *Psychological First Aid: Field Operations Guide* (Second edition). http://www.ncptsd.va.gov/ncmain/ncdocs/manuals/PFA_2ndEditionwithappendices.pdf (A potential limitation of this resource is that it was specifically developed for Western disaster settings. The guide describes an advanced form of psychological first aid because it was developed for use by previously trained mental health professionals.)

5. Patel V. (2003). *Where There is No Psychiatrist. A Mental Health Care Manual*. The Royal College of Psychiatrists. http://www.rcpsych.ac.uk/publications/gaskellbooks/gaskell/1901242757.aspx

6. Sphere Project (2004). *Humanitarian Charter and Minimum Standards in Disaster Response*. Minimum Standards in Health Services, pp.249-312. Geneva: Sphere Project.
http://www.sphereproject.org/handbook/index.htm

7. WHO/UNHCR/UNFPA (2004). *Clinical Management of Survivors of Rape: Developing protocols for use with refugees and internally displaced persons (revised edition)*. Geneva: WHO/UNHCR.
http://www.who.int/reproductive-health/publications/clinical_mngt_survivors_of_rape/

Sample process indicators

- General health staff know how to protect and promote their patients' rights to dignity through informed consent, confidentiality and privacy.

- General health staff are able to give psychological first aid (PFA) to their patients as part of their care.

- General health staff make appropriate referrals to (a) community social supports outside the health system, (b) trained and clinically supervised community workers (support workers, counsellors) attached to health services (if available) and (c) clinicians trained and supervised in the clinical care of mental health problems.

Example: Macedonia, 1999

- Large numbers of Kosovar refugees were accommodated in makeshift camps. Community health workers (CHWs) received a brief training on identifying (medically and socially) vulnerable cases and where to refer them. Training included basic knowledge on stress management.

- CHWs worked under the supervision of specialist staff in emergency PHC facilities. They were recruited from the local and refugee populations and were responsible for monitoring, identifying vulnerable people in the camps, referring such people to medical and social organisations, providing follow-up on medical/mental health cases (outreach) and providing information to new arrivals.

- Mental health services (psychiatric and acute crisis psychological support) were attached to the PHC service and addressed referrals from PHC staff. When the emergency stabilised, the CHWs received intense training and supervision and became camp counsellors.

Action Sheet 6.2
Provide access to care for people with severe mental disorders

Domain: Health services
Phase: Minimum Response

Background

Mental disorders account for four of the ten leading causes of disability worldwide, but mental health is among the most under-resourced areas of health care. Few countries meet their clinical mental health needs in normal times, let alone in emergencies. Those clinical mental health services that do exist in low- and middle-income countries tend to be hospital-based in large cities, and are often inaccessible to the wider population.

It has been projected that in emergencies, on average, the percentage of people with a severe mental disorder (e.g. psychosis and severely disabling presentations of mood and anxiety disorders) increases by 1 per cent over and above an estimated baseline of 2–3 per cent. In addition, the percentage of people with mild or moderate mental disorders, including most presentations of mood and anxiety disorders (such as post-traumatic stress disorder, or PTSD), may increase by 5–10 per cent above an estimated baseline of 10 per cent (see WHO, 2005a under Key resources). In most situations natural recovery over time (i.e. healing without outside intervention) will occur for many – but not all – survivors with mild and moderate disorders.

This action sheet describes the **minimum** humanitarian response necessary to care for **severe** mental disorders. Although the language used refers mostly to care of severe mental disorders, it should be noted that many of the recommended actions also apply to the care of selected neurological disorders in countries where care for such disorders is the responsibility of mental health workers.

The severe disorders covered in this sheet may be **pre-existing or emergency-induced** and include the following conditions:

- Psychoses of all kinds;

- Severely disabling presentations of mood and anxiety disorders (including severely disabling presentations of PTSD);

- Severe mental disorders due to the use of alcohol or other psychoactive substances (see Action Sheet 6.5 for guidance on problems related to substance use);

- Severe behavioural and emotional disorders among children and youth;

- Severe pre-existing developmental disabilities;

- Neuropsychiatric disorders including epilepsy, delirium and dementia and mental disorders resulting from brain injury or other underlying medical conditions (e.g. toxic substances, infection, metabolic disease, tumour, degenerative disease);

- Any other severe mental health problem, including (a) locally defined severe disorders that do not readily fit established international classification systems (see Action Sheet 6.4) and (b) risk behaviours commonly associated with mental disorder (e.g. suicidal feelings, self-harm behaviour).

People with mental disorders may initially present at primary health care (PHC) facilities to seek help for medically unexplained somatic complaints. However, people with severe mental disorders may fail to present at all because of isolation, stigma, fear, self-neglect, disability or poor access. These people are doubly vulnerable, both because of their severe disorder and because the emergency may deprive them of social supports that had previously sustained them. Families are often stressed and stigmatised by the burden of care in normal times. This puts such individuals at an elevated risk of abandonment in emergencies that involve displacement. Once they are identified, however, steps can be taken to provide immediate protection and relief, and to support existing carers. Priority should be given to those at major survival risk or who are living in settings where their dignity and human rights are being undermined, or where social supports are weak and where family members are struggling to cope.

Treatment and support of people with severe mental disorders typically requires a combination of biological, social and psychological interventions. Both under-treating and over-medicalisation can be avoided through staff training and supervision. Typically, people suffering from disaster-induced, sub-clinical distress should not receive medication but will respond well to psychological first aid (see Action Sheet 6.1) and to individual and community social support (see Action Sheet 5.2). Moreover, some mental disorders can be effectively treated by practical psychological interventions alone, and medication should not be used unless such interventions have failed.

While the actions outlined below are the minimum response necessary to address the needs of people with severe mental disorders in emergencies, they can also provide the first steps in a more comprehensive response. They are addressed to local health authorities, local health care workers and local and international medical organisations. If at the outset there is no local health infrastructure or local capacity,

outside organisations should provide emergency mental health services. However, services need to be established in such a way that they do not displace existing social and informal means of healing and coping, and in such a way that they can be integrated with government-run health services at a later date.

Key actions

1. Assess. Determine what assessments have been done and what information is available. Design, as needed, further assessments. For guidance on the assessment process and what needs to be assessed, see Action Sheet 2.1. With relevance to the current action sheet, it is important in particular to:

- Determine pre-existing structures, locations, staffing and resources for mental health care in the health sector (including policies, availability of medications, role of primary health care and mental hospitals, etc.) and relevant social services (see WHO *Mental Health Atlas* for data on formal mental health care resources in all countries of the world);

- Determine the impact of the emergency on pre-existing services;

- Determine if local authorities and communities plan to address the needs of people with severe mental disorders who are affected by the emergency, and determine what may be done and what supports may be needed;

- Identify people with severe mental disorders requiring assistance by:

  - Asking all relevant government and non-government agencies (particularly those covering health, shelter, camp management and protection) and community leaders to alert health care providers when they encounter or are informed about people who seem very confused or disorientated, are incoherent, have strange ideas, behave oddly or appear unable to care for themselves, and to register such people;

  - Visiting and, where appropriate, collaborating with existing traditional healers. They are often well informed as to the location of sufferers and may provide cultural information to non-local practitioners (see Action Sheet 6.4);

  - Visiting any formal or informal institutions to assess needs and to ensure the basic rights of those in care (see Action Sheet 6.3);

  - Teaching national and international PHC staff to document mental health problems in PHC data, using simple categories that require little instruction for

recognition. For example, the average primary health worker will require little additional training in use of the following four categories:

- · Medically unexplained somatic complaints

- · Severe emotional distress (e.g. signs of severe grief or severe stress)

- · Severe abnormal behaviour (described on the PHC form in locally understood terms for 'madness')

- · Alcohol and substance abuse.

• Share results of assessments with the mental health and psychosocial coordination group (see Action Sheets 1.1 and 2.1) and with the overall health sector coordination group.

2. Ensure adequate supplies of essential psychiatric drugs in all emergency drug kits.

• The minimum provision is one generic anti-psychotic, one anti-Parkinsonian drug (to deal with potential extra-pyramidal side effects), one anti-convulsant/anti-epileptic, one anti-depressant and one anxiolytic (for use with severe substance abuse and convulsions), all in tablet form, from the WHO Model List of Essential Medicines.

• The Interagency Emergency Health Kit (WHO, 2006) does not include (a) an anti-psychotic in tablet form, (b) an anxiolytic in tablet form, (c) an anti-Parkinsonian nor (d) an anti-depressant. Arrangements for either purchasing these four drugs locally or importing them will be necessary if this kit is used.

• Overall, generic medicines from the WHO Model List are recommended, because they tend to be as effective as branded, newly-developed drugs but are much cheaper, and thus enhance sustainable programming.

3. Enable at least one member of the emergency PHC team to provide frontline mental health care. Possible mechanisms for making this happen include:

• National or international mental health professionals attaching themselves to government and/or NGO PHC teams. International workers need to be oriented to local culture and conditions (see Action Sheets 4.3 and 6.1), and should work with competent translators;

• Training and supervising local PHC staff to integrate mental health care, including

the rational use of psychotropics, into normal practice and to give it dedicated time (see key action 4 below and Action Sheet 4.3);

• Training and supervising one member of the local PHC team (a doctor or a nurse) to provide full-time mental health care alongside the other PHC services (see key action 4 below and Action Sheet 4.3).

4. Train and supervise available PHC staff in the frontline care of severe mental disorder (see also Action Sheet 4.3).

• Training should involve both theory and practice and can be begun at the outset of the emergency by a national or international mental health supervisor working in collaboration with local health authorities. This training should continue beyond the emergency as part of a more comprehensive response. Training should include all skills mentioned in key action 4 of Action sheet 6.1 plus:

- · Treating all service users and their care-givers with dignity and respect;

- · The mental status examination;

- · Recognition and frontline management of all the severe disorders listed in the background section above;

- · The provision of guidelines and protocols for the above (see Key resources);

- · Time management skills, focusing on how to integrate mental health work into normal clinical work;

- · Simple practical psychological interventions, as covered in *Where There is No Psychiatrist* (see Key resources);

- · Keeping proper clinical records. Give copies to care-givers if possible, as the population may be mobile;

- · Maintaining confidentiality. When confidentiality must be broken for protection reasons, address guardianship and medico-legal issues and inform service users and care-givers;

- · Setting up appropriate lines of referral to supports in the community (see Action Sheets 5.2 and 6.4) and to secondary and tertiary services if they exist and are accessible.

• For personnel authorised to use medication in the affected country, good prescribing practices include:

- Rational use of essential psychiatric drugs in emergency kits, according to the guidelines in *Essential Drugs in Psychiatry* and consistent with *Where There is No Psychiatrist* (see Key resources);

- How to facilitate continuing access and adherence to prescribed medication for people with chronic disorders (e.g. chronic psychosis, epilepsy);

- How to avoid prescribing psychotropics to people with disaster-induced, non-pathological distress (see Action sheet 6.1) by developing non-pharmacological strategies for stress management;

- How to avoid prescribing placebo medications for medically unexplained somatic complaints;

- Understanding both the risks and benefits of benzodiazepines, particularly the risk of dependence from long-term prescribing;

- How to minimise the unnecessary prescription of multiple medications.

• The management of and support for persons with severe mental disorders who have been chained or physically restrained by care-givers involves the following steps:

- First, facilitate very basic means of psychiatric and social care e.g. the provision of appropriate medication, family education and support.

- Promote humane living conditions.

- Second, consider untying the person. However, in those rare instances where the person has a history of violent behaviour, ensure basic security for others before doing so.

5. Avoid overburdening PHC workers with multiple, different training sessions.

• Trainees should have time to integrate mental health training into their daily practice so that they can deliver mental health care.

• Trainees should not be trained in numerous different skill areas (e.g. mental health, TB, malaria, HIV counselling) without planning how these skills will be integrated and used.

• Theoretical training in short courses is insufficient and may result in harmful interventions. It must always be followed up with extensive on-the-job supervision (see Action Sheet 4.3 and example on page 131).

