MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT MINIMUM RESPONSES IN EMERGENCY SETTINGS

Based on the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

TRAINING MANUAL
FACILITATOR'S GUIDE

Christian Children's Fund

Prepared by Jolanta Midor, December 2006

FOREWORD

The *Training Manual Facilitator's Guide on Mental Health and Psychosocial Support Minimum Responses in Emergency Settings* was produced by Christian Children's Fund through a ten-month project funded by the European Commission Humanitarian Aid Office (ECHO) beginning March 2006 through the Interagency Regional Steering Committee (RSC) Sub-Regional Child Protection Project. The Regional Steering Committee (RSC) is comprised of agencies concerned with the protection of children affected by armed conflict, operating in the Mano River Union countries and Côte d'Ivoire: Save the Children Alliance, International Rescue Committee (IRC), Christian Children's Fund (CCF), United Nations' High Commissioner for Refugees (UNHCR) and United Nations' Children's Fund (UNICEF) and International Committee for the Red Cross (ICRC), with observer status.

West Africa has struggled with a series of wars and unstable regimes during the last decade. Notably, the brutal wars in Sierra Leone and Liberia have caused unrest in the entire sub-region, spilling over into Guinea and Côte d'Ivoire. The causes have differed and the scenes of the worst violations have shifted from one country to another, while the region as a whole has been trapped in humanitarian crisis for the best part of 15 years. Children have been the greatest victims of the regional conflict. Tens of thousands of children associated with fighting forces have been uprooted and displaced from their homes. Most have witnessed and some have taken part in atrocities and are left with deep emotional scars. Many have been sexually abused and exploited. However, in most cases these children who have been deeply affected by these events have received little focused support, limiting their functioning and healthy development. The response to the psychosocial needs of children affected by armed conflict in the sub-region has been patchy and generally inadequate.

The field of mental health and psychosocial support in emergencies is becoming a major area of concern for all providers of humanitarian assistance. Consensus on good practice is emerging on how quality services can be provided if inter-agency collaboration is strengthened.

The purpose of the training manual is to provide effective guidance in delivering necessary mental health and psychosocial support responses in emergency settings. It is based on the Action Sheets recently developed by the Interagency Standing Committee Task Force on Mental Health and Psychosocial Support in Emergency Settings. The Action Sheets identify the Minimum Responses, that is, the first things that need to be done either from within the affected group or by outsiders such as government, NGOs, INGOs, etc., even in the midst of an emergency. This training manual was developed to be used in the field.

The training manual focuses on four selected Action Sheets, and uses lessons learned on mental health and psychosocial support from theWest African sub-region. It is the product of the collective experience of many people and agencies who have contributed to the training. They should not therefore be seen as representing the views of any one agency. The Manual also contributes to the IASC Task Force work to implement the Guidelines by operationalizing four Action Sheets and learning from the field practitioners' successes and challenges in using them.

Overview of Training Curriculum

The curriculum begins with the background information on West African Interagency Regional Steering Committee, and the Inter-Agency Standing Committee (IASC) Task Force on Mental Health and Psychosocial Support in Emergency Settings and its Guidelines. It provides key suggestions on how to organize mental health and psychosocial support in emergencies.

The curriculum continues to provide detailed information, group work, participatory activities and discussions on selected Action Sheets to be conducted in emergency settings that will lead participants to a clear understanding of the agencies' roles and effective implementation practices.

The IASC Taskforce's Guidelines include twenty-five Action Sheets on mental health and psychosocial support in emergency settings. However, this training focuses on only four Action Sheets.

The four selected Action Sheets include:

- Enforce staff codes of conduct and ethical guidelines
- Organize orientation and training of aid workers in mental health and psychosocial support
- Facilitate community social support and self-help
- Strengthen access to safe and supportive education

Acknowledgements

Christian Children's Fund gratefully acknowledges the contribution of the many people who helped develop and pilot this training manual. We are indebted to the 60 Master Trainers trained in workshops held in Freetown, Monrovia and Conakry, and field practitioners. These Master trainers were selected from among the Inter-agency Regional Steering Committee Group, government (Ministry of Social Welfare), police (Family Support Unit, S/Leone), UN and humanitarian NGOs representatives operating in the sub-region: SC UK S/Leone, SC UK Liberia, UNHCR Liberia, CVT S/Leone, CVT Liberia, IRC S/Leone, IRC Liberia, IRC Cote d'Ivoire, Caritas Makeni, War Child Holland, Don Bosco Fambul, MSWGCA, NNEPCA, FSU, GOAL, NACWAC, CCC, CAP, YMCA, WVI, CCF. The Master Trainers were trained in three ToT workshops held in Freetown, Monrovia and Conakry. The Master Trainers in turn held six step-down trainings with field practitioners in selected cross-border field sites in Guinea, Sierra Leone, Liberia and Côte d'Ivoire. The experiences of all of the participants were documented and have contributed to the revision of this manual.

CCF was pleased to work with our partner organizations mentioned above and we appreciate their collaboration and permission to use materials contained within these sections.

Thanks to all who reviewed the initial drafts and made valuable contributions, shared their experiences, lessons, insights and support.

Sincere appreciation is given to the CCF technical advisors who worked closely with this Project: Martin Hayes and Mike Wessells.

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INTRODUCTION TO THE TRAINING WORKSHOP

Workshop Goal

The goal of the workshop is to strengthen the capacity of agencies to respond in a coordinated manner to mental health and psychosocial support needs of children in emergency settings by applying the IASC Taskforce Guidelines on Mental Health and Psychosocial Support in Emergency Settings.

Participants will operationalize four selected Action Sheets through their participation and provision of practical examples from their own work in emergency settings. They will be encouraged to share these examples during the group-work sessions.

They will then be provided with participatory training methods that will assist them in training others about how to apply the Action Sheets. This will include information on the principles of adult learning. Participants will also be provided with the opportunity to practice teaching what they have learned.

Objectives

Training

By the end of the workshop, participants will:

1. Understand the recommended Mental Health and Psychosocial Support (MHPSS) Action Sheets in Emergency Settings.
2. Be able to advocate for the implementation of the minimum responses within their work context.
3. Be able to operationalize at least four selected Action Sheets in their emergency work.
4. Be prepared to train others about the principles and use of the IASC MHPSS Guidelines within their organizations and leave the training with concrete plans to conduct step-down training workshops at field and local community project levels.
5. Be able to apply participatory training methods when training others about the IASC MHPSS Guidelines.

Planning

By the end of the workshop, participants will also be provided with the opportunity to develop plans for better coordination. Together they will develop plans for how to enhance mental health and psychosocial coordination and networking in emergency settings at local, national and regional levels by outlining next steps for continued follow up actions after the workshop.

Participants

The training curriculum is designed for governments and humanitarian agencies/ NGOs workers and volunteers to enhance their knowledge, understanding and application of the MHPSS Guidelines .

Training Methods

The training sections are designed to be used by facilitators familiar with participatory learning techniques. Methods include small group work, individual work, lectures, case studies, training simulations and large group discussions.

Sessions and activities are participatory and inter-active and they should be conducted in an open manner, so all participants feel free to contribute to the discussion and analysis of situations, which we regularly face when working in emergency settings. There should be at least two facilitators and a maximum of 25 participants.

Facilitators

It is important therefore that the facilitators:

- Are skilled and comfortable with a participatory learning approach
- Are familiar with the *IASC Guidelines on MHPSS in Emergency Settings* and the process of development of these Guidelines
- Have studied the *Training Manual* and the associated materials and understand the structure of the sessions sufficiently well that they do not need to work from the guide, just consult it occasionally in the course of a session
- Have attended the course themselves as participants

Materials

For the facilitator: The *Training Manual* is for facilitators. It contains workshop objectives, the structure of each session, presentations and instructions for conducting the activities. It also has several sections that need to be extracted, copied and cut up for distribution to the participants (i.e. work assignment). This needs to be done in advance of the session.

