HEALTH EMERGENCY RESPONSE UNIT

PSYCHOSOCIAL SUPPORT COMPONENT

DELEGATE MANUAL

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The International Federation Reference Centre for Psychosocial Support

International Federation of Red Cross and Red Crescent Societies

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Chapter 1: Introduction

This manual covers the emergency phase of a crisis response. The chapter provides an initial description of the ERU psychosocial support component and describes some important aspects of addressing psychological and social issues and problems in emergency settings.

Background

The International Federation of Red Cross and Red Crescent Societies maintain a rapid response tool for various global disasters. The Emergency Response Units (ERU) exist for a number of different sectors (seven to date) and are deployed after an emergency to fill gaps and ensure efficient provision of emergency assistance to the affected population. The seven sectors can be seen
below:

There are two ERUs dedicated to address disaster health needs: a *Basic Health Care Unit* and a *Referral Hospital*. These ERUs have tended to focus on curative aspects in acute emergency settings, often replacing damaged or destroyed local facilities. Recent disasters show a need to address public and community health concerns and priorities and make dedicated personnel focus on these intervention areas.[1] One of these concerns relates to dealing with the psychological and social effects on individuals and communities affected by crisis situations.

Purpose of psychosocial Component

The purpose of the ERU psychosocial support component is to enable a positive social and physical environment where children and adults find opportunities for stimulation, skill building and socialization.

Providing psychosocial support has in recent years become part of humanitarian action following disasters. The term 'component' encompasses all psychosocial support activities that take place within the context of the ERU and is used to describe the kits and materials contained within the kits, the location and activities carried out and all interventions enacted by the psychosocial delegate.

Among humanitarian actors it is commonly known that 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 and can undermine the long-term mental health and psychosocial well-being of the affected population, 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.[2]

What is psychosocial support?

Psychosocial support is defined as any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent mental disorder.[1] Within the International Federation, psychosocial support is seen a process of facilitating resilience within individuals, families and communities. This is done by implementing relevant and culturally appropriate activities that respect the independence, dignity and coping mechanisms of individuals and communities. In this way psychosocial support promotes the restoration of social cohesion and infrastructure within communities that have lived through disasters or crisis situations.[1]

A technical assessment of the International Federation's deployment of health ERUs after the 2004 Indian Ocean tsunami and after the earth quake in Haiti recommended that psychosocial support be integrated into the work of the health ERUs and that psychological first aid and psychosocial support awareness training be made available to expatriate ERU health staff.[3,4] A subsequent needs assessment among National Societies involved in health ERU work confirmed an interest in establishing a psychosocial support component for the ERU.[5]

All materials available in the ERU psychosocial support component aim to facilitate support that address the psychosocial needs of disaster-affected populations, and raise awareness among staff and volunteers about the benefits of providing such assistance as part of emergency response.

A timeline for the implementation of the ERU psychosocial support component can be seen on the page 20.

The ERU psychosocial support component is designed as a service to the community to which the ERU is deployed. Supporting staff and caring for colleagues and volunteers is crucial, and it is acknowledged to be the responsibility of the ERU team leader to ensure the psychological well-being of all ERU staff. The psychosocial support is a non-therapeutic approach, thus the psychosocial delegate will not provide therapeutic assistance to ERU staff but may provide collegial support and advice. However, as every deployment is different, there may arise situations where it will be natural to offer assistance to an ERU staff member after having consulted with the head of the ERU.

Impact of emergencies

> ***In an ERU that was deployed in Haiti there was uncertainty of how long the ERU was to remain in place. Whilst the daily work continued there was a pervading sense of not knowing what was going to happen. This caused distress among some delegates in the ERU. The psychosocial delegate intervened on behalf of the staff. The delegate informed the ERU team leader and suggested that all available information should be provided to staff at the daily meeting. The aim was to relieve the distress and uncertainty among staff.***

Integrating a psychosocial support component into the work of the ERU enables an outreach to vulnerable groups in affected communities, including those who suffer from mild to severe psychological or social distress. Previous ERU deployments have shown high numbers of patients presenting multiple somatic complaints; this group of patients places a heavy burden on the available health care delivery system.[6] Emergencies create a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies erode protective support that is normally available, increase the risks of diverse problems and tend to amplify pre-existing problems. Pre-existing problems, as well as emergency and humanitarian aid-induced mental health and psychosocial problems in emergencies are highly interconnected, yet may be predominantly social or psychological in nature. The table below provides examples of the problems that affected populations may experience:[7]

	Social problems	Psychological problems
Pre-existing	Belonging to a group that is discriminated against or marginalised; political oppression	Severe mental disorder; depression, alcohol abuse
Emergency-induced	Family separation; disruption of social networks; destruction of livelihoods, community structures, resources and trust	Grief, non-pathological distress; alcohol abuse; depression and anxiety disorders, including post-traumatic stress disorder (PTSD)
Humanitarian aid-induced	Undermining of community structures or traditional support mechanisms; exclusion due to lack of access to services	Anxiety due to a lack of information about food distribution; aid dependency

Mental health and psychosocial problems in emergencies encompass far more than the experience of PTSD or disaster-induced depression. A selective focus on these two disorders risks ignoring many other mental health and psychosocial problems in emergencies. Affected groups often have assets or resources that support mental health and psychosocial well-being. 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. It is important to be aware of not only the problems but also the nature of local resources, whether they are helpful or harmful, and the extent to which affected people can access them.[8]

Psychosocial support in the ERU

Addressing psychosocial needs in the context of the ERU is based on the principle that most acute stress problems during emergencies are best managed without medication, following the principles of psychological first aid.[9] This involves non-intrusive emotional support, coverage of basic needs, protection from further harm, and organization of social support and networks.[10] By creating an enabling social and physical environment, the ERU psychosocial support component contributes to increasing resilience and reducing vulnerability in the affected population. Restoring social structures and providing stability allows people to cope with the effects of a disaster, and return to economic activities, family life, and supportive roles for each other.[11]

Location of the psychosocial support component

If space allows it the ERU psychosocial support component is housed in one or two tents where the various activities take place. There may be settings where space and security issues will make it necessary to share the tent with other ERU components such as Community Health. There may also be settings where the only space available for the psychosocial activities is outside the ERU compound. Not all beneficiaries will be mobile as they may be confined to hospital beds and not be able to join the psychosocial activities. The psychosocial activities will then have to be conducted in the wards or other

An ERU deployed after a severe mudslide in Gonaives in Haiti had problems with the capacity as a number of patients occupying beds had no somatic illnesses but they would not leave the hospital beds. The medical staff was busy and did not know how to approach the matter. The psychosocial delegate was asked to step in as there was an urgent need for beds for other beneficiaries. The delegate took time to talk to the patients and after some time at their bedside they found solutions that would help them back into the community. One patient was simply extremely scared. After explaining that his reactions were normal in an abnormal situation, he felt relief and left the hospital. Other patients called family members who accompanied them home.

places where beneficiaries are gathered in beds. Activities centre on the materials in the kits (described in chapters 3, 4 and 5) as well as community outreach activities identified as relevant and appropriate in the local context. The set-up and procedures for interaction are explained in subsequent chapters of this manual.

Following a natural disaster that hit a poor community, the psychosocial delegates established a meeting with the local administration during the first couple of weeks of the operation. The objective of the meeting was to promote a plan for establishing a school-based programme as soon as possible.

In the Haiti earthquake the school-based activities were conducted in a tent as most buildings were destroyed. The local administration appreciated the initiative of the delegate as they had limited knowledge of the importance of school-based

The main functions of the ERU psychosocial support component

1. Play and recreational activities for children.

This is facilitated through creating a child-friendly space[12] i.e. a space that is perceived as safe by both the children themselves and their parents. Child-friendly spaces create a sense of normality and provide a safe place for children to play, learn and socialize. Activities have a strong psychosocial support component as they provide a caring and normalizing environment to mitigate the impact of the crisis on the children while their parents or guardians may be otherwise occupied. Activities are offered regularly and include games, drama, art activities, non-formal educational activities and sports. They are facilitated by volunteers who are familiar with the contents of the kits and have been instructed in how to use the materials. The psychosocial delegates supervise all activities led by volunteers.

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

Try to combine the types of activities in a Child-Friendly Space. Mix between structured, and less structured, physical and quiet, and indoor and outdoor. The table below shows how you can use activities to accomplish different purposes[13].

Child-friendly Spaces - Activities to Organize for Different Purposes

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

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

In the context of the ERU the play and recreational activities have the dual function of both caring for the children and occupying them while they wait for examination or treatment of themselves and/or parents. Eventually these activities may transition into formal schooling, after-school recreational activities for school-age children, out-of-school activities for adolescents and youth, and club activities or community social activities.

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

Adults who are either transferred from triage in the health ERU or seek assistance directly from the ERU psychosocial support component are given practical help, such as provision of information about the emergency or assistance to link up to missing family members, as well as emotional and social support. The help is offered through supportive listening, providing psychological first aid, and constructive dialogue about local resources and places to seek help. Interaction with adults is facilitated through volunteers who have been trained to provide this type of support. A set of brochures is available in the kit to facilitate the transfer of information.

A psychosocial delegate working in Bam, Iran, after the earthquake in 2003 realized the need for an information campaign on the Restoration of Family Links (RFL). A high number of people had turned to the psychosocial tent to search for their relatives. The Psychosocial delegate shared this information with the ICRC (the RCRC entity mandated to restore family link) and posters were hung on buildings in the communities on where and how to register missing family members and how to report family reunifications.

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

3. Reaching out to communities

The ERU psychosocial support component is potentially a hub for reaching out into the surrounding communities. If feasible, support groups and other outreach activities may be organized. Part of this work goes on inside the ERU psychosocial support component itself, whereas other parts take place in the surrounding communities. It can also be carried out in collaboration with local resource organizations such as local health authorities, the operating National Society, NGOs or other existing entities, that have been identified during the initial assessment and mapping procedures. Please see chapter 2 for more details on this.

4. Training interventions

Different types of training interventions also take place in the context of the ERU psychosocial support component. An initial activity after deployment of the ERU is to identify and recruit volunteers to assist in enabling and facilitating the activities described above (see chapter 2 of this manual). These volunteers will be trained in supportive listening and psychological first aid (see chapter 5) and receive instruction in how to use the materials contained in the kits. Initial training will be followed by refreshers and/or training of newly recruited volunteers. There may be orientation sessions for ERU colleagues and other humanitarian staff working in the area and awareness-raising sessions aimed at the general population of the area or specific groups that have been identified. The outline of such an orientation session is also described in chapter 5.

Following the Haiti earthquake a psychosocial delegate was requested to step in to assess if an old man that would not communicate with the busy medical staff had a mental disorder. The man had been treated for wounds but no one knew anything of his origin or family The psychosocial delegate and a volunteer spent some time with the man who slowly began communicating. He was overwhelmed by the crisis events, but did not have a mental disorder. The volunteers offered psychological first aid and the man regained his wits and started communicating again.

Limitations of ERU psychosocial work

Providing psychosocial care as part of emergency health work has great potential and is a basic premise for the ERU psychosocial support component, but it is never the aim to deliver individual or group counselling or psychotherapy. It is important to differentiate between psychosocial support on the one hand and psychiatric and psychological care on the other. There is a distinction in the origin and nature of the conditions that individuals suffer from. People with psychiatric disorders must be treated differently by health workers in the field as psychosocial activities and care do not include psychiatric disorders i.e. depression, post-traumatic stress disorder and related conditions. Assistance to people with severe mental disorders requires medical diagnosis and treatment and is undertaken by medical personnel with a specialized training in this field. Usually it involves a combination of biological, social and psychological interventions.[14] Most often such cases require referral to specialized services and the decision on appropriate action will be taken by the ERU medical staff. In some occasions the psychosocial delegates will be the first to meet people with mental disorders and they will liase with the local authorities in identifying help for these patients, and in other occasions the psychosocial delegate may be requested to assist other ERU staff in the assessment of patients with mental disorders.