6. Establish mental health care at additional, logical points of access.
Use general public health criteria (e.g. population coverage, expected caseload of service users with severe disorders, potential sustainability of services) to determine where to establish mental health care. Mobile PHC or community mental health teams may be an effective way of establishing emergency care at different places within an area. Examples of logical points of access are:

• Emergency rooms;

• Outpatient clinics at secondary and tertiary facilities;

• Mental health drop-in centres;

• General hospital wards with a high number of emergency-related hospitalisations;

• Home visits (including visits to tents, collection centres, barracks or any temporary housing location);

• Schools and child-friendly spaces.

7. Try to avoid the creation of parallel mental health services focused on specific diagnoses (e.g. PTSD) or on narrow groups (e.g. widows). This may result in fragmented, unsustainable services and the continuing neglect of people who do not fit the specific diagnostic category or group. It may also contribute to the labelling and stigmatisation of those who do. This does not preclude targeted outreach to broad populations (such as outreach clinics for children at schools) as part of an integrated service.

8. Inform the population about the availability of mental health care.

• Advertise using relevant information sources, such as radio (see Action Sheet 8.1).

• Ensure that all messages are delivered in a sensitive manner that does not result in people viewing normal behaviours and responses to stress as indicative of severe mental disorder.

• Inform the community leadership and, if appropriate, local police of the availability of mental health care.

9. Work with local community structures, to discover, visit and assist people with severe mental disorders (see Action Sheets 5.2 and 6.4).

10. Be involved in all inter-agency coordination on mental health (see Action Sheet 1.1). Engage in strategic longer-term planning processes for mental health services. Emergencies are frequently catalysts for mental health reforms, and improvements can occur rapidly.

Key resources

1. Forum for Research and Development. (2006). *Management of Patients with Medically Unexplained Symptoms: Guidelines Poster*. Colombo: Forum for Research and Development. http://www.irdsrilanka.org/joomla/

2. Médecins Sans Frontières (2005). 'Individual treatment and support'. In *Mental Health Guidelines*, pp. 40-51. Amsterdam: MSF. http://www.msf.org/source/mentalhealth/guidelines/MSF_mentalhealthguidelines.pdf

3. Patel V. (2003). *Where There is No Psychiatrist. A Mental Health Care Manual*. The Royal College of Psychiatrists. http://www.rcpsych.ac.uk/publications/gaskellbooks/gaskell/1901242757.aspx

4. WHO (1993). *Essential Drugs in Psychiatry*. http://whqlibdoc.who.int/hq/1993/WHO_MNH_MND_93.27.pdf

5. WHO/UNHCR (1996). 'Common mental disorders'. In *Mental Health of Refugees*, pp.39-61. Geneva: WHO/UNHCR. http://whqlibdoc.who.int/hq/1996/a49374.pdf

6. WHO (1998). *Mental Disorders in Primary Care: A WHO Educational Package*. Geneva: WHO. http://whqlibdoc.who.int/hq/1998/WHO_MSA_MNHIEAC_98.1.pdf

7. WHO (2001). *The Effectiveness of Mental Health Services in Primary Care: View from the Developing World*. Geneva: WHO. http://www.who.int/mental_health/media/en/50.pdf

8. WHO (2003), *Mental Health in Emergencies: Mental and Social Aspects of Health of Populations Exposed to Extreme Stressors*. Geneva: WHO. http://www.who.int/mental_health/media/en/640.pdf

9. WHO (2005a). *Mental Health Assistance to the Populations Affected by the Tsunami in Asia*. http://www.who.int/mental_health/resources/tsunami/en/index.html

10. WHO (2005b). *Mental Health Atlas*. Geneva: WHO. http://www.who.int/mental_health/evidence/atlas/

11. WHO (2005c). *Model List of Essential Medicines*. Geneva: WHO. www.who.int/medicines/publications/essentialmedicines/en/

12. WHO (2006). *The Interagency Emergency Health Kit: Medicines and Medical Devices for 10,000 People for Approximately 3 Months*. Geneva: WHO. http://www.who.int/medicines/publications/mrhealthkit.pdf

Sample process indicators

- Number of PHC workers trained and supervised, number of training hours, number of on-the-job supervision sessions.

- Essential psychotropic medications in each therapeutic category (anti-psychotic, anti-Parkinsonian, anti-depressant, anxiolytic, anti-epileptic) are purchased and sustainable supply lines are established.

- Number and types of mental health problems seen in PHC clinics and other mental health services.

- Number of referrals made to specialised mental health care.

Example: Aceh, Indonesia, 2005

- An international NGO initiated emergency mental health care in PHC after discussion with relevant authorities, coordination bodies and national and international organisations.

- National PHC staff working from fixed and mobile clinics received mental health training and supervision. A trained and supervised national nurse was added to each PHC team to run a mental health service. Six months' training was needed to enable staff to work unsupervised. Training and supervision continued for a year after the acute phase of the emergency.

- The NGO engaged in the province's strategic mental health planning. Subsequently, the province's mental health strategy included the model of training mental health nurses to be attached to PHC facilities.

Protect and care for people with severe mental disorders and other mental and neurological disabilities living in institutions

Domain: Health services

Phase: Minimum Response

Background

People living in institutions are among the most vulnerable people in society, and they are especially at risk in emergencies. The chaos of the emergency environment adds to their general vulnerability. People in institutions may be abandoned by staff and left unprotected from the effects of natural disaster or conflict.

Severe mental disorder is often met with stigma and prejudice, resulting in neglect, abandonment and human rights violations. Living in an institution isolates people from potential family protection and support, which may be essential for survival in emergencies. Some people with severe mental disorders living in institutions are (too) dependent on institutionalised care to easily go elsewhere during an emergency. Total dependency on institutional care may create further anxiety, agitation or complete withdrawal. Difficulties in reacting adequately to the fast-changing emergency environment may limit self-protection and survival mechanisms.

Local professionals should lead the emergency response whenever possible. Intervention must focus on protection and the re-establishment of basic pre-existing care. Basic care and dignity includes appropriate clothing, feeding, shelter, sanitation, physical care and basic treatment (including medication and psychosocial support). Attention should be given to pre-existing levels of care that fall below medical and human rights standards. In such cases, the emergency intervention should focus not on re-instituting pre-existing care but on meeting general minimum standards and practices for psychiatric care. In most countries, as soon as the worst phase of the emergency is over, sound intervention involves developing community mental health services.

This action sheet focuses mostly on the emergency-related needs of people with mental disorders living in psychiatric institutions. It should be noted, however, that typically these institutions hold not only people with severe mental disorders but often also people with other chronic and severe mental and neurological disabilities, to whom this action sheet also applies. In addition, many of the same needs and recommended actions in this sheet apply to people who have severe mental disorders or other mental and neurological disabilities and who live in prisons, social welfare institutions and other residential institutions, including institutions run by traditional healers (see also Action Sheet 6.4).

Key actions

1. Ensure that at least one agency involved in health care accepts responsibility for ongoing care and protection of people in institutions.

- The primary responsibility for this lies with the government, but the mental health and psychosocial support coordination group (see Action Sheet 1.1) and the health coordinating group/Health Cluster should help identify a health agency if there is a gap in response.

- Emergency action plans should be developed for institutions in line with key actions 2–4 below. If these plans have not been developed before the emergency, then they should be developed during the emergency, as appropriate.

2. If staff have abandoned psychiatric institutions, mobilise human resources from the community and the health system to care for people with severe mental disorders who have been abandoned. When the condition of the patient allows, care should be provided outside the institution.

- Discuss with community leaders the responsibilities of the community in providing a supportive and protective network. The following groups may be mobilised:

  - Health professionals and, if possible, mental health professionals;

  - When appropriate, local non-allopathic health care providers (e.g. religious leaders, traditional healers: see Action Sheet 6.4);

  - Social workers and other community-based mechanisms (e.g. women's groups, mental health consumer organisations);

  - Family members.

- Provide basic training on topics such as ethical use of restraint protocols, crisis (including aggression) management, ongoing care and simple ways to improve patients' self-management.

- Ensure ongoing, close supervision of those mobilised to provide basic care and provide access to information on how to maintain their own emotional health (see Action Sheet 8.2).

3. Protect the lives and dignity of people living in psychiatric institutions.

- Protect patients against self-harm or abuse by others (e.g. visitors, staff, other patients, looters, fighting factions). Address issues of sexual violence, abuse, exploitation (e.g. trafficking, forced labour) and other violations of human rights at appropriate levels (see Action Sheets 3.1 and 3.3).

- Ensure that patients' basic physical needs are met. These basic needs include potable water, hygiene, adequate food, shelter and sanitation, and access to treatment for physical disorders.

- Monitor the overall health status of patients and implement or strengthen human rights surveillance. This should be done by external review bodies (if available), human rights organisations or protection specialists.

- Ensure that evacuation plans exist for patients in or outside facilities and that staff are trained on evacuation procedures. If the institution contains locked facilities or cells, establish a hierarchy of responsibilities for keys to ensure that doors can be unlocked at any time.

- If an evacuation occurs, keep patients with their families as far as possible. If this is not possible, keep families and carers informed of where people are being moved. Keep records of this.

4. Enable basic health and mental health care throughout the emergency.

- Perform regular medical (physical and psychiatric) examinations.
- Provide treatment for physical disorders.
- Provide ongoing basic mental health care:
  - Ensure that essential medications, including psychotropics, are available in sufficient quantities throughout the emergency. Sudden discontinuation of psychotropics can be harmful and dangerous. Ensure that drugs are rationally prescribed by evaluating medication prescriptions regularly (at least weekly).
  - Ensure safe storage of drugs.
  - Facilitate the availability of psychosocial supports.
- Though physical restraint and isolation are strongly discouraged, these conditions frequently occur in many institutions. Implement a protocol regulating frequent inspections, feeding, treatment and regular evaluation of the necessity of separations.

Key resources

1. WHO (2003). 'Custodial hospitals in conflict situations'. Geneva: WHO.
http://www.who.int/mediacentre/background/2003/back4/en/print.html

2. WHO (2003–2006). *WHO Mental Health Policy and Services Guidance Package*. Geneva: WHO.
http://www.who.int/mental_health/policy/en/. (This package is relevant for comprehensive, post-emergency response. In particular, see the module 'Organisation of Services for Mental Health'.)
http://www.who.int/mental_health/resources/en/Organization.pdf

3. WHO/ICRC (2005). 'Mental health in prisons: Information sheet'. Geneva: WHO/ICRC.
http://www.who.int/mental_health/policy/mh_in_prison.pdf

Sample process indicators

- The basic physical needs of people in psychiatric institutions continue to be addressed.

- People in psychiatric institutions continue to receive basic health and mental health care.

- Human rights for those in psychiatric institutions are monitored and respected.

- Proper evacuation and emergency plans are in place.

Example: Sierra Leone, 1999

- In the midst of conflict, all staff at a psychiatric institution had left, except for two psychiatric nurses. The building was partly damaged and patients were wandering in the community, some returning for the night to sleep. Patients were being used to run errands through the frontline and to smuggle food.

- Community leaders were gathered to discuss the situation. The community agreed to help identify patients, with guidance from the two remaining psychiatric nurses. A regular food supply to both the community and the institution was arranged.

- An international medical NGO supported the medical screening of patients and secured supplies of medicines.

- Family members of patients were approached to help support them, under the supervision of the psychiatric nurses and the NGO's health staff.

- Some basic reconstruction was done and an emergency plan was prepared in case the institution came under subsequent attack.

Action Sheet 6.4

Learn about and, where appropriate, collaborate with local, indigenous and traditional healing systems

Domain: Health services
Phase: Minimum Response

Background

Allopathic mental health care (a term used here to mean conventional Western, biomedical mental health care) tends to centre on hospitals, clinics and, increasingly, communities. It is provided by staff trained in medicine, behavioural sciences and formal psychotherapy or social work. However, all societies include non-allopathic i.e. local, informal, traditional, indigenous, complementary or alternative healing systems of health care that may be significant. For example in India, Ayurveda, a traditional system of medicine, is popular and well developed (including medical colleges to train practitioners), while in South Africa traditional healers are legally recognised. In Western societies, many people use complementary medicines, including unorthodox psychotherapies and other treatments (e.g. acupuncture, homeopathy, faith-based healing, self-medication of all kinds) in spite of a very weak scientific evidence base. In many rural communities in low-income societies, informal and traditional systems may be the main method of health care provision.