For the participants: The handouts are designed for the participants and each participant should receive one. Handouts are included at the back of each session and should be copied and cut up for distribution to the participants in advance of the session. In addition to the handouts, every participant should receive one copy of the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* as their referral materials. They should be given this prior to the workshop, to study them carefully, to use during the course and to take with them after the workshop.

Workshop Agenda

The facilitators will need to develop a workshop agenda, based on the number of training days. Each section builds on the other, and they are intended to go in order (Section 1, 2, 3, 4, and 5). The sections can be tailored to the needs of particular providers and audiences through shortening, lengthening or use of different formats.

Manual layout

Each section begins with learning objectives and time needed. Times throughout the sections are estimated - and can be shortened or lengthened depending on the trainer. In each section, there are a number of individual sessions. Each session begins with information about objectives, preparation, timing, provides notes, instructions for facilitators and key messages. The procedure for each session is laid out step by step, with interactive exercises and potential points to be made during sessions.

TRAINING CURRICULUM BY SECTION

SECTION 1: Welcome and Workshop Introduction

Learning Objectives

- Ensure that the objectives of each session in the workshop are clear
- Identify the needs and concerns of participants
- Create a comfortable environment where participants know each other and have set ground rules relating to communications and respect
- Clarify the workshop plan, including schedule and agenda

Time needed: Approximately 35 minutes

1.1: Opening and introductions

Time: 10 minutes

Facilitator's instructions

Begin the workshop by greeting participants. Introduce yourself and any other workshop staff working with you. Conduct introduction activity so that all participants are aware of who is in the room: names, organizations, work sites, and general information about each other's work. Participants will learn more about each other as the workshop continues.

1.2: Review of the participants' expectations, workshop objectives and the agenda

Time: 10 minutes
Facilitator's Instructions

- Ask participants to brainstorm on expectations they have for the workshop. Write these on the flipchart paper.
- Explain whether or not this workshop will address each of the shared expectations. If it will not, explain why and how interested participants can gain access to such knowledge.
- If there are other expectations of the workshop that were not mentioned by participants, explain these.
- Present the prepared objectives; take time to be sure participants understand the workshop's objectives, and intended outcomes.
- Review the workshop agenda (see Appendix 1). Explain how the workshop sessions will build upon each other to achieve the workshop objectives.

1.3: Review of logistics and administrative issues

Time: 5 minutes
Facilitator's Instructions

- Inform participants of locations of toilets, break area, etc.
- If relevant, review the workshop policies on seeking reimbursement for travel, how food and beverages will be handled (i.e., does the workshop provide these and pay for them directly, or does the participants pay for them and get reimbursed, etc.), and how accommodations will be paid. Set deadlines for receipt submission and announce when reimbursements will be distributed.
- Explain who from the workshop staff will be handling logistics and direct participants to contact her/him directly outside of the sessions.
- This is also a good time to identify a volunteer a timekeeper who will remind the facilitator and participants to stay on time. Two observers should also be identified who each day will provide feedback on the proceedings of the workshop. An "energizer" can also be appointed. This person will check on energy levels throughout the training and at any point can suggest carrying out an energizer activity.

1.4: Establishing Ground Rules for the workshop

Time: 10 minutes
Facilitator's Instructions
Explain that in order for the training to go well, participants will have to follow certain rules, it is important to review some ground rules for the time you will share together. Ask participants to list what they feel should guide the next days of discussions. Write these on the flipchart. Some ground rules that will probably come up include:

- *Respect for all in the workshop*
- *Keep confidentialities*
- *No side conversations*
- *Contribute to the discussion*
- *Keep cell phones off*
- *Start on time, end on time*
- *One person speaks at a time*

Ask participants if they agree to abide by these ground rules. Post the ground rule list on the wall in the training room.

SECTION 2: Introduction and background to MHPSS Guidelines

Learning Objectives

At the end of this section participants will

- Be able to pass on the information about the Sub-Regional Child Protection Project, Regional Steering Committee, the IASC Task Force on Mental Health and Psychosocial Support in Emergency Settings and the inter-agency work to define minimum responses.
- Be knowledgeable about the Guidelines on Mental Health and Psychosocial Support in Emergency Settings established by IASC Task Force.
- Be familiar with key psychosocial concepts and the objective of psychosocial support in emergencies.
- Understand the rationale and importance of organizing mental health and psychosocial support response in emergencies.
- Be more aware of the importance of working on capacity building of humanitarian agencies' staff, teachers and community workers to improve the quality of psychosocial supports for children in need.

2.1: Introduction to the background of the Sub-Regional Child Protection Project

Time: 15 minutes
Method: lecture, discussion

Facilitator's instructions

Review the learning objectives for this session. Briefly introduce the Sub-Regional Child Protection Project and Inter-Agency Regional Steering Committee:

The Sub-Regional Child Protection Project was launched against a general backdrop of sub-regional cross-border conflict affecting children in the Mano River Union countries and Cote d'Ivoire. In 2004, agencies concerned with children's protection in the sub – region (Save the Children Alliance, International Rescue Committee (IRC), Christian Children's Fund (CCF), International Committee for the Red Cross (ICRC-as active observer), United Nations' High Commissioner for Refugees (UNHCR) and United Nations' Children's Fund (UNICEF) developed a common vision a) to reinforce protection for children literally crossing borders and b) to harmonize polices and procedures across key protection program areas.

From August 2004, this common vision has been put into action via an inter-agency, sub-regional project across the four countries that was coordinated by UNICEF and funded by ECHO and the Governments of Sweden and Canada. Phase I of the project, with a set of 10 intended results went

from August 2004 to June 2005. Phase II of the project, with a set of 5 intended results began in January 2006 and ends in December 2006.

The Inter-Agency Regional Steering Committee is evolving as the principle mechanism to support actions between countries in the sub-region to re-enforce protection for children crossing borders and to harmonize approaches to specific protection areas.

The principal tasks of the RSC in 2006 were:

1. Build capacity across the region in relation to information management and develop a regional information system that collects and produces regular reports on child protection data. (UNICEF).
2. Develop and field-test training materials related to minimum standards for psychosocial support in emergency settings. (CCF).
3. Develop a strategy to enhance the capacity of child protection agencies in the area of gender-based violence based on a review of best practices and training needs. (IRC).
4. Repatriate or integrate locally up to 100 Sierra Leonean separated and unaccompanied children in Guinea. (IRC and UNHCR).
5. Review policy and practice within the region for the reintegration of children and develop best practice guidelines. (Save the Children Alliance).

One of the Project's objectives is to build the capacity of child protection agencies staff within the Mano River Union countries and Côte d'Ivoire. Therefore, CCF has selected the four Action Sheets from the IASC Guidance on Mental Health and Psychosocial Support that emphasize the need to build capacity of the human resources involved in response interventions in emergencies – agencies staff, community members and teachers.

This inter-agency sub-regional child protection project represents an exciting, innovative and ground-breaking approach to the protection of children affected by armed conflict and other crises. The products of the project and – perhaps more importantly – should be used in all humanitarian responses where there is a regional dimension. The products and the approach are fundamentally replicable, with appropriate amendments according to the context.

Close this session by allowing the questions and summarizing the discussion.

