

Psychosocial Centre

 International Federation
of Red Cross and Red Crescent Societies

COPING WITH CRISIS

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**Life after the
diagnosis was confirmed**

**Are we barking up the
wrong research tree?**

**Enforced disappearances and
psychosocial support**



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Editorial board: Nana Wiedemann and Hedinn Halldorsson

Disclaimer: The opinions expressed are those of the contributors and not necessarily those of the IFRC Psychosocial Centre.

Cover photo: Port-au-Prince, Dalmas 2 district. Resident of a home for elderly people made homeless as the result of the earthquake. 26 January 2010. Marko Kovic/ICRC. - The emergency operation in Haiti, after the January 12, 2010 earthquake, represents one of the largest ever deployment of international emergency response units (ERU) in the history of the Red Cross Red Crescent. The psychosocial component to the ERUs, deployed for the first time ever, aims to facilitate support that meets the psychosocial needs of disaster-affected populations. Psychosocial support delegates and volunteers have already made a difference to the lives of hundreds of survivors of the earthquake. In our next issue of Coping with Crisis, you will find an extensive coverage of the Movement's work on psychosocial support in the aftermath of the Haiti earthquake.



Editorial

How the past impacts psychosocial responses

How does one find the strength to go on when everything has been lost? Especially one's loved ones, livelihoods, home, and hopes for the future? Fortunately, that is a question most of us will never have to answer. Twelve days into 2010, the world watched in awe as the lives of millions of people were scattered in a devastating earthquake that hit Haiti. As of now, around 170,000 bodies have been removed from the rubble. Behind each and every individual of these 170,000 there is a big and tightly knitted network of people that have to cope with loss and rebuild their future.

It is a fact that psychosocial responses to a natural disaster are different than to a man made one, and that they differ depending on past experiences of the population in question. In the case of Haiti, its inhabitants have always had to face hardship, and now, the country has been struck once more. Haitians have for decades faced economical, political and environmental challenges with resilience and strength. Infrastructure has always been weak in Haiti, and that fact also contributed to the enormous challenge of providing humanitarian aid to millions of people, in a matter of days. This very operation represents the largest ever deployment of international emergency response teams in the history of the Red Cross Red Crescent.

The Relief operation in Haiti is also the first one ever to see psychosocial delegates and volunteers as an integrated part of responses, working alongside doctors, nurses and

paramedics. A psychosocial support component was deployed a few days into the disaster, as a part of a field hospital. By training local volunteers in giving psychosocial support, hundreds of lives were affected to the better. The deployment of the psychosocial support component to the Emergency Response Unit (ERU) turned out to be a success and I hope that its deployment will be a rule in future emergencies, and not an exception. Or as an Israeli paramedic, from the Magen David Adom put it, sensing which difference it made for patients and the affected to have access to psychosocial support: "I don't understand why this hasn't been done before".

Just as a wound will leave a scar on human skin, the emotional wounds experienced by Haitians in the past months, will leave scars, invisible to the human eye. The society has already started functioning again, although the loss is still and will always be felt, everyone is marked for life. In the aftermath of the earthquake in Haiti, mass burials have been carried out, as in most sudden disasters. Not being able to identify one's loved ones, and being denied to follow cultural rituals of burial and grief, complicates recovery, contributes to potential mental health problems and delays the bounce back of survivors. The journey ahead towards recovery, for hundreds of thousands of Haitians is long, and psychosocial support is and will continue to be one of their most urgent needs.

In this first issue of Coping with Crisis in 2010, we bring you



different stories on different topics; stories from Russia to Indonesia. Psychosocial support is a cross cutting theme in all humanitarian work, and the content of this issue clearly reflects that, for instance our photo essay on a kite flying competition of amputees, beneficiaries of one of IRCR's Orthopedic Centres in Kabul, or the story from Banda-Aceh on the most vulnerable, those with pre-existing conditions of mental illness. A story worth mentioning is one on psychosocial support and enforced disappearances, which is still practiced in several regimes of the world. - I hope you find the read useful and pleasant. ■

Yours sincerely,

Nana Wiedemann

Nana, Wiedemann,
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International Federation of Red
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Living with uncertainty

Enforced disappearances and psychosocial support

By Katharina Lauritsch

Two and a half years ago, in summer 2007, May's mum wanted to visit some relatives in a province 450 km South of Manila, Philippines. She only wanted to stay for a week, didn't take much luggage with her, said goodbye to her children and hitched a hike with some friends down South. That day was the last day May saw her mother. She and her sister searched for days, weeks, months, inquired in hospitals, police stations, army bases, asked friends and contacted victims organizations, without luck.

May's story is only one of many. Thousands of relatives of enforced disappeared persons in numerous countries all over the world have experienced the same. The phenomenon of enforced disappearances was and unfortunately still is practiced to silent, political, opponents all over the world. To those who relate the 1970's and Latin American military dictatorships with enforced disappearances, it comes as a surprise that the continent that reported the highest number of cases to the

groups in opposition to the current administration in power. The victims may have complained about the society they inhabit, or they belonged to a different social, political or religious group. Finally, one can simply find himself in the wrong place at the wrong time. The exact number of enforced disappearances remains unknown. No one knows how many people disappear every year nor what their fate is. This is also the reason why the perpetrators use enforced disappearances to reach their aim. If there is no dead body, no crime has been committed. If the victim cannot be found, the perpetrators cannot be punished.