Even when allopathic health services are available, local populations may prefer to turn to local and traditional help for mental and physical health issues. Such help may be cheaper, more accessible, more socially acceptable and less stigmatising and, in some cases, may be potentially effective. It often uses models of causation that are locally understood. Such practices include healing by religious leaders using prayer or recitation; specialised healers sanctioned by the religious community using similar methods; or healing by specialised healers operating within the local cultural framework. The latter may involve the use of herbs or other natural substances, massage or other physical manipulation, rituals and/or magic, as well as rituals dealing with spirits.

Although some religious leaders may not sanction or may actively proscribe such practices, such local healers are often popular and sometimes successful. In some cultures such beliefs and practices are blended with those of a major religion. In addition, local pharmacies may provide health care by dispensing both allopathic and indigenous medications. Some religious groups may offer faith-based healing.

It should be noted that some traditional healing practices are harmful. They may, for example, include the provision of false information, beatings, prolonged fasting, cutting, prolonged physical restraint or social cleansing rituals that involve the expulsion of 'witches' from the community. In addition some rituals are extremely costly, and in the past some healers have used emergencies to proselytise and exploit vulnerable populations. The challenge in such cases is to find effective, constructive ways of addressing harmful practices, as far as is realistic in an emergency environment. Before supporting or collaborating with traditional cleansing or healing practices, it is essential to determine what those practices involve and whether they are potentially beneficial, harmful or neutral.

Whether or not traditional healing approaches are clinically effective, dialogues with traditional healers can lead to positive outcomes, such as:

- Increased understanding of the way emotional distress and psychiatric illness is expressed and addressed (see Action Sheet 2.1) and a more comprehensive picture of the type and level of distress in the affected population;

- Improved referral systems;

- Continuing relationships with healers to whom many people turn for help;

- Increased understanding of beneficiaries' spiritual, psychological and social worlds;

- Greater acceptance by survivors of new services;

- Identifying opportunities for potential collaborative efforts in healing and thus increasing the number of potentially effective treatments available to the population;

- Establishing allopathic services that may be more culturally appropriate;

- The potential opportunity to monitor and address any human rights abuses occurring within traditional systems of care.

Some traditional healers may seek a physical and symbolic 'distance' from allopathic practitioners, and may avoid collaboration. At the same time, health staff trained in allopathic medicine may be unsympathetic or hostile to traditional practices, or may be ignorant of them. Although in some situations keeping a distance may be the best option, the key actions outlined in this action sheet may be used to facilitate a constructive bridge between different systems of care.

Key actions

1. Assess and map the provision of care.

Identify key local healing systems and their significance, acceptance and role in the community. Information may not be immediately volunteered when people fear

disapproval from outsiders or consider the practices to be secret or accessible only to those sanctioned by the community. International and national 'outsiders' should take a non-judgmental, respectful approach that emphasises interest in understanding local religious and spiritual beliefs and potential cooperation with the local way of working. Emergencies should never be used to promote outsiders' religious or spiritual beliefs.

- Ask local community representatives of both genders where they go for help with difficulties and to whom they turn for support.

- Ask primary health care providers and midwives what traditional systems exist.

- Visit local pharmacies to assess what drugs and remedies are available and how dispensing takes place.

- Ask people seeking help at health service points how they understand the nature and origin of their problems, and who else they see or have seen previously for assistance.

- Ask local religious leaders whether they provide healing services and who else in the community does so.

- Ask any of the above if they will provide an introduction to local healers and set up a meeting.

- Remember that more than one system of informal care may exist, and that practitioners in one system may not acknowledge or discuss others.

- Be aware that local healers may compete over 'patients' or be in conflict over the appropriate approach. This means that the above processes may need frequent repetition.

- Talk with local anthropologists/sociologists/those with knowledge of local beliefs and customs and read the available relevant literature.

- Observe. Ask permission to watch a treatment session, and visit local shrines or religious sites used for healing. There may be informal systems of institutional care, including those that hold patients in custody (see Action Sheet 6.3).

- Visit places of worship that conduct healing sessions, and attend services.

- Discuss with patients their understanding of the processes involved in illness and healing.

- Determine whether traditional practices include measures that may be harmful or unacceptable.

- Share results of assessments with the coordination group (see Action Sheets 1.1 and 2.1).

2. Learn about national policy regarding traditional healers.
Recognise that:

- Some governments and/or medical authorities discourage or ban health care providers from collaborating with traditional healers;

- Other governments encourage collaboration and have special departments engaged in the formal training of healers, as well as in research and evaluation of traditional medicine. Such a department may be a useful resource.

3. Establish rapport with identified healers.

- Visit the healer, preferably in the company of a trusted intermediary (former patient, sympathetic religious leader, local authority such as a mayor, or friend).

- Introduce oneself; explain one's role and desire to assist the community.

- Show respect for the healer's role and ask if they might explain their work and how this has been affected by the emergency (e.g. are there increased numbers of patients, or difficulties carrying out work because of a lack of necessary materials or the loss of facilities?). Some healers may be concerned about revealing details of their methods, and it will take time to establish trust.

- If appropriate, emphasise interest in establishing a cooperative relationship and a mutual exchange of ideas.

4. Encourage the participation of local healers in information sharing and training sessions.

- Invite healers to community information meetings and training sessions.

- Consider giving healers a role in training, e.g. by explaining their understanding of how illness is caused or their definitions of illness. On occasions when this is incompatible with the approach of local or international organisations involved in the emergency response, an understanding of local healers' models is still essential to good patient care as it may underpin the patient's own understanding of their problem.

- Try to find points of mutual agreement and discuss opportunities for cross-referral (see key action 5 below).

- Be aware that many traditional healers in many countries may not read or write.

5. If possible, set up collaborative services.
- Active collaboration (as opposed to simply exchanging information as described above) is useful if:
  - Traditional systems play a significant role for the majority of the population;
  - The systems are not harmful. (However, in the case of harmful practices, a constructive dialogue is still required for the purposes of education and change.)
- Useful forms of collaboration could include:
  - Invitations to consultations;
  - Cross-referral (for example, problems such as stress, anxiety, bereavement, conversion reactions and existential distress may potentially be better treated by traditional healers, while allopathic healers are better at treating severe mental disorders and epilepsy);
  - Joint assessments;
  - Joint clinics;
  - Shared care: for example, healers may be prepared to learn how to monitor psychotic patients on long-term medication and to provide places for patients to stay while receiving conventional treatment. Traditional relaxation methods and massage can be incorporated into allopathic practice.

Key resources

1. Center for World Indigenous Studies. www.cwis.org

2. *International Psychiatry*, Vol 8, 2005, pp.2-9. Thematic papers on traditional medicines in psychiatry. http://www.rcpsych.ac.uk/pdf/ip8.pdf

3. Save the Children (2006). *The Invention of Child Witches in the Democratic Republic of Congo: Social Cleansing, Religious Commerce And The Difficulties Of Being A Parent In An Urban Culture.* http://www.savethechildren.org.uk/scuk_cache/scuk/cache/cmsattach/3894_DRCWitches1.pdf

4. WHO/UNHCR (1996). 'Traditional medicine and traditional healers', pp.89-99, *Mental Health of Refugees*. Geneva: WHO/UNHCR. http://whqlibdoc.who.int/hq/1996/a49374.pdf

5. WHO (2003). *Traditional Medicine: Fact Sheet*. http://www.who.int/mediacentre/factsheets/fs134/en/

6. WHO (2006). *Traditional Medicine*. http://www.who.int/medicines/areas/traditional/en/index.html.

Sample process indicators
- Assessments of key local healing systems have been conducted and shared with relevant aid coordination bodies.

- Non-allopathic healers are given a role in mental health training sessions (when appropriate in the local context).

- Number of non-allopathic healers attending mental health training sessions.

Example: Eastern Chad, 2005-06
- An international NGO, providing mental health care within primary health services, worked with traditional healers from the Darfurian population in refugee camps.

- NGO staff met healers for discussions in which healers examined the NGO's credibility. Subsequently, healers (a) explained their difficulties in carrying out work because of the absence of prayer books and herbs; (b) identified the whereabouts of people with severe mental illness who had been chained; (c) described their classifications and interventions for people with emotional problems or mental illness; and (d) explained that most refugees sought traditional and allopathic health care concurrently.

- Training seminars were organised in which knowledge and skills were exchanged. Over a period of six months, healers met regularly with NGO staff for discussions that included mutual exchanges of understanding on female circumcision, medical aspects of fasting, nutrition and breastfeeding, emotional stress, trauma and post-traumatic reactions, serious mental disorders, learning disabilities and epilepsy.

Action Sheet 6.5
Minimise harm related to alcohol and other substance use

Domain: Health services
Phase: Minimum Response

Background
Conflict and natural disasters create situations in which people may experience severe problems related to alcohol and other substance use (AOSU). These include far-reaching protection, psychosocial, mental health, medical and socio-economic problems.

- AOSU may increase among emergency-affected populations as people attempt to cope with stress. This may lead to harmful use or dependence.

- Communities have difficulties recovering from the effects of emergencies when:
  - AOSU inhibits individuals and communities from addressing problems;
  - Limited resources in families and communities are spent on AOSU;
  - AOSU is associated with violence, exploitation, neglect of children and other protection threats.

- AOSU is associated with risky health behaviour, such as unsafe sex while intoxicated with alcohol, and it promotes transmission of HIV and other sexually transmitted infections. Sharing injection equipment is a common means of transmitting HIV and other blood-borne viruses.

- Emergencies can disrupt supply of substances and any pre-existing treatment of AOSU problems, causing sudden withdrawal among people dependent on substances. In some cases, particularly with alcohol, such withdrawal can be life-threatening. Moreover, lack of access to commonly available drugs can promote transition to injection drug use as a more efficient route of administration, and may promote unsafe injection drug use.

Harm related to AOSU is increasingly recognised as an important public health and protection issue that requires a multi-sectoral response in emergency settings.

Key actions
1. Conduct a rapid assessment.
- Coordinate assessment efforts. Organise a review of available information on AOSU, and identify a responsible agency or agencies to design and conduct further rapid, participatory assessments as needed (see Action Sheets 1.1 and 2.1).

- As part of further assessments, identify commonly used substances; harms associated with their use; factors promoting or limiting these harms; and the impact of disruption caused by the emergency to supply, equipment and interventions (see box on pages 145–146).

- Reassess the situation at regular intervals. Problems associated with AOSU may change with time, as changes occur in the availability of substances and/or financial resources.

- Share results of assessments with the relevant coordination groups.

2. Prevent harmful alcohol and other substance use and dependence.
- Informed by all assessment information (see also Action Sheet 2.1), advocate for implementing a multi-sectoral response – e.g. as outlined in the matrix (Chapter 2) – to address relevant underlying stressors for harmful use and dependence.

- Advocate or facilitate that educational and recreational activities and non-alcohol-related income-generating opportunities are re-established as soon as possible (see Action Sheets 1.1, 5.2 and 7.1).

- Engage both men and women from the community in AOSU problem prevention and response (see Action Sheets 5.1 and 5.2), as well as members of any existing self-help groups or associations of ex-users.

- Train and supervise health workers, teachers, community workers and other resources in:
  - Early detection and so-called *brief interventions* (see Key resources 6 and 9) to identify and motivate people at risk of harmful or dependent use to reduce AOSU;
  - Non-medical approaches to dealing with acute distress (psychological first aid: see Action Sheet 6.1).

- Train and supervise health workers in:
  - Rational prescription of benzodiazepines and (where available and affordable) use of non-addictive medication alternatives;
  - Detection of hazardous, harmful and dependent AOSU;
  - Identification, treatment and referral of people with severe mental disorders, who are at elevated risk of AOSU problems (see Action Sheet 6.2).

- Discuss AOSU in stress management training of health and other workers (see Action Sheet 4.4 and Key resources below for guidance on self-help strategies).

- Train and supervise community workers to identify and target at-risk groups for additional support (e.g. survivors of violence, families of dependent users), while avoiding setting up a parallel service (see Action Sheets 4.3 and 5.2).