People with severe mental disorders belong to an extremely vulnerable group in disaster settings. Often it is beyond the scope of ERU work to care directly for this group; however it might be possible to interact with local health authorities to look for possible solutions and to do referrals to specialized health services if available in the country. Supporting the care-givers of individuals suffering from mental disorders is an indirect way of addressing this complex issue.[15]

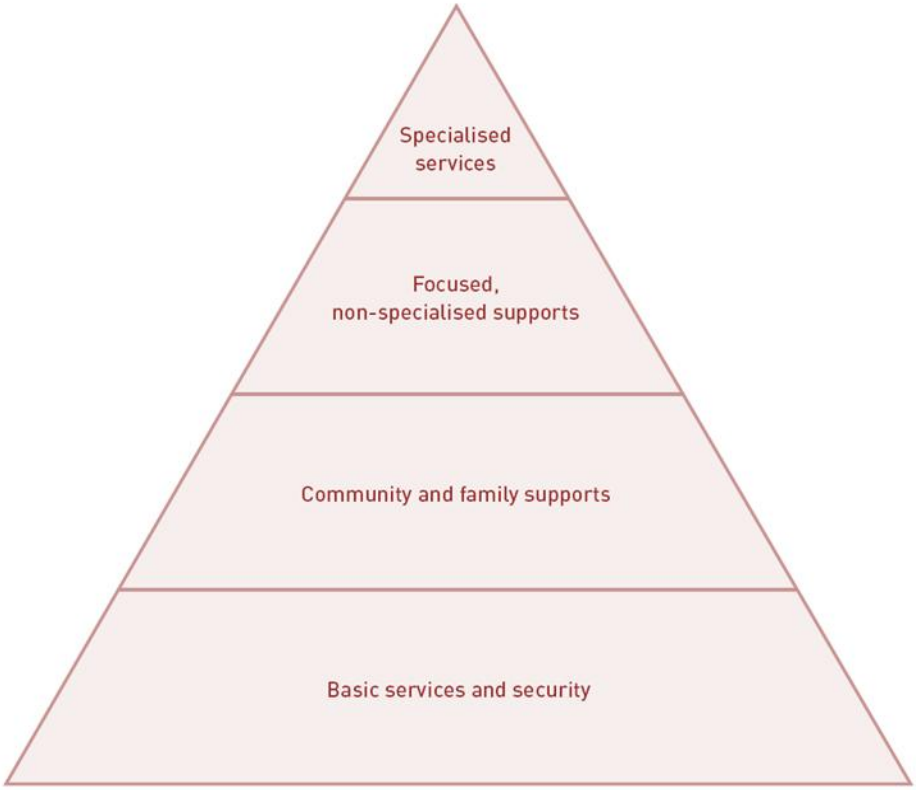
At-risk groups

In emergencies, not everyone has or develops significant psychological problems. Many people show resilience – the ability to cope relatively well in situations of adversity. Depending on the emergency context, different groups of people are at increased risk of experiencing social or psychological problems. All sub-groups of a population can potentially be at risk, depending on the nature of the crisis. The following are groups of people who frequently have been shown to be at increased risk of various problems in diverse emergencies[16]:

Group	Vulnerability characteristics
Women	**Pregnant women, mothers, single mothers, widows and, in some cultures, unmarried adult women and teenage girls**
Men	**Ex-combatants, idle men who have lost the means to take care of their families, young men at risk of detention, abduction or violence**
Children (from new-born infants to young people 18 years of age)	**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 or under-stimulated children**
Elderly people	**Especially when they have lost family members who were caregivers**
Extremely poor people	**Low income and poor access to services, often marginalised**
Refugees, internally displaced persons (IDPs) and migrants in irregular situations	**Especially trafficked women and children without identification papers**
People who have been exposed to extremely stressful events/trauma	**People who have lost close family members or their entire livelihoods, rape and torture survivors, witnesses of atrocities, etc.**
People with severe mental disorders	**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**

Multi-layered supports

In emergencies, people are affected in different ways and require different kinds of supports. A key to organizing mental health and psychosocial support is to develop a layered system of complementary supports that meets the needs of different groups. This may be illustrated by a pyramid[17] . All layers of the pyramid are important and should ideally be implemented at the same time.



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). These basic services should be established in participatory, safe and socially appropriate ways that protect local people's dignity, strengthen local social supports and mobilise community networks.

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

iv. **Specialized services.** The top layer of the pyramid represents the additional support required for the small percentage of the population whose suffering, despite the supports already mentioned, is intolerable and who may have significant difficulties in basic daily functioning. This assistance should include psychological or psychiatric supports for people with severe mental disorders whenever their needs exceed the capacities of existing primary/general health services. Such problems require either (a) referral to specialised services if they exist, or (b) initiation of longer-term training and supervision of primary/general health care providers.

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

Recognizing the signs of stress

While many people show remarkable resilience and capacity to deal with the hardship of emergency or crisis situations, it is important to be aware of the signs of social or psychological stress or distress that they may experience. Stress is a state of pressure or strain that comes upon human beings in many different situations. It can be caused by any change – positive or negative. It is an ordinary feature of everyday life and is positive when it makes a person perform optimally e.g. at an exam. Distress occurs when an individual cannot adapt to the stress they are experiencing and often implies a certain degree of suffering. It is normal for human beings to react when experiencing an abnormal situation. Sometimes people become disoriented, have intrusive memories

and try to avoid being reminded of the crisis situation they have experienced. Other reactions include not feeling anything at all, difficulties in making decisions and isolating oneself from other people.

Roughly the same patterns of reactions are observed across different geographical locations. However, it is important to note that how a person presents a complaint is closely linked to the local interpretation of what it means to go through these reactions. Such interpretations and thus local significance of physical, emotional or behavioural reactions can differ widely from one cultural and social context to the next.

Some commonly recognized reactions of psychosocial stressor factors are:

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

It is common that people reporting these complaints are unaware that emotional and physical stress reactions are normal reactions that follow after exposure to abnormal events. Some are in fact anxious of their own reactions and become even more distressed by fear of not understanding what is going on inside them.[18] Awareness-raising about the normality of such reactions in the aftermath of an abnormal event is an important first step in assisting people to cope with their present situation.

Community mobilization – considering local culture

Community mobilization refers to efforts made from both inside and outside the community to involve its members (groups of people, families, relatives, peers, neighbours or others who have a common interest) in all discussions, decisions and

actions that affect them and their future. The ERU psychosocial support component can play an important role, both in supporting community members in coping with the crisis situation that they have lived through and by initiating and organizing activities that will help communities reassume their normal lives.

As people become more involved, they are likely to become increasingly hopeful, better able to cope and more active in rebuilding their own lives and communities. At every step, relief efforts should support participation, build on what local people are already doing to help themselves and avoid doing for local people what they can do for themselves.[19]

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

When interacting with local communities it is imperative to understand the local social, cultural and religious/spiritual factors that influence the way people experience an emergency. It can be a challenge for relief-workers to consider world views that are very different from their own. There is a delicate balance of respecting a culture or religious values that one does not share or even agree with, while at the same time being aware of potentially harmful practices that may be culturally acceptable in the local setting. Examples of such harmful practices are corporal punishment of children and female genital mutilation; if a relief worker becomes aware that such irregularities take place, he or she has the responsibility to immediately act, take necessary measures and inform relevant authorities.

Protection and human safety

Threats to the safety of individuals and communities influence negatively on 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, 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.

Attention to protection issues often unfolds on several levels at the same time: There is an immediate need to protect and care for individuals or groups whose safety has been compromised, while at the same time addressing protection issues at a higher level, e.g. by interacting with relevant authorities and promote improvement of present conditions. Humanitarian workers can contribute to protection in many ways. It is essential to deliver relief aid and services in a dignified way that supports vulnerable people, restores their dignity and helps rebuild local networks. It is often seen that the most effective social protection occurs when local people organize themselves to address threats, thereby creating a sense of empowerment and the possibility of sustainable protection mechanisms.[20]

Do no harm

The principle of 'do-no-harm' originates in emergency medicine. It reminds healthcare providers that they must consider the possible harm that any intervention might do to a patient. In humanitarian aid it refers to the unintentional harm that may be caused to those who are supposed to benefit from an emergency intervention.[21] Psychosocial action in emergencies can potentially cause harm because it deals with sensitive issues that are culturally specific. Humanitarian workers ideally esteem the culture, belief systems, established habits, attitudes, behaviour, and religion in the place where they work. They possess the skills to communicate and work closely together with community leaders and representatives, as well as the pedagogical skills to transfer knowledge and skills to community members or voluntary workers that are delivering many of the actual interventions.

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

Chapter 2: Getting started

This chapter describes some of the major tasks involved for psychosocial delegates and provides guidance on how to structure initial activities after ERU deployment.

Responsibilities of the psychosocial delegate

The overall task of psychosocial delegate is to plan and support basic psychosocial activities as part of the work of the ERU, together with the Operating National Society and/or local health authorities.[22]

This entails the following tasks:

- Set up the psychosocial component where possible and appropriate in the vicinity of the ERU
- Interface with ERU colleagues, agree on modes of collaboration and flow of patients through the clinic
- Establish the line of command and the reporting requirements together with the ERU team leader and the hospital Administration
- Establish the budget for psychosocial activities
- Take part in health assessment activities with specific focus on psychosocial issues, mapping of resources and identification of gaps
- Assess existing mental health and psychosocial resources and link up where necessary and possible
- Interact with Operating National Society to identify volunteers to assist in running the psychosocial activities
- Facilitate training of volunteers in psychological first aid and emotional support to affected groups and individuals
- Instruct volunteers on how to organize games and play activities for children
- Launch psychosocial activities
- Organize outreach activities, e.g. community-awareness raising sessions and establishment of support groups
- Inform ERU team members on psychosocial issues, including psychosomatic, grief and extreme stress reactions that can occur within the affected population
- Liaise with local health authorities, WHO, UNICEF and others regarding psychosocial interventions and mental health care at e.g. cluster meetings if applicable
- Conduct short awareness raising trainings on the need for psychosocial support to people in leadership positions for example in the emergency response organizations, camp committees or military personnel assisting the ERU
- Establish opportunities for mourning of the dead
- Continuously asses, monitor and evaluate needs and activities, follow up when necessary

Successful psychosocial delegates possess the communication skills necessary to enable them to work closely with community leaders and representatives, as well as the

pedagogical skills to transfer knowledge and skills to community volunteers who will conduct most of the activities. It is essential that the delegate works on the premise that culture, belief systems, established habits, attitudes, behaviour, and religion are to be respected and leveraged, in order to facilitate improvements in the health and general well-being of the public.

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

Setting up the psychosocial support component

A psychosocial delegate in an ERU will be working in challenging and chaotic circumstances with limited access to resources. There will be situations where the psychosocial delegate will have to improvise to find the best possible solutions to many unforeseen challenges and problems. A timeline describing activities in relation to ERU deployment and the psychosocial support component is found on page 20. All activities described in this and later chapters relate to this overview.

