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Federation Reference Centre for Psychosocial Support

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Danish Red Cross

Psychological Support in Somalia

By Stephen Regel, member of the Reference Centre for Psychosocial Support's Roster Group

Somalia has for the past fifteen years been affected by a protracted and destructive civil conflict. Parts of Somalia remain beset by ongoing conflict and divisions prone to drought and flood and inevitably vulnerable to disease. At the time of writing, there has been an escalation of the conflict in the south, further adding to an already difficult and complex political situation.

The country continues to experience huge and persistent humanitarian needs, population displacements, minimal healthcare education and faint hope of economic recovery. The majority of the Somali population is poor and vulnerable. In the absence of any public institutions and services, NGO's and other international organisations have provided most of the support in terms of health systems and healthcare over the years.
The Somali Red Crescent Society (SRCS) has managed to survive the conflict and is generally credited as being the largest indigenous organisation with representation across the entire country. International Federation and other partners have continuously provided support to the national society in terms of establishing and implementing its mission.

Somalia is situated on the Horn of Africa.
Map courtesy of the International Federation

Why a Psychological Support Programme?

The Tsunami Operational Review report in February 2005 highlighted the urgent need for a psychosocial/ psychological component to the work of the SRCS and a recommendation was made that psychological support could be included in the training of disaster response /first aid teams and volunteers. This was the catalyst for discussions between the SRCS/IFRC and the PS Centre, which indicated that an assessment to establish key aims and goals for a psychological support programme was essential and that this would also be able to formulate the type of training that was required. The assessment took place in April 2006, the training mission took place a month later and an evaluation is anticipated around May 2007.

The assessment process

The assessment mission began with a series of meetings with key members of the SRCS /IFRC team based in Nairobi in order to elicit their views on key issues the situation within the region, for targeting within the Psychological Support Programme (PSP) and most importantly, other cultural considerations within the context

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of developing a programme which would be unique not only within the country but within the region. The assessment was continued with field visits to a health clinic and psychiatric facilities. Additionally a number of relevant reports were consulted.

NGO's and other international organisations including the Somali Red Crescent Society and the International Federation have provided most of the support in terms of health systems and healthcare over the years in Somalia.
Photo: Stephen Regel.

Assessment findings
The findings of the assessment were multifaceted and highlighted the following problems:
Mental health problems – primarily among men. This seemed linked to the civil conflict, wide spread unemployment which in turn increases family problems. Disillusionment among ex-combatants who had expected a better life and socio-economic circumstances was also wide spread.
The lack of employment and socio-economic development, particularly amongst youth led to a variety of personal and psychosocial problems. The key issue here (and amongst ex-combatants and those with mental health problems) was the increased use of khat, drugs and alcohol. The extensive use of khat which has been used for generations in Somalia and in neighbouring regions as a social acceptable stimulant and activity (much as alcohol is used in the West) has tended to increase to what many consider to be problematic to long term psycho-social and mental health problems.

Female genital mutilation and rape
Female genital mutilation (FGM) or female circumcision was also highlighted as a significant problem and one that was cultural rather than religious in origin (though religion was often cited as a reason for carrying out FGM within communities). However, despite the problems and prevalence of FGM, there was distinct and significant evidence that much was being done to try and educate communities about the negative impact of FGM.
Other problems highlighted were an increase in crime in Somaliland and Puntland, especially in the increase in cases of rape. Inevitably this creates further serious social and economic problems for the survivors of rape, who then cannot get married. In addition, women were perceived by many of the health staff and volunteers as being more sensitive and prone to difficulties in many ways. The reasons for this were multifactorial, but the loss of social support, an inability to express problems or ask for support and very natural concerns about having children without a father or with any visible means of economic or other form of support. Silence is an issue around the problem of rape. It is seldom that cases of rape are identified outside of the family. This problem remains a taboo in Somali communities.

Basic mental health facilities
While many of these problems may be common to many countries in the region, a number of issues were seen as particularly pertinent to Somalia.
Particularly highlighted was the psychosocial and psychological impact of natural disasters, the long-term effects of the conflict and the increased use in the main of khat (but also the use of drugs and alcohol). The visits to both psychiatric facilities indicated that mental health problems range from psychosis (possibly khat induced) to anxiety disorders which were described by staff as Post Traumatic Stress Disorder (PTSD) and obsessive compulsive disorders. Whilst there was evidence that such conditions may have been present, diagnosis may have been complicated by socio-cultural factors. Facilities were very basic to say the least. Appropriate medications were in short supply or non-existent. In the absence of appropriate medication restraint by physical means were common place to control difficult behaviour and symptoms. Nevertheless, it was clear that

staff were doing their best to provide the optimum care in extremely challenging circumstances, with every effort made to improve the lives and conditions of those in their care.