3. Facilitate harm reduction interventions in the community.

- Ensure access to and information on the use of condoms at sites where people involved in AOSU congregate (such as alcohol sales points) in a culturally sensitive manner (see *IASC Guidelines for HIV/AIDS Interventions in Emergency Settings*).

- Advocate with responsible authorities and community groups to relocate alcohol sales points to minimise disruption to the community.

- Provide risk reduction information to targeted groups (e.g. concerning injection drug use, alcohol use or unsafe sex).

- Ensure access to and disposal of safe injecting equipment for injection drug users, if indicated by assessment.

- Conduct AOSU and harm reduction awareness sessions among male and female community leaders, as appropriate. For example, in some settings interventions to reduce harm from heavy alcohol use have included teaching safe distillation methods for local brewing, restricting sales hours, requiring payment at the time of serving and agreeing to a ban on weapons on premises where alcohol is sold or consumed.

4. Manage withdrawal and other acute problems.

- Develop protocols for clinics and hospitals on the management of withdrawal, intoxication, overdose and other common presentations, as identified in the assessment.

- Train and supervise health workers for the management and referral of withdrawal or other acute presentations, together with provision of sufficient medication, including benzodiazepines, for alcohol withdrawal. Community agencies should train and supervise community workers in the identification, initial management and referral of common acute presentations such as withdrawal.

- In areas where opiate dependence is common, consider establishing low-threshold

substitution treatment (such as with methadone or buprenorphine).

- Re-establish pre-existing substitution therapy as soon as possible.

Assessment for alcohol and other substance use (AOSU)

For guidance on assessment methodology, see Action Sheet 2.1 and Key resources below. Relevant data include:

A. Contextual factors and availability of alcohol and other substances

- Pre-emergency cultural norms regarding AOSU and the way that this was addressed by the community (for displaced and host populations, men and women).

- Any available baseline data on AOSU, and other associated psychological, social and medical problems, including HIV prevalence.

- Relevant regulatory and legislative frameworks.

B. Current patterns and trends in AOSU

- Availability and approximate cost of most prevalent psychoactive substances, and other supply chain information, including disruption to supply as a result of the emergency.

- Substances used and method of administration (including changing patterns of use such as transition from smoking to injecting, introduction of new substances) by sub-groups (e.g. age, sex, occupation (e.g. farmer, ex-combatant, sex worker), ethnicity, religion).

C. Problems associated with AOSU

- Associated psychosocial and mental health problems (e.g. gender-based and other violence, suicide, child abuse or neglect; substance-induced (or exacerbated) mental and behavioural disorders; discrimination; criminalisation).

- Associated high-risk behaviours (e.g. unsafe sexual behaviour and/or injection practices).

- Associated medical problems (e.g. transmission of HIV and other blood-borne viruses, overdose events, withdrawal syndromes, particularly life-threatening alcohol withdrawal).

- Socio-economic problems (e.g. households selling essential food and non-food items, drug/alcohol trafficking, drug-related sex trade).

D. Existing resources (see also Action Sheet 2.1)

- Health, psychosocial and community services (including alcohol and other substance abuse services, harm reduction efforts and self-help groups or associations of ex-users, if any). Document disruption to services due to the emergency.
- Basic services including food, water, shelter.
- Functioning community and cultural institutions.
- Safe spaces for those at risk of AOSU-related violence (if any).
- Family and community care for those with substance dependence (if any).
- Educational, recreational and employment opportunities (if any).

Key resources

1. Costigan G., Crofts N. and Reid G. (2003). *The Manual for Reducing Drug Related Harm in Asia*. Melbourne: Centre for Harm Reduction. http://www.rararchives.org/harm_red_man.pdf

2. Inter-Agency Standing Committee (2003). *Guidelines for HIV/AIDS Interventions in Emergency Settings*. 7.3 Provide condoms and establish condom supply, 7.5. Ensure IDU appropriate care, pp.68-70, pp.76-79. Geneva: IASC.

http://www.humanitarianinfo.org/iasc/content/products/docs/FinalGuidelines17Nov2003.pdf

3. Patel V. (2003). *Where There is No Psychiatrist. A Mental Health Care Manual*. The Royal College of Psychiatrists. http://www.rcpsych.ac.uk/publications/gaskellbooks/gaskell/1901242757.aspx

4. WHO/UNHCR (1996). 'Alcohol and other drug problems'. In *Mental Health of Refugees*, pp.101-109. Geneva: WHO/UNHCR. http://whqlibdoc.who.int/hq/1996/a49374.pdf

5. WHO (1998). *Rapid Assessment and Response Guide on Injecting Drug Use* (IDU-RAR). Geneva: WHO. http://www.who.int/substance_abuse/publications/en/IDURARguideEnglish.pdf

6. WHO (2001). *Brief Intervention for Hazardous and Harmful Drinking: A Manual for Use in Primary Care*. Geneva: WHO. http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6b.pdf

7. WHO (2001). *What Do People Think They Know of Substance Dependence: Myths and Facts*. Geneva: WHO. http://www.who.int/substance_abuse/about/en/dependence_myths&facts.pdf

8. WHO (2002). SEX-RAR Guide: *The Rapid Assessment and Response Guide on Psychoactive Substance Use and Sexual Risk Behaviour*. Geneva: WHO. http://www.who.int/reproductive-health/docs/sex_rar.pdf

9. WHO (2003). *Brief Intervention for Substance Use: A Manual for Use in Primary Care*. Draft Version 1.1 for Field Testing. Geneva: WHO. http://www.who.int/substance_abuse/activities/en/Draft_Brief_Intervention_for_Substance_Use.pdf

10. WHO (2003). *The Alcohol, Smoking And Substance Involvement Screening Test (ASSIST): Guidelines for Use in Primary Care*. Draft Version 1.1 for Field Testing. Geneva: WHO. http://www.who.int/substance_abuse/activities/en/Draft_The_ASSIST_Guidelines.pdf

11. WHO (2003). *Self-help Strategies for Cutting Down or Stopping Substance Use: A Guide*. Draft Version 1.1 for Field Testing. Geneva: WHO. http://www.who.int/substance_abuse/activities/en/Draft_Substance_Use_Guide.pdf

Sample process indicators

- A recent assessment of harms related to alcohol and substance use (AOSU) has been conducted.
- Condoms are continuously available in areas where people involved in AOSU congregate.
- Estimated proportion of health workers that have been trained to conduct brief interventions for AOSU.

Example: Bam, Iran, 2003–04

- An earthquake occurred in an area where opiate dependence was known to be prevalent. Informally, the government immediately contacted all of the country's hospitals recommending that addicted survivors who had been evacuated received substitution therapy when clinically indicated.
- Ten days later, Iranian researchers conducted an assessment of the substance use situation at the request of the Ministry of Health.
- The assessment confirmed that the earthquake had disrupted supplies to a large number of opiate-dependent men, triggering opiate withdrawal.
- Standard treatment protocols for health facilities for pain management in opiate dependence, clinical management of withdrawal and low-dose substitution therapy were made available.

Strengthen access to safe and supportive education

Domain: Education

Phase: Minimum Response

Background

In emergencies, education is a key psychosocial intervention: it provides a safe and stable environment for learners and restores a sense of normalcy, dignity and hope by offering structured, appropriate and supportive activities. Many children and parents regard participation in education as a foundation of a successful childhood. Well-designed education also helps the affected population to cope with their situation by disseminating key survival messages, enabling learning about self-protection and supporting local people's strategies to address emergency conditions. It is important to (re)start non-formal and formal educational activities immediately, prioritising the safety and well-being of all children and youth, including those who are at increased risk (see Chapter 1) or who have special education needs.

Loss of education is often among the greatest stressors for learners and their families, who see education as a path toward a better future. Education can be an essential tool in helping communities to rebuild their lives. Access to formal and non-formal education in a supportive environment builds learners' intellectual and emotional competencies, provides social support through interaction with peers and educators and strengthens learners' sense of control and self-worth. It also builds life skills that strengthen coping strategies, facilitate future employment and reduce economic stress. All education responses in an emergency should aim to help achieve the *INEE Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction* (see Key resources).

Educators – formal classroom teachers, instructors of non-formal learning and facilitators of educational activities – have a crucial role to play in supporting the mental health and psychosocial well-being of learners. Far too often, educators struggle to overcome the challenges that they and their learners face, including their own emergency-related mental health and psychosocial problems. Training, supervision and support for these educators enable a clear understanding of their roles in promoting learners' well-being and help them to protect and foster the development of children, youth and adult learners throughout the emergency.

Key actions

1. Promote safe learning environments.

Education serves an important protection role by providing a forum for disseminating messages on and skills in protection within a violence-free environment. Immediate steps include the following:

- Assess needs and capacities for formal and non-formal education, considering protection issues, as well as how to integrate and support local initiatives. Formal and non-formal education should be complementary and should be established concurrently where possible.

- Maximise the participation of the affected community, including parents, and of appropriate education authorities (e.g. education ministry officials if possible) in assessing, planning, implementing, monitoring and evaluating the education programme.

- Evaluate safety issues in the location and design of spaces, learning structures or schools:
  - Locate schools away from military zones or installations;
  - Place schools close to population centres;
  - Provide separate male and female latrines in safe places.

- Monitor safe conditions in and around the learning spaces/schools (e.g. by identifying a focal point in the school) and respond to threats to learners from armed conflict.

- Make learning spaces/schools zones of peace:
  - Advocate with armed groups to avoid targeting and recruiting in learning spaces/schools;
  - Ban arms from learning spaces and schools;
  - Provide escorts to children when travelling to or from education activities/ school.

- Identify key protection threats external to the educational system (e.g. armed conflict) and those that are internal (e.g. bullying, violent punishment):
  - Identify key protection threats from within the educational system such as gender-based violence (GBV), child recruitment or violence in educational settings;

- Incorporate messages on how to prevent and respond to these and other protection issues (such as separated children and community-based protection measures: see Action Sheet 3.2) in the learning process;
- Set up education/protection monitoring efforts of individual children to identify and support the learners at risk of or experiencing protection threats;
- Use the *IASC Guidelines on Gender-Based Violence Interventions in Humanitarian Settings* to prevent GBV in and around learning spaces and schools.

- Rapidly organise informal education such as child- and youth-friendly spaces (*centres d'animation*) or informal community-based educational groups. Community members, humanitarian aid workers and educators may help organise these without physical infrastructure such as centres while the formal education system is being (re)established or reactivated. The staff of child-friendly spaces should have strong interpersonal skills, the ability to utilise active learning approaches and experience of working with non-formal education or community programmes. A background in formal education is not necessary in these settings.

2. Make formal and non-formal education more supportive and relevant.
Supportive, relevant education is important in promoting learners' mental health and psychosocial well-being during an emergency, while simultaneously promoting effective learning.

- Make education flexible and responsive to emergency-induced emotional, cognitive and social needs and capacities of learners. For instance, offer shorter activities if learners have difficulty concentrating; establish flexible schedules to avoid undue stress on learners, educators and their families by offering variable hours/shifts; adapt exam timetables to give learners additional time to prepare.

- Aim to provide education that helps to restore a sense of structure, predictability and normality for children; creates opportunities for expression, choice, social interaction and support; and builds children's competencies and life skills. For instance, establish activity schedules and post these visibly in the education facility/learning space; avoid punishment of learners whose performance in class suffers due to mental health or psychosocial problems; use collaborative games rather than competitive ones; increase the use of active, expressive learning approaches; use culturally appropriate structured activities such as games, song, dance and drama

that use locally available materials.

- Include life skills training and provision of information about the emergency. Life skills and learning content that may be particularly relevant in emergencies includes hygiene promotion, non-violent conflict resolution, interpersonal skills, prevention of GBV, prevention of sexually transmitted diseases (e.g. HIV/AIDS), mine or explosive awareness and information about the current situation (e.g. earthquakes, armed conflicts, etc.). The content and facilitation of life skills training should be informed by a risks assessment and by prioritisation of need.

- Utilise participatory methods that involve community representatives and learners in learning activities. Adolescent and youth participation in conducting activities for younger children is particularly valuable. Peer-to-peer approaches should also be considered.