Once the ERU has been deployed and all delegates have arrived on the location for the ERU operation, the initial action is to identify a suitable site for setting up the psychosocial support component. As part of the health ERU, this may either be in the immediate vicinity of the Basic Health Care Unit or Referral Hospital. If a more appropriate location is identified, e.g. in connection with a spontaneous camp or a camp for internally displaced people (IDPs), the psychosocial support component may be set up here.

The ERU psychosocial support component may be housed in one or two tents where most of the activities are coordinated and carried out if space allows. Some interaction requires one-on-one communication

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

and a relatively quiet space to create a sense of privacy. If needed this space may occasionally be used hosting a group mourning a dead relative.

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

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

Checklist for setting up the psychosocial component

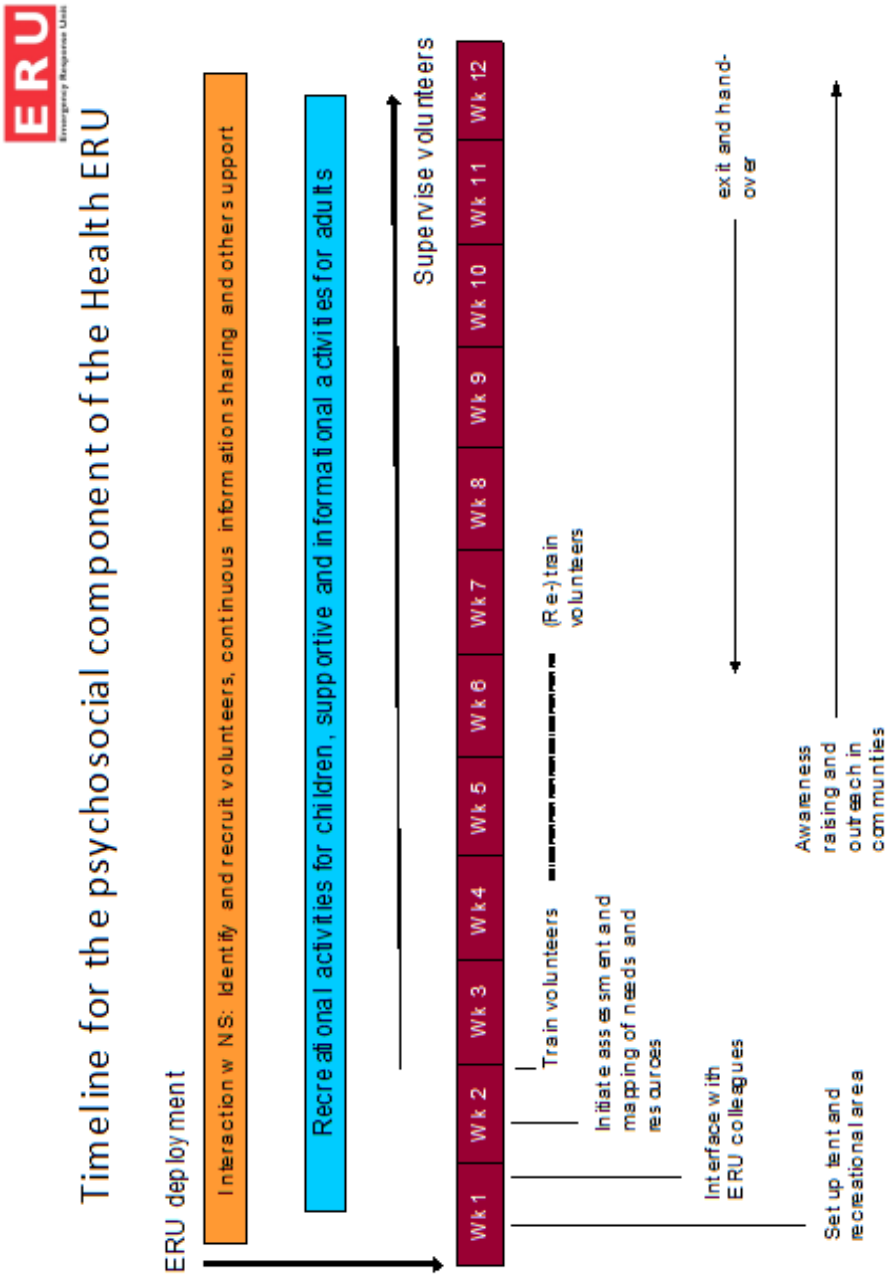
- Decide the appropriate spot for the tent of the psychosocial component
- Coordinate with the ERU colleges
- Initial assessment of needs and opportunities for activities
- Inform and liase with other ERUs, NGOs and local authorities
- Ensure budget for activities such as training, development, translation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

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

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

Dual function: psychosocial support to the ERU and to the general public

The psychosocial component of the ERU has a double function as it serves the ERU and at the same time serves the community. Regardless of its location, the psychosocial support component has the potential to become a hub for interacting with the surrounding community and a place from where to organize outreach activities. It is important to signal the dual function of the ERU psychosocial support component; that it operates in relation to the ERU specifically and as a service to the general public.



Interaction with the Operating National Society

An important next step is to approach the Red Cross Red Crescent National Society in the country of operation. Depending on the location of the ERU deployment, this may be at either headquarters or branch level. The decision for how and when to get in touch with the Operating National Society lies with the ERU team leader as interaction must be coordinated. The primary purpose of the visit is for the ERU psychosocial delegate to explain the purpose of the ERU psychosocial support component and to request a number of volunteers who may assist in carrying out the activities. The availability of volunteers is dependent on both the nature of the disaster that the ERU is responding to and the resources and capacity of the Operating National Society. If possible the psychosocial delegate should seek to have a contact person in the Operating National Society with whom to interact.

Checklist for interaction with Operating National Society

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

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

An information sheet has been developed on how best to support National Society volunteers; this is found in kit 3 of the psychosocial support component (see overview of printed materials in chapter 4, page 46). The information sheet explains how working as a volunteer during or after an emergency is often beneficial, but that it also puts pressure on most people, due to the hectic and chaotic environment of emergency settings. The information sheet describes how it is the responsibility of the National Society to create a supportive work environment for the

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

volunteers and that, if possible, support mechanisms should be established. The information sheet deals with the well-being and working conditions of volunteers in general and may be used as an advocacy tool when interacting with the Operating National Society.

Establishing a profile of psychosocial needs

While planning the launch of the ERU psychosocial activities, the psychosocial delegate must assess the context in which the psychosocial support activities will be implemented. This may be done either in connection with the general health assessment carried out by the ERU team or as a separate activity. Establishing contact with local health authorities, organizations and stakeholders in the psychosocial field, with the aim of locating resources and identifying gaps, is an important first step. In most emergencies different groups such as government departments, UN organizations and NGOs will collect information on psychosocial and mental health issues. Psychosocial action must always be coordinated as much as possible with other entities.

An overview of key information to be collected includes:

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

	• Mapping of potential partners and the extent and quality/content of previous MHPSS training • Mapping of emergency MHPSS programmes
Programming needs and opportunities	• Recommendations by stakeholders • Extent to which key actions outlined in IASC guidelines are implemented • Functionality of referral systems between and within health and other, social, education, community and religious sectors

To complement the information collected when following the above headers, and in order to facilitate a mapping of existing or disrupted services and activities, a checklist has been developed to facilitate the assessment procedures. This is found in Annex 2 of this manual and is also available in the tools section of the ERU psychosocial support electronic folder for direct print-out.

Information to establish an initial profile of on-going activities, as well as to identify gaps and unmet needs, will be collected mainly through qualitative methods, including focus group discussions, key informant interviews, observations and site visits.[23] Quantitative information, e.g. existing data in health systems, can be helpful to complement the picture.[24]

Recruiting and engaging volunteers

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

Checklist for recruiting and engaging volunteers

- Draw up an initial plan for activities
- Conduct training of psychosocial volunteers on PFA and activities
- Establish a daily routine with volunteers, role call, working hours, meetings etc.
- Set up procedures for inclusion and exclusion of volunteers
- Ensure volunteer policy is in place

Ideally, volunteers recruited to assist with implementing ERU psychosocial activities should have a background in providing social support services; however it may be impossible to recruit volunteers who already have such experience. In reality, there may little room for the delegate to influence or decide on the volunteers who come to work in the psychosocial support component; however the delegate should use every

opportunity he or she has to recruit volunteers with appropriate background, as school teachers and social workers, as well as those with experience.

In the first days of ERU deployment, the psychosocial delegate will be planning the launch of activities and at the same time organizing and facilitating the initial training of the volunteers that have been recruited or allocated through the National Society. Chapter 5 of this manual deals with the issue of training volunteers and others, in preparation for taking part in ERU psychosocial activities. It is important to note that training of volunteers should not be seen as a one-time exercise, as it most likely must be repeated during the period of ERU deployment. There are several reasons for this: The volunteers may not be the same throughout the period of deployment and it may be necessary to retrain the same group of people after they have become familiar with the activities. There will often be an influx of people looking for a job and thus approach the ERU requesting to join the team. If the team of volunteers is complete it is essential to instruct i.e. guards and volunteers on how to turn requests down in a respectful way.

If a volunteer seems dispirited or shows lack of understanding of psychosocial support it is recommended to talk to the volunteer to find out if the volunteer needs more guidance or is not interested in the work and would prefer to take part in other activities or in taking on other tasks.

In a particular situation two psychosocial volunteers were no longer engaging in the work of the ERU and preferred chatting cosily – or so it seemed - under a shady tree. The psychosocial delegate approached the volunteers and asked them how they were, what they thought about the psychosocial support, etc. This clarified that there was a minor misunderstandings between the two and some of the other volunteers. The misunderstanding was rectified and after this they were able to participate fully in the daily work.

In most cases the volunteers will get an incentive or a per diem – that is a small amount to cover daily expenses for instance when travelling to and from the ERU. The volunteers may be without any means having lost their jobs. There is a roll call every day to ensure who will get the per diem in the end of the week. It is important to ensure the handover of money is done in a locally acceptable manner.

Launching psychosocial activities

Throughout the time span of ERU deployment, it is the responsibility of the psychosocial delegate to plan, coordinate and oversee the activities that are carried out, while the volunteers facilitate the activities. This is done by using the materials contained in the three ERU psychosocial kits. An in-depth description of the items contained in the kits

and suggestions for relevant activities for children and adults are provided in chapter 3 and 4. It is expected that the delegate will spend more time closely supervising activities early on during deployment. As volunteers become familiar with facilitating activities and interacting with community members, the psychosocial delegate may devote more time to other activities as organizing outreach activities in surrounding communities, re-training volunteers, linking up to local organizations and initiatives and gradually preparing the exit and handover.

In order to be recognized as a resource within the local community, it is important to clearly communicate opening hours for the psychosocial support component, and announce both the on-going activities and special events as awareness-raising sessions and support groups.

The ERU psychosocial support component is an open space. Children come to play and adults come to socialize, seek assistance and information about the emergency and possibilities for further assistance. Both children and adults may receive emotional and social support in dealing with the distress or grief they are experiencing. Some community members will come only once, and the intention is that they benefit from this visit by being informed, made aware of their own reactions or simply have a pleasant time while playing or talking.

Other community members will become part of a group of 'regulars' and activities must be designed in a way that meets their needs as well.[25]

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

The timeframe of operation of health ERU deployment is usually up to three months. After this time the contents of the ERU including the psychosocial support component

will usually be handed over to the Operating National Society or other another organization working in the area of operation. It is important to continuously interact and coordinate with other psychosocial support action implemented by local or international agencies. It may be that there is an interest to continue activities as part of a formalised psychosocial support programme.