2.2: Introduction to the Interagency Standing Committee Task Force on Mental Health and Psychosocial Support in Emergency Settings

Time: 15 minutes
Method: lecture, discussion
Resource needed: Copies of *the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*

Facilitator's instructions

Review the learning objectives for this session. If you have not already done so prior to the workshop, distribute copies of *the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* to participants. Then briefly introduce the Interagency Standing Committee Task Force on Mental Health and Psychosocial Support in Emergency Settings.

Over the past decade, there has been increasing consensus about the importance of providing mental health and psychosocial support (MHPSS) in emergency settings. The question for most agencies is no longer whether to provide MHPSS but how to provide it in the most effective, appropriate manner.

The question how to provide effective support is inherently thorny because the field of psychosocial support is young and, accordingly, lacks an extensive research base. Nevertheless, experience by agencies in many emergencies, from armed conflicts to natural disasters, has created a growing set of lessons, tools, and principles that can guide effective MHPSS. In many respects, the time is ripe for systematizing the field by developing coherent, practice-based guidance.

In this spirit, in 2005 the Inter-Agency Standing Committee (IASC) established a Task Force on Mental Health and Psychosocial Support in Emergency Settings. The Task Force Co-Chairs are WHO and InterAction, which is the umbrella organization for 160 U. S. based NGOs working in international settings. The Task Force members include a mixture of U. N. partners (UNOCHA, UNFPA, UNICEF, UNHCR, WFP, WHO), IOM, Red Cross and Red Crescent Movement (IFRC), the NGO consortia

InterAction and ICVA (represented in the Task Force by Action Aid International, American Red Cross, CARE Austria, CCF, IMC, ICMC, IRC, MdM-E, Mercy Corps, MSF-H, Oxfam-UK, RET, SC-UK, and SC-US) and the INEE.

This inter-agency approach has the advantage of drawing on the respective strengths of many different actors and of engaging diverse parts of the humanitarian system.

Present the rationale of having interagency guidelines:

- Interagency relations better if there is interagency guidelines
- Emergency not the time for heated discourse
- Enough consensus on good practice to develop interagency guidelines
- Transcend unnecessary ideological debates
- Use strengths of different agencies' expertise
- Facilitate attention to a range of issues from psychosocial well-being to severe disorder engaging a wide array of relevant sectors
- Reduce clearly inappropriate practices
- Reduce chaos and facilitate coordination in the field
- Improve inter-agency staff relations (social capital)

Mention the development of the Guidelines from IASC Task Force on Mental Health and Psychosocial Support:

Through a highly consultative process engaging partners worldwide, the Task Force has constructed a matrix of 25 key interventions from multiple sectors. The matrix includes common functions (coordination, assessment, monitoring and evaluation, human rights standards, human resources), core MHPSS domains (community organization and support, protection, health, education, dissemination of information), and social considerations in sectors (food, shelter, water and sanitation). Because of its broad coverage and emphasis on integrating MHPSS elements into multiple sectors, the Guidelines offers practical steps to all humanitarian actors, not to mental health professionals only.

Elicit the following key points on the IASC Guidelines:

- Embodies the collective insight and support of 27 agencies worldwide
- Product of extensive consultation and participatory dialogue
- Endorsed by the participating agencies
- Emphasis on *social* interventions and supports
- Guidelines on minimum response—the first MHPSS activities in an emergency setting
- The goal of mental health and psychosocial support is to build on and strengthen existing social supports - focus on the positives, not on the deficits.

Draw the participants' attention to the terminology used in the IASC Guidelines; explain that throughout it is best to talk about **mental health and psychosocial support** rather than **psychosocial support** alone. This reflects the integrated approach and mandate of the Task Force and avoids privileging one group to another.

Explain that **minimum response** refers to the key actions, the first things that need to be done either from within the affected group or by outsiders such as government, NGOs, INGOs, etc., to be conducted even in the midst of an emergency to mitigate its impact on the affected population. The minimum responses, which are presented in the 25 Action Sheets, reflect the experience and insights of people working in the field; they are based on a review of existing guidelines, consultation

with field workers in different contexts, expert consensus on best field practices, research evidence, existing practical manuals and inputs from agency colleagues and experts.

The Guidelines are based on the principle that affected populations have the right to life with dignity as articulated by the Sphere Humanitarian Charter and the various legal instruments which underline it.

For each intervention, agencies have written brief action sheets that operationalize the minimum responses that are needed. At present, the Guidelines are in their fourth revision and has been translated into French, Spanish, and Hindi for review by many partners worldwide. The final Guidelines are available by internet at:http://www.humanitarianinfo.org/iasc/mentalhealth_psychosocial_support

Display the ways of using the IASC Guidelines by agencies:

- Reflect as agencies and coordination groups on how to use it effectively, for example, in identifying gaps and planning and in facilitating effective coordination
- Build capacities through workshops
- Provide regular orientation for agencies or groups working here or just entering
- Use in advocacy
- Reach out to other coordination groups & ministries
- Write brief notes on what's useful and what needs improvement, case studies, etc.
- Share any implementation tools or strategies—we're all learning together

Close the session by pointing out that the Guideline provides programmatic standards which can be expanded after the workshop by participants and then used for developing plan to strengthen psychosocial programming.

2.3: Key Psychosocial Concepts

Time: 40 minutes
Method: lecture, brainstorming, scenario and discussion.
Resource needed: *Handout 2.2 -Limits of Trauma Counseling Approach in the Current Context,* flipchart, markers

Facilitator's instructions

Review the learning objectives for this session. Explain that is important start with the background on the concepts that we will be using so participants:

- Understand the relationship between our psychological world, our physical world, and our social world in relation to an emergency;
- Strengthen their understanding of key concepts related our work in PS support;
- Begin to think about what can be done to support psychosocial recovery in the wake of an emergency.

Brainstorm with participants on the following terms: *Mental health, Psychosocial, Psychosocial well-being, Psychosocial support.* List participants' answers on a flipchart, go through each term and bring out the key points; refer them to the terms as follow:

Mental health is more than the absence of disease or disorder. It is defined as a state of complete mental wellbeing including social, spiritual, cognitive and emotional aspects.

Psychosocial - the term is used to underscore the close and dynamic connection between the psychological and the social spheres of human experience.

Psychological aspects are those that affect thoughts, emotions, behavior, memory, learning ability, perceptions and understanding.

Social aspects refer to the effects on relationships, traditions, culture and values, family and community, also extending to the economic realm and its effects on status and social networks. The term is also intended to warn against focusing narrowly on mental health concepts (e.g., psychological trauma) at the risk of ignoring aspects of the social context that are vital to wellbeing. The emphasis on psychosocial also aims to ensure that family and community are fully integrated in assessing needs and interventions. If we help people psychologically, we improve their social relationships and effectiveness. If we help people function socially (cooperate, communicate and interact well with others, or find their role in the family and community and fill social roles as children and parents), we support their mental health.

Psychosocial well-being is holistic and reflects the mutual interaction between mental, emotional, spiritual, and physical dimensions, all of which are influenced by culture and social and political context. Keys to psychosocial well-being include healthy family and community relationships, engagement in meaningful roles and religious or spiritual practices as culturally defined, having basic needs met, physical security, and a sense of identity, dignity, and positive self-esteem.

Psychosocial supports are activities, relationships, and tools that support holistic well-being, mobilize the existing resources or introduce the new ones to alleviate the psychological and social consequences of armed conflict on individuals and their social world by strengthening people to deal with them and ensure their active participation in rebuilding their lives.

Point out that some of the best psychosocial support comes from friends, family, religious leaders, etc. Children, women and men affected by emergency should not be treated as helpless spectators and recipients of support, but must be actively involved from the outset in improving their situation. It is important to think of how psychosocial support is organized since it can be local, affected people themselves who do the organizing.