- Use education as a mechanism for community mobilisation (see Action Sheet 5.1). Involve parents in the management of learning and education and engage the community in the (re)construction of education facilities (which may be temporary and/or permanent structures). Organise weekly community meetings with child/youth/community representatives to facilitate activities that are appropriate to the local context and that utilise local knowledge and skills.

- Ensure that any education coordination or working group takes into account mental health/psychosocial considerations. Designate a point person to link the mental health/psychosocial coordination group (see Action Sheet 1.1) to the education coordination mechanism.

- Include opportunities in child- and youth-friendly spaces for children and young people to learn life skills and to participate, for example, in supplementary education, vocational training, artistic, cultural and environmental activities and/or sports.

- Support non-formal learning such as adult education and literacy and vocational training to provide learners with skills that are relevant for the current and future economic environments and that are linked to employment opportunities. For children under 15, non-formal education should serve as a complement to, not a substitute for, formal education.

- Use food-for-education programmes to promote mental health and psychosocial well-being, where appropriate. Providing food (on-site or as take-home rations) in educational settings can be an effective strategy for increasing attendance and

retention, which in itself contributes to mental health and psychosocial well-being (see Action Sheet 9.1). In addition, food in education can directly benefit psychosocial well-being by increasing concentration, reducing social distinctions between 'rich' and 'poor', etc. The provision of food or feeding programmes in educational settings should occur only when this can be done efficiently, does not harm the nutritional status of the learners and does not significantly undermine social traditions (e.g. the role of the family in providing appropriate nutrition for children).

3. Strengthen access to education for all.

- Rapidly increase access to formal and/or non-formal education. This may require creative and flexible approaches, such as opening schools in phases, double-shifting or using alternative sites.

- Temporarily ease documentation requirements for admission and be flexible about enrolment. Emergency-affected populations may not have certificates of citizenship, birth/age certificates, identity papers or school reports. Age limits should not be enforced for emergency-affected children and youth.

- Support the specific needs of particular learners e.g. provide child-care services for teenage mothers and siblings tasked with caring for younger children; provide school materials to learners in need.

- Make educational spaces accessible to and appropriate for different groups lof children, especially marginalised children (e.g. disabled or economically disadvantaged children, or ethnic minorities). Develop separate activities for adolescents and youth, who often receive insufficient attention.

- Where appropriate, provide catch-up courses and accelerated learning for older children (e.g. those formerly associated with fighting forces or armed groups) who have missed out on education.

- When appropriate, conduct back-to-school campaigns in which communities, educational authorities and humanitarian workers promote access for all children and youth to education.

4. Prepare and encourage educators to support learners' psychosocial well-being.
Educators can provide psychosocial support to learners both by adapting the way they interact with learners, creating a safe and supportive environment in which learners may express their emotions and experiences, and by including specific structured psychosocial activities in the teaching/learning process. However, they should not attempt to conduct therapy, which requires specialised skills. Providing support for educators' own psychosocial well-being is an essential component of supporting learners.

- Adapt interaction with students by:
  - Integrating topics related to the emergency in the learning process;
  - Addressing the cause of problem behaviours in the class (e.g. aggressiveness);
  - Helping learners to understand and support one another.

- Provide educators with continuous learning opportunities, relevant training and professional support for the emergency, rather than through one-off or short-term training without follow-up (see Action Sheet 4.3). Key topics may include:
  - Encouraging community participation and creating safe, protective learning environments;
  - Effects of difficult experiences and situations on the psychosocial well-being and resilience of children, including girls and boys of different ages; ethics of psychosocial support (see Action Sheet 4.2);
  - Life skills relevant to the emergency (see key action 2 above for suggestions);
  - Constructive classroom management methods that explain why corporal punishment should not be used and that provide concrete alternatives to the use of violence;
  - How to deal constructively with learners' issues such as anger, fear and grief;
  - How to conduct structured group activities such as art, cultural activities, sports, games and skills building;
  - How to work with parents and communities;
  - How to utilise referral mechanisms to provide additional support to learners who exhibit severe mental health and psychosocial difficulties (see key action 5 below);
  - How to develop plans of action for implementing psychosocial support in educators' work;
  - Helping educators to better cope with life during and following the emergency, including the effects of stress on educators, coping skills, supportive

supervision and peer group support.

- Use participatory learning methods adapted to the local context and culture. Ensure that educators have opportunities to share their own knowledge and experience of local child development and helping practices and to practise new skills. The appropriateness and usefulness of training must be evaluated periodically. Ongoing support, including both professional supervision and materials, should be provided to educators.

- Activate available psychosocial support for educators. For instance, bring educators together with a skilled facilitator to start talking about the past, present and future, or put in place a community support mechanism to assist educators in dealing with crisis situations.

5. Strengthen the capacity of the education system to support learners experiencing psychosocial and mental health difficulties.

- Strengthen the capacity of educational institutions to support learners experiencing particular mental health and psychosocial difficulties:
  - Designate focal points to monitor and follow up individual children;
  - If school counsellors exist, provide training on dealing with emergency-related issues.

- Help school staff such as administrators, counsellors, teachers and health workers understand where to refer children with severe mental health and psychosocial difficulties (this may include children who are not directly affected by the emergency but who may have pre-existing difficulties) to appropriate mental health, social services and psychosocial supports in the community (see Action Sheet 5.2) and to health services, when appropriate (see Action Sheet 6.2, including the criteria for referral of severe mental health problems). Ensure that learners, parents and community members understand how to use this system of referral.

Key resources

1. Active Learning Network for Accountability and Performance (ALNAP) (2003). *Participation by Affected Populations in Humanitarian Action: A Handbook for Practitioners*. Chapter 12, 'Participation and Education', pp.331-342. http://www.globalstudyparticipation.org/index.htm

2. Annan J., Castelli L., Devreux A. and Locatelli E. (2003). *Training Manual for Teachers*. http://www.forcedmigration.org/psychosocial/papers/WiderPapers/Widerpapers.htm

3. Crisp J., Talbot C. and Cipollone D. (eds.) (2001). *Learning for a Future: Refugee Education in Developing Countries*. Geneva: UNHCR. http://www.unhcr.org/pubs/epau/learningfuture/prelims.pdf

4. Danish Red Cross (2004). *Framework for School-Based Psychosocial Support Programmes: Guidelines for Initiation of Programmes*. http://psp.drk.dk/graphics/2003referencecenter/Doc-man/Documents/2Children-armed/PSPC.Final.Report.pdf

5. IASC (2005). *Guidelines on Gender-Based Violence Interventions in Humanitarian Settings*. http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/gbv.asp

6. Inter-Agency Network on Education in Emergencies (INEE) (2004). *INEE Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction*. http://www.ineesite.org/minimum_standards/MSEE_report.pdf

7. Inter-Agency Network on Education in Emergencies (INEE) (2005). *Promoting INEE Good Practice Guides – Educational Content and Methodology*. http://www.ineesite.org/page.asp?pid=1238, then the following links:
http://www.ineesite.org/page.asp?pid=1134
http://www.ineesite.org/page.asp?pid=1137
http://www.ineesite.org/page.asp?pid=1146

8. Macksoud M. (1993). *Helping Children Cope with the Stresses of War: A Manual for Parents and Teachers*. UNICEF. http://www.unicef.org/publications/index_4398.html

9. Nicolai S. (2003). *Education in Emergencies: A Tool Kit for Starting and Managing Education in Emergencies*. Save the Children UK. http://www.ineesite.org/core_references/EducationEmertoolkit.pdf

10. Save the Children (1996). *Psychosocial Well-Being Among Children Affected by Armed Conflict and Displacement: Principles and Approaches*. Geneva. http://www.savethechildren.org/publications/technical-resources/emergencies-protection/psychosocwellbeing2.pdf

11. Sinclair M. (2002). *Planning Education In and After Emergencies*. UNESCO: International Institute for Educational Planning (IIEP). http://www.unesco.org/iiep/eng/focus/emergency/emergency_4.htm

Sample process indicators

- Percentage of learners who have access to formal education.

- Non-formal education venues are open and accessible to girls and boys of different ages.

- Percentage of teachers trained in and receiving follow-up support on how to support learners' psychosocial well-being.

- Teachers and other educational workers refer children with severe mental health and psychosocial difficulties to available specialised services or supports.

Example: Occupied Palestinian territory, 2001

- In response to the second intifada, the Palestinian National Plan of Action for Children (a body of NGOs and INGOs) coordinated the work of national and international organisations to provide safe and supportive formal and non-formal education.

- Organisations conducted back-to-school campaigns and supported summer camps and child- and youth-friendly spaces. The education process was revised to be more protective, relevant and supportive by providing greater opportunities for expression and by developing life skills for protection.

- Educators were trained to understand and respond to students' emotional and behavioural needs; youth-led mentoring programmes for adolescents were introduced; and structured psychosocial sessions were introduced in the schools.

Provide information to the affected population on the emergency, relief efforts and their legal rights

Domain: Dissemination of information
Phase: Minimum Response

Background

In addition to lives and health, truth and justice often become casualties in emergency situations. Emergencies tend to destabilise conventional channels of information and communication. Communications infrastructure may be destroyed, and existing communication channels may be abused by those with specific agendas e.g. the spreading of rumours or hate messages, or the fabrication of stories to cover neglect of duties.

Rumours and the absence of credible and accurate information tend to be major sources of anxiety for those affected by an emergency and can create confusion and insecurity. Moreover, a lack of knowledge about rights can lead to exploitation. Appropriate information received at an appropriate time may counter this. A responsible mechanism should proactively disseminate such useful information.

Information and communication systems can be designed to help community members play a part in recovery processes and thus be active survivors rather than passive victims. Information and communication technology (ICT) and traditional methods of communication and entertainment – such as sketches, songs and plays – can play a crucial role in disseminating information on survivors' rights and entitlements, while appropriate information about relief and the whereabouts of displaced people can help to reunite families.

In addition to the specific actions described below, ensuring good governance during emergencies through transparency, accountability and participation will help to improve access to information.

Key actions

1. Facilitate the formation of an information and communication team.

- If regular communication systems (in terms of people and infrastructure) are not fully functional, help to constitute a team of communicators to provide information on the emergency, relief efforts and legal rights and to strengthen the voices of marginalised or forgotten groups. The team may be drawn from local media organisations, community leaders, relief agencies, the government or other parties involved in the emergency response. Members of the affected community themselves may play a key role in disseminating information about services.

2. Assess the situation regularly and identify key information gaps and key information for dissemination.

- Study available assessments and the challenges they highlight (see Action Sheet 2.1).

- Analyse who controls channels of communication, asking whether particular groups are disseminating information in ways that advance specific agendas.

- Conduct, when necessary, further assessments that address the following questions:

  - Which communities/groups of people are on the move and which have settled?

  - Who are the people at risk: are they the commonly recognised vulnerable groups (see Chapter 1) or are they new ones?

  - Are there reports of survivors who have lost mobility? If so, identify where they are located and the existing response.

  - Where can people locate themselves safely and which places are dangerous?

  - If mental health and psychosocial supports are available, who is providing these supports? Which agencies are active in this area? Are they covering all affected communities and segments of the population? Are there sections of the community that have been left out?

  - What opportunities exist to integrate information and communication campaigns with other, ongoing relief efforts?

  - What is the level of literacy among men, women, children and adolescents in the population?

  - Which pre-existing communication channels are functional? Which channels would be the most effective in the current situation to carry messages related to the emergency, relief efforts and legal rights?

  - Which are the population groups that do not have access to media?

  - Which are the groups that have no access to media due to disability (e.g. people with visual or hearing impairments)? What methods may need to be developed for dissemination of information to reach out to such people?

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

  - Availability and safety of relief materials;

  - Ceasefire agreements, safe zones and other peace initiatives;

  - Recurrence of emergency-related events (e.g. violence or earthquake aftershocks);

  - The location and nature of different humanitarian services;

  - The location of safe spaces (see Action Sheet 5.1) and the services available there (see Action Sheets 5.1, 5.2, 5.4 and 7.1);

  - Key results of assessments and aid monitoring exercises;

  - Major decisions taken by political leaders and humanitarian coordination bodies;

  - Rights and entitlements (e.g. quantity of rice that a displaced person is entitled to, land rights, etc.).