Daily and weekly reporting requirements

In the first weeks of an ERU deployment there are daily oral and written reporting requirements. The PS delegate will give a daily oral report to the team leader; head of ERU or to all colleagues at the daily staff meetings. There will be daily reporting of statistics as well as situational reporting to the head of the ERU. The format for the written documentation in the form of statistics and Situational reports (Sitrep) will be supplied by the ERU. A weekly narrative report with statics is to be done once a week after the form is in Annex 3 of this manual and found in the 'tools' section of the ERU psychosocial support folder. They may be requests for other reporting requirements depending on the context. It may be the local hospital administration wishing to get an update on the psychosocial activities or the National Society gathering information to gather an overview of all psychosocial activities in the area. After the first weeks deployment delegates will usually hand in situational reports for a period of two to three days and at the end of a deployment it will probably only be once a week.

Checklist of reports

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

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

Monitoring and reporting of on-going activities

When activities are being carried out by volunteers on an everyday basis, the psychosocial delegate will assume the role of monitoring what goes on within the ERU psychosocial support component. The delegate is the supervisor of the volunteers and must make sure that volunteers interact with children and adults in an appropriate manner. The delegate must also be aware of possible signs of stress and continuously assess the dynamics within the group of volunteers. The group composition may change over the period of ERU deployment and most likely the volunteers training will be repeated for new and old volunteers. There may be opportunity to raise awareness of the benefits of psychosocial support or the importance of self-care with volunteers working in other sectors or staff working for other organizations.

At the same time the delegate will continually assess psychosocial needs with the community and look out for local initiatives. There will be coordination activities and information sharing with local and international organizations working in the field of mental health and psychosocial support. The activities carried out within the ERU psychosocial support component will continuously be adapted to the surrounding environment. A monitoring form has been developed to register activities and numbers of people assisted on a daily and weekly basis. The form is in Annex 3 of this manual and found in the 'tools' section of the ERU psychosocial support folder. The psychosocial delegate should integrate their reporting of psychosocial activities with reporting of other activities within the ERU as per agreement with the ERU team leader.

Right after a cyclone in Bangladesh the psychosocial delegates established a daily routine of gatherings with the volunteers: in the morning for the role-call and planning of the day's activities; at lunch to follow up on the incidents of the morning and in the evening to talk about the work of the day This allowed the delegates to monitor the activities and the well-being of the volunteers.

Visibility and the media

Following the deployment of ERUs there will be visits from journalists who wish to know more about the effect of the relief operation. The psychosocial activities provide excellent media and photo opportunities and as the approach is relatively new, it is interesting to the media. Exposure is essential to mobilize interest – also moneywise - for the relief operation and it is an opportunity to explain the need for

Checklist for contact with the media

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

psychosocial support and to give the world an impression of the work in the ERU. It is important to keep the goal of the ERU in mind when setting aside time for the media. The influx of reporters may get in the way of the work and may overwhelm the beneficiaries. The delegates must secure the acceptance from the head of the ERU for interviews and if beneficiaries are portrayed, they need to give informed consent to interviews as well as photos.

After the initial phase

All ERU deployments differ and the timeline will vary according to the circumstances. Whilst it is easy for the psychosocial delegates to get caught up in the running of the day to day activities it is important to build capacity of volunteers and local branch to enable sustainability of psychosocial activities when the ERU mission is over. It is advised to set up a meeting with the local branch to assist in the planning of future psychosocial efforts in the community. The delegate may (depending on the rotation they are deployed to) experience that the operation has entered a recovery phase and may need to adjust and design the activities according to this. It is important to be flexible and work on an exit strategy together with the national society and their partners.

Checklist for the early recovery phase

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

Ending the ERU mission

The ERU mission is usually of duration of up to three months but in some cases this period may be extended depending on the nature of the crisis event. The hand over and exit is prepared in advance and the psychosocial delegates will prepare a hand over report for the head of the ERU. In this phase the psychosocial delegate will prepare the practical hand over and may offer advice and consult with the local branch to ensure the continuation of the psychosocial support in the community. The local branch and the delegate will prepare plans for future activities and designate who will be responsible for these. Adequate training is prepared well in advance for the volunteers to be able to carry on the activities of the next phase together with the coordinator from the National Society. It is recommended that the efforts of the volunteers are celebrated in a formal farewell ceremony.

Checklist for handover to National Society

- Arrange the handover of material to the National Society
- Plan future activities with National Society
- Prepare documentation for volunteers
- Arrange a ceremony for volunteers

Chapter 3: Activities for children

This chapter deals with providing support to children after crisis situations and describes the contents of the two kits that are dedicated to organizing activities for children.

Supporting children after emergencies

During and after emergencies children are a particularly vulnerable group. Their well-being will most likely become affected if they have overwhelmed exhausted or depressed parents or caregivers who are physically or emotionally unable to provide care, routine and support. Early childhood activities should provide stimulation, facilitate basic nutrition in situations of food shortage, enable protection and promote bonding between children and their caregivers.[26]

An ERU was deployed to a community after a natural disaster that caused the death of a group of adults that had been inside a building that was completely destroyed. Some children lost one parent and some were rendered orphans. The psychosocial delegate was asked to assess the needs of the children and to record the situation of each child in collaboration with the local administration. The aim was to find out if some of children had relatives that could care for them.

The ERU psychosocial support component contains materials for play and recreational activities which represent one aspect of children's well-being. Stimulation and children's opportunities to play and education are often interrupted during crises and emergency situations, and it should be sought to re-establish such opportunities at the earliest possible. Children benefit from having routines that are adhered to as much as possible. Play is important and necessary for children as it develops their understanding of the world around them. Children realise their potential through play and it helps them develop physically, intellectually, emotionally and socially. Skills development falls within several categories:[27]

Why conduct play activities?

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

Skills	Description
Cognitive skills	Involve mental processes in learning, understanding, reasoning, decision making, remembering and problem solving
Sensory skills	Encompass hearing (auditory skills), seeing (visual skills), touching (tactile skills), tasting, smelling and sensing body/muscles and balance (kinaesthetic skills).
Hand-eye	Refer to the control of eye movement and hand movements as well as the

coordination skills	processing of visual input to guide bodily movement. Training of hand-eye coordination happens in e.g. hand writing, drawing, games and sports activities.
Social and language skills	Deal with the interaction of children with other people through communication and cooperation. Encompass the ability to express and respond to feelings in a respectful way, to engage in relationships, to cooperate and solve conflicts. Language skills include understanding what others say as well as developing a differentiated language through expansion of the vocabulary.
Motor skills	Gross motor skills deal with large muscle movements, i.e. using the large muscle groups through physical movement as i.e. when jumping, running or kicking. Fine motor skills deal with small muscle movement when using the mouth, wrists or fingers i.e. when sewing, eating with utensils or writing.

Play kits for children

The play kits contain items to facilitate play and recreational activities for children up to six years old and six to 18 years old respectively. The kits have been designed and assembled based on several premises:
Items are appropriate and usable all over the world and may be adapted to different settings. Each kit contains materials to facilitate play and games activities for approximately 50 children. Toys are made of robust quality that may last for a long time. These toys are appropriate to facilitate social interaction and developmental support, and are suitable for both younger and older children and girls as well as boys.

Volunteers and staff (later referred to as instructors) conducting play and recreational activities with children within the ERU psychosocial support component play area should:

- Adapt games and activities to the local culture and introduce activities that are known and accepted locally[28]
- Supplement with games and activities that do not require material from the play kit, to create a variety of activities and to utilise locally available resources and materials.
- Safe guard the items in the kit and make them last as long as possible.

A detailed presentation and explanation of the use of the contents in the kits are to be found on page 32-44.

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

A. CONTENTS AND USE OF PLAY KIT 1 – FOR CHILDREN UP TO SIX YEARS

This section provides a description of each item contained in kit 1. The description contains some activity suggestions related to each item in the kit. The list is an extended version of the overview provided in the *complete items overview catalogue*. Suggestions for additional activities and games can be found in the document 'List of additional games, play and relaxation activities for children' in the ERU psychosocial support folder

Four transportation boxes with padlock

The play kit comes in boxes that can be locked for protection of the contents. The boxes are made of aluminium and have handles for moving it.

Materials for instructors
P1-09 Soap **P1-03 Adhesive tape** **P1-10 Glue** **P1-04 Pens** **P1-05 Pencils** **P1-06 Eraser** **P1-07 Pencil sharpener** **P1-08 Exercise notebooks**
In order to maintain hygiene in a place where potentially many children stay and use the same toys, soap for washing hands is included in the play kit. All children coming to participate in activities should be shown how to wash their hands in adjourning facilities before engaging in activities. The above items are for the use of those conducting games and activities with the children. Adhesive tape may be used to place drawings or posters on the walls or when making their own activity material from e.g. paper for home-made games etc. Pens and pencils are generally not appropriate for children up to six years old due to their stage of development of motor functions. They should use large crayons when drawing.

Toys and materials for activities

P1-19 Material book

Age 10 months+

The material book is a sensory, tactile and malleable toy. The book is made of one kind of material and on each page there is material of a different quality which the child can explore by feeling it and it is possible to use the little pockets to put the small items into

or to take the items out of the pockets. This stimulates both the child's sensory skills as well as fine motor skills.

P1-12 Rattle
Age 6 months+
The rattle is used by the smaller children as it is relatively easy to grab and hold on to. The bell inside gives a pleasant and interesting sound when the rattle is shaken.

P1-13 Trix manipulation toy
Age 6 months+
The trix toy is a manipulative toy consisting of small coloured pieces of wood put together with an elastic band. Playing with the toy stimulates the child's fine motor skills and colour recognition.

P1-14 Stacking ring
Age 2 years+
The stacking ring helps children learn about sequencing and supports hand-eye coordination when the rings are placed on the rod. Children can experiment with placing the rings either in sequence or out of sequence. The rings are coloured and thus present an opportunity to deal with colour recognition.

P1-20 Hammer peg
Age 2 years+
The hammer peg supports hand-eye coordination, motor skills and muscle performance. The physical action involved in hammering releases energy.

P1-15 Shape-sorter, plastic
Age 1 to 3 years
The shape sorter is a container with holes in it as well as blocks in the same shapes as the holes in the container. The blocks are to be put into the container through the holes and in this way the child learns how to identify different shapes and sizes of objects.

P1-16 Ball, sponge, diameter 10 cm
Age 1+ years
The small sponge balls are used for simple throw and catch games involving one, two or more children. The balls may also be rolled across the floor between players and the game may simply consist of giving and receiving time and again between the child and the adult. The advantage of sponge balls are that they are easy to grip for small hands and are not hard or heavy to play with.

P1-17 Toy blocks, wood, coloured

Age 1 year+

Blocks are used for building simple structures and, in the case of younger children, for mounting one on the other. This supports the development of manipulative skills, fine motor skills and the use of imagination when constructing. Large blocks are well suited for the smallest children as they are big and easier to grip for little hands. They do not stick together like Plus plus (see below), thus it is easy and fun e.g. to push over a tower or a wall built by these bricks and watch the tower collapse.

P1-21 Plus plus blocks, light foam material

Age 3 years+

Plus plus blocks are used for construction at any level the child is able to. This aids the development of manipulative skills, fine motor skills, hand-eye coordination and social skills in terms of learning to cooperate when two or more children build something together. Playing with Plus plus blocks also teach the children about cause and effect, spatial relation, part/whole, proportions and problem solving.