The psychosocial impact

Not only is the disappeared person affected, but also their families and friends. As well as having to face emotional consequences of the loss of a loved one and the economic consequences of surviving without a breadwinner, some cases, they have to cope with the impact of the insecurity about the destiny of their beloved one, social stigma and the resulting psychological and psychosocial problems.

May and her family were lucky. They were supported by the family organization *Desaparecidos* that formed a fact finding mission, filed the case, organised workshops on legal and political aspects and also art workshops and psychological support. Most importantly they could establish the contact to other families that also lost a member and could share with them. By providing peer support and integrating the

relatives in a big movement, family organizations like *Desaparecidos* are not only helping on the legal level, but also on the emotional. Or as stated by one of the beneficiaries: "I became the son of the mothers who lost their sons and they became my mothers".

Actors involved

Many actors are involved in the search for enforced disappeared persons and in the consequent (legal) struggle for truth. Among these actors are family organizations, but also lawyers, human rights activists, psychologists, social workers and forensics - in the case of exhumations taking place. In order to help the families in the best possible way, good coordination and cooperation of all involved actors is important. This led to the idea of organizing a conference and invite experts from all disciplines involved in the search, in the struggle for truth and justice and in exhumation processes.

A circle of conferences

The first impulses in this direction came from ECAP, a Guatemalan NGO providing psychosocial support for victims of violence. The first conference took place in Guatemala in 2007 where nearly 150 international experts came together, discussed and shared their experiences and worked on a validation form of minimum standards in the psychosocial work with families of enforced disappeared. These standards aim to be the sum of all experiences, good practice recommendations, but also orientation for countries with less



Dhading district, Jogimara, Nepal. A father whose son disappeared in 2002. July 2008. ICRC/Kayastha, Kishor.

UN-working group on enforced and involuntary disappearances (UNWGEID) is Asia. Not only in the regions' countries, torn by internal difficulties like Nepal or Pakistan are people disappearing, but also in stable democracies like the Philippines, Thailand, India and Indonesia.

An unknown number

People disappear for various reasons. In some cases, they are suspected to be either political or social activists, or because they are suspected to form part of political



Dhading distric, Jogimara, Nepal. A family whose one of the sons have disappeared. July 2008. ICRC/Kayastha, Kishor

experiences and means of pressure facing governments that are not keen to cooperate.

Towards global minimum standards

Because of the actuality of the issue and in order to continue the interdisciplinary dialogue, a Second International Conference will be celebrated in Bogotá on 21, 22 and 23 April 2010, supported by a diverse organizational table, amongst others is the International Committee of the Red Cross (ICRC) and the UNDP. Although the first conference was “international”, experiences from Latin America prevailed. That is why in preparation for the second seminar the validation form of minimum standards has been discussed in the Middle East, in Africa and in Asia where a regional conference took place in winter 2009 in the Philippines to work on an Asian position and reflect upon Asian particularities and experiences.

The main aim of the conference

in Manila was to share and learn from the rich experiences the Asian region has to offer in the field of psychosocial support for families, and to strengthen the network of professionals and family organizations. The purpose was also to discuss the validation form of Minimum Standards in the Asian context while a final aim was to encourage the participants to document their work. Nearly 40 experts from 9 countries followed the invitation of AFAD (Philippines), ECAP (Guatemala) and GEZA (Austria).

Among issues the participants focused on in the Asian context, was psychosocial support for families of enforced disappeared, the role of the State, the alternatives to exhumations if not possible and how the collaboration and coordination between the different actors can be improved. Some of the main findings, was the importance of cultural and religious aspects in the support of families as well as

alternatives to exhumations when not possible as is the case in most of the Asian countries. These will be integrated in the minimum standards document and further discussed in the international meeting in Bogotá, spring 2010.

Documenting a tragic story

The words of one of the conference participants reflect the importance of strengthening cross-border solidarity, documenting enforced disappearances as well as empowering the living and give them a voice to express their suffering: “It was a beautiful experience for me to meet a girl my age, whose father also disappeared, who is in the same situation as I am but who lives in another country. To know that I’m not the only one, that I’m not alone gives me force to continue.” ■

Web sources:

<http://www.ecapguatemala.org>
<http://www.afad-online.org>
<http://www.geza.at>

“Enforced disappearance” is considered to be the arrest, detention, abduction or any other form of deprivation of liberty by agents of the State or by persons or groups of persons acting with the authorization, support or acquiescence of the State, followed by a refusal to acknowledge the deprivation of liberty or by concealment of the fate or whereabouts of the disappeared person, which place such a person outside the protection of the law.

Are we barking up the wrong research tree?