- Monitor relevant information issued by governments or local authorities, in particular information relating to relief packages.

- Ask different stakeholders in the population, as well as relief workers, about the key information gaps that should be addressed (e.g. lack of knowledge about services, entitlements, location of family members, etc.). Work with survivors to identify the kind of messages they would like to disseminate and the appropriate way of doing this, anticipating the public impact it can have.

- Identify on an ongoing basis harmful media practices or abuses of information that should be addressed. Such practices include:

  - Dissemination of prejudicial/hate messages;

  - Aggressive questioning of people about their emotional experiences;

  - Failure to organise access to psychosocial support for people who have been asked about their emotional experiences in the disaster;

  - Stigmatising people by interviewing them in inappropriate ways;

  - Use of images, names or other personally identifying information without informed consent or in ways that endanger survivors.

- Identify on an ongoing basis good media practices, such as:

  - Inviting experienced humanitarian workers (in the area of MHPSS) to give advice through media;

  - Providing specific advice through news briefings.

3. Develop a communication and campaign plan.

• Maximise community participation in the process of developing a communication and campaign plan.

• Develop a system to disseminate useful information that addresses gaps identified.

• Educate local media organisations about potentially helpful and potentially harmful practices, and how to avoid the latter.

• Respect principles of confidentiality and informed consent.

4. Create channels to access and disseminate credible information to the affected population.

• Identify people in the affected population who are influential in disseminating information within communities.

• Generate a media and communications directory, including:

  • A list of local media with the names and contact details of key journalists covering stories relating to health, children and human interest;

  • A list of names and contact details of journalists who are covering the emergency;

  • A directory of personnel in different humanitarian agencies working in communications.

• Communication teams may create channels to disseminate information using local languages. This may include negotiating airtime on local radio stations or space on billboards at main road junctions and in other public places, or at schools, relief camps or toilet sites.

• In the absence of any media, consider innovative mechanisms such as distributing radios.

• Engage local people at every stage of the communication process, and make sure that messages are empathetic (showing understanding of the situation of disaster survivors) and uncomplicated (i.e. understandable by local 12-year-olds).

• Organise press briefings to give information about specific humanitarian activities planned to happen in the next few days i.e. what, when, where, who is organising the activity, etc.

• Ensure that there is no unnecessary repetition of past horrific events in local media (e.g. avoid frequently repeating video clips of the worst moments of the disaster) by organising media briefings and field visits. Encourage media organisations and journalists to avoid unnecessary use of images that are likely to cause extreme distress among viewers. In addition, encourage media outlets to carry not only images and stories of people in despair, but also to print or broadcast images and stories of resilience and the engagement of survivors in recovery efforts.

• Sustain local media interest by highlighting different angles, such as the various dimensions of mental health and psychosocial well-being, survivors' recovery stories, the involvement of at-risk groups in recovery efforts and model response initiatives.

• Disseminate messages on the rights and entitlements of survivors, such as disability laws, public health laws, entitlements related to land for reconstruction, relief packages, etc.

• Consider preparing messages on international standards for humanitarian aid, such as the Sphere Minimum Standards.

• Consider distribution methods that help people to access information (e.g. batteries for radios, setting up billboards for street newspapers).

5. Ensure coordination between communication personnel working in different agencies.

Coordination is important to:

• Ensure the consistency of information disseminated to the affected population;

• Facilitate the development of inter-agency information platforms (e.g. bulletin boards) where survivors can go to receive all essential information, including information on positive ways of coping (see Action Sheet 8.2).

Key resources

1. ActionAid International (forthcoming) *Mind Matters: Psychosocial Response in Emergencies* (video).

2. IASC (2003). *Guidelines for HIV/AIDS Interventions in Emergency Settings*.
Action Sheet 9.1: Provide information on HIV/AIDS prevention and care, pp.91-94. Geneva: IASC.
http://www.humanitarianinfo.org/iasc/content/products/docs/FinalGuidelines17Nov2003.pdf

3. OCHA (forthcoming). *Developing a Humanitarian Advocacy Strategy and Action Plan: A Step-by-Step Manual.*

4. Office of the United Nations Secretary-General Special Envoy for Tsunami Recovery (2006). *The Right to Know: The Challenge of Public Information and Accountability in Aceh and Sri Lanka*. New York: United Nations. http://www.tsunamispecialenvoy.org/pdf/The_Right_to_Know.pdf

5. Sphere Project (2004). *Humanitarian Charter and Minimum Standards in Disaster Response*. Geneva: Sphere Project. http://www.sphereproject.org/handbook/index.htm

6. UNICEF (2005). *Ethical Guidelines for Journalists: Principles for Ethical Reporting on Children*. http://www.unicef.org/ceecis/media_1482.html

7. UNICEF (2005). *The Media and Children's Rights (Second Edition)*. New York: UNICEF. http://www.unicef.org/ceecis/The_Media_and_Children_Rights_2005.pdf

Sample process indicators

• Assessments are conducted to identify whether the affected population is receiving key information on the emergency, relief efforts and their legal rights.

• When there are gaps in key information, the relevant information is disseminated in a manner that is easily accessible and understandable by different sub-groups in the population.

Example: Gujarat earthquake, India, 2001

• National and international NGOs, together with local social action groups, organised a '*Know your entitlements*' campaign. They compiled all government orders, demystified legal jargon and translated the material into simple, local-language information sheets. Sheets provided questions and answers on key entitlements and instructions on how to apply for these.

• Street plays that communicated the entitlements of survivors were enacted by community volunteers. After each play, application forms were distributed, and applicants were supported by volunteers throughout the application process until they received their entitlements.

• People's tribunals were organised to enable survivors to register their grievances and to educate them about their entitlements.

Action Sheet 8.2
Provide access to information about positive coping methods

Domain: Dissemination of information
Phase: Minimum response

Background

In emergency settings, most people experience psychological distress (e.g. strong feelings of grief, sadness, fear or anger). In most situations, the majority of affected individuals will gradually start to feel better, especially if they use helpful ways of dealing with stress – i.e. positive coping methods – and if they receive support from their families and community. A helpful step in coping is having access to appropriate information related to the emergency, relief efforts and legal rights (see Action Sheet 8.1) and about positive coping methods.

Making available culturally appropriate educational information can be a useful means of encouraging positive coping methods. The aim of such information is to increase the capacity of individuals, families and communities to understand the common ways in which most people tend to react to extreme stressors and to attend effectively to their own psychosocial needs and to those of others. Dissemination of information on positive coping methods through printed materials or via radio is one of the most frequently used emergency interventions, and has the potential to reach the vast majority of affected people.

Key actions

1. Determine what information on positive coping methods is already available among the disaster-affected population.

• Coordinate with all relevant organisations to determine (a) whether culturally appropriate information on positive coping methods already exists and (b) the extent to which this information is known to the population. Key action 2 below provides guidance on determining whether the available information is appropriate.

2. If no information on positive coping methods is currently available, develop information on positive, culturally appropriate coping methods for use among the disaster-affected population.

• Coordinate and plan the development of information on positive coping methods with other organisations. Make sure that the messages are simple and consistent to

avoid confusion. To the extent possible, reach an inter-agency consensus about the content of the information and agree on how to share tasks (e.g. dissemination).

- In developing appropriate materials, it is important to identify the range of expected individual and community reactions to severe stressors (e.g. rape) and to recognise culturally specific ways of coping (e.g. prayers or rituals at times of difficulty). To avoid duplicate assessments, review results from existing assessments (see Action Sheets 2.1, 5.2, 5.3 and 6.4). Gaps in knowledge may be filled by interviewing people knowledgeable about the local culture (e.g. local anthropologists) or by conducting focus groups. When selecting participants for focus groups, make sure that different age and gender groups within the community are appropriately represented. Separate male and female groups are usually required to allow different perspectives to be heard.

- It is important to recognise positive methods of coping that tend to be helpful across different cultures, such as:
  - Seeking out social support
  - Providing structure to the day
  - Relaxation methods
  - Recreational activities
  - Gently facing feared situations (perhaps along with a trusted companion), in order to gain control over daily activities.

- Workers should familiarise themselves with helpful coping methods by reviewing examples of self-care information produced by other organisations or through focus group discussions with community members who are coping well. Sometimes giving out messages about how to help others can be effective, as they encourage affected people to take care of others and, indirectly, of themselves.

- The following table offers specific guidance on 'do's and don'ts' in developing information for the general public on positive coping methods:

Do's	Don'ts
Use simple, direct language. Invest the time and energy needed to ensure that concepts are worded in a way that makes sense in the local context and can be understood by a local 12-year-old. Use colloquial expressions when these are clearer (e.g. use local terminology for words such as 'coping').	Do not use complicated or technical language (e.g. psychological/psychiatric terms).
Focus on priorities identified by communities and keep the message short, focused and concrete.	Do not include too many messages at one time, as this can confuse or overwhelm people.
Point out that it is common to experience distress after a stressful event and that people affected by a disaster may notice changes in their feelings, behaviour and thoughts. Emphasise that this is a common and understandable reaction to an abnormal event.	Do not include long lists of psychiatric symptoms in materials for the general population (i.e. materials used outside clinical settings).*
Emphasise positive coping methods, solution-focused approaches and positive expectations of recovery, and warn against harmful ways of coping (e.g. heavy alcohol use). Aim to include community, family and individual coping strategies.	Do not emphasise psychological vulnerability in materials for the general population.*
State that most people will probably feel better over the coming weeks and months. If their distress does not decrease over a period of weeks or if it becomes worse, they should seek help from available community supports or seek professional help (though only include this advice if such help is available). Provide information on how and where people can access these services.	Do not specify a precise timeframe for recovery (e.g. 'You will feel better in three weeks') and do not suggest seeking professional help if such help is unavailable.
Ask members of the local community to review any materials developed. Ensure the accuracy of translated materials.	Do not literally translate written materials into a language that is not commonly used in a written format. It may be better to find a non-written format (e.g. pictures, drawings, songs, dances, etc.) or to translate the materials into a national written language that is understandable by at least one member of each household.

* This 'do not' applies to self-care materials directed to the general population outside clinical settings. Listing and explaining symptoms for materials developed for clinical care settings for those having a diagnosable mental disorder is often appropriate and part of treatment.

3. Adapt the information to address the specific needs of sub-groups of the population as appropriate.

- Different sub-groups within a population may also have particular ways of coping that are different from those of the general population. Develop separate information on positive coping mechanisms for sub-groups as appropriate (e.g. men, women, and (other) specific groups at risk: see Chapter 1). Consider including a special focus on 'children's coping' and 'teenagers' coping', noting in the latter that short-term coping methods such as drinking or taking drugs are likely to cause long-term harm.

4. Develop and implement a strategy for effective dissemination of information.

- Although printed materials (leaflets and posters) are the most common method of disseminating information, other mechanisms such as radio, television, drawings/pictures, songs, plays or street theatre may be more effective. Explore with community and religious leaders ways of delivering non-written information. The most appropriate form of delivery depends on the target group, literacy rates and the cultural context. For example, non-written materials (e.g. comic books depicting well-known characters, drama) may be more effective in communicating with children. A combination of dissemination methods conveying consistent messages may be used to maximise reach within the general population.

- Ask permission to place copies of written materials in community institutions such as churches, mosques, schools and health clinics and on noticeboards in camps. It is helpful to place materials in areas where people can pick them up with appropriate privacy.

- Some NGOs have found that talking to people while providing them with a handout/leaflet is more effective than simply leaving handouts for collection, as often people will not read them.

- If possible, make a copy of written materials available on the internet. While most disaster survivors will not have access to the web, disseminating materials in this way enables them to be shared among organisations, which in turn can increase distribution (see also Action Sheet 8.1).

Key resources

1. American Red Cross (2004). *From Crisis to Recovery, the Road to Resiliency: A Small Pocket Manual.* American Red Cross Psychosocial Group, New Delhi.

http://www.who.int/mental_health/emergencies/mh_key_res/en/index.html

2. International Catholic Migration Commission (ICMC) (2005). *Setelah Musibah (After Disaster).* ICMC, Indonesia. http://www.who.int/mental_health/emergencies/mh_key_res/en/index.html

3. World Health Organization (2005). *Some Strategies to Help Families Cope with Stress.* WHO, Pakistan. http://www.who.int/mental_health/emergencies/mh_key_res/en/index.html

Sample process indicators

- Self-care information that is disseminated has a focus on positive coping methods.