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

P1-22 Crayons, jumbo size, coloured, wax
9 months+
The jumbo size crayons are suited for the younger children as they are easy to grip for small hands.

P1-23 Crayons normal size, coloured, wax
Age 3 years+
Depending on the individual child's preference and motor skills, they may start using crayons of normal size by the age of 3.

Caution: for both jumbo and normal size crayons please note that they may break into small pieces which small children may put in their mouth, eat or choke on. Therefore, drawing activities with small children should always be supervised.

P1-24 Safety scissors, plastic
Age 5+ years
Children aged may use scissors when carrying out creative activities with paper. The scissors are safety scissors with blunt tips as children this young do not yet have full command of their motor function and may hurt themselves or others if playing with ordinary scissors.

P1-02 Drawing paper (sugar paper), A-4, white
The paper, also called sugar paper, is used for drawing activities. It has a slightly rough surface making it well suited for drawing on as the colour attaches more easily to this kind of paper than to e.g. photocopy paper. As there is a limited amount of paper available in the boxes it is recommended to be fairly specific about the drawing activity – talking to the children about what they want to draw and give suggestions, not letting them draw some squiggles and then throw the paper away for lack of inspiration. The drawings can be hung on the walls of the playing room afterwards or the children can take them home.

P1-23 Paper roll, brown
The paper can be used for drawing activities. It can be used in long pieces either placed on a row of tables or on the floor. It may also be hung in one long piece on the wall in a suitable height for the children to stand beside each other and draw. The paper roll is used when the drawing activity is a common activity as when a group of children draws a big picture together as a town, a ZOO, a forest with animals.

P1-25 Plasticine

Age 3+ years

Plasticine is used to form small figures using your hands in the same way as one would use clay. This stimulates the tactile and fine motor skills as the soft material is squeezed, shaped and manipulated. Children use their imagination and train their ability to concentrate when playing with plasticine. It may be shaped into anything imaginable; animals, vegetables, plants, people, household items or anything else.

Before starting to play with the plasticine children should be instructed that after the play has finished they must dismantle their figures, split them by colour and put the different coloured plasticine bits back into their containers. In other words, plasticine is for playing with here and now, and not for producing something to take away afterwards. Otherwise the plasticine will soon be gone. In order to keep the colours clean, children should be instructed not to mix the colours, - only use them on top of each other (e.g. a red hat on top of a yellow head – but not mixing red and yellow into orange). When it is not being played with, the plasticine must be kept in its containers with the lid properly closed as it will otherwise soon dry and become useless. It may help to keep a small piece of wet cloth in the containers while the plasticine is not in use.

While at the age of 3 children would normally stop putting everything into their mouth, when playing with plasticine, children must be closely supervised by adults in order to make sure that the smallest children do not eat it.

P1-27 Puzzle with knobs on the pieces

Age 2 years+

This puzzle only has a limited amount of pieces and the pieces fit into holes in the puzzle without fitting together. Each piece has a knob on it and is suitable for the smallest children who equally enjoy placing the pieces and taking them back. Through trial and error, children will slowly realise that shape and position matters, - after a while, with some adult guidance, the process of comparing the hole, the brick and its position begin to solidify.

P1-28 Puzzle (six puzzles of 4-9 pieces each)

Age 3 years+

At this age the child may move from fitting pieces of a puzzle in the wood frame to assembling loose pieces in a puzzle. The process of making a puzzle supports the development of hand-eye coordination when manipulating the piece into the right position, the pincer grip, which is later used for holding a pencil, when writing picking up the pieces and laying them down, concentration, problem solving, spatial awareness

and coordination of thoughts and actions. When more than one child lays a puzzle, social skills as cooperation and compromising are also trained.

P1-29 Puzzle (of 18-35 pieces)
Age 5 years+
Please see description above.

P1-30 Memory game, bingo and domino (in one package)
Age 3 years+
Board games are useful for learning social skills such as waiting for your turn, following rules and accepting that sometimes you win, and sometimes you lose. The three games are specifically designed for younger children, with big and colourful pieces. The games should be played under the guidance and supervision of an instructor. For all three games please see the English language instruction of the games.

It is also possible to make your own memory game, e.g. with numbers or signs or pictures by drawing small drawings matching in pairs on paper and cutting them out in small squares. The game may be varied and made more challenging by pairing objects which are not the same but connected as pencil and rubber, book and school bag, shirt and trousers.

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

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

This section provides a description of each item contained in kit 2. The description contains some activity suggestions related to specific items. The list is an extended version of the overview provided in the complete items overview. Suggestions for additional activities and games can be found in the document 'List of additional games, play and relaxation activities for children' in the ERU psychosocial support folder.

Eight transportation boxes with padlock

The Play kit comes in boxes that can be locked for protection of the contents. The box is made of aluminium and has handles for moving it.

Materials for instructors
P2-02 Soap **P2-03 Adhesive tape** **P2-04 Glue** **P2-05 Pens** **P2-06 Pencils** **P2-07 Eraser** **P2-08 Pencil sharpener** **P2-11 Exercise notebooks**
In order to maintain hygiene in a place where potentially many children stay and use the same toys, soap for washing hands is included in the play kit. All children coming to participate in activities should be shown how to wash their hands in adjourning facilities before engaging in activities. The above items are for the use of those conducting games and activities with the children. Adhesive tape may be used to place drawings or posters on the walls or when making their own activity material from e.g. paper for home-made games etc.

Arts activities

P2-09 Drawing paper (sugar paper), white, A4

The paper, also called sugar paper, is used for drawing activities. It has a slightly rough surface making it well suited for drawing on as the colour attaches more easily to this kind of paper than to e.g. photocopy paper. As there is a limited amount of paper available in the boxes it is recommended to be fairly specific about the drawing activity – talking to the children about what they want to draw and possibly give suggestions and not letting the children just draw some squiggles and then throw the paper away for lack of inspiration. This will also help children figure out, what they want to draw and result in a feeling of accomplishment having worked with concentration on their idea and what

they want to express. The drawings can be hung on the walls of the playing room afterwards or the children can take them home.

P2-45 Paper roll
The paper can be used in long pieces either placed on a row of tables or on the floor, It may also be hung in one long piece on the wall in a suitable height for the children to stand beside each other and draw. The paper roll is used when the drawing is a common activity as when a group of children draws a big picture together of e.g. a town, a ZOO or a forest with animals.

P2-12 Crayons, wax
Crayons are used for drawing and colouring drawings.

P2-13 Colour pencils
From approximately the age of 4 to 5 children are able to use pencils for drawing as their fine motor skills are more developed.

P2-14 Pencil sharpener
Sharpeners are used to sharpen colour pencils.

P2-15 Plasticine, coloured
Plasticine is used to form small figures using hands in the same way as one would use clay. This stimulates the tactile and fine motor skills as the soft material is squeezed, shaped and manipulated. Children use their imagination and train their ability to concentrate when playing with plasticine. It may be shaped into anything imaginable; animals, vegetables, plants, people, household items or anything else they may think of.

Before starting to play with the plasticine children should be instructed that after the play has finished they must dismantle their figures and split it by colour and put the different coloured plasticine bits back into their containers. In other words, plasticine is for playing with here and now, and not for producing something to take away afterwards. Otherwise the plasticine will soon be gone. In order to keep the colours clean children should be instructed not to mix the colours, - only use them on top of each other (e.g. a red hat on top of a yellow head – but not mixing red and yellow into orange). When it is not being played with, the plasticine must be kept in its containers with the lid properly closed as it will otherwise soon dry and become useless. It may help to keep a small piece of wet cloth in the containers while the plasticine is not in use.

Sports activities

Physical and sports-oriented activities are beneficial for both children and adults to engage in. While sports activities provide exercise, it is commonly known that physical movement is also helpful to improve social and psychological well-being.

P2-17 Football, size 5

Footballs are used for playing football or kicking around a ball. For training purposes, different kinds of skills may be practiced, e.g. different kinds of kicks, dribble, curbing, tackling, heading etc. Also tactical elements may be practiced when playing together and rehearse positioning in the field. Football size 5 is the normal size for adolescents and adults to play with.

P2-19 Football, size 3

Football size 3 is used as described above, however is smaller and therefore suited for younger children.

P2-21 Volleyball

Volleyballs are used for volleyball and for training skills used in volleyball such as underhand serve, overhand serve, underarm pass, overhand pass, floater, smash, blockade and many more. These skills may be trained by the children in pairs hitting the ball and catching it between them. If many children are to participate, they may line up in two lines opposing each other and the persons in front will hit and catch respectively, and when a person has had their turn, they will go to the back of the row and wait for their turn.

P2-47 Posts for volleyball net

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

P2-22 Volleyball net

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

P2-23 Inflating kit

The kit is used to inflate footballs and volleyballs.

P2-18 Referee's whistle

The whistle is used by the referee when playing ball games and may also be used to call to attention participants of other games. It can also be used like sounding a bell if you want to make it known to the children in the surroundings that now the play area is open for visit or closed.

P2-24 Sponge ball
Sponge balls can be used when playing with younger children or children who feel uncomfortable playing with the ordinary balls due to their weight and the force with which they can be thrown or kicked. Sponge balls are not suitable for the ordinary ball games but may be used in throw and catch games, in games where the players hit each other with the ball and in singing games involving throwing an item between participants as part of the game.

P2-26 Tennis ball
Tennis balls can be used for various ball games and for throwing and catching games. They may also be used for juggling with two or more balls in the air or against a wall.

P2-25 Round bat
The bat is used to strike the ball when playing e.g. players in two teams.

P2-46 Pickets with flags
Pickets are used mark a playing field e.g. when playing a ball game, thus determining the area within which the game has to take place. They can also be used to mark off a certain section of an outdoor area dedicated to a certain activity.

P2-31 Rope, hemp, 10 m
Rope can be used for the game known as Tug-of-War. Participants are split into two groups consisting of an equal number of players. There may be any number of players on the teams. The two teams will hold on to one end of the rope, each standing behind each other in a row on either side of the middle of the rope. On the ground between the two opponents in the middle a line is drawn and now the two teams will pull each their side of the rope. The team which manages to pull the other team (i.e. the innermost positioned person) across the line on the ground has won.

Rope may also be used to mark the outline of a playing ground in connection to e.g. a ball game by placing it on the ground.

P2-29 Skipping rope, one-person
One-person skipping ropes are used for individual skipping by children for whom the size is appropriate. The ropes may be tied together for skipping in groups. Two participants will swing the rope for the rest of the group, which will skip. Rules for changing who is swinging should be made so that a fair distribution of skipping vs. swinging is experienced by every one.

P2-32 Frisbee
Frisbees are used to throw and catch between players. The frisbee is held in horizontal position and thrown by a twist of the hand towards the catcher horizontally so that the frisbee floats on the air while travelling between the players.

Frisbees can also be used to play 'frisbee golf'. A course of e.g. pickets or other markers is laid out with some distance in between. It is determined which picket is number 1, 2, 3 etc. The players try to throw the frisbee so that it touches the first picket of the course, then the second, the third and so on. Players take turns throwing and have one throw each. If a player's frisbee hits the intended picket he or she gets an extra throw. The player who finishes the whole course first has won.