The quest for evidence based research in psychosocial interventions

By Stephen Regal, Centre for Trauma, Resilience and Growth

At the time of writing, the impact of the earthquake in Haiti is slowly unfolding. An impact that many are beginning to describe as a humanitarian disaster to rival the Asian Tsunami of 2004 in its scale. The complexity and challenges of the relief operation are clearly overwhelming to those organisations and agencies whose job it is to alleviate the suffering of the thousands of victims. Inevitably, the implications of a disaster of this magnitude occurring in the poorest country in the Western hemisphere and with a barely functioning infrastructure, has not been lost to those responding to the crisis. The other inevitability is that whilst relief operations are quite rightly focussing on the distribution and provision of food, water, shelter and medical care many in the humanitarian field will also be thinking about the psychosocial impact and implications.

The past decade has seen an increasing focus and consensus on the importance of providing psychosocial support following disasters and complex emergencies. NGOs have been actively involved in the delivery of Psychosocial Support Programmes (PSPs) in varied contexts and settings, whether it is following natural disasters, as in the case of the recent earthquake in Haiti, the South Asian Tsunami or in the wake of armed conflict. The term 'psychosocial' has become the preferred term when describing interventions designed to positively impact on the mental health needs of those individuals and communities affected by complex emergencies. In addition, the field of psychosocial interventions is relatively young and inevitably there have been calls to determine the evidence base for such interventions. There have also been critiques of the notion of PSP, as there is a view that many communities affected by complex emergencies are resilient and thus have an innate capacity to heal themselves without external intervention. Inevitably, there have also been critiques of the appropriateness and what has often been perceived as the 'medicalised' nature of such interventions.

Which evidence base?

In the context of this article, the psychosocial well-being of individuals and communities can be defined with reference to three core domains: human

capacity, social ecology, cultures and values. These domains form the conceptual framework for mapping the human, social and cultural resources available to people responding to the challenges of complex emergencies such as natural or man made disasters and armed conflict (Psychosocial Working Group, 2003). Nevertheless, there is an increasing recognition that individuals, families and communities affected by adversity can also be vulnerable.



Haitian Red Cross volunteer Ralph Toussaint with Kengo Jean at Camp Simon, Port-au-Prince, Haiti. 29 January 2010. Talia Frenkel/American Red Cross.

Therefore, whilst a key question is how to deliver effective psychosocial support and thus promote resilience and coping following exposure to extreme traumatic events, another key question which increasingly is being asked is 'What is the evidence base for such interventions?'

Resilience

There are numerous definitions of the concept of resilience, which have relevance dependant on the context in which they are used. The definition

of the International Resilience Project as '...universal capacity that allows the person, group or community to prevent, minimise or overcome the damaging effects of adversity' has utility for the concept of resilience in or following disasters and other complex emergencies. Resilience is sometimes attained over the long term at the expense of resilience in the short term. Resilience can be regarded as a common characteristic of all human beings, yet what may be regarded as deprivation and hardship in one context or country, may simply pass for a way of life in another. For example, disruption of electrical power in a western context creates serious disruptions to everyday life and work. However, in many parts of the developing world, the mere search for raw materials to prepare food and provide other necessities is a daily chore to be faced with stoic acceptance.

A common theme

These examples point toward a common theme. That is the importance of understanding the innate ability of individuals, communities and societies, not only to cope with, but also to adapt to adversity and to focus psychosocial interventions at building on these strengths. Whilst it may be a common perception that emergency appeals and media representations of disasters concentrate on identifying the vulnerable and their needs, there is little



Jean Wilfred on the destroyed streets of once-bustling downtown Port-au-Prince, 24 January 2010. Talia Frenkel/American Red Cross.

attention paid to what communities have achieved for themselves. There has been an inevitable shift from vulnerability to capacity, particularly in the area of psychosocial programmes and how they attempt to address mental health needs. There have indeed been detractors and critiques of PSP and these will be addressed later, but these have since been superseded by innovative and challenging approaches to PSP in areas affected by complex emergencies. It is also inevitable that the notions of resilience and the impact of traumatic events have become inextricably linked, but as yet this has not been addressed by the literature in any specific way.

The literature

The psychosocial literature is awash with references to research, evaluation, outcomes, tools and guidelines, however, a review of the existing literature throws up some interesting features. There are position papers (Ager et al, 2006), case studies (Anasarias et al, 2007; Keough and Samuels, 2004), reviews (Hobfoll et al, 2007; Rao, 2006; Batniji et al, 2006; Mollica et al, 2004; Yule, 2006), critiques (Summerfield, 1999; Bracken et al, 1995; Pupavac, 2001) and related literature outside the field (Clay et al 2008). Some of the most prolific literature in the field are the critiques

on psychosocial intervention, which on closer examination offer few new insights, if any at all to our thinking about this important and emerging aspect to humanitarian work, other than to revisit the same themes, with a slightly different focus.