Eurocentric approach?
Much discussion also centred on the applicability and relevance of post-traumatic reactions in Somali culture. This was seen to be an important element of the assessment as there has been significant criticism of psycho-social programmes and psychological support programmes, which have been perceived to be both Eurocentric and to export western ideas and concepts of the impact of traumatic events to non-western cultures. Nevertheless, there was a clear indication from all those consulted (health staff and volunteers) that post-traumatic reactions were an issue and did need addressing. That is to say that these were not pathologised in the sense of being abnormal reactions or diseased focused, but that raising knowledge and awareness in the first instance of the use of psycho-educational principles would be an appropriate way of introducing the concept of psychological support into the community based first aid programme (CBFA). It is in the context of the above that the psychological support programme (PSP) was to be incorporated within the Somali Red Crescent society.

Given that notions of counselling, and other forms of "talking help" would be alien within a Somali culture and society, it was felt that the programme needed to be initiated at a very basic level within the community based first aid programme CBFA and DM and that the main target group would be the volunteers. This would consist of a very simple introduction to PSP, accompanied by a brief and practical booklet or manual which could be used by the volunteers, either individually or in small groups. This would not only raise knowledge and awareness but also be instrumental in providing the support as highlighted by the Tsunami Operational Review Report (2005).

The training
Discussions during the assessment with health staff, volunteers and others highlighted that the programme should contain the following elements:

- What is a psychological support programme?
- Culturally specific (common) reactions to extreme stress and trauma
- Supportive communication
- Self care for volunteers

It is important to note that the SRCS staff felt that the term 'psychological support' as opposed to 'psycho-social support' should be used as they felt the term 'psycho-social' would have very different connotations within a Somali culture and society and give rise to false expectations i.e. that it would indicate an element of economic or social care support.

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After careful consideration, assessment and planning, a customised training was delivered based upon culturally driven indicators of need. The decision was made to design the programme around what could be considered as a 'programme development workshop'. For example, rather than the traditional workshop format of providing theory based lectures, seminars etc. followed by activities to consolidate learning and illustrate particular concepts, there would be activities in the first instance based around common themes and concepts of psychological support. The aim of these activities would be to revise and culturally determine the format and content of the eventual training. This would then be used to develop specific training materials for use by the SRCS who would then have ownership over the content and dissemination. This led to a stimulating and active

three-day workshop which focussed on the themes mentioned above. There was animated and active discussion over content, accessibility and 'cultural fit'. There was discussion and debate about specific examples regarding the use of language and concepts such as empathy, cynicism, trauma.

Fifteen SRCS staff (including some senior volunteers) attended the workshop which was held over three days in Hargeisa, Somaliland. Some of the health staff had a formal qualification of training in nursing or social care, though this was not widespread amongst those attending. Discussions and group activities were encouraged, as was the use of participants own language during the proceedings. The use of meaning, context, language was culturally adjusted and was used in the development of a brief manual to be used within the SRCS.

Summary
Overall, the workshop was evaluated as successful, though there was a general consensus that much work was to be done in terms of the development of the PSP training within the CBFA/DM. In addition there will be the development of key indicators, reporting and supportive supervision from team leaders through to the volunteers. Furthermore, the workshop format i.e. running it as a programme development workshop was seen to be a useful model for other countries within the region. There were clear indications from the workshop that this would be a useful and timely addition to the CBFA/DM, but challenges remain as to how much of the content can be usefully included within a short space of time. It is inevitable that the inclusion of the PSP will be brief and very basic as far as the volunteers are concerned and that the manual would be distributed in order for them to utilise some of the concepts and practical applications within their own communities.

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HIV and AIDS in Swaziland

By Pernille Hansen, Psychologist (MSc.) working as a consultant for UNICEF Swaziland

Swaziland is one of the smallest and oldest kingdoms in Africa. It is also the country worst hit by HIV and AIDS in the world. In a population of just over one million, HIV prevalence among pregnant women visiting antenatal clinics has increased from 3.9 % in 1992, to 42.6 % in 2004, decreasing slightly to 39.2 % in 2006.

The combination of poverty and HIV and AIDS has led to novel societal dynamics that contain extraordinary challenges and impact the population in many intricate ways. The crisis has overwhelmed the extended family and other community support systems which Africa has always in the past relied upon to get through crises. AIDS has mainly targeted the strong, men and women in productive years of life, with responsibilities for children and the aged, who themselves have been deprived of their extended family breadwinners. Traditional practices such as "wife inheritance" (when a woman's husband dies, his nearest brother 'inherits' her and her children) originally designed to preserve the extended family and protect women and children, have become a further means for HIV to spread, particularly in extended families.