P2-28 Hoola hoop
Firstly the hoola hoop rings must be assembled as they come in pieces in order to fit into the play kit box. They can be assembled using six or eight pieces for a bigger or smaller ring. Hoola hoops mainly are used by trying to have the hoola hoop circulate around your waist for as long as possible. Besides this, the hoola hoop may be played with in various ways, twirling it around your arms or legs or throw/catch between two or more persons. Hoola hoops may also be placed on the ground in order to mark a playing ground or for jumping from one hoola hoop to the next.

Board games

Board games support the development of social skills, e.g. having to wait your turn, to accept winning/loosing, to accept rules and decisions and to cooperate when this is part of the game.

P2-34 Domino
Age 5 years+
Game for 2-4 players.
Please see the English language instruction of the game.

P2-35 Ludo
Age 5 years+
Game for 2 or more (players may also form teams)
Please se the English language instruction of the game.

P2-36 Backgammon
Age 8 years+
Game for 2 players.
Please see the English language instruction of the game.

P2-37 UNO
Age 7 years+
Game for 2 to 10 players.
Please see the English language instruction of the game.

P2-39 Playing cards
Playing cards are used for any locally well known card games (see below). Playing cards may also be used for building houses of cards, which trains fine motor skills and concentration. This activity may also be organized as a competition amongst a number of players who get 10 or 15 cards each and have to try to build the tallest tower possible. The player whose tower is the tallest has won.

One easy game is “Snap”: Divide the cards evenly between the players. Players hold them face down and take turns to flip the card over into the centre of the table. If the new card and the previous card are equal (e.g. two queens) the first player to shout “snap” wins the cards on the table and adds them to his/her own.[29]

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

P2-39 Mikado
Age 7 years+
2 or more players
The game of Mikado or Spillikins consists of a number of sticks. The game begins by one of the players holding all sticks in one hand up-right over a table or on the ground, and then letting them fall at random. Taking turns the players now try to remove the sticks one by one without making any other stick, than the one they are trying to remove, move. If another stick moves it is the next player’s turn to try. Whenever a player has succeeded in removing a stick without any other sticks moving, she keeps the stick in front of her. The person who has removed the most sticks, when all sticks are taken, has won the game.

Music, song and dance
All instruments in the kit are percussion instruments and are used to mark rhythm. Rhythmical instruments may be used by instructors and children when making music, singing and dancing. The instruments should be used for this purpose – having specific

common activities – not for ordinary playing as the instruments should be handled with care and will make too much noise if just played with at any time in the play area.

P2-41 Xylophone and mallets
Playing the xylophone is not complicated as it is possible to identify the basic notes in a known tune and memorise where they are placed. Playing the xylophone the instructor or children are able to accompany song and dance activities with a tune.

P2-42 Drum, flat, mallet
Flat drums are played by holding the drum in one hand and beating the drum with the mallet which is held in the other hand. It is also possible to place the drum flat on a flat surface and beat it with ones hands or the mallet.

P2-43 Wood block drum, mallet
The wood block drum is played by hitting the drum with the mallet, holding the drum in one hand and the mallet in the other.

P2-44 Tambourine
The tambourine is held in one hand grasping the wooden frame and holding the tambourine in the air. The tambourine may be hit by one's other hand to produce a drum as well as a bell sound. It may also be used by holding it in the same way in the air and shaking it to the rhythm so that the bells on the side of the tambourine sound.

Additional games and activities

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

Chapter 4: Activities for adults

This chapter deals with providing psychosocial support to adults who are affected by emergencies or crisis events and describes necessary action in connection with starting up activities.

Social support and self-help for individuals and communities

All communities contain effective naturally occurring psychosocial support structures and sources of coping and resilience. These may be partially or fully disrupted due to an emergency or crisis situation, and the ERU psychosocial support component will play a role both in providing immediate support in lieu of the disrupted structures, and be instrumental in restoring social support and self-help mechanisms in communities.[30]

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

Purpose of psychosocial component

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

The services available in the ERU psychosocial support component include:

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

Interaction is facilitated through volunteers who have been trained to provide the different types of support.

When designing the physical lay-out of the psychosocial support component, it is important to consider the need for space for different types of interaction and activities that are taking place (see bullet list in chapter 2, page 17. Some interaction requires one-on-one communication and a relatively quiet space to create a sense of privacy.

Other activities as support groups and awareness-raising sessions are group activities that require more space and by nature are noisier as they involve group discussions.

Printed information material

As an initial action in the ERU psychosocial support component, volunteers will be trained in providing emotional and social support to individuals who are experiencing distress or grief following the emergency or crisis situation (see chapter 5 of this manual). The purpose of this interaction is that those seeking support become comforted, informed, made aware of own reactions or simply benefit from having talked to and interacted with someone. A set of brochures is available in kit 3 to facilitate the interaction and transfer of information.

No	Title	Type	Target group	Content
1	**Coping with stress and crisis**	Brochure	Beneficiaries and patients	Helps adults to understand their reactions to extreme events and what they can to help themselves and others
2	**Children's stress and how to support**	Brochure	Beneficiaries: parents, teachers and adults in general	Provides information on children's reactions to crisis situations and how adult may help them cope
3	**Working in stressful situations**	Brochure	Red Cross Red Crescent volunteers, ERU staff and humanitarian staff in general	Provides information on work-related stress and useful action for how to deal with stress
4	**Psychological first aid**	Brochure	Red Cross Red Crescent volunteers, ERU staff and humanitarian staff in general	Provides information on the benefits of psychological first aid and describes basic elements
5	**Supporting volunteers**	Information sheet	Operating National Society	Informs National Societies on how to support and care for their volunteers, and how to keep them safe
6	**Common reaction of persons affected by disasters**	Information sheet	ERU staff and other humanitarian staff	Information on common reactions of persons affected by disasters

7	**All children deserve to be safe**	Information sheet	Volunteers, ERU and humanitarian staff, parents, teachers	One-page information sheet with pictures about violence against children

In the context of this chapter, brochures number 1 and 2 will be especially helpful to inform individuals about normal reactions of either adults or children to crisis events and what can be done to get through a difficult time. It is recommended to spend time during the training session with the volunteers to go through the contents of the brochures and make sure that they are comfortable in using them. All brochures are available in Word format in the ERU psychosocial support folder for quick translation into the local languages.

Group activities

Groups of people with similar problems or life situations – for instance, those who have experienced the same crisis situation benefit from meeting together. In the context of the ERU psychosocial support component, establishing a support group may be an effective way of empowering participants, helping them to support one another and learning that they can make a difference to the group members. It is, however, important that support groups are not used to replace professional help when that is needed. Volunteers who have received basic training in psychosocial support can assist in facilitating support groups. Very often people who have learned to cope with a certain problem can become good role models and are good facilitators when starting a group. The idea is that over time, the group should be self-sustaining.

As part of the initial assessment of psychosocial needs and resources within the setting of an ERU deployment, the psychosocial delegate must seek to identify human resources that will be helpful in providing information on community resources and thus in facilitating psychosocial activities. Examples of such resources are community leaders (including government officials), significant elders, religious leaders or groups, local health practitioners, traditional healers, teachers, social workers, youth and women's groups, neighbourhood groups. A useful strategy in locating resources is to ask which community member people - either themselves or others - normally turn to for support in times of crisis.

Psychosocial support activities for adults within the ERU deployment context should first and foremost support the needs and existing initiatives structures within a community. In addition a range of activities may be undertaken, depending on the context and needs identified during assessment. The following suggestions are by no means exclusive:[31]

- Family tracing and reunification for all age groups
- Re-establishment of normal cultural and religious events for all

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

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

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

Reaching specific groups

Initial mapping and assessment procedures will help in establishing a list of priority areas for psychosocial support activities. Specific groups have particular vulnerability characteristics (see matrix in Chapter 1, page 11) that should always be looked into.

Needs and possible activities aimed at two specific groups are provided below, these are seen to a key intervention area but should not exclude a focus on other, equally vulnerable, groups:

Mothers with young children

Mothers of infants or young children bear responsibility for the well-being of not only themselves, but also their children. It is commonly seen that women who are distressed or grieving neglect the needs of their children. The ERU psychosocial support component is able to address the needs of both children and mothers.

The children may be engaged in the ERU psychosocial support component play activities while their mothers attend support groups with the aim of providing care for caregivers, having a space to share problem-solving, addressing issues in relation to e.g. mother and child health or nutrition, and supporting one another in caring for their children. It is also possible for the mothers to come and play with their children, using the toys and play items contained in the kits. Here the volunteers may be role models for mothers of young children – showing positive interaction and stimulation that the mothers may learn.[32]

Men

In many places all over the world men are the bread-winners of the family and often provide most of a family's monetary income. When disasters hit, men are affected because they often lose the means of being able to care for their families and thus their traditional role in society. Men are also at greater risk of being detained or abducted by armed forces, or they may be ex-combatants who have lost their traditional role in society and become ostracised by community members. These factors add to the distress that they may experience. After a disaster or crisis event, men are more likely to engage in risk-taking behaviour that may be harmful to themselves or others, e.g. alcohol or substance abuse, and inflict physical harm on others.

When conducting the psychosocial assessment in connection with the ERU psychosocial support component and subsequently planning the relevant activities, it is necessary to specifically consider the role and needs of men in the given context. It is not unusual that men (and adolescent boys) may be employed in clean-up or reconstruction activities following a disaster. Men may have specific forums or places where they meet to discuss and socialise and the ERU psychosocial support component may be instrumental in facilitating the specific coping strategies of men.

Chapter 5: Training activities

This chapter goes into detail regarding the organization and facilitation of training sessions for volunteers, as well as orientation sessions for ERU staff and staff of other humanitarian organizations.

The facilitation of trainings is a key task for the delegate in the ERU psychosocial support component. The delegate is likely to conduct trainings and transfer of knowledge and skills on several occasions and will be using many different approaches throughout the period of ERU deployment. It is desirable that the delegate has prior experience in this field and is able to apply this when facilitating trainings and interactive processes for individuals and groups.

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

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

It is important that the delegate continuously assesses the needs and possibilities for trainings and other occasions for transferring knowledge and skills involving members of the affected community as well as volunteers, ERU colleagues and other humanitarian staff.

Refresher training with volunteers is done on a continuous basis and may also be repeated with ERU staff and other humanitarian workers, as there is usually a high turn-over of staff.

Contents and use of training kit 3

The items included in kit 3 will assist the implementation of trainings and various interactive sessions for volunteers, community members and ERU colleagues. The items are thus not to be used directly by community members, but rather to facilitate the work of the volunteers and others involved in the work of the ERU psychosocial support component. The items in kit 3 are listed below and also found in the ‘complete items overview’ catalogue.

Two transportation boxes with padlock

The training kit comes in boxes that can be locked for protection of the contents. The boxes are made of aluminium and have handles for moving it.

P3-08 Flipchart stand, foldable
P3-09 Flipchart paper
P3-02 Markers for flipchart
The flipchart stand, flipchart paper and markers are used by the ERU psychosocial delegate, or another person designated by the delegate, during training and facilitation sessions. These items may also be used by participants in the training sessions, during group exercises or when presenting the outcome of group discussions.

P3-03 Exercise books, lined
P3-04 Pens
The exercise books and pens are handed out to volunteers and others who attend the trainings facilitated in the ERU psychosocial support component. Training participants will use the notebook during the training and keep it afterward as a source of reference and to make further notes.

The printed information materials to facilitate interaction with adults, described in chapter 4 are also stored in kit 3, as are extra copies of this manual and the *Handbook for volunteers*. In addition, all these materials are found in electronic format in the ERU psychosocial support folder.