The focus of psychosocial interventions

Overall, the critiques have focussed, rather puzzlingly, on the idea that PSPs are concerned with the prevention or treatment of post traumatic stress disorder (PTSD) (Summerfield, 1999). There is no doubt that much of the 'conventional' trauma literature published in many of the high ranking peer reviewed journals tend to concentrate on either large randomised controlled treatment trials, longitudinal studies or the epidemiology and manifestation of trauma in a range of contexts and settings (Johannesson et al, 2009; Mezuk et al, 2009). Many of these studies of course tending to focus on psychopathology following exposure to extreme stressors and that of course is a wholly legitimate goal. However, in the literature on disasters and other complex emergencies, the focus tends to be on populations at the top of the pyramid of those affected by disasters. However, those of us involved in psychosocial work know that the

focus and energy of psychosocial interventions are aimed at populations at the bottom of that pyramid. The work is multifaceted, aimed at enhancing and promoting natural resilience, rather than the prevention or treatment PTSD.

Rationale for psychological debriefing

There is another discourse surrounding the provision of Psychological Debriefing (PD) as an intervention, which has entered the debate, and this has to some extent served to confuse things further. PD is a crisis intervention technique and used by many organisations and agencies following exposure to trauma in a diverse range of workplaces. There is an increasing trend to change the name of the intervention, but of course it is still in essence used widely in practice. Again, it could be argued that it is a psychosocial intervention as it is not a therapy or treatment, but an intervention meant to enhance and promote natural resilience through psycho-education and signposting. This notion would certainly find many agreeing on the aims and rationale for providing PD, which would be to:

- Provide pragmatic psychological support in an empathic manner, provide information about common reactions, course of these

reactions and advice on coping strategies and 'signpost' for further help.

- Early support should be based on good assessment.
- Individuals who show continued symptoms should be offered/ may benefit from formal intervention.
- An approach that takes account of individual's natural resilience, is built on psychological triage and should be voluntary. (Bisson et al, 2007)

The aims described are of course by no means new and have always been the foundations of practice in PD, but publication in the American Journal of Psychiatry appears to have given legitimacy to the use of PD as an intervention. In addition, a recent large group randomised trial on PD peacekeepers stated that 'it would be inappropriate to abandon the human, social, and informational needs of workers exposed to serious trauma' (Adler et al, 2008, p. 262).

Nevertheless, the discussion and inclusion of PD in a PSP context within Red Cross Red Crescent and other NGO's activities, as has been erroneously suggested by many critics in the past, has the potential to confuse issues surrounding the evidence base and efficacy of psychosocial programmes. No doubt the debate and discussions surrounding PD will continue, though

it has to be recognised that the debate around early interventions needs to move on rather than become embroiled around the outcomes of methodologically flawed research (Regel, 2007).

Future directions

Therefore it could be argued in the first instance that many of the critics and sceptics are barking up the wrong research tree when there are calls for the 'evidence base' in order to justify the implementation and use of psychosocial interventions because the literature is lacking. There is of course as mentioned above, a growing literature base consisting of case studies, reviews, position papers and 'best practice' guidelines. These are inevitably qualitative in nature and therefore perhaps seen as perhaps less valid by some sections of the academic community.

Secondly we need to move away from the notion that PSP focuses on PTSD and formal mental health interventions. Inevitably, within the content of the training materials there has to be recognition of the nature and management of reactions to trauma and loss and therefore an understanding and awareness of longer-term complications problems is necessary in the context of PSP. However, the key issue here is that

we have over 30 years of research that demonstrates the following:

- There is overwhelming evidence from 30 years of research that social support is a major protective factor following life events/trauma.
- There are different types of social support – informational, practical, and emotional.
- That the type of social support required is a function of context and individual needs and these will and do vary over time.
- It is important to match any support provision to the needs of beneficiaries, whoever they may be. (Joseph, 1999).

Therefore, we need to be looking toward the social support literature where there is an extensive and sound evidence base for the provision of psychosocial interventions. We also need to be considering and looking toward the burgeoning literature on growth following adversity (Joseph and Linley, 2006). This also means we need to be developing new indicators and outcomes which are based on resilience and growth in individuals and communities, rather than continually focus on psychopathology following exposure to traumatic events in its many forms. ■

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Life after the diagnosis was confirmed

Photo from Temirtau, Kazakhstan. March 2009. Claudia Janke/British Red Cross

Providing psychosocial support to people living with HIV

By **Anna I. Zagaynova**, Deputy Head of Irkutsk branch of Russian Red Cross and **Hedinn Halldorsson**, Communications Advisor, IFRC Psychosocial Centre

A woman weeps in a room where the Irkutsk branch of the Russian Red Cross gives psychological counseling. For the psychologist Svetlana such situations have become a part of her daily life, although she still hasn't gotten used to them. Her client Irina faces a situation that is all too familiar to the inhabitants of Irkutsk. Irina has been diagnosed with HIV. She had just married the man she loved, and they were anticipating their first baby. It was despair that brought Irina to the psychosocial support services of the Russian Red Cross.

One could say that every day, a citizen of Irkutsk comes around or interacts with someone with HIV in one way or the other. Irkutsk City, with a population of 600,000, has one of the highest HIV prevalence rates in Russia; more than 2% of the entire population is infected. According to estimates the percentage might be as high as 10 per cent.