Heightened vulnerability
This disruption and destabilization of families and communal support systems, together with the dramatic increase in the numbers of orphans, vulnerable children and child headed households, naturally heightens the vulnerability to emotional distress and suffering. Opportunities for experiencing both positive physical and mental health are challenged which in turn increases further susceptibility to situations that can lead to contracting HIV.

Although all populations in Swaziland are affected by the described situation, the children are naturally at greatest risk for experiencing the accompanying adverse consequences. According to national estimates, there are presently 130,000 orphans and vulnerable children (OVC). Of these, over 70,000 are orphans and the remaining 60,000 have parents who are so ill or destitute that the children need support and protection from the community or Government. The number of orphans is projected to double by 2010. Children living in extreme poverty and without parental or adult supervision are often exposed to dangerous and abusive situations, with sexual abuse and physical violence rating the highest.

Risky behaviour in spite of information

A major international response to the pervading crisis in the last four years has led to a vast expansion of resources available in Swaziland through the Global Fund and other major donors. A multitude of innovative programmes have been initiated, which mainly focus on attempting to prevent the further spread of HIV (including Prevention of Mother to Child programs) and / or addressing the physical, social, emotional and spiritual impact of living in a society where poverty and illness ravage and most weekends are marked by funerals. Billboards, radio shows, TV and all other possible media forms consequently infiltrate every day life with loud and explicit messages encouraging abstinence, faithfulness and 'know your status'. Yet, a recent survey undertaken at the University of Swaziland, with the educated youth indicated that despite improved access to information on HIV and AIDS, the risky behaviors of multiple sexual partners and resistance to condoms remains common. The social and sexual culture amidst the poverty, gender inequality and limited opportunities for personal development is much more complex than feeding the population with "HIV prevention information' and expecting them to instantly change their behaviour.

The 'orphan' response:

Consensus has been reached in all of the sub-Saharan African countries including Swaziland that orphanages are not the solution to the huge orphan crisis. Focus should rather be on strengthening communities so that they can care for the orphans and allow them to remain in their inherited households and grow up in familiar surroundings. Although this solution seems logical in theory and it is obviously the most desirable for the welfare of the child, it is fraught with complications:

Firstly, the majority of the Swazi live in rural communities, enveloped in poverty, which diminishes the 'coping capacity' of families to take care of themselves and more so of additional orphaned or vulnerable children in the community. Secondly, despite almost half the population being infected with and all of the population affected by HIV and AIDS, stigma and discrimination prevail in most communities. This prevents 'open doors' to children whose parents obviously died of AIDS related illnesses, and socially ostracizes the children. Thirdly, protection mechanisms for children, physical and legal, are minimal in Swaziland. It is common that relatives of the deceased parents rip the homesteads and households of all valuables, leaving the orphans completely destitute. It is not surprising that many children are either roped into physical labour or exchanges of sexual favours for survival.

A group of orphans and vulnerable children outside a Neighbourhood Care Point. 430 Neighbourhood Care Points throughout the country daily serve 33,000 children with food and adult care and supervision. Photo courtesy of UNICEF Swaziland

Neighbourhood Care Points

In the face of these recognized challenges, a large number of stakeholders (including the Government) have, in partnership, pledged support to implement the National Plan of Action for Orphans and Vulnerable Children (2006 – 2010) that outlines in detail the responses needed to address the physical, social and emotional needs of the children.

Little over one million people live in Swaziland. More than 70,000 of them are orphans. This little boy is being cared for by his grandmother.
Photo courtesy of UNICEF Swaziland

A positive example of a rapidly spreading response to the OVC crisis has been the establishment of "Neighbourhood Care Points" (NCPs). This initiative was sparked by a caring mother in a single community, who started to feed the orphans in her village on a daily basis in late 2002. Word spread of her endeavours and in 2003 UNICEF and some of her partners embarked on a national project to establish NCPs to be run by community volunteers. Although the emphasis is on encouraging communities to "own" the NCPs and take responsibility for running them on a daily basis, each of the NCPs receive donor-funded 'emergency supplies' (basic equipment to set up a shelter, cooking pots, eating utensils and hygiene supplies) and those in the worst drought affected areas of the country receive food supplies. Caregivers are trained on how to manage the NCPs and on psychosocial support. To date there are over 430 NCPs that serve 33, 000 children on a daily basis with food and adult care and supervision. To reach all the children who need it, it estimated that at least 3, 000 NCPs are needed.