Instructions for training facilitation

The trainings described in this manual have been designed to be very practical and hands-on, with high emphasis on interaction both between the psychosocial delegate and participants and amongst the participants. The use of pre-prepared presentations and power points[33] are kept to a minimum; instead focus should be on providing specific tips or instructions for the various topics of the training.

When facilitating trainings, the delegate must plan and adapt according to the circumstances, background knowledge and experience of participants and the overall aims of the training. For more information and tips about training facilitation please refer to the *Trainers book* of the *Community-based psychosocial support training kit*[34] which is available in the ERU psychosocial support folder. The introductory sections of the *Trainers book* deal with how to plan psychosocial support trainings, the learning process in a psychosocial context, and preparing and conducting a workshop in psychosocial support. The book also provides useful insights and tips on how to organize trainings.

A set of resources and materials have been developed to support training and the transfer of skills and knowledge within the ERU psychosocial support component. The delegate should utilise these resources to the largest extent possible when interacting with participants in the training sessions. Referring to the overview of printed material on

in Chapter 4, especially brochures number 3 and 4 and information sheets 5, 6 and 7 will be useful hand-outs during the trainings.

A. Training of volunteers

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

- Have some knowledge of what an ERU is
- Understand what kind of activities go on inside the ERU psychosocial support component
- Be able to support another person through psychological first aid and supportive listening
- Have received an introduction to the items in the kits and on how to interact with children and adults respectively
- Be aware of the possible stress of their work as volunteers and how to take care of themselves

The identification and selection of volunteers for the ERU psychosocial support component is in collaboration with the Operating National Society. The process of establishing contact to the Operating National Society is described in Chapter 2. As soon as a group of volunteers has been identified, the initial training should be planned and carried out, preferably within the first or second week of ERU deployment. In order to facilitate the planning a checklist has been developed; listing some practical considerations. It is included as Annex 4 in this manual and found in electronic format in the ERU psychosocial support folder.

1-day training programme

The volunteer training programme that has been developed for this manual lasts for one day. It may be extended if circumstances permit. The template programme is shown below, but might need to be adjusted by the delegate according to the situation. An extended version of the programme is included as Annex 5 in this manual and found in electronic format in the ERU psychosocial support folder. The full programme template is a planning tool for the trainer; it includes instructions and information on what materials must be made available to the participants during the sessions.

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

In the following, each session of the above programme is briefly described, providing suggestions for contents and structure.

Session 1 – Welcome

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

After the formal opening, the ERU psychosocial delegate describes the purpose of the training and goes through the programme for the day. The programme may be handed

to participants or written on a piece of flipchart paper which is posted on the wall so that it is visible to all participants.

It is important to start the course on a positive note by making sure all participants feel comfortable, and that they get to know each other as soon as possible. The activities used by the delegate at the beginning of the training to facilitate this are known as icebreakers. Below are listed some examples of useful icebreakers:

Name of icebreaker	Description
Unique characteristics	Even if the participants already know each other, the trainer must get to know them. The trainer may divide the group into pairs and give participants a few minutes to interview each other. Then, each participant should introduce their partners by name and to share at least two unique characteristics about them. Characteristics to be presented may be agreed upon in advance of the interviews.
Time machine	Participants are divided in pairs and the trainer instructs them that they will take turns being in a time machine. They strap themselves in, set the dial to after the workshop ends, and push the button. They feel a vibration and wonder if the machine is working. Then they look out the window and see themselves at work. They realize that they are watching themselves in the future, after this training is over. Then they must open the door to the time machine and tell their partner how they see themselves working and what they do differently after having gone through the training.
Your favourite …	The trainer prepares a list of topics on a flip-chart, e.g. favourite TV programme, ideal holiday, secret ambition, etc, etc. The chairs are arranged in two rows, facing each other. When people are seated ring a bell and tell half the group to spend one minute talking with the person opposite them on the topic given. Every time the trainer rings the bell each person moves around one place, clockwise. They then spend one minute talking to another person on topic two, and so it goes on. The trainer may keep this going until everyone is back in their original place, or stop at an appropriate time.
Three questions	Participants write down three questions and find someone in the room they do not know well. Each participant then asks questions of the other. The participants then introduce their partners to the group by sharing both the questions and the answers.

Session 2 – What is an Emergency Response Unit?

In this session, the delegate will give a description of what an Emergency Response Unit is, what it is composed of and why it has been deployed. This should be described in non-technical language and with examples or pictures from previous deployments. If possible the presentation may be extended, e.g. during a break, to include a walk through the ERU area, to give the volunteers an idea of the activities that take place.

Session 3 – Psychological first aid

Psychological first aid implies extending basic, human support, and delivering practical information to individuals who are visibly distressed or are known to be or have been in shock or crisis. It is a useful way for humanitarian staff and volunteers to meet a person and initiate interaction. The volunteers should learn how to meet affected persons with compassion and a listening ear. Psychological first aid is provided by following some basic steps which will be explained and practiced in this session.

A PowerPoint presentation is available in the ERU psychosocial support folder. The presentation comes from the *Community-based psychosocial support training kit*[35] - A set of additional role plays to practice psychological first aid skills are also found in the folder[36].

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

Session 4 – The psychosocial support component – an introduction

In this session, participants start familiarising themselves with the contents of kits 1 and 2, containing toys and play items for children aged zero to six years and six to18 years respectively. As the play kits are a core feature of the ERU psychosocial support component it is crucial that the volunteers understand the purpose of the toys and play items, how they are used and handled in the most appropriate manner. In order to start this process, it is suggested to divide participants into smaller groups and give each group a number of items from the play kits. They will unpack and try the items (it is OK for them to play a little!) and at the end of the group work they will present the items to the rest of the group, explain how they are used by the children and how they, as instructors, can facilitate play sessions using these items.

The complete items overview catalogue will be used as a reference guide by the participants during this session.

Session 5 – Psychosocial support to children through play and recreational activities

This session follows directly from the previous one and focuses on games and play activities that are conducted either using the play kit items, or with games that are known and accepted locally or that are described in the document available on the ERU psychosocial support folder.

It is suggested to play one or more game with the participants (either in a big group or smaller ones) and after each game, as a group, to reflect on the benefits of playing a particular game or activity. The delegate should aim to stimulate discussion among participants about what kind of activities children in this particular location normally engage in, and should also generate ideas for how to adapt local materials and resources for use in the ERU psychosocial support component.[37]

Each participant in the training will receive a personal copy of the *Handbook for volunteers*. *Brochure 2: Children's stress and how to support* is another key resource to generate and guide discussion about ERU psychosocial work.

Session 6 – What to do if someone is being hurt or not treated right
Using the information sheet *All children deserve to be safe*, the aim of this session is to generate discussion among participants about how best to protect children after crisis events and what can be done if it is suspected or known that a child is suffering from abuse or maltreatment.

Session 7 – Self care and stress management for volunteers
The session will cover a well known but often forgotten topic in emergency settings: that relief work is highly demanding on those involved. Volunteers and other humanitarian workers are likely to be subjected to stress, and should know how to avoid stress and how to care for themselves and others.

The PowerPoint presentation is available in the training resources section in the ERU psychosocial support folder[38]. Towards the end of the presentation there are some breathing and relaxation exercises. Instructions on how to facilitate these exercises are also found on the USB memory stick.

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

The day will end with a recap of the major topics of the training. An informal evaluation of the day's programme and contents should be carried out to give the participants an opportunity to provide feedback on the training and suggestions for changes.

B. Briefing session for ERU colleagues

Another occasion for sharing information and raising awareness on psychosocial issues is through interaction with ERU colleagues or other humanitarian staff who are present in the area where the ERU psychosocial component operates. This section describes possible contents of a short (30 minutes to one hour) module for ERU colleagues may look like. The overall objective of such a session is to raise awareness about the possible psychosocial impacts on affected people who live in the area where the ERU operates. Many humanitarian workers do not consider that armed conflicts or natural disasters cause significant psychological and social suffering to the affected people. Furthermore, they need to know that psychosocial actions may significantly influence people's abilities to adopt positive coping mechanisms to handle their situation.

A PowerPoint presentation is available in the ERU psychosocial support folderSB memory stick for use during this session. The brochures and information sheets will also be useful during this session. Some main points to highlight and discuss are mentioned below. When interacting with ERU colleagues, the psychosocial delegate should stimulate discussion on the significance of psychosocial issues in crisis situations. Humanitarian staff involved in e.g. general health care, camp management or water and sanitation may not be overtly aware of how they, as part of their work, may support the resilience and coping mechanisms of people affected by disasters or crisis situations. This should be explained using the arguments of the following paragraphs.

General health care

General health care settings such as the one provided by the health ERU are often entry points for supporting people with mental health and psychosocial problems. Health care providers frequently encounter psychosocial issues when treating diseases and injuries. The strong connections between social, mental and physical aspects of health are commonly ignored in the rush to organize and provide health services. General health care providers may benefit from learning the principles of psychological first aid and the module from the volunteers' training may be used in this context.

The delegate should stress the importance of meeting and treating affected people with respect for their dignity, and provide basic information about the mental health and psychosocial impact of crisis events and situations. It is crucial to give information about local understandings of, and responses to, crisis, as these may be very different from what health care workers are used to. The delegate should present the findings of the initial assessment and mapping procedures, which should have taken place before the activities started, and inform about local resources, social support- and protection structures as these may be helpful in the overall implementation of ERU activities.

Furthermore, the delegate should stress the importance of avoiding inappropriate pathologizing and medicalization by distinguishing non-pathological distress from mental disorders requiring clinical treatment or referral. Patients presenting non-pathological distress may benefit from taking part in the activities organized in the ERU psychosocial support component and general health care personnel should be made aware of this possibility. The initial assessment undertaken by the psychosocial delegate may also provide information on local referral mechanisms for people with mental disorders.

General health care providers should use communication methods that encourage positive coping. The aim of such communication is to increase the capacity of individuals, families and communities to understand the common ways in which most people tend to react to crisis events or situations. This will enable the community members to more effectively acknowledge their own psychosocial needs as well as those of others. If feasible, general healthcare providers in the ERU may make use of the printed information materials that are available in the ERU psychosocial support component to facilitate communication with patients.[39]

Shelter and site planning

When interacting with camp management staff the psychosocial delegate should stress a number of relevant psychosocial points about organizing shelter. The provision of safe and adequate shelter in crisis situations saves lives, reduces morbidity and enables people to live in dignity without excessive distress. There are obvious psychosocial benefits of involving people affected by an emergency in decisions regarding shelter and site planning. It reduces helplessness and promotes well-being. The participation of displaced people furthermore promotes self-reliance, builds community spirit and encourages local management of facilities. Some additional important aspects relating to shelter are mentioned here:[40]

- Focus on cultural requirements for shelter; where cooking is done and, if inside, how ventilation is provided. Privacy issues and proximity to neighbours, accessibility to latrines for those with restricted mobility; how much light is required if income-generating activities are to be carried out inside; etc.
- Organize support for people who are unable to build their own shelters.
- Consult women in particular about privacy and security, including safe, ready access to local resources (e.g. firewood) for cooking and heating and the location of latrines.[41] If centralised cooking facilities are provided, they should be located close to the shelters.

- Select and design sites that enable ready and safe access to communal services, e.g. health facilities, food distribution points, water points, markets, schools, places of worship, community centres, fuel sources, recreational areas and solid waste.
- Include communal safe space in site design and implementation.
- Distribute shelter and allocate land in a non-discriminatory manner.
- Whenever possible, avoid separating people who wish to be together with members of their family, village, or religious or ethnic group.