Summarize by saying that psychosocial support in the emergency should focus on improving security, bringing together family members, improving communication, and providing support during mourning process rather then isolated trauma therapy programs. In cases where community or family separation occurs, alternative social support mechanisms must be established, such as adult and youth support groups, child centered spaces, camp leadership and school.
Addressing mental health and psychosocial needs in conflict and post-conflict situations is critical for reducing the likelihood of future conflicts and ensuring effective and sustainable reconstruction.

Briefly introduce the **Mental and Psychosocial impacts of armed conflict**: The impacts of conflict are complex and wide ranging. They are not confined to countries at war - they ripple outward from

the initial violence, spreading from individuals and communities to countries and regions. Conflicts cause widespread insecurity due to forced displacement, sudden destitution, the breakup of families and communities, collapsed social structures and the breakdown of the rule of law. This insecurity can persist long after the conflicts have ended as internally displaced persons (IDP), refugees, and asylum seekers try to adjust to new circumstances around them, cope with loss, and regain a sense of normalcy. Widespread insecurity and increased poverty, coupled with a lack of basic services such as healthcare, education, housing, water and sanitation, exacerbate levels of stress.

Psychosocial impacts of armed conflict often include not only changes in individual feelings, thoughts, and behavior but also changes in social roles, relationships, and status that arise from experiences such as family separation, loss of home and belongings, torture, stigmatization, social polarization, loss of social supports, and disruption of patterns of play, work, education, and religious and spiritual practice that create a sense of meaning and hope.

Point out that most people do not develop mental disorders as a consequence of distressful experiences. Natural recovery over time i.e. healing without outside intervention will occur for many, but not all, emergency survivors.

In emergencies, the incidence of mental and psychosocial distress increases substantially. Population's responses to stressful environment caused by armed conflict or natural disaster can be outlined as:

- **Basic Services and Security:** Most people in the emergency-affected areas experience increased distress due to loss of security and lack of access to basic necessities such as food, water, shelter, and health care.
- **Community and Family Supports:** A segment of the population typically experiences distress due to disruption of family and community networks and need family, community, traditional, religious, spiritual support;
- **Focused Non-Specialized Support:** Some members population in emergency-affected areas have ongoing distress and might need focused support by trained and supervised MHPSS workers
- **Specialized Services:** A smaller proportion of the population suffer extensively and experience difficulty functioning in daily roles. It may not only be the mentally ill but also people with retardation, epilepsy and other neurological disorders.

Coping means that a person is able to manage, adjust, live with, adapt to their experiences and continue to lead a functional life. In order to cope, people use their **resilience** and **protective factors** and personal **coping style**.

Resilience is the **ability of individuals, families or communities to cope and respond adaptively in the face of adversity**. This resilience allows people to manage their experiences and continue with their lives without major destruction to their mental health or psychosocial well-being.
Protective factors are factors that help to offset the negative effects of exposure to risks and that increase well-being. They include: Security or safety, Family support, Prior coping experience, Community support, Access to adequate survival tools, income and employment, Constructive activity, Support for human rights, Free cultural and spiritual practice, Ability to find Meaning in the problems etc. After a traumatic event, people use their protective factors to assist them in coping.

Every person develops his or her own **coping style** using his/her protective factors. There is no right or wrong way to cope. Some people talk to others in their family or community and ask for help, while others think privately until they come to a resolution. Some turn to activities like work or play to divert their thoughts, some try to forget, some try to find meaning or solace through prayer while others think about it over and over until they find an answer.

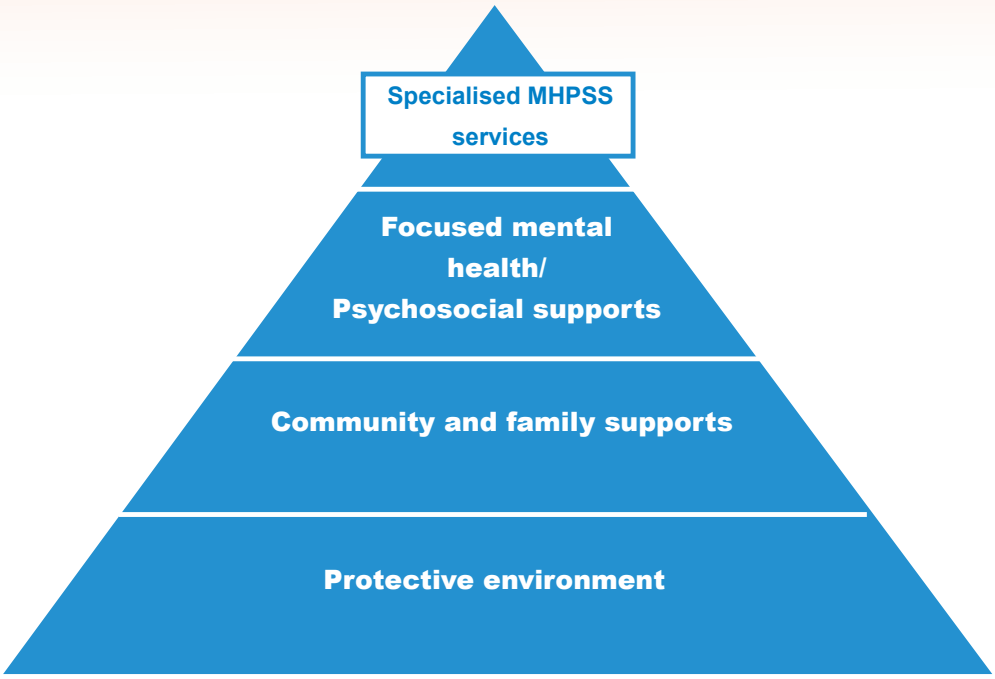
Some people are victim to extreme events and respond without a problem, yet have symptoms of stress later, while others never have symptoms. Other people have symptoms at the beginning, that later disappear. Some people experience, what appear to be minor traumas, yet develop serious psychological reactions so it does not seem to be the event alone that triggers symptoms of distress. The balance between the traumatic experience or stressors and protective factors has an impact on the reactions. This explains why there are differences in reactions even when people are exposed to the same events.

Not everyone who experiences a traumatic event is traumatized.
Explain that often the word, traumatized is used to describe anyone who is disturbed, upset, distressed or shocked by an event. With this definition, everyone who has experienced a traumatic event is traumatized since they all feel some level of distress due to the event. However, the psychological or psychiatric definition of traumatized refers specifically to someone who has experienced a traumatic event and is unable to cope with the event and develops a mental disorder.

- Point out that only a small percentage of people actually develop mental disorders after a traumatic event. Commonly, people with severe mental disorders after a traumatic event had prior mental health problems and seem to have a predisposition to a major mental disorder
- People with severe mental health problems may fail to present at all because of stigma, fear, self-neglect, disability or poor access. These people are doubly vulnerable, both because of their severe disorder and because the emergency may deprive them of social supports that previously sustained them. The burden on families or communities taking care of them puts such individuals at elevated risk of abandonment in emergencies that involve displacement.
- Once they are identified, however, steps can be taken to provide immediate protection and relief, and to support existing caregivers.
- Emphasize that only specialized agencies with health professionals are able to serve the small proportion of people affected in this way. This makes having referral networks important where agencies recognize their limitations in providing mental health assistance.
- Briefly outline how children can be affected by emergencies:

Among conflict-affected populations, children are the most vulnerable. Armed conflict alters their lives in direct and indirect ways, and in addition to the risk of being killed or injured, they can be orphaned, abducted, subjected to sexual violence or left with deep emotional scars and psychosocial trauma from direct exposure to violence, dislocation, poverty and the loss of loved ones (UNICEF 2004).