Psychosocial Support to OVC

In a country that only has 4 qualified Social Workers and not a single psychiatrist or psychologist working at any of the public (Government funded) hospitals or health centres, developing an adequate Psychosocial Support response to the overt needs in Swaziland is an overawing task, that at times feels impossible. Reports of children and adults alike suffering from depression, unresolved grief from watching their relatives die in front of their eyes, trauma-reactions due to experiences of abuse or desertion and a lack of hope for the future are common place.

In the past two years, I have worked closely with a group of about 20 very committed and passionate men and women, to develop a training curriculum and training material to train caregivers of OVC on PSS. However, due to limited funding and consequently limited time available for training, the material we have developed is mainly for sensitization. It highlights warning signs of children who are not coping well, and discusses the various causes (trauma and loss, living with HIV and AIDS, abuse, and substance abuse) briefly giving the caregiver a better understanding of the issues involved that cause the reactions they see in so many children. What to do thereafter is more complex. Most community caregivers take care of many children at the same time so they are restricted in how much attention they can give one child. The majority are also unsure of what to do with the children who are not coping well. We stress that they must refer the child for help if they are concerned. The problem is where? A variety of NGOs offer counselling services to children, but they are so incredibly limited in resources and manpower that they cannot do regular outreach visits to counsel children who need it. There is nowhere in Swaziland where interested persons can train to counsel, other than the Voluntary Testing and Counselling Training that is specific to HIV testing sites. So, whilst we, with all good intentions, encourage caregivers to note children who need special attention, we have such a long way to go to be able to offer them the care and support they need. Thankfully psychosocial support has been recognized as one of the most important gaps in services that need to be filled by all stakeholders working the HIV and AIDS field, leaving a hopeful prospect for the future and an exciting time ahead for further developing the psychosocial support response.■

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The Well-being of volunteers

A research project on fostering resilience, post-traumatic growth, health and psychosocial wellbeing in volunteers

By Sigridur Thormar and Nelden Djakababa

On 26 December 2004 massive tidal waves or tsunamis swept into coastal villages in South-East Asia and killed over 240,000 people. In Banda Aceh, the provincial capital of Aceh in Northern Sumatra, Indonesia, close to 150,000 lives were lost and an estimated 545,000 people were displaced.

Then again on 27 May 2006 another disaster hit the Indonesian community when an earthquake killed more than 5,000 people in Yogyakarta and Central Java and left thousands homeless. In such times the influx of humanitarian aid is vast and the Indonesian Red Cross (PMI) contributes enormously to the relief effort by responding with hundreds and sometimes thousands of volunteers. The volunteers work on e.g. recovery of bodies, tracing and mailing services, water and sanitation as well as giving support, first-aid and food to the affected population. Before returning to their "old life", psychosocial support is provided to them. However, little is known about their current health status and psychosocial wellbeing. How are they doing, and what can be learned from their experiences in order to improve volunteer management?

In times of disaster the Indonesian Red Cross (PMI) contributes enormously to the relief effort by responding with hundreds and sometimes thousands of volunteers. The volunteers work on recovery of bodies, tracing and mailing services, water and sanitation as well as giving support, first aid and food to the affected population.
Photo: Anders Ladekarl, Danish Red Cross

The Centre for Psychological Trauma at the University of Amsterdam in co-operation with the PMI is leading a research project that aims at answering these questions in two steps: Firstly, with an in-depth quantitative as well as qualitative psychosocial assessment of Indonesian Red Cross volunteers. Secondly, with practical advice based on results of the assessment on how to recruit, select, train, support and reward volunteers in order to foster their resiliency, post-traumatic growth, health and psychosocial wellbeing.

This project is done by the authors under Dutch and Indonesian supervision. Prof. Dr.Berthold Gersons, MD, Dr. Miranda Olff and Dr. Maaike de Vries at the Centre for Psychological Trauma, AMC, University of Amsterdam and the IMPACT foundation are the Dutch supervisors. Prof. Amal Chalik Sjaaf, MD, DrPH Vice President of the Indonesian Red Cross (PMI) is the Indonesian supervisor. The project is done in co-operation with the French Red Cross, the Icelandic Red Cross, the Austrian Red Cross and the International Federation of Red Cross/Red Crescent (IFRC).

Research overlooks volunteers

Disaster work puts a lot of strain on the rescue personnel. There is substantial research on professional workers in emergency or disaster situations e.g. fire fighters, police, international relief and development personnel, etc. However, there is a gap in the literature on the impact of disaster work on volunteer helpers.

Volunteer helpers should be classified differently than professional helpers since they come from various backgrounds in the community and return there after the disaster work is over. Therefore, they do not have the same structured support network like those that might exist within the police force and fire service organisations where a group shares a common experience. Social support has been shown to be one of the big predictors for recovery from traumatic

experiences.