Water and sanitation

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

Watsan specialists may or may not be aware of the important human consequences of how services are organized and provided, and the psychosocial delegate is encouraged to generate discussion if an opportunity arises. In previous 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.

In many countries, strict cultural norms and taboos influence the usage of latrines and the disposal of human excreta. Inattention to cultural norms can lead to the construction of latrines or water points that are never used. In some cases, water points or latrines are not utilized because they may have been used to dispose of dead bodies. Attention to social and cultural norms will help to minimise the distress of adjusting to unfamiliar surroundings and different ways of performing daily tasks. Other psychosocial aspects of watsan include:[42]

- Involve members of the affected population, especially women, people with disabilities and elderly people, in decisions on the location and design of latrines and, if possible, of water points and bathing shelters. This may not always be possible due to the speed with which facilities have to be provided, but community consultation should be the norm rather than the exception.
- Ensure that adequate water points are close to and accessible to all households, including those of vulnerable people such as those with restricted mobility.

- Ensure that all latrines and bathing areas are secure and, if possible, well-lit. Providing male and female guards and torches or lamps are simple ways of improving security.
- Ensure that latrines and bathing shelters are private and culturally acceptable and that wells are covered and pose no risk to children.
- When there is an influx of displaced people, take steps to avoid the reduction of water supplies available to host communities and the resulting strain on resources.
- Encourage community clean-up campaigns and communication about basic hygiene.

Annex 1: Job description

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

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

DUTIES Applicable to All

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

Specific DUTIES Responsibilities AND accountabilities

These are the duties and accountabilities applicable to the ERU team members, within the ERU deployed in a Federation coordinated operation, and are complimentary to the specific tasks elaborated in the ERU deployment Order / Terms of Reference.
Standard Operating Procedures for Emergency response Units as agreed to by the deploying National Society apply.

1. To undertake professional duties under direction of the ERU Team leader
2. To plan and support basic psychosocial activities as part of the work of the ERU, together with the host National Society and/or local health authorities. This may include:
   - Set up the psychosocial component where appropriate in the vicinity of the ERU
   - Interface with ERU colleagues, agree on modes of collaboration and flow of patients through the clinic
   - Take part in health assessment activities with specific focus on psychosocial issues, mapping of resources and identification of gaps
   - Assess existing mental health/psychosocial resources and link up where necessary and possible
   - Interact with host National Society to identify volunteers to assist in running the psychosocial activities
   - Facilitate training of volunteers in psychological first aid and emotional support to affected groups and individuals
   - Instruct volunteers on how to organise games and play activities for children
   - Launch psychosocial activities

- Organise outreach activities, e.g. community-awareness raising sessions and establishment of support groups
- Inform ERU team members on psychosocial issues, including psychosomatic, grief and extreme stress reactions that can occur within the affected population
- Liaise with local health authorities, WHO, UNICEF and others regarding psychosocial interventions and mental health care at e.g. cluster meetings if applicable
- Continuously asses, monitor and evaluate needs and activities, follow up when necessary

3. To provide regular and timely reports, to the ERU team leader
4. To work according of the SOP, to the Ministry of Health / WHO guidelines and meet standards as stated in the IASC February 2007 document.[1]
5. To support the capacity of the host National Society and develop skills where possible.
6. To interact and, if necessary advocate with the local authorities concerned in matters of mental health and psychosocial support

Lateral Relationships

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

Person specification	Required	Preferred
General		
In good mental & physical health	x	
Qualifications		
Basic Delegates Training Course or equivalent	x	
Professional qualification as a psychologist, social worker, nurse or teachers – multiple years field experience	x	
In addition, Delegate needs a strong public health background with *skills of training, diplomacy, cultural awareness and practical approach.* Must possess both the communication skills necessary to enable him/her to work closely with community leaders and representatives, as well as the pedagogical skills to transfer knowledge/skills to community volunteers that will actually conduct most of the activities. The delegate must have a holistic Public Health oriented approach to health in emergencies and related sectors with the view that culture, belief systems, established habits, attitudes, behaviour, and religion are to be respected and leveraged to facilitate improvements in the health of the public.	x	
Basic technical ERU training (health)	x	
Experience		
Experience of managing & supporting staff		x
Experience of working for the Red Cross/Red Crescent		x

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

Person specification	Required	Preferred
Experience of planning and managing budgets		x
Experience of writing narrative & financial reports		x
Skills		
Skills in training and developing staff	x	
Self-supporting in computers (Windows, spreadsheets, word-processing)	x	
Valid international driving licence (manual gears)	x	
Languages Intermediate Berlitz level 6 English	x x	
Core competencies - a high degree of competence in		
Commitment to the International Red Cross & Red Crescent Movement; integrity & personal conduct; sensitivity to diversity; flexibility & adaptability; proactivity; solution focused; decisiveness; accountability; teamwork; interpersonal skills; resilience	x	
Management competencies * - a high degree of competence in		
Management of strategy; management of change; leadership; planning; management of budgets; management of resources; monitoring; supervision and control; reporting; communication; networking; management of self; management of others; inspiring others; forming vision; organisation building;		x

Annex 2: Mapping and collecting information on psychosocial issues

The table below will be the initial guide when collecting information on psychosocial responses to an emergency or crisis event.[43]

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

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

In addition to collecting the above information, the psychosocial delegate should seek to talk with a variety of key informants and formal and informal groups, to learn 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. The questions below may be used to guide discussion:[44]

Question	Answer
In previous emergencies, how have local people confronted the crisis?	
In times of crisis, who do people normally turn to for support?	
In what ways are people helping each other now?	

How can people here participate in the emergency response?	
Who are the key people or groups who could help organise health supports, shelter supports, etc.?	
How can each area of a camp or village 'personalise' its space?	
Would it be helpful to activate pre-existing structures and decision-making processes? If yes, what can be done to enable people in a camp setting to group themselves (e.g. by village or clan)?	
If there are conflicts over resources or facilities, how could the community reduce these? What is the process for settling differences?	

Annex 3: Daily and weekly monitoring form

Daily reporting form – information collected on:

Date xx
Age under 5 years Male Female Sub-total
Age over 5 years Male Female Sub-total

Totals for the above categories

Number of first-time visitors
Number of returning visitors

Number of volunteers Male Female Total

Summarizes week dates xx to xx

Weekly reporting form covering the dates to

Narrative section

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

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

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

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

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

Annex 4: Check list for organising trainings

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

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

Things to consider	Own notes/comments
12.	
13.	
14.	
15.	
16.	
17.	
18.	

Annex 5: One day volunteer training programme

For ERU psychosocial support component

Date: Venue: Trainer:

Time	Topic	Activities	Participants Material	Trainers Material/Notes
08.00 – 09.00 Session 1	Welcome Participants presentations Training programme and goals of training Film on psychosocial support	Welcome by trainer and/or RC/RC branch chairperson and/or ERU team leader Round of presentations Presentation of programme and goals of training	Programme for the day	Introductory name game/ice-breaker Present the purpose of the training and how the day is structured Film on psychosocial support
09.00 – 09.30 Session 2	What is an Emergency Response Unit (ERU) for Health What is the psychosocial support component of the Health ERU	Presentation by trainer		Short overview presentation of what is an ERU, what goes on in general and in the psychosocial support component specifically Film on ERU available on USB
09.30 – 10.00 Session 3	Introduction to psychological first aid	Presentation by trainer Activity		PowerPoint presentation
10.00 – 10.15	**BREAK**			
10.15 – 12.00	Psychological first aid - continued How to support a person in distress	Presentation, group work, role plays	Brochure 1: Stress and coping Brochure 2: Children's stress and how to support Brochure 4: Psychological first aid	PowerPoint presentation Role plays
12.00 – 13.00 Session 4	The psychosocial support component – an introduction	Look through the items in the kits Group exercise and presentation	Complete items overview of all three kits	Divide participants in groups, ask them to familiarise themselves with a selected number of items from the kit and present to the rest the group
13.00 – 14.00	**LUNCH**			
14.00 – 15.00 Session 5	Psychosocial support to children through play and recreational activities	Interactive play Group work and discussion	Handbook for volunteers Brochure 2: Children's stress and how to support	Play one or two games with participants Group work on ideas for local games and plays that can used when interacting with the children

Time	Topic	Activities	Participants Material	Trainers Material/Notes
				Plenary discussion how to organise activities
15.00 – 15.15	**BREAK**			
15.15 – 15.45 Session 6	What to do if someone is being hurt or not treated right	Interactive session / brainstorm	Information sheet 7: All children deserve to be safe	Generate discussion on how to act if abuse is observed or detected
15.45 – 17.15 Session 7	Stress management and self care for volunteers working in disaster settings: what may be stressful, how to avoid stress, how to help yourself and others	Presentation, group work and plenary discussion on issues related to work-induced stress	Brochure 3 : Working in stressful situations	PowerPoint presentation
17.15 – 17.30	Wrap-up and final comments			

Endnotes

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

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

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

[4] The technical assessment particularly stressed the need to clarify the limitations of psychological and psychosocial support by delegates during an emergency operation.

[5] Integration of psychosocial support programmes (PSP) in the Emergency Response Unit (ERU) for health – compilation of contributions. International Federation PS Centre (2007)

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

[7] Adapted from IASC MHPSS

[8] IASC MHPSS. The issue of assessing existing assets and resources, as well as identifying gaps, is covered in chapter 2.

[9] The topic of psychological first aid is covered in chapter 5 of this manual

[10] van Ommeren et al: Mental Health and Psychosocial Health during and after acute emergencies:

emerging consensus? (2005, p 73)

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

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

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

[14] Ibid); Public Health in Crisis-Affected Populations. A Practical Guide for Decision-Makers. HPN Network Paper 61 (2007)

[15] See IASC MHPSS Action Sheets 6.2 and 6.3

[16] IASC MHPSS

[17] Ibid Figure 1, p 12

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

[19] IASC MHPSS

[20] Ibid

[21] Mary B. Anderson: How Aid can support Peace – or War (1999)

[22] As described in the terms of reference for the psychosocial delegate position (see Annex 1)

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

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

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

[26] IASC MHPSS Action Sheet 5.4

[27] The *Handbook for volunteers* provides more explanation regarding child development and the purpose of establishing psychosocial activities for children in crisis situations.

[28] Annex 2 of the UNICEF ECD Manual available on the ERU psychosocial support USB memory stick shows examples of toys and play materials that may be created, using local materials.

[29] Courtesy of ECPAT International

[30] IASC MHPSS Action Sheet 5.2

[31] Adapted from IASC MHPSS Action Sheet 5.2

[32] Annex 2 of the UNICEF ECD Manual available on the ERU psychosocial support USB memory stick shows examples of toys and play materials that may be created, using local materials.

[33] The delegate cannot be certain of having a power point projector at their disposal during trainings.

[34] International Federation Reference Centre for Psychosocial Support 2009

[35] International Federation Reference Centre for Psychosocial Support 2009; the full version of this training programme is available in the 'additional training resources' section of the Laptop and USB memory sticks.

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

[37] The delegate may use as inspiration 2 of the UNICEF ECD Manual available on the ERU psychosocial support USB memory stick which shows examples of toys and play materials that may be created, using local materials.

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

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

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

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

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

[43] Please refer to IASC MHPSS Action sheet 2.1 for more information on psychosocial assessment.

[44] Please refer to IASC MHPSS Action sheets 5.1 and 5.2 for more how to facilitate community mobilisation.