Due to their sensitive, developing neurological systems, children are more susceptible to shocks to their developmental process than adults. These shocks may include direct traumatic events or more subtle shocks such as chronic, severe malnutrition leading to stunting and cognitive impairments (i.e., seizure disorders and retardation).



In the explanations, point to the triangle that represents the layers of support.
Most children affected by emergencies do not need professional attention but will recover through the establishment of a **protective environment** and the activation of community and family supports and participation in the age- and gender-appropriate activities as defined by the local society. With these layers of support the majority of affected children's natural resilience will help them cope and recover.

Some children who are at risk due to the experiences related to child soldiering, family separation, gender-based violence, disability (among others) will need focused psychosocial support such as life-skills, family reintegration, and child centered spaces interventions (**Community and family supports, Focused mental health/ Psychosocial supports**)

Only a small minority of children will need **specialized mental health and psychosocial services**. It is important that agencies recognize limitations in their capacity to deliver specialized services and seek establish effective networks for making referrals to agencies that have the relevant capacities .

Of utmost importance in emergency settings is normalizing the lives of children as much as possible. This helps to promote positive coping mechanisms, minimizes the consequences of deprivation and traumatic experiences and lays the foundation for skills and values for their healthy development.
CCF has developed the Child Centered Space, a unique entry-level emergency response for children. The objective of Child Centered Spaces is to provide protection and psychosocial support for children who have been affected by emergencies as quickly as possible. These "safe spaces" provide regular, structured activities for children under the supervision of caring adults to mitigate the psychosocial impacts of the emergency.

Child Centered Spaces reflect CCF's philosophy of holistic support for the well-being of children through attention to their safety, psychosocial and development needs. Child Centered Spaces also provide an avenue for engagement and support of parents and families to begin community mobilization around the needs of their children.

Introduce the scenario on psychosocial support in the acute phase of an emergency. Distribute the *Handout 2.2 Limits of Trauma Counseling Approach in the Acute Emergency Phase.*

Read the scenario aloud. Paraphrase and repeat as needed until everyone understand the scenario. Ask the group the question about the appropriateness of trauma counseling. Ask the group what kind of psychosocial support a child might need to reduce the harmful consequences of the disaster.

Scenario: Psychosocial support in the acute phase of an emergency

Two days after a flood, a child who has lost her home cries, spends time alone, and has difficulty sleeping.
Question: Do you think the child has post-traumatic stress disorder and needs trauma counseling?

After their answers are given, facilitate a discussion to elicit the key points from their discussions and refer them to the key points that follow:
Following the emergency, some helpers seek to provide psychosocial support by means of trauma counseling. Although trauma and trauma counseling are popular topics in emergencies, it is important to reflect on whether trauma counseling is appropriate for the current context. Trauma counseling, although useful in some contexts, is not appropriate currently since it is too early to diagnose trauma, much less treat it.

Also, the trauma focus downplays the greatest sources of mental health and psychological distress, which have less to do with emotional residues of past experience than with survivors' current life stresses such as damaged homes, insecurity, no livelihoods, the loss of loved ones, gender-based violence, and living in overcrowded camps, among others. Overall, an emphasis on trauma counseling is ill suited to the local context and likely to cause harm.

A more appropriate approach is to strengthen local social supports through community mobilization of local resources and networks that enable mental health and psychosocial well-being in this early phase of the emergency.

With reference the previous scenario, draw the participants' attention to the need for community-based, social interventions in emergencies: Efforts to provide professional trauma counseling assume that trauma is the main psychosocial issue following the natural disaster. In fact, however, trauma is only a small part of a wide array of psychosocial issues that ought to be addressed.

For many natural disaster survivors, the main issue is not traumatic memories of the event but stresses associated with their current living situation. These stresses include the lack of safety and security, the loss of livelihoods, lack of appropriate shelter, changes in family relations, exposure to gender-based violence, substance abuse, and uncertainties about the future. Because these stresses are inter-linked, they require comprehensive supports that go beyond trauma counseling.

Inherently, the supports needed are social rather than psychological and include such things as normalizing life by reestablishing daily activities such as working for parents and education for children,

protection from rape and other forms of gender-based violence, the development of livelihoods, and the strengthening of community networks of social support.

However it is not just the kind of support, social or psychological, that makes a difference. Across humanitarian sectors, the way in which relief is provided has strong impact on psychosocial well-being. A common error is to view natural disaster survivors as passive victims who need to be taken care of or healed by outsiders.

In the present emergency, the most effective means of providing psychosocial support is through a process of community mobilization and empowerment wherein communities make their own decisions and develop their own systems of protection, care, and support for survivors. When communities make choices about how to move forward, they reestablish a sense of control that is powerful antidote to feelings of being overwhelmed. As they engage in collective planning and action, they gain a sense of hope for the future and move out of the victim's role they too often are cast into.

An important way of enabling psychosocial support in an emergency is to integrate psychosocial elements into the humanitarian response in different sectors of aid. For example, in providing water and sanitation, one can reduce the stresses and threats associated with rape and sexual violence by engaging women in the assessment and planning process, building separate, lockable latrines for girls and boys, and insuring latrines are well lit and safe. Similarly, decisions about how to provide shelter can include women's participation and careful attention to issues of privacy, which is invariably one of the most significant stressors in living in crowded camps. The participation of local people in the process of humanitarian aid helps to restore dignity and build collective hope and empowerment. Participation also encourages a sense of local ownership for the relief and development process. The participatory approach to psychosocial support stands in sharp contrast to a trauma counseling approach that regards people as suffering from a clinical disorder or pathology.

Elicit the Keys to Effective Mental Health and Psychosocial Support recommended in the IASC Guidelines

- Community mobilization & empowerment—reestablish a sense of control and processes of collective planning and action
- Enable the community to play a lead role in the humanitarian response
- Think holistically—work on issues of shelter, education, livelihoods, protection, GBV, information
- Identify MHPSS resources and build on them—avoid focusing only on deficits
- Develop competencies for coping, empathy, support
- Pay attention to gender, class differences and inequalities
- Respect the "Do No Harm" imperative
- Build capacities, working at levels from the government to community-based organizations
- Effective referral systems

Trainers should conclude this session on key concepts by pointing out that psychosocial support is not mainly something done to or for people by psychologists or psychiatrists but a process of local people activating their own social supports for their collective well-being and positive futures. Taking heed of this key point, the emphasis in the emergency response should be on social interventions that empower local people. At best, trauma counseling is a very small part of the much wider array of supports that will help local people get on with their lives.

Handout 2.2 - Limits of Trauma Counseling Approach in the Acute Emergency Phase

What is trauma and when is trauma counseling appropriate?

Trauma is a psychological disorder that leaves people feeling emotionally overwhelmed or incapacitated and can have life-long effects. In most emergencies, a frequently discussed type of traumatic reaction is post-traumatic stress disorder (PTSD), which can occur in people of all ages.

People who suffer from trauma may exhibit irritability, sleeplessness, and difficulties concentrating. Not uncommonly they spend too much time alone and turn to alcohol and other substances as a means of self-regulation. Some will have difficulties performing jobs or daily responsibilities, and some may develop related disorders such as depression and anxiety. As a result they suffer and the affects weigh heavily not only on individuals but on their families, friends, and communities.

Post-Traumatic Stress Disorder (PTSD)

According to the DSM IV which sets an international standard for mental disorders all of the following criteria are required for a diagnosis of PTSD:

1. Person must have been exposed to a traumatic event.
A traumatic event is defined as one that was an actual threat of life, serious injury or physical integrity to the person or another close to that person. After the event, the person must have a response of intense fear, helplessness or horror.