- Estimated proportion of population that has access to the disseminated information.

- Information that is disseminated is culturally appropriate and understandable to most of the population.

Example: Aceh, Indonesia, 2005

- After reviewing existing self-care materials, national staff from an international NGO were trained to conduct focus groups to identify what people were going through (common reactions) and what activities people used to cope with the stress.

- An artist was contracted to draw pictures depicting people from Aceh in local dress, portraying concepts that the community had identified. Another set of pictures illustrated the deep breathing relaxation technique.

- The brochures were explained and distributed during community gatherings, e.g. after evening prayers at the mosque. Brochures were also distributed to other organisations, which in turn distributed them through their intervention programmes.

- Through the psychosocial coordination group, agencies jointly continued producing newsletters with information that represented the concerns of tsunami-affected communities and local civil society. A local NGO was funded and supervised to continue producing relevant newsletters.

Action Sheet 9.1

Include specific social and psychological considerations (safe aid for all in dignity, considering cultural practices and household roles) in the provision of food and nutritional support

Domain: Food security and nutrition

Phase: Minimum response

Background

In many emergencies, hunger and food insecurity cause severe stress and damage the psychosocial well-being of the affected population. Conversely, the psychosocial effects of an emergency can impair food security and nutritional status. Understanding the interactions between psychosocial well-being and food/nutritional security (see table below) enables humanitarian actors to increase the quality and effectiveness of food aid and nutritional support programmes while also supporting human dignity. Ignoring these interactions causes harm, resulting for example in programmes that require people to queue up for long hours to receive food, treat recipients as dehumanised, passive consumers, or create the conditions for violence in and around food deliveries.

Table: Social and psychological factors relevant to food aid

Factors relevant to food aid	Type of effect and examples
General social factors (including pre-existing factors) related to food security and nutritional status	• Marginalisation of particular groups, reducing their access to scarce resources • Socio-cultural aspects of diet and nutrition (dietary beliefs and practices: what food is eaten; how food is cultivated, harvested, distributed, prepared, served and eaten; cultural taboos)
Emergency-related social and psychological factors that affect food security and nutritional status	• Disruption of gender, household and family roles (e.g. deaths of income earners) • Disorientation and/or disruption of formal and informal community leadership (e.g. death of a community leader who could organise assistance) • Disruption of informal social networks that assist at-risk people (e.g. volunteers providing care to bed-ridden people) • Lack of security (e.g. attacks on women who collect fuel wood)

Factors relevant to food aid	Type of effect and examples
	• Reduced capacity of individuals to provide food to dependants (e.g. due to severe depression) • Severe disorientation that prevents or inhibits individuals from accessing food (e.g. due to severe mental or neurological disorder) • Fear that prevents individuals or groups from accessing food (e.g. due to misinformation, political persecution or supernatural beliefs related to emergency) • Loss of appetite (e.g. due to severe grief after the loss of family members)
Impact of hunger and food insecurity on mental health and psychosocial well-being	• Serious mental or cognitive disabilities, especially in young children (e.g. due to chronic nutritional deficits, lack of social/emotional stimulation) • Harmful coping strategies (e.g. selling important assets, exchanging sex for food, taking children out of school, abandoning weaker family members such as a child) • Breakdown of law and order (e.g. fighting over resources) • Loss of hope or perspective for the future (e.g. in situations of protracted armed conflict) • Feelings of helplessness and resignation (e.g. after loss of livelihood) • Aggressive behaviour (e.g. in situations of perceived unfairness of food entitlement or distribution)

The Sphere Handbook outlines the overall standards for food security, nutrition and food aid in emergencies. The key actions described below give guidance on social and psychological considerations relevant to working towards such standards.

Key actions

1. Assess psychosocial factors related to food security, nutrition and food aid.

• Review available assessment data on food and nutrition and on mental health and psychosocial support (see Action Sheet 2.1). If necessary, initiate further assessment on key social and psychological factors relevant to food and nutritional support (see table above).

- Food and nutrition assessment reports should be shared with relevant coordination groups (see Action Sheets 1.1 and 2.1) and should indicate:
  - How and to what extent food insecurity/malnutrition affects mental health and psychosocial well-being, and vice versa (see also Sphere general nutrition support standard 2 on at-risk groups and Sphere assessment and analysis standards 1–2 on food security and nutrition);
  - Which psychological and socio-cultural factors should be considered in the planning, implementation and follow-up of food aid and nutritional interventions.

2. Maximise participation in the planning, distribution and follow-up of food aid.
- Enable broad and meaningful participation of target communities during assessment, planning, distribution and follow-up (see Action Sheet 5.1).
- Maximise the participation of at-risk, marginalised and less visible groups (see Chapter 1).
- Make the participation of women a high priority in all phases of food aid. In most societies women are the household food managers and play a positive role in ensuring that food aid reaches all intended recipients without undesired consequences.
- Consider using food assistance to create and/or restore informal social protection networks by, for example, distributing food rations via volunteers providing home-based care (see also Action Sheet 3.2).

3. Maximise security and protection in the implementation of food aid.
- Pay special attention to the risk that food is misused for political purposes or that distributions marginalise particular people or increase conflict.
- Avoid poor planning, inadequate registration procedures and failure to share information, which may create tensions and sometimes result in violence or riots.
- Take all possible measures to guard against the misuse of food aid and to prevent abuse, including the trading of food for sex by aid workers or persons in similar positions (see Action Sheet 4.2 and Action Sheet 6.1 of *IASC Guidelines on Gender-Based Violence Interventions in Humanitarian Settings*).

4. Implement food aid in a culturally appropriate manner that protects the identity, integrity and dignity of primary stakeholders.
- Respect religious and cultural practices related to food items and food preparation, provided that these practices respect human rights and help to restore human identity, integrity and dignity.
- Avoid discrimination, recognising that local cultural norms and traditions may discriminate against particular groups, such as women. Food aid planners have the responsibility to identify discrimination and ensure that food aid reaches all intended recipients.
- Provide suitable, acceptable food together with any condiments and cooking utensils that may have special cultural significance (see also Sphere food aid planning standards 1–2).
- Share important information in suitable ways (see Action Sheet 8.1). If food items are unfamiliar to the recipients, provide instructions for their correct preparation.

5. Collaborate with health facilities and other support structures for referral.
- Use food and nutrition programmes as a possible entry point for identifying individuals or groups who urgently need social or psychological support.
- For specific guidance on facilitating stimulation for young children in food crises, see the WHO (2006) reference under Key resources.
- Ensure that workers in food aid and nutrition programmes know where and how to refer people in acute social or psychological distress.
- Raise awareness among the affected population and food workers that certain micronutrient deficiencies can impair children's cognitive development and harm foetal development.
- Help food aid and nutrition workers to understand the medical implications of severe malnutrition.
- Identify health risks and refer people who are at risk of moderate or acute malnutrition to special facilities (supplementary or therapeutic feeding centres respectively; see also Sphere correction of malnutrition standards 1–3; and Action Sheet 5.4).
- Give pregnant and lactating women special attention regarding the prevention of

micronutrient deficiencies.

- Consider the potential appropriateness of introducing school feeding programmes to address the risk of malnourishment in children (see Action Sheet 7.1).

6. Stimulate community discussion for long-term food security planning.
Because food aid is only one way to promote food security and nutrition, consider alternatives such as:

- Direct cash transfers, cash-for-work and income-generating activities;
- Community-driven food and livelihood security programmes which reduce helplessness and resignation and engage the community in socio-economic recovery efforts.

Key resources

1. Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) (2003). 'Participation and food security'. In: *Participation by Crisis-Affected Populations in Humanitarian Action: A Handbook for Practitioners*, pp.231-275. http://www.alnap.org/publications/protection/index.htm

2. Engle P. (1999). 'The Role of Caring Practices and Resources for Care in Child Survival, Growth, and Development: South and Southeast Asia'. In: *Asian Development Review*, vol. 17 nos. 1, 2, pp.132-167. http://www.adb.org/Documents/Periodicals/ADR/pdf/ADR-Vol17-Engle.pdf

3. IASC (2005). *Guidelines on Gender-Based Violence Interventions in Humanitarian Settings*. Action Sheet 6.1: Implement safe food security and nutrition programmes, pp.50-52. Geneva: IASC. http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/gbv.asp

4. Sphere Project (2004). *Humanitarian Charter and Minimum Standards in Disaster Response*. Minimum Standards in Food Security, Nutrition and Food Aid, pp.103-203. Geneva: Sphere Project. http://www.sphereproject.org/handbook/index.htm

5. WHO (2006). *Mental Health And Psychosocial Well-Being Among Children In Severe Food Shortage Situations*. Geneva: WHO. http://www.who.int/nmh/publications/msd_MHChildFSS9.pdf

Sample process indicators

- Food aid and nutrition assessments and programme planning efforts include social and psychological dimensions.
- Effective mechanisms exist for reporting and addressing security issues associated with food aid and nutrition.

- Food aid coordinators link up with psychosocial coordination mechanisms and take an active role in communicating relevant information to the field.

Example: Afghanistan, 2002

- An international NGO provided food aid to 10,000 war-affected widows, some of whom had severe psychological issues such as depression and were unable to function well as sole breadwinners.
- The NGO partnered with another agency that specialised in counselling, referred the severely affected women for support and continued to include the women in the food aid programme.
- Representatives of the affected population participated in planning and monitoring the food distributions, helping to make adjustments that promoted local people's dignity and identity.

Include specific social considerations (safe, dignified, culturally and socially appropriate assistance) in site planning and shelter provision, in a coordinated manner

Domain: Shelter and site planning
Phase: Minimum response

Background

The provision of safe, adequate shelter in emergencies saves lives, reduces morbidity and enables people to live in dignity without excessive distress. The participation of people affected by an emergency in decisions regarding shelter and site planning reduces the helplessness seen in many camps or shelter areas, promotes people's well-being (see Action Sheet 5.1), and helps to ensure that all family members have access to culturally appropriate shelter. The engagement of women in the planning and design of emergency and interim shelters is vital to ensure attention to gender needs, privacy and protection. The participation of displaced people also promotes self-reliance, builds community spirit and encourages local management of facilities and infrastructure.

A range of shelter or camp options should be explored in an emergency. Initial decisions on the location and layout of sites, including self-settled camps, can have long-term effects on protection and the delivery of humanitarian assistance. Although camps or collective centres are often the only option, displaced people, in certain situations, may be hosted with local families who provide shelter and social support. This is a useful option provided that services to the hosting families are strengthened.

The organisation of sites and shelters can have a significant impact on well-being, which is reduced by overcrowding and the lack of privacy commonly found in camps and other settings. Mental health and psychosocial problems can arise when people are isolated from their own family/community group or are forced to live surrounded by people they do not know, who speak other languages or who arouse fear and suspicion. Also at risk are people such as the elderly, single women, people with disabilities and child-headed households, who are not in a position to build, rent or secure their own shelter. Conflicts among displaced people or between displaced people and host communities over scarce resources such as space or water can often be a significant problem, and site planning must minimise such potential risks.

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

Key actions

1. Use a participatory approach that engages women and people at risk in assessment, planning and implementation.

- Conduct participatory assessments (see Action Sheet 2.1) with a broad range of affected people, including those at special risk (see Chapter 1).

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

- Identify the best solution to shelter problems for everyone in the community, aiming to reduce potential distress and worry for the inhabitants.

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

2. Select sites that protect security and minimise conflict with permanent residents.

- Consult with local government and neighbouring communities to ensure that the land chosen is not already used by the local community for grazing or crop production and to understand other land tenure issues.

- Ensure that the site identification and selection process includes an environmental survey that analyses the natural resource base in the area and guides proper environmental management. Failure to do this can cause environmental degradation and distress stemming from a lack of natural resources for eating, drinking and cooking. A survey also helps to ensure that permanent residents' access to these resources is not at risk.