Today, the Red Cross/Red Crescent Movement responds to the needs of about 200 million people yearly. The Movement has up to 90 million volunteers at its disposal. In the last 40 years the number of disasters has increased more than fourfold. Good management and support of volunteers is therefore gradually becoming more demanding.

Are volunteers at risk?
Red Cross/Red Crescent volunteers are a population that has received little empirical study and may be at increased risk for Post Traumatic Stress Disorder (PTSD) or other psychological problems due to their work with disaster victims. However, Red Cross/ Red Crescent volunteers receive training and have chosen to help people in the aftermath of disasters and receive considerable social acknowledgement. Positive social acknowledgement has been shown to be related to fewer mental health problems after a traumatic experience. Furthermore, this self-selection may foster a sense of control over the situation. A sense of control during traumatic events has been shown to be associated with decreases in PTSD symptoms.

Many individuals who have been exposed to traumatic stressors have been shown to suffer negative psychological consequences such as anxiety, depression, avoidance and intrusion, PTSD and/or pathological grief reactions. This is often accompanied by physical symptoms such as poor self-reported health status and a greater number of self-reported medical problems. It is often referred to as medically unexplained symptoms or somatization and expresses itself mostly as fatigue, muscle pain, dizziness, and gastric troubles. These individuals have increased mortality and morbidity rate as well as greater service utilization. Reviews show interesting similarities in symptoms reported post-disaster.

Several major studies have shown that people who have been exposed to a traumatic event are actually more likely to be diagnosed with organic diseases and conditions. Moreover, they are more likely to engage in risky behaviours such as drinking and dangerous driving.

Post-traumatic growth
Most people are exposed to loss or potentially traumatic events at some point in their lives. Of trauma exposed individuals, 20–30% of women and 8–13% of men will develop posttraumatic stress disorder (PTSD) and a substantial proportion will develop major depressive disorder (MDD), substance disorder or a combination of those. Although this certainly warrants great concern, the fact that the vast majority of people exposed to potentially traumatic events **do not go on to develop the disorder** has not received adequate attention. Many people seem resilient and continue to have positive emotional experiences and show only minor and transient disruptions in their ability to function. Many of them report post-traumatic growth. Post-traumatic growth is both a process and an

Red Cross and Red Crescent volunteers are a part of the local communities affected by the tsunami. Listening to them and affected populations, and planning reconstruction according to their wishes and designs ensures sustainable aid delivery and is vital part of the healing process.
Photo: Olav A. Saltbones/International Federation

outcome in which an individual attains, and maintains, at least one perceived positive change directly attributable to the traumatic event.

In today's world, humanitarian organizations operate within a complex global context where disaster management, health issues and development are closely interrelated. At a local level, Red Cross/Red Crescent volunteers are at the heart of activities to assist vulnerable people. It is essential for humanitarian organizations to review their place in the world and see how they can build on their experiences in order to

scale up efforts to achieve greater results in volunteer management. Improvement of methods to recruit, select, train, manage, support and reward volunteers needs evidence based data and real, innovative development work sensitive to the culture, religion and tradition of the country concerned.

Until now, very few studies have looked into volunteers and no study has looked at post-traumatic growth in volunteers after working in a disaster situation. The focus has mainly been on mental health problems or behaviour problems e.g. anxiety, depression and drinking behaviour as a result of disaster work. It is important to acknowledge the broader range of volunteer work and direct our focus also to the positive aspects of volunteering in a disaster situation without diverting our attention from the all too real mental health problems that might persist in a minority of volunteers. Highlighting the found benefit in volunteer work would enhance recruitment of volunteers for disaster work.

In order to increase well-being in volunteers and facilitate post-traumatic growth, it is important to identify which variables facilitate such a process.

This study will explore which individuals are the most vulnerable to psychological and physical sequelae and the possible predictors that account for the differences in the nature, severity and duration of those reactions. Furthermore the study will explore, which individuals experience post-traumatic growth and what are possible predictors that account for that outcome.

The scientifically based results, although culturally specific, will be a step forward towards creating quality management guidelines for the Movement's volunteers. ■

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Psychosocial Support Programmes following Complex Emergencies

Directions in Research and Implications for Practice
By Stephen Regel & Peter Berliner

The past decade has seen an increasing focus and consensus on the importance of providing psychosocial support programmes following disasters and complex emergencies. However, the field is not without its critics (Ganesan, 2006; Almedom and Summerfield, 2004; Pupavac, 2001; Summerfield, 1999; Bracken et al, 1995).