2. Intrusive: The traumatic event must be intrusive and be relived persistently.

- Intrusive recall
- Dreams that are persistent reminders.
- Reliving event through hallucinations, dissociation or flashbacks
- Psychological distress at cues that remind person of the event.
- Physical distress at cues that remind person of the event.

3. Avoidant: Avoidance of stimuli associated with the event (at least 3) of these:

- Avoid thoughts / feelings related to traumatic event.
- Avoid activities, places, people that remind person of event.
- Unable to recall event.
- Diminished interest in activities that were of interest prior to event.
- Feel detached from others.
- Restricted affect.
- Sense of shortened future.

4. Physical: Persistent symptoms of increased arousal (at least 2):

- Difficult falling or staying asleep.
- Irritable / angry outbursts.
- Difficulty concentrating.
- Hyper-vigilance.
- Exaggerated startle response.

5. Social: Significant distress or impairment in social, occupational or other functioning.

1. *Time: Numbers 2-3-4 must have occurred for more than 1 month*

In many Western societies, counseling is one of the primary methods for treating PTSD and enabling survivors to resume their normal lives. Although there are many different counseling approaches, most emphasize the establishment of rapport with the client and the creation of a safe space in which to express and explore feelings under the guidance of a competent professional, who engages in compassionate listening and helps survivors to manage their reactions, express and deal in a productive manner with their feelings, come to terms with the difficult experiences they have lived through, and solve daily problems in living.

Counseling is challenging not only because of the complexity of human psychological reactions and healing processes but also because of the enormous ethical responsibility it entails. Effective counselors must know how to identify people who are at risk to themselves or others, how to support

people experiencing a range of problems, when to probe feelings and when to leave them untouched, and how to analyze the ethical complexities associated with counseling. Effective counselors are not made overnight but are shaped by years of learning, supervision by experienced counselors, and real life practice.

In any emergency the appropriateness of trauma counseling depends on three conditions:

1. Legitimate diagnostic methods must have indicated that trauma is a significant psychological problem. In the absence of an accurate diagnosis, no basis exists for selecting a treatment.
2. The efficacy of trauma counseling must have been demonstrated in the particular context. If there is no evidence that trauma counseling is effective, no basis exists for suggesting the use of trauma counseling. Also, if there were reasons to believe that trauma counseling might be harmful, this would weigh against its use.
3. People must have access to competent, trained counselors.

Why Not Trauma Counseling?

At present, it is too early to diagnose the occurrence of PTSD. By definition, PTSD can be diagnosed only if particular symptoms persist for a period of months following the event. Psychological reactions such as crying, nightmares, and fear of sleeping indoors occur and are normal reactions to frightening events.

Clinically, however, these early reactions are regarded as **acute stress reactions**, most of which will clear up spontaneously over time, that is, without any psychological treatment. It is inappropriate at this time to suggest that widespread trauma has occurred or to identify particular people as suffering trauma. It is also incorrect to assume that everyone affected by the natural disaster is traumatized. Quite often, two people who have lived through similar life-threatening experiences react in very different ways. Whereas one person might be overwhelmed and struggling, the other might be resilient and capable of getting on with his or her life. Broadly, people's responses to life threatening events depends on their temperament, age, gender, social class, access to social support, coping skills, and ability to make meaning out of what happened. Too often, the search for traumatized people leads helpers to overlook sources of resilience and social support that could improve people's well-being.

Furthermore, there are good reasons for questioning the appropriateness of trauma counseling in the West Africa context. In many societies where counseling is not widely used, people who receive counseling or other psychological interventions are regarded as "crazy." To label people as "traumatized" creates stigma and harm. When people are called traumatized, they learn to regard themselves as passive victims, thereby reducing their sense of agency and harming their chances of recovery.

In many emergencies, the influx of international NGOs and expatriate psychologists results in local people abandoning their own resources and becoming dependent on outsiders, thereby weakening the support systems already present in local communities. An important question to ask, then, is "What are the harmful consequences of providing trauma counseling on a widespread basis and do they outweigh the benefits?" It is crucial to ask questions such as this as part of our collective obligation to respect the "Do No Harm" humanitarian imperative: his paradigm in Humanitarian Action recognizes that some humanitarian interventions might be a high-risk practice to be more

harmful than beneficial. Wrong decisions may lead to longer-term problems, and yet the humanitarian imperative remains the focus of the responder.

Doubts about the appropriateness of trauma counseling in the current situation grow even larger when one considers the lack of well-trained counselors. Because counseling and the open expression and processing of feelings is not a widely used methodology in West Africa, only a handful of well trained counselors are present in the emergency context. The training of effective counselors requires extensive time, ongoing supervision, and resources. It is unrealistic to assume that effective "counselors" can be trained in a matter of days or weeks. In this respect, there is little merit to attempts to train large numbers of counselors in an emergency context for immediate deployment. In fact, there is considerable cause for concern that poorly equipped "counselors" will do more harm than good.

2.4: Overview of the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings

Time: 10 minutes
Method: presentation, discussion
Resource needed: Copies of *the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*

Facilitator's notes

It is very useful to include an overview of the IASC Guidelines and the process through which it was created. There is a lot of confusion and debate about what counts as minimum response, and being clear about the mandate and collaborative process of the Task Force is crucial. A good way to contextualize the discussion of minimum response is to show the overall matrix, which allows contrast with emergency preparation and comprehensive response. This has also the advantage of providing the context for the four items that are the focus of this training manual (in line with the Sub-Regional Child Protection Project). It is also really vital to emphasize the importance of **all** the Action Sheets in the Guidelines. By raising these issues and settling the context, there is less chance that participants will see the four selected Action Sheets as privileged or designed to provide by themselves comprehensive mental health and psychosocial support.

Facilitator's instructions

Make sure that each participant has received a copy of the IASC Guidelines. Give an overview of the Guidelines objective, target audience, its nature and format:

Objective: The *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* is intended to enable a wide variety of stakeholders in humanitarian action, including affected communities, to deliver the *minimum* multi-sectoral response required in the midst of an emergency. The emphasis on practical guidance is highly appropriate since the field of MHPSS has been divided into factions favoring individual, clinical approaches and holistic, participatory approaches; respectively. The Guidelines are designed to support people who vary according to gender, age and culture.

Target audience: Humanitarian actors, e.g. the UN system, Inter-Governmental and Non-Governmental Organizations, the Red Cross and Red Crescent Movement, Member States, affected communities.

Interdisciplinary nature: An important premise of the guidance is that work in multiple sectors of humanitarian assistance has MHPSS implications. Mental health and psychosocial support interventions can occur through work in a wide variety of areas, such as health (e.g. community interventions), social services (e.g. community-based social work), education (e.g. (re)starting schooling), protection (e.g. family tracing), information (e.g., providing reliable information on disaster and aid response), nutrition (e.g. prevention of mental retardation), shelter (e.g., organizing shelter to ensure child-friendly space), socio-economic support (e.g. income generating activities) and disaster coordination.

While you're explaining the format, refer participants to the relevant sections in the Guide, allowing them to page through and have a quick look at what is written on the pages.

Present the **format of the guidelines** as a practical handbook with the following key elements:
1. A **matrix** that summarizes key actions for 3 phases:

- **emergency preparedness**
- **minimum response** to be conducted even in the midst of emergency
- **comprehensive response**: potential additional response for stabilized phase and early reconstruction.