- 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 of latrines (for guidance see the *IASC Guidelines for Gender-based Violence Interventions in Humanitarian Settings*). If centralised cooking facilities must be provided, they should be located close to 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 disposal areas).

3. Include communal safe spaces in site design and implementation.
Develop communal safe spaces that offer psychological assurance and enable social, cultural, religious and educational activities (see Action Sheets 5.1 and 3.2) and the dissemination of information (see Action Sheet 8.1). These safe spaces should include child-friendly spaces where children can meet and play (see Action Sheets 5.4 and 7.1).

4. Develop and use an effective system of documentation and registration.
All concerned actors should agree on a common registration and individual documentation system that assists site planners in designing layout and shelter plans, while protecting the confidentiality of data. The documentation system should include provision for age- and gender-disaggregated data.

5. Distribute shelter and allocate land in a non-discriminatory manner.
- Map the diversity (age groups, gender, ethnic groups, etc.) among the affected population in order to address the needs of each group, as appropriate.
- Ensure that shelter distribution and land allocation to all families and households occur in a non-discriminatory manner, without preference based on ethnicity, gender, language, religion, political or other opinion, national or social origin, property, birth or other status.

6. Maximise privacy, ease of movement and social support.
- Emphasise family-size shelters that maximise privacy and promote visibility and ease of movement. If large emergency shelters are used, include partitions to increase privacy and reduce noise.
- Ensure that people can move easily through group shelters or around family dwellings without invading the privacy of other people or causing significant disruption.
- Whenever possible, avoid separating people who wish to be together with members of their family, village, or religious or ethnic group.
- Enable reunited families to live together.
- Facilitate provision of shelter for isolated, vulnerable individuals who are living alone due to mental disorder or disability.

7. Balance flexibility and protection in organising shelter and site arrangements.
- Recognise that camps are necessary in some situations; however, displaced people often prefer to live with host families in their own makeshift dwellings, or sometimes they may choose hotels, schools or other available communal buildings.
- Enable people to choose to the extent possible their own shelter arrangements, neighbours and living areas. This helps people to live according to their own goals, culture and values and to regain a sense of control and livelihood opportunities, all of which support psychosocial well-being.
- Caution people against living in unsafe conditions if safer alternatives exist.

8. Avoid creating a culture of dependency among displaced people and promote durable solutions.
- Establish large-scale camps or semi-permanent camps only when absolutely necessary and ensure, where possible, that there is a proper balance between safety and distance from the area of origin.
- Use familiar and locally available construction materials that allow families to make their own repairs and avoid dependency on external aid, as this can help to avoid distress.
- Encourage early return and resettlement of displaced people as a durable solution and provide support to those families who want to return to their areas of origin and are able to do so.
- Ensure that services are provided not only in camps but also in return areas.
- Care should be taken to ensure that supportive social structures are kept intact.

Key resources

1. Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) (2003). 'Participatory Habitat and Shelter Programmes'. In *Participation by Crisis-Affected Populations in Humanitarian Action: A Handbook for Practitioners*, pp. 295-314.
http://www.odi.org.uk/ALNAP/publications/gs_handbook/gs_handbook.pdf

2. IASC (2005). *Guidelines on Gender-Based Violence Interventions in Humanitarian Settings*. Action Sheets 7.1, 7.2, 7.3 on settlement and shelter, pp.53-60. Geneva: IASC.
http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/gbv.asp

3. Sphere Project (2004). *Humanitarian Charter and Minimum Standards in Disaster Response*.

Minimum Standards in Shelter, Settlement and Non-Food Items, pp.203-249. Geneva: Sphere Project.

http://www.sphereproject.org/handbook/index.htm

4. UN Habitat (2003). Toolkit for Mainstreaming Gender in UN-Habitat Field Programmes.

http://www.unhabitat.org/downloads/docs/1267_94527_Iraq_Gender.pdf

5. UNHCR Handbook for Emergencies (2000). Chapter 1.

http://www.unhcr.org/cgi-bin/texis/vtx/publ/opendoc.pdf?tbl=PUBL&id=3bb2fa26b

6. UNHCR Environmental Guidelines (2005). www.unhcr.org/environment

7. UNHCR Tool for Participatory Assessment in Operations (2006).

http://www.unhcr.org/cgi-bin/texis/vtx/publ/opendoc.html?tbl=PUBL&id=450e963f2

8. Women's Commission on Refugee Women and Children (2006). 'Beyond firewood:
Fuel alternatives and protection strategies for displaced women and girls'.

http://www.womenscommission.org/pdf/fuel.pdf

Sample process indicators

- Local people, particularly women, participate in the design and layout of shelter and in selecting the materials used for construction.

- People who are unable to build their own shelters receive support in shelter construction.

- Shelter is organised in a manner that maximises privacy and minimises overcrowding.

Example: Liberia, 2004 and East Timor, 2006

- In East Timor (in 2006), Liberia (2004) and several other emergencies, the privacy of displaced people was increased by grouping 10–20 family shelters in a U shape around a common area.

- To reinforce privacy, shelters were placed at an angle to one another. No front door of a shelter directly faced another, and no shelter blocked the direct view of another shelter. Each shelter opened onto the common area, which included cooking and recreational areas and retained trees for shade and environmental protection, and which the community cleaned.

- Each shelter had a private backyard area used for storage, laundry, kitchen gardening, cooking etc. Water points and latrines were located nearby and were kept visible from the common area to prevent the risk of GBV.

Action Sheet 11.1
Include specific social considerations (safe and culturally appropriate access for all in dignity) in the provision of water and sanitation

Domain: Water and sanitation
Phase: Minimum response

Background

In emergencies, providing access to clean drinking water and safe, culturally appropriate hygiene and sanitation facilities are high priorities, not only for survival but also for restoring a sense of dignity. The manner in which humanitarian assistance is provided has a significant impact on the affected population. The engagement of local people in a participatory approach helps to build community cohesion and enables people to regain a sense of control.

Depending on how they are provided, water and sanitation (watsan) supports can either improve or harm mental health and psychosocial well-being. In some emergencies, poorly lit, unlocked latrines have become sites of gender-based violence, including rape, whereas in others, conflict at water sources has become a significant source of distress. Part of the stress experienced in relation to watsan provision has cultural origins. In Afghanistan, for example, girls and women have reported that the lack of separate women's latrines is a major concern, since the exposure of any part of their bodies is punishable and could shame and dishonour their families.

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

Key actions

1. Include social and cultural issues in water and sanitation and hygiene promotion assessments.

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 used 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. For these reasons, assessment teams should not only have core watsan technical expertise but should also be familiar with the psychosocial aspects of emergency response.

2. Enable participation in assessment, planning and implementation, especially engaging women and other people at risk.

- Involve members of the affected population, especially women, people with disabilities and elderly people, in decisions on the siting 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.

- Establish a body to oversee watsan work. A useful means of doing this is to facilitate the formation of gender-balanced water committees that consist of local people selected by the community and that include representatives from various sub-groups of the affected population.

- Encourage water committees to (a) work proactively to restore dignified watsan provision, (b) reduce dependency on aid agencies and (c) create a sense of ownership conducive to proper use and maintenance of the facilities. Consider incentives for water committees and user fees, remembering that both have potential advantages and disadvantages and need careful evaluation in the local context.

3. Promote safety and protection in all water and sanitation activities.

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

- Make waiting times sufficiently short so as not to interfere with essential activities such as children's school attendance.

- Ensure that all latrines and bathing areas are secure and, if possible, well-lit. Providing male and female guards and torches or lamps 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.

4. Prevent and manage conflict in a constructive manner.

- 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.

- Prevent conflicts at water sites by asking water committees or other community groups to develop a system for preventing and managing conflict e.g. by rotating access times between families.

- Consider trying to reduce conflict between neighbouring displaced groups or between displaced and permanent residents by encouraging the conflicting groups to cooperate in building a common well.

5. Promote personal and community hygiene.

- Provide access for women to menstrual cloths or other materials (the lack of which creates significant stress) and to appropriate space for washing and drying them. Consult women on the need for special areas for washing menstrual cloths, and provide technical assistance with their design. Where existing water supplies cannot support washing, alternative sanitary materials should be provided (for guidance, see Action Sheet 7.4 of the IASC *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*).

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

- Distribute soap and other hygiene articles, in accordance with advice received from women, men and children, including disabled and elderly people.

- Initiate child-to-child watsan activities that are interactive and fun, such as group hand-washing before meals. These activities can be done in schools or in child-friendly spaces if these are functioning.

6. Facilitate community monitoring of, and feedback on, water and sanitation facilities.

- Enable community monitoring to track safety and to identify and respond to community concerns. Ensure that a feedback mechanism exists for stakeholders to report problems or concerns to the water committee or to relevant agencies responsible for watsan activities. This same mechanism can be used to keep the affected population informed as to what facilities and services they can expect.

- Monitor that sites and facilities are clean and well maintained, as having clean facilities helps to restore stakeholders' dignity.

- Ask the affected population, including children and people at risk (See Chapter 1), about their perceptions of access to, and quality of, watsan supports and also about their concerns and suggestions.

Key resources

1. Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) (2003). 'Participation and water/sanitation programmes'. In: *Participation by Crisis-Affected Populations*

in Humanitarian Action: A Handbook for Practitioners, pp.275-294.
http://www.odi.org.uk/ALNAP/publications/gs_handbook/gs_handbook.pdf

2. IASC (2005). *Guidelines on Gender-Based Violence Interventions in Humanitarian Settings*.
Action Sheet 7.4: Provide sanitary materials to women and girls, p.61. Geneva: IASC.
http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/gbv.asp

3. Jones H. and Reed B. (2005). *Access to Water and Sanitation for Disabled People and Other Vulnerable
Groups*. http://wedc.lboro.ac.uk/publications/details.php?book=1%2084380%20079%209

4. Sphere Project (2004). *Humanitarian Charter and Minimum Standards in Disaster Response*.
Minimum Standards in Water, Sanitation and Hygiene Promotion, pp.51-102. Geneva: Sphere Project.
http://www.sphereproject.org/handbook/index.htm

5. UNHCR. (2000). *Handbook for Emergencies*.
http://www.unhcr.org/publ/PUBL/3bb2fa26b.pdf

6. University of Wisconsin, Emergency Settlement Project (1996). T*opic 14 – Environmental Health:
Water, Sanitation, Hygiene, and Vector Management.*
http://dmc.engr.wisc.edu/es96/Environhealth.html

Sample process indicators

- In a monthly focus group discussion, more than two-thirds of women express satisfaction with the safety and privacy of the sanitation facilities provided.

- Water committees that include women and men are in place and meet regularly.

- There is no reported conflict between host and displaced communities.

Example: Pakistan, 2005

- During the earthquake response in the North-West Frontier Province in 2005, an international NGO built special covered areas for women where they could go to the latrine, bathe and wash children, clothes and menstrual cloths without being seen by outsiders.

- These spaces enabled women to meet and talk in a safe environment that took cultural norms into consideration.

- The women said this greatly reduced the stress and anxiety of living in a displaced persons camp.

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The IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings reflect the insights of numerous agencies and practitioners worldwide and provide valuable information to organisations and individuals on how to respond appropriately during humanitarian emergencies.

Specific action sheets offer useful guidance on mental health and psychosocial support, and cover the following areas:

> Coordination
> Assessment, Monitoring and Evaluation
> Protection and Human Rights Standards
> Human Resources
> Community Mobilisation and Support
> Health Services
> Education
> Dissemination of Information
> Food Security and Nutrition
> Shelter and Site Planning
> Water and Sanitation

The Guidelines include a matrix, with guidance for emergency planning, actions to be taken in the early stages of an emergency and comprehensive responses needed in the recovery and rehabilitation phases. The matrix is a valuable tool for use in coordination, collaboration and advocacy efforts. It provides a framework for mapping the extent to which essential first responses are being implemented during an emergency.

The Guidelines include a companion CD-ROM, which contains the full Guidelines and also resource documents in electronic format.

Published by the Inter-Agency Standing Committee (IASC), the Guidelines give humanitarian actors useful inter-agency, inter-sectoral guidance and tools for responding effectively in the midst of emergencies.