The situation in Irkutsk

Most of the infected are people in their twenties and thirties. While drug users used to represent more than half of the infected, the number of cases attributed to sexual transmission is on the rise. In recent years the epidemic has also been experiencing a certain "feminization". With regards to new cases in 2008, 70% of the

women and 30% of the men got infected through sexual transmission. Due to the fact that more and more women of child-bearing age are becoming victims of the epidemic, there is also a notable increase in the number of children born to HIV-positive women. Due to lack of information, many HIV-positive couples do not know how to care for the health of their child, relatives and neighbors often reject their child. Parents also face a number of social problems, such as lack of financial resources for bringing up the child and giving it treatment is just one of them.

The beginning

The epidemic of HIV-infection in Irkutsk in Russia, Eastern Siberia, began in 1999. At the time of the outburst of the epidemic, there were

practically no psychologists familiar with the issue of HIV. Moreover, the practical psychologists had extremely high level of stigma and discrimination towards people living with HIV. Such a situation greatly limited the access of those infected to psychological services, as their needs were not met which made the acceptance of the diagnosis more difficult.

Self-stigmatisation in many cases deprives the HIV positive of the power to fight for his life. It negatively affects practically all sides of life and often leads to severe depressions. Self-stigma then becomes the ground upon which external stigma blooms, which is what, happened in Irkutsk. This was the situation and the setting when a psychosocial support project was launched in Irkutsk years ago.

Some of the initial goals and aims were to improve the access of households affected by the HIV epidemic to different services, to care for children born to HIV-positive women, to support those infected in carrying out their work tasks, to strengthen family relations and to prevent social abandonment of children.

frames were supplemented with other grant projects focusing on prevention of social abandonment of children born to HIV-positive mothers, palliative care and providing support to caregivers.

In order to implement these ideas, the Red Cross initiated the opening of Information-Counseling Center called "Steps", the Early Development School, Family Health Center, and the

establishments on the issues of reducing stigma and discrimination, by conducting trainings, psychological counseling and case management for medical workers at hospitals and local clinics.

Working with elderly guardians

One group of society came to the programme planner's attention somewhat by accident since no one had considered them as being a target group, namely elderly guardians of children born to HIV positive mothers, the guardians in most cases being grandmothers. This group turned out to have its own concerns and acute needs. It was often less informed about HIV, more concerned about saving the child's health and less concerned about their own health. The women were also less confident in their ability to provide quality care for the child, and often had their own health or financial problems, as an additional burden. Although lacking necessary skills, knowledge and supplies, the grandmothers in most cases, give their grandchildren enormous love, and care for them even better and with more responsibility than the child's parents could have.

In 43% of the cases where a grandmother brings up a child born to an HIV positive woman, the mother was a drug user. In 33% of the cases, the mother had died. Other reasons were that the mothers were on rehabilitation, in prison or rejected to take care of their child. As of January 2009, at the Visiting Nurse Service, there were 38 children-clients brought up by grandmothers, which makes 15% of the total number of children-clients of the program. The types of services available for grandmothers at the Red Cross in Irkutsk are among others home visits by a visiting nurse, trainings on child care, social assistance, additional food and vitamins, counseling on HIV, support groups, counseling by psychologist, lawyer; assistance in registration of guardianship, detecting the child's father etc. One of the lessons learnt is that working with elderly guardians can substantially lower the risk of children being abandoned, as

Stories of beneficiaries - Valentina

Valentina is a pensioner. She has two grown children, a son and a daughter, that she brought up on her own. After her son, Andrei, found out about being HIV positive, he withdrew into himself and didn't speak to anyone about the diagnosis. Valentina helped her son move to a small village, to distance him from the drugs in Irkutsk. His indifference and depression got more severe as he got sicker. There were ulcers on his skin, he coughed hard, but refused to see a doctor. He told his mother to leave him alone, soon he would be gone.

As Valentina had no knowledge about HIV and did not know how to move on from here, she went for her first counseling session, where she received support, and information on how to live with HIV. She came to a support group meeting, met members of the group, inquired how they accepted their diagnosis, how they lived with it, and finally, asked them to call her son and support him. Valentina also got some support to understand her son's sickness and the nature of their relationship.

Counseling was eventually provided to Andrei over the phone, where a psychologist managed to persuade him to see a specialist. Andrei's mood has changed and so has his relationship with his mother. He is currently getting treatment and works as a dentist-technician together with his uncle. Valentina continues to come for support sessions with the psychologist from time to time.

Launching the programme

"Care & Support for people living with HIV/AIDS" was launched by the Irkutsk regional branch of the Russian Red Cross with support from the American Red Cross. The people affected by the epidemic were to be provided with counseling services, a "Hot Line" and home visits to households with children born to HIV-positive mothers. The self-stigma had to be fought, beneficiary's own resources had to be strengthened and they had to learn to accept one's diagnosis, to lead a productive life, and to learn skills of protecting one's rights and health. In short, there was work to be done. As the programme got established, activities within its

Visiting Nurse Service. All these greatly expanded access of those living with HIV to psychological, legal, and other



Irkutsk Branch, Russian Red Cross.

services, including medical services. The Centers and services of the Red Cross do not provide direct medical services, but actively cooperate with medical workers from healthcare



Photo from Temirtau, Kazakhstan, of a beneficiary of a Tuberculosis/HIV coinfection programme. March 2009. Claudia Janke/British Red Cross

well as having positive effects on the child's health.