2. **Action sheets** with **key actions** describing how each intervention should be operationally implemented and listing key resources.
Point out that the action sheets (27) cover only the **minimum response** interventions from multiple sectors to be conducted even in the midst of emergency (described in the matrix). Tell participants that the development of the MHPSS Guidelines considered various cross-cutting issues. The main areas include:

- **Common functions** (coordination, assessment, monitoring and evaluation, human rights standards and human resources),
- **Core MHPSS domains** (community organization and support, protection, health, education and information dissemination),
- **Social considerations in sectors** (food, shelter, water and sanitation). Because of its broad coverage and emphasis on integrating MHPSS elements into multiple sectors, the guidance offer practical steps to all humanitarian actors, not to mental health professionals only.

2.4.1: Exercise – Advocating for implementation of the MHPSS Guidelines in Emergency Settings

Time needed: 50 minutes
Method: individual work, plenary discussion
Resource needed: *Handout 2.4.1 Actions Sheets describing Mental Health and Psychosocial Support Minimum Responses drawn from the IASC Guidelines – summary of key actions*, notepads, pens

Facilitator's instructions

Explain that the exercise is set up to familiarize participants with all MHPSS Action Sheets and to give them an understanding of the importance of being an advocate for implementing the MHPSS minimum responses.
If you have not already done so, distribute *Handout 3.1 Actions Sheets describing Mental Health and Psychosocial Support actions drawn from the IASC Guidelines – summary of key actions*, notepads and pens.
Invite participants to the individual work. Ask them to turn to the distributed handout, to read the summary of all Action Sheets, reflect on them and choose two of them that they would like to advocate for.
Ask participants to relate instances where they would have to convince someone (i.e. their Country Director, their colleagues, authorities) of the value of using MHPSS Action Sheets. Encourage participants to be creative, yet realistic, in devising persuasive arguments to gain the approval of this audience.
Allow 30 minutes for this activity.
Reconvene the participants and allow approximately 20 minutes for sharing their choices and arguments in plenary.
Depending on the time, you might allow all participants to share or only a few volunteers.
Close the session by summarizing that this information on the Action Sheets can be expanded after the workshop by participants and then used for developing plan to strengthen psychosocial programming within their agencies.

Handout 2.4.1 - Actions Sheets describing Mental Health and Psychosocial Support Recommended by the IASC Guidelines

Summary of Action Sheets

Part A. Common functions across domains	
Coordination	**1.1 Establish coordination of intersectoral mental health and psychosocial support** ■ Calls for intersectoral MHPSS coordination, among a diverse range of actors, inclusive of health, education and social services and representatives of affected communities, as well as the food, protection, security, shelter and water and sanitation sectors. ■ Good coordination as insurance of humanitarian actors' compliance with basic principles, coverage of all disaster-affected communities and an overall strategy and division of labour are agreed between MHPSS actors
Assessment, monitoring, and evaluation	**2.1. Conduct coordinated assessments** ■ Assessment as the basis of program design, monitoring and evaluation ■ Deals with dialogue between organizations and communities about how communities can promote their own recovery and healing ■ Intra agency sharing information as insurance of no duplication and comprehensive understanding of situation. **2.2 Initiate participatory systems and processes for monitoring and evaluation** ■ Assessment, monitoring and evaluation as part of the same process. Monitoring and evaluation (M&E) should inform policy and planning. ■ AS focuses on participation by the affected population ■ Deals with evidence-based or information-based actions ■ Calls for reflection, learning and change to improve MHPSS.

Human rights standards

3.1 Apply a human rights framework through mental health and psychosocial assistance

- AS outlines advocacy for compliance with international human rights in all MHPS interventions in emergencies,
- Deals with monitoring and reporting of instances of abuse and exploitation of civilians
- Focuses on human rights and protection in training of multisectoral staff, government officials, police and military
- Violations of human rights negatively impact on the mental health and psychosocial well-being of individuals, while the respect for human rights reduces mental health and psychosocial risks.
- The promotion of mental health and psychosocial well-being as capital that puts people in a position to assert their rights and prevent further rights abuses.

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

- Learn from specialized protection assessments, when and how to collect information on protection threats.
- Conduct multi-sectoral participatory assessment of protection threats and capacities
- Activate or establish social protection mechanisms, building local protection capacities where needed.
- Monitor protection threats, sharing information with relevant agencies and protection stakeholders
- Respond to protection threats by taking appropriate community-guided action
- Prevent protection threats through a combination of programming and advocacy

3.3 Identify, monitor, prevent, and respond to protection threats and failures through legal protection

- Identify the main protection threats and status of existing protection mechanisms, especially for people at heightened risks
- Increase affected people's awareness of their legal rights and their ability to assert these rights in the safest possible way, using culturally appropriate communication methods.
- Support methods for monitoring, reporting and acting on violations of legal standards.
- Advocate for compliance with international law, and with national and customary laws consistent with international standards.
- Implement legal protection in a manner that promotes psychosocial wellbeing, dignity and respect

Human resources

4.1 Identify and recruit suitable staff and engage volunteers who have a deep understanding of local culture

- Deals with recruitment and selection principles procedures of employees, consultants and volunteers
- Focuses on gender balance and representatives of key cultural and ethnic groups
- Deals with checking references and professional qualifications when recruiting staff

4.2 Enforce staff codes of conduct and ethical guidelines

- Calls for minimum standards of behavior required from staff
- Deals with sexual abuses of beneficiaries and mechanisms of complaints
- Outlines sensitization of communities about the standards and ethical guidelines

4.3 Organize orientation and training of aid workers in mental health and psychosocial support

- Deals with capacity building and training for humanitarian aid staff
- Outlines appropriate type and training content, and follow-up for staff working in emergency
- Emphasizes that all national and international aid workers share the responsibility for delivering an emergency mental health and psychosocial support (MHPSS) response

4.4 Prevent and manage mental health and psychosocial problems in staff and volunteers

- Deals with 'critical incidents' (extreme stressful events)
- Deals with staff conflict & staff relations
- Intra agency staff relations as social capital implicitly covered

Part B. Core mental health and psychosocial support domains

Community organization and support

5.1 Facilitate conditions for community mobilization, ownership and control of emergency response in all sectors

- Deals with the efforts made from both inside or outside the community to involve its members in all the discussions, decisions and actions that affect them and their future.
- Community involvement as empowerment of its resources

5.2 Facilitate community social support and self-help

- Focuses on the human resources in the community
- Deals with facilitation of community's ability to organize psychosocial support
- Emphasizes the role of community initiatives and activities

5.3 Facilitate conditions for appropriate cultural and religious healing practices

- Deals with approaches to cultural healing practices
- Focuses on ethical sensitivity
- Emphasizes challenges linked to local beliefs and practices potentially harmful

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

- Focuses on early childhood programs that should support the care of young children by their mothers, families and other care-givers.
- Deals with practical guidance on how to initiate play activities
- Emphasizes on helping mothers to fulfill their maternal role effectively

Health services

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

- Outlines strong inter-relationships between social, mental and physical aspects of health as they are commonly ignored in the rush of organizing and providing emergency health care
- Calls for basic psychological support for people in acute psychological distress as it does not require specialist knowledge and is an essential part of a minimum aid response.
- Deals with orientation of health staff in psychological components of emergency health care.
- Deals with clinical cases: Psychological support for survivors of extreme stressors

6.2 Provide access to care for people with severe mental disorders

- Deals with the care for people with severe mental health problems
- Focuses on appropriate care for severe mental disorder that usually involves combined biological, psychological and social interventions.
- Additional psychosocial intervention is important to facilitate functioning in the community.

6.3 Protect and care for people with mental disorders and other mental and neurological disabilities living in institutions

- This action sheet addresses the emergency-related needs of people with mental disorders in custodial mental hospitals, prisons and other residential institutions, including informal systems of institutional care.