Today we see a growing need for a stronger evidence-based foundation resulting from methodologically robust evaluations and outcomes of the impact of these programmes (Boyden et al, 2006; MacLachlan, 2006; Yule, 2006; Eisenbruch et al, 2004). The purpose of this series of short articles is to address some of these challenges and examine a variety of developments that have taken place over the past decade within the arena of psychosocial care following complex emergencies, such as the community based approach, the need for participatory action research as capacity building and models that integrate western methods and traditional healing practices.

Only a few days before the tsunami, Mollica et al (2004) urged countries throughout the world to prepare themselves to deal with 'Mental health in complex emergencies'
Photo: Till Mayer, International Federation

There is recognition and acknowledgement that complex emergencies such as major disasters, especially those involving severe injuries, bereavement and loss, will indeed have mental health consequences for many

survivors (Staub et al, 2006; Silove, 2004; Joseph et al, 1997). This would be specially so where the social infrastructure has been compromised, whatever mental health systems existed prior to the emergency may be insufficient to meet the multifaceted needs of communities affected. Only a few days before the tsunami, Mollica et al (2004) urged countries throughout the world to prepare themselves to deal with 'Mental health in complex emergencies'.

Psychosocial programmes are designed in collaboration with local agencies and communities, especially those conducted through the International Red Cross and Red Crescent Societies' Reference Centre for Psychosocial Support. A key element is, and always has been, the facilitation and enhancement of local resources and communities, together with capacity building. Requests for psychosocial programmes come from a wide variety of RC/ RC National Societies and a recent example has been the PS Centre's experience of working with the Somali Red Crescent in developing a culturally sensitive framework for the development and delivery of psychosocial training for volunteers. In many low-income countries the local RC/RC provides basic health and social care. The request for a psychosocial support programme came from the Somali Red Crescent and was developed using the framework of a 'programme development' workshop. The materials used were adapted and developed by the workshop participants, all members of the Somali Red Crescent health teams and this will be utilised and delivered as part of a community based first aid programme.

The notion of resilience in disaster, whilst often implicit in our understanding of how individuals recover following exposure to trauma and loss, needs a greater, far more explicit exposition of the factors which account for individual and cultural differences. The need for an integrative theory of cultural responses to trauma, positive growth and resilience in adversity, which further enhances the quality of such interventions is paramount and deserves to be the focus of key actors in the humanitarian agencies and academic institutions.■

A full list of references to this article can be found in the end of this newsletter.

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Short News from the Reference Centre for Psychosocial Support

New Face in the Centre

Training in psychosocial issues has always been a high priority for the PS Centre. From 1 March 2007 this will have even higher priority, as we are happy to announce that we have hired an additional staff member to concentrate on training and fundraising.

The position will be filled by Ms. Vivianna Nyroos, who holds a MA in International Development and Social Sciences. Vivianna has among others worked for various UN agencies in the Balkans, the Swedish Afghanistan Committee and the Danish International Development Assistance. She has experience in training and teaching, facilitation and capacity building.
Vivianna's tasks will include:

- Preparation of teaching material and manuals, information material and articles on psychosocial work.
- Planning training courses for our partners, as well as teaching and facilitating these

courses.
- Advocacy and fundraising work.
- Presentations of the PS Centre and psychosocial work.
- Participation in coordinating the work when disasters occur and any ad hoc work together with the team.■

Donations to the Reference Centre for Psychosocial Support

By Anni Harris, coordinator, Reference Centre for Psychosocial Support

The main function of the PS Centre is to promote capacity building of National Societies in order for them to facilitate good quality psychosocial assistance. Documentation and dissemination, and operational assistance to international programmes, serve to support the capacity building function.

If the PS Centre is to accomplish this important psychosocial work and give assistance to the International Federation and to the National Societies, it is essential that we receive sufficient funding. The PS Centre is hosted by the Danish Red Cross and they have agreed to provide annual funding of up to 1 million Danish Kroner (Euros 134,185) as a contribution to core costs. The balance of the funding comes from our generous donors: Canadian Red Cross, Finnish Red Cross, Hellenic Red Cross, Icelandic Red Cross, Norwegian Red Cross and the Swedish Red Cross. Without our donors' valuable financial support the PS Centre would not be able to assist those requesting assistance. Besides the donations we have received, our donors also support and often finance the work done by our Roster members.