Integrating children

When the programme started, integrating children affected by HIV in children's facilities and schools was acute, and even more now due to a rising number of affected children. The level of stigma in society was extremely high, and teachers in kindergartens and schools were no exception, completely lacking information and some preparation on how to respond. In order to improve the rights of the children, special attention was paid to the teachers in the Programme of the Red Cross. They were provided with reliable information about the disease and problems arising from it, and got help to overcome their fear; discrimination and neglect was to be replaced by information and tolerance.

The work with the elderly guardians and the aim of integrating children affected by HIV are only two of many examples of the project in Irkutsk. As of today, thousands of HIV-positive people have received psychosocial support in the region; and likewise have thousands of children

born to HIV-positive mothers received care services by visiting nurses and

become some kind of a knowledge hub on HIV and psychosocial support for

Stories of beneficiaries - Galya

Galya used to be successful at work, married with one son. But now, she spends all day in bed. She easily gets mad at her husband for not understanding the severity of her disease. "Throw it out of your head", he says, but Galya can't, which is why she decided to refer to professional support. She learned about the Information-Counseling Centres of the Red Cross and decided to come to the peer support group meeting.

Galya got infected by her first husband, they parted and she eventually learned to live with her diagnosis, getting support from her mother and sister. She even acquired a second master's degree and got married again.

Last summer she was down with pneumonia and pleuritis. The disease started taking its toll. Four months into the healing, during a regular visit to the AIDS Center she learned that her viral load was very high. It was suggested to Galya to start ART (anti-retroviral therapy), something she was not fond of. Galya became depressive. She went for a support group meeting to learn what other people thought about ART. Katya, mother, of a young baby-girl taking ART, told Galya her story and that seemed to calm Galya. As she listened to the stories of the others, tears ran down her face. She also learned to know Yulia, whose situation was similar to hers. The two women found strength in each other and decided to face their fears together and start therapy.

children's psychologist of the Red Cross. The Irkutsk branch has in fact

the entire Russian Red Cross. The project is still ongoing. ■

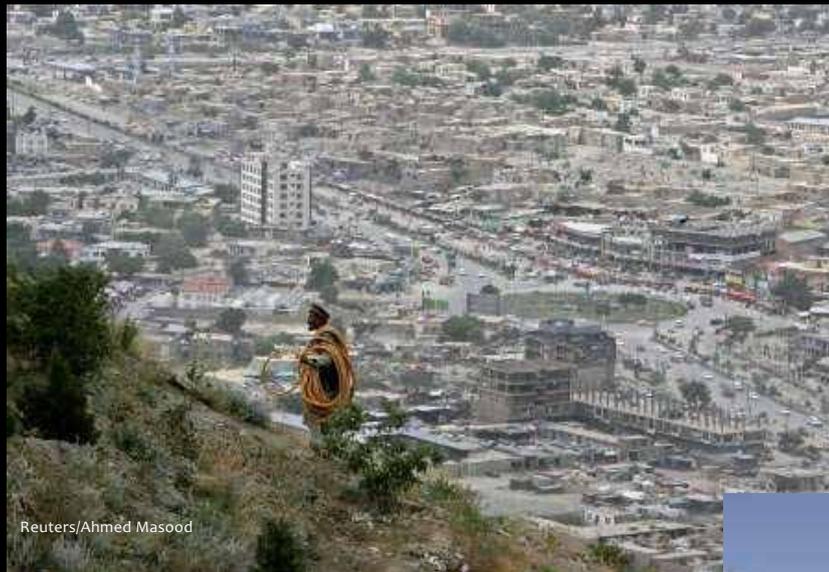
One can also fly a kite sitting in a wheelchair

Photo essay by **Hedinn Halldorsson**, Communications Advisor, IFRC Psychosocial Centre

Photos: Reuters/**Ahmad Masood** and **Fardin Waizi/ICRC**, November 2009

The skies were clear blue and the air was crisp on the November day when the ICRC orthopedic center organized a kite flying competition. The participants were actively engaged. The aim is to cut the other kites' string. The winner's kite remains flying while the loser's kites drift free with the wind until they fall to the ground. But what they all had in common in this specific competition was that they were all wheelchair-bound.

The lives of the Afghans have been blighted by war for decades - and the impact of conflict is broad. Exhaustive figures of the disabled in Afghanistan due to conflict, are difficult to ascertain. However, it is estimated that those with mobility impairments are around 800,000, of whom 40,000 are limb amputees. The number is constantly rising, as the inhabitants struggle, still in the middle of war.



But disability and deformity are not the only problems one has to face when coping with a new reality. Mental health is an issue as well. Landmine victims often have to rebuild their identity, and face a future they could never have imagined awaited them. "Social rehabilitation is the toughest part of the job", says Mr. Alberto Cairo, in charge of the International Committee of the Red Cross (ICRC) orthopedic programme in Afghanistan since 1992.



air

Centre held a kite-
flying competition so the winner's
prize was shared by all competitors



The ICRC runs 6 orthopedic centres in the country, the biggest one in the capital Kabul, and five others in Mazar, Jalalabad, Herat, Gulbahar and Faizabad. The first centre was opened in 1988 and so far, more than 90,000 patients have been registered, with disabilities, ranging from landmine victims to those with motor impairment. Every month more than 1000 prosthesis and orthosis are produced, and 80% of those in need of prosthesis are landmine victims.



The Orthopedic Centre in Kabul is one of the biggest rehabilitation centres in the world. It employs around 300 people, all of them disabled themselves. This has had an enormous positive effect on patients, particularly on new arrivals that often are depressed when starting treatment, having lost hope in life and their future. The feeling of being amongst other disabled has regained their dignity and faith in life, and been a giant leap for many patients.

The centres also run a home care programme, applicable for people with spinal cord injuries, where medical, economic and psychosocial support and rehabilitation is provided.

The centres are places of hope, where thousands of people share a common burden, hopes and strength. "We soon realized that we were still not doing enough. A disabled person needs more than a plastic leg and the ability to walk again. He/she needs a role in society to which he/she returns, needs to recover his/her dignity, his/her respect. In Afghanistan where life is difficult enough for everybody, the disabled need even more help than others", states Alberto Cairo.

When psychosocial support is not enough

Mental health in Banda Aceh

By Vivian Poulsen, Norwegian Red Cross

Millions of people were affected by the Indian Ocean tsunami in December 2004. Some 226,000 people were killed across two continents, making this the fourth largest death toll from an earthquake in recorded history. The mentally ill or those with pre-existing conditions are a vulnerable group and often neglected in most societies. They are, as a rule, particularly badly affected when a disaster strikes. This was also the case in Indonesia when the tsunami hit. This is the story of the only mental hospital in Banda Aceh province, and how it has developed after the tsunami, with assistance from a Red Cross Society.

Tens of thousands of people received psychosocial support in the wake of the Indian Ocean tsunami. Survivors always react individually to a catastrophe and have their own ways of coping and managing grief; one person's loss can never be compared to someone else's. In Indonesia, the country that was worst hit of all 13 that were hit by the tsunami, some only experienced minor loss and were back up on their feet within weeks. Others had lost entire families and suffered from serious psychological problems. A small minority, badly traumatized and already with a history of mental illnesses, did nothing but get worse. That is the group we all too rarely hear about, the group of people that psychosocial support cannot reach, people with pre-existing conditions that need more serious interventions.

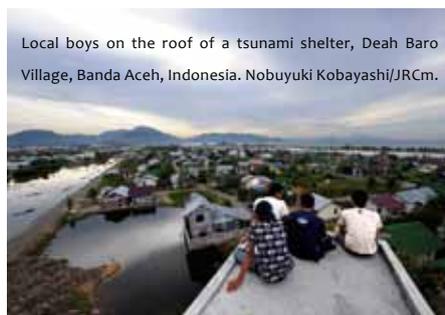


Photo by Norwegian Red Cross

Reaching the most vulnerable

Faced by the enormous destruction in the aftermath of the tsunami, the Norwegian Red Cross Society chose to participate in modernising and rebuilding the only existing mental hospital in the province, serving a population of four million. "To be able to give patients, who alternatively would have lived at home, or been

locked inside, even in chains, to give them access to a proper psychiatric hospital, is truly to reach the most vulnerable amongst us", stated Børge Brende, the Secretary General of the Norwegian Red Cross, at the opening of the hospital in the region of Aceh in November, 2009.



Local boys on the roof of a tsunami shelter, Deah Baro Village, Banda Aceh, Indonesia. Nobuyuki Kobayashi/JRCm.

Trauma after the tsunami

After the tsunami there was an increase of 13 per cent of patients to the mental hospital that was already stretched to its limits. The psychiatrist Magne Tauler, overseeing the development of the patient care programme at the mental hospital in Banda Aceh, in cooperation with the Norwegian Red Cross, explains: "It is certain that the mental health services are totally under dimensioned for the needs in the province, based on a normal situation. Then they had the tsunami on top of that, with more than 150,000 people killed across the province. People lost their relatives, were injured and traumatised. Many needs were not covered by far. Of course the longstanding conflict also contributed to people needing psychiatric care. However, it did not result in as many deaths as the tsunami, and therefore

the trauma can not be compared".

State of depression

During the tsunami the mental hospital was also affected, with water rising over one meter up the walls. "No one died there, but a number of the personnel died in their homes. For about a year after the tsunami, the personnel and the hospital were in a state of depression. They had no funds to do any improvements to the situation. No water supply, the patients had to bathe outside their units at some water points, the sewage system did not function properly. There was a very depressing atmosphere, where people were despondent about nothing being done", Tauler adds.