Donations received for 2006

Canadian Red Cross	13,150 euros
Finnish Red Cross	30,000 euros
Icelandic Red Cross	10,744 euros
Norwegian Red Cross	28,000 euros
Swedish Red Cross	32,980 euros
Danish Red Cross	134,185 euros

The Hellenic Red Cross has generously agreed to support the PS Centre in 2007 with 25,000 euros.
In the last year there has been an increase in requests for assistance and we are therefore actively fundraising. We have and will approach several National Societies and we hope that they will also be able to give support to the PS Centre and the psychosocial work.■

Inter-Agency Guidance on Mental Health and Psychosocial Support in Emergencies is now final

By Lene Christensen, Reference Centre for Psychosocial Support

The guidelines will be field tested in five different countries during 2007. One of those countries may be Afghanistan. Photo: Thorkell Thorkelsson, International Federation

The work of the Inter-Agency Standing Committee (IASC) on Mental Health and Psychosocial Support (MHPSS) in emergencies was described in an earlier issue of *Coping with Crisis* (no. 2, August 2006). This article highlighted how a multi-stakeholder Task Force has been instrumental in developing a guidance document for setting up MHPPS with the aim to reduce harmful practices and enable effective co-ordination in emergency settings.

The overview of the guidance is presented in a matrix which is available by internet: http://www.humanitarianinfo.org/iasc/mentalhealth_psychosocialsupport and each of the 25 key in-

terventions is described in detail in separate action sheets. The first full version of the guidance will soon be available from this address as well.
What happens now you may ask, now that this groundbreaking piece of work is finalised? To ensure that the guidance is suited to meet the needs of those who need it when working with MHPSS in emergencies, a series of field tests will be undertaken in 2007. The field testing is organised around five focal sites where structured data collection will take place. It is kicked off in Sri Lanka in February 2007, followed by Liberia, Columbia, a country in the Middle East (possibly Afghanistan) and one new emergency. Data collection, through dissemination of a semi-structured questionnaire, will also be carried out in a number of non-focal field sites. Data will be analysed in order to decide whether it is necessary to revise the guidance. Finally early implementation of the guidance will be supported through a set of tools and training materials which explains the nature and purpose of the guidance.

If you work in a setting where data may be collected to support the field testing, or if you are interested to know more about the work carried out by the task force in 2007, please get in touch with the facilitators of the field testing process: Mark van Ommeren, WHO (vanommerenm@who.int), Mike Wessells, CCF (mwessell@rmc.edu) or Lene Christensen, IFRC (lec@drk.dk) ■

Helpful Conversations

- a look into the world of UngPåLinie/UngOnline

By Pernille Thomsen, volunteer

Boy15: *I... My dad... He... He sometimes touches me. It's hard to talk about... :/*
Sigrid: *It's okay. Take your time. I'm listening...*
Sigrid: *Can you tell me more about your dad?*
Boy15: *He says that it is my own fault, because I'm not doing well at school.*
Sigrid: *What do you think about that?*
Boy15: *Sometimes, I think he's right. I stink at math. :) But at the same time, it feels weird and wrong... :'(*
Sigrid: *Can you explain how? What is it that makes you feel like that?*

UngPåLinie/UngOnline (UPL/UOL) – Youth on line – is a project within Danish Red Cross Youth, where young people talk on the phone or chat over the internet with children and other young people in need of somebody to talk to. The conversations are anonymous and unprofessional, and the project is solely driven by volunteers.

The conversation above is a fabricated example of a conversation that easily could have taken place on a shift in UPL/UOL: A 15-year-old boy tries to explain the pain and the sadness that he experiences because of sexual abuse.

UngPåLinie started in 1990 with two phone lines, and later, in 1997, UngOnline joined with two internet chat lines. Today UPL/UOL has 80 volunteers responsible for two phone lines and three chat lines. The lines are open five evenings a week, the phone lines are also open on Sundays.

High demands – with succes
It is essential for UPL/UOL that the volunteers are stabile and strong young people who know how to express their emotions and feelings. For that reason, every applicant must write an application and go through an interview from which it is assessed if the applicant suitable. Usually, it is only half of the applicants that are accepted. It is also a requirement that the applicants are aged 20-30 years and do not have a professional background as psychologist or social worker or similar.

It is a neccesity for the project to make high demands on the volunteers to attend meetings, supervision and take their share of the organizatorial work. A member of UPL/UOL spends 25 hours a month in the project on thing like:

- Weekend of training. Every volunteer must go through a weekend of training. The weekend of training consists of three days with a psychologist that teaches interview technique and the art of listening.
- Shift. Every volunteer takes 2,5 shift a month – that means 2 shifts and a standby shift in case of illness or the like.
- Group meeting. Every month a group meeting is held to plan shifts, discuss problems and to talk about the conversations in general.
- Supervision. Four times a year, each group attend supervision – a meeting with a qualified psychologist.
- Organizational work. In order to be in UPL/UOL, you have to be a member of the PR-group, the interview-group or party-group, e.g. of the Danish Red Cross Youth.
- Monthly meeting. Each month, the monthly meeting is held. This is the decision-making unit, and therefore everybody has to attend.