Photo by Norwegian Red Cross

Towards improvement

There were difficult conditions for both the staff and the patients. "35 patients shared a room, often with no more than 5 cm between each sleeping mattress, some did not even possess one. The personnel were totally overwhelmed and spent most of the time in another room, separated from the patients by barred doors and windows. Many of the patients had heavy mental disorders, such as

schizophrenia, displaying aggression, and being potential escapees. Now there has been a positive development, both in the number of patients per room and the number of personnel per patient. Earlier there were 4-5 personnel per 35 patients during the day, and only one during the night". According to Tauler, the number of staff has now increased to 6-8 per patient and to at least 2 at night.

Rejected by their families

Money rather than one's illness dictates one's treatment, laments Tauler. "If you have money you get first class treatment, both in mental health and in somatic treatment facilities. If you don't have money and your family can't pay, you get nothing or 3rd class treatment. There is no health insurance. The family has to pay for medicines

A changed atmosphere

Head nurse Nuraini who has worked at the hospital for 32 years, explains that the way the patients are being treated has improved. "Both the new buildings and the ideas of how we can work closer with the patients have resulted in better quality work and a better atmosphere amongst staff".

Her views are echoed by the 39 year old patient Lailatul Qadriah. She has been a patient at the hospital for over 10 years, after being admitted for showing aggressive tendencies. Now both her parents have died and she has no one left to go home to. "I would prefer not to be here at all. However, now it's much

The Norwegian Red Cross has built four patient wards, a kitchen, accident and emergency intake, and an administration building. The hospital has a capacity of 320 patients. The project is a cooperation between the mental hospital in Banda Aceh, Sørlandet Hospital in Norway, the Norwegian Red Cross and a mental hospital in Semarang, on Java, further south in Indonesia.

and the treatment in the hospital. Once they're released into the community again, the family has to keep paying the medicines and the visits by health visitors. For many families this is then an additional burden. At one point the hospital had a real problem with approximately 50 patients who were returned there after their families didn't want them or couldn't provide for them".

Focus on respect

The focus throughout the process in developing the patient care has been that the patients deserve better service, explains Tauler. "They deserve to be treated with humanity and respect, with information, and with the staff meeting the families. I pointed out that in Norway, as in many other Western countries, we had gone through the same not so long ago, where the patients just used to get handed food and medicine, and there would be minimal interaction between personnel and patients. We have had to go through this long process to develop in a positive way, and through time this seems to have sunk in amongst the personnel at the mental hospital here in Banda Aceh".

better. The new building is more comfortable, there's more room and the kitchen is closer".

Growing understanding

The staff at the hospital seems highly motivated to continue the positive development and improve the facilities and the patient care, Tauler reflects. "They have been under an enormous pressure, with building new parts of the hospital, working with the authorities regarding funding, and of course keeping up the patient care. Now that some of the work at least is over with they can get some quiet time to concentrate on developing in a positive direction. The cooperation with the mental hospital in Semarang has resulted in it not being only Norwegian doctors who come to Banda Aceh to tell the staff how they should do their job, but there is also an Indonesian example to get inspired by and attempt to follow". ■



Psychosocial Centre

 International Federation
of Red Cross and Red Crescent Societies

The **IFRC Psychosocial Centre** was established in 1993 and is a delegated function of the International Federation of Red Cross and Red Crescent Societies, hosted by Danish Red Cross and situated in Copenhagen, Denmark. Its primary function as a "Centre of Excellence" is to develop strategically important knowledge and best practice which will inform future operations of the Federation and National Societies.

The centre was established to promote, guide and enhance psychosocial support initiatives carried out by Red Cross and Red Crescent National Societies globally. The International Federation Psychological Support Policy Paper, adopted May 2003, established the basis of Red Cross and Red Crescent intervention both in emergency response operations and in the implementation of long-term development programmes. Within this policy, the mandate of the Psychosocial Centre is to mainstream psychosocial support in all National Societies. As stated in the consultation on National Society centres and networks commissioned by the Governing Board of the International Federation in March 2007, the centre provides a potentially flexible and creative structure to develop and disseminate expertise.

The Seven Fundamental Principles

Proclaimed in Vienna in 1965, the seven Fundamental Principles bond together the National Red Cross and Red Crescent Societies, The International Committee of the Red Cross and the International Federation of the Red Cross and Red Crescent Societies. They guarantee the continuity of the Red Cross Red Crescent Movement and its humanitarian work.

Humanity

The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples. Read more about the principle of Humanity.

Impartiality

It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress. Read more about the principle of Impartiality.

Neutrality

In order to continue to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature. Read more about the principle of Neutrality.

Independence

The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement. Read more about the principle of Independence.

Voluntary service

It is a voluntary relief movement not prompted in any manner by desire for gain. Read more about the principle of Voluntary service.

Unity

There can be only one Red Cross or one Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory. Read more about the principle of Unity.

Universality

The International Red Cross and Red Crescent Movement, in which all Societies have equal status and share equal responsibilities and duties in helping each other, is worldwide. Read more about the principle of Universality.

Research partners:



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