Chat or phone? Advantages and disadvantages

The subjects that UPL/UOL deal with vary a lot. The content of the conversations can be about teenage-love, friendship and "My stupid and annoying mom" – but also about violence, eating disorders and abuse. In general, conversations about abuse and family are frequent, but the conversations also reflect the public debate. In previous years, eating disorders have been a popular subject, while cutting has gained momentum in the last couple of years.

The variation in the subjects also attests to the fact that it is all kinds of children and young people that contacts UPL/UOL. Conversations with a regular Danish teenager are usually about teenage-love or friendship, while the conversations about abuse and violence are with weaker and more exposed children and young people. Some of them are calling or writing from replacement homes or minimum security prisons.

The difference in the subjects are also encouraged by the options to call or to write. First of all, it is a matter of how you express yourself in the best way, and second of all, it depends on the content of the conversation. In the chart room, there is room for breaks, there is time to find the right words and "to see" what you say, before you say it. Some children and young people find it easier to tell their story in writing, because they don't have to share tears and anger. In this way, they feel that they are in control.

At the same time, the conversations in the chat room can be saved, and then used to show family members or therapists how the child or the young people really feels. The conversation becomes a remedy in more than one way.

Last but not least, the chat room is the cheapest and easiest option. It's cheaper to use the internet and it is hard to explain to your abusive mother why you were on the phone for three hours.

On the other hand, the conversations over the phone offer a more careful and slow

process. They are more personal, because the user can hear a considerate and sympathetic voice.

The brilliant thing about UPL/UOL is that it is not either or. Many of the users use the phone and the chat at the same time. In this way, they get to tell their story many times and they get more than one perspective, because the volunteers have different ways of conversing. This is also why, Boy15 will contact us again to tell the story about his abusive father, but next time the volunteer on duty will try a different angle and reveal a new side of the story.

For more information, please contact upl@urkmail.dk ■

Highlights from Central America and the Caribbean 2006

By John Fleming, regional health delegate, Central America and the Caribbean

During 2006 the Panama Regional Delegation for Central America and the Caribbean continued to strengthen regional capacity in PSP.

In particular the following was achieved.

Adaptation of the Costa Rican Red Cross "Psychological First Aid" manual
St. Georges University, Grenada completed a brief consultancy to adapt the Costa Rican Red Cross "Psychological First Aid" manual to the Caribbean reality. The final word document of the contents of the original translated manual is a big improvement. We are now putting the final touches to the document and will hopefully be able to do a limited print-run and field test early in 2007.

PSP Consultancy focusing on the Continental PSP Strategic Plan and the Jamaican Red Cross PSP manuals.
With extra DfID Funding we have contracted Samora Bain - a volunteer with the Jamaican RC Mental Health Unit and has worked extensively on PSP issues with the University of the West Indies (MONA Campus). She was involved in PSP interventions in Grenada, Jamaica and the Cayman Islands in 2004 and after the Guyana Floods in early 2005. Samora has already revised the Draft Continental Strategic Plan on PSP and has begun work on investigating how the Costa Rican manual can be incorporated into a Caribbean PSP Methodology using the existing resources that we have in the region – especially the Jamaican RC manuals. After a three month consultancy we now have a draft Caribbean PSP Methodology provisionally entitled "Helping to Heal" that we will field test early in 2007.

International PSP Roster – Caribbean participation
Dr. Angela Gordon-Stair participated in the IFRC International PSP Roster Workshop in Copenhagen, Denmark in October organized by the Reference Centre for Psychosocial Support.

Alliances with Academia
Samantha Dickson (Grenada RC) and the Regional Health Delegate (RHD) met with St. Georges University who expressed an interest in continuing the collaboration begun with the Grenada RC in 2005 after Hurricane Ivan in the area of PSP. The RHD also met with the Head of Health Unit, University of West Indies St. Augustine Campus in Trinidad and Tobago and discussed possible collaboration in the area of PSP. The university was quite receptive to seeing how they can collaborate with the Red Cross. The University of West Indies MONA Campus in Jamaica has had a long-standing and positive relationship with the Red Cross and it would be interesting to see how we can promote this type of strategic alliance elsewhere.

Support for PSP in Emergencies Diploma in Panama
The IFRC and Panamanian Red Cross are supporting the first diploma in "PSP in Emergencies in the University of Panama". We plan to lend support through scholarships, support to course material, support to guest speakers and a small financial contribution.

We are gradually building up capacity in Psychological Support Programmes (PSP) and will continue to do so in 2007.■

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