6.4 Learn about and, where appropriate, collaborate with local, indigenous and traditional healing systems

- Deals with acknowledgement of non-allopathic (non-conventional) healing systems within societies
- Focuses on collaboration with non-allopathic (non-conventional) healers

6.5 Minimize harmful use of alcohol and other substances

- Focuses on social and public health problem in emergency settings, such as use of alcohol and other psychoactive substances

Education

7.1 Strengthen access to safe and supportive education

- Promote safe learning environments
- Make formal and non-formal education more supportive and relevant.
- Strengthen access to education for all
- Prepare and encourage educators to support learners' psychosocial well-being
- Strengthen the capacity of the education system to support learners experiencing psychosocial and mental health difficulties

Information dissemination	**8.1 Provide information to the affected population on the emergency, relief efforts and their legal rights** ■ Emphasizes the role of Information and communication systems in helping community members to become active survivors rather than passive victims ■ Focuses that appropriate information about relief and the whereabouts of displaced people can help to reunite families in emergency situations **8.2 Provide access to information about constructive coping methods** ■ Deals with dissemination of information on positive coping mechanisms to increase the capacity of individuals, families and communities to understand the common ways in which people tend to react to extreme stressors and to attend effectively to their own and others' psychosocial needs.
Part C. Social considerations in sectoral domains Because of its broad coverage and emphasis on integrating MHPSS elements into multiple sectors, the guidance offers practical steps to all humanitarians, not to mental health professionals only.	
Food security and nutrition	**9.1 Include specific social and psychological considerations (safe aid for all in dignity, considering cultural practices and household roles) in provision of food and nutritional support** ■ Emphasizes that the hunger and food insecurity in an emergency can negatively affect the social and psychological status of the affected population ■ Focuses on respect towards affected population and its participation in this sector
Shelter and site planning	**10.1 Include specific social considerations (safe, dignified, culturally and socially appropriate assistance) in site planning and shelter provision in a coordinated manner** ■ Emphasizes local people's participation in decisions regarding shelter and site planning as fundamental to their mental health and psychosocial well-being ■ Advocates for early return and resettlement of displaced people as a durable solution to avoid them becoming dependent on external aid, which can elevate stress and decrease self-esteem.
Water and sanitation	**11.1 Include specific social considerations (safe and culturally appropriate access for all in dignity) in the provision of water and sanitation** ■ Focuses on cultural origins of watsan provision ■ Outlines approaches that handle conflicts between communities about water provisions ■ Focuses on respect towards assisted community

2.5: Exercise – Emergency context

Time: 60 minutes
Resource needed: *Handout 2.5 - Emergency definition,* instructions for groups, flipchart paper, markers

Facilitator's instructions

Review the learning objectives for this session. Explain that this exercise is meant to help participants understand key definitions associated with the emergency context. It is also meant to help participants to remember and reflect about what the emergency setting is like or was like. This will prepare participants for upcoming training exercises, which will require participants to operationalize selected Action Sheets in an emergency setting.
If you have not done so before the session, distribute handouts now.

Ask participants to turn to the *Handout 2.5 - Emergency definition*. Review the definitions from the distributed document with participants by requesting one-by-one to read aloud. After each definition, ask participants to summarize the definition in their own words and to provide local examples.
Allow 20 minutes for this activity.

Once the definitions review has been completed, ask participants to split up into groups of five, give participants their assignment, read it to the large group, paraphrase as needed to ensure everyone understands (and write it on flipchart):

Read the questions below and discuss the answers. One group member should be designed to write proposed answers on flipchart paper.

1) **What emergencies have taken place in your country?**
2) **What was your organization's role in responding to the emergency?**
3) **What was your role in responding to the emergency?**
4) **What psychosocial support activities did you or your organization as a whole provide to the affected people?**
5) **How are your activities different now than during the emergency?**

You have 30 minutes to answer the questions

Reconvene the participants, for group reports, consider very short presentations.
Summarize all presentations and analyze with participants.
Close the activity by pointing out that each emergency requires immediate response. Our role is to advocate for taking into consideration psychological and social considerations that arises during emergencies in order to alleviate suffering of affected population.

Handout 2.5 – Emergency definition

What is an Emergency?

Emergency – a serious situation or occurrence in which large segments of the population are at acute risk of dying, immense suffering, or losing their dignity.
Emergencies may be due to:
1) Natural crises, such as a hurricane, an earthquake, a flood.
2) A failure of technology, such as an airplane crash or the collapse of a bridge.
3) An act of human violence, such as the destruction of the World Trade Center, or a situation of an armed conflict.

What is Minimum Response?

Minimum Response refers to the key actions, the efforts, the first things that need to be done either from within the affected group or by outsiders such as government, NGOs, INGOs, etc., to be conducted even in the midst of an emergency to mitigate its impact on the affected population.

What is Emergency Management?

Emergency management is the process of coordinating available resources to deal with emergencies effectively, thereby saving lives, avoiding injury, and minimizing economic loss.
This protection process involves four phases of emergency management. They are:

1. **Mitigation** Taking specific actions that will reduce the possibility of an emergency occurring or to reduce the loss.

2. **Preparation** The process if writing plans, identifying resources, negotiating agreements, training and exercising.

3. **Response** The mobilization of the forces using the resources available to stabilize a situation

4. **Recovery** The immediate and long-range effort made to assist in returning a situation to near normal conditions again.

SECTION 3: Review of key MHPSS Action Sheets

Learning Objectives

This section aims to help participants gain the knowledge and understanding of the selected Action Sheets on Mental Health and Psychosocial Support in Emergency Settings. Through this section participants will learn about Selected Action Sheets developed by the IASC Task Force that are needed to build humanitarian agencies' staff, community workers' and teachers capacities to better respond to children's mental health and psychosocial needs in emergency settings. The section also lays the groundwork for further discussion about multi-sectoral and interagency coordination on MHPSS.

Trainers who complete this section will

- Be knowledgeable about selected key Action Sheets in the IASC Guidelines on Mental Health and Psychosocial Support in Emergencies
- Operationalize key action points of selected Action Sheets.
- Understand the need to incorporate Mental Health and Psychosocial Support for children when implementing projects or specific emergency interventions for children
- Demonstrate how implementing the Action Sheets will create a more effective protection support for children affected by armed conflict
- Be able to discuss key concepts in ways that can be well understood by the community and by staff

Time needed: The entire exercise should require approximately 6 hours: A total of 4 hours of group work; one hour of plenary presentations and one hour for questions and recaps.
Resources needed: *Handout 3.1 "Action Sheets with key actions from IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings",* flipchart, markers, wall tape

Facilitator's notes

One of the expected results of the workshop is to operationalize the Action Sheets by drawing on participants' own work experiences during emergencies. This session will be a key step in making this happens. The section is built on four group-work sessions each followed by case study exercises. Each session is aimed to introduce one of four Action Sheets to participants; they will be asked to recollect their emergency experiences so that they can say how the Key Actions associated with all four Minimum Responses were actually or would have been carried out during the emergency.

The first matrix at the end of this session - *Operational Response Matrix (CCF-WA, August 2006) – Mental Health and Psychosocial Support Minimum Responses in Emergency* - is for the facilitators only and include responses (which are not intended to be comprehensive) that participants might suggest in the exercises that lay ahead. Make sure to read all of the columns focusing on the Example Operational Responses and familiarize yourself with these before conducting these working sessions. Use this matrix as necessary, to raise any points or questions as the groups make their presentations.

The matrices that are at the end of each session on Minimum Responses - *Examples of Operational Reponses suggested by participants of MHPSS in Emergency Settings workshops held in West Africa Region, 2006* - are for participants and provide a set of examples that illustrate the kinds of operational responses that participants from the MHPSS in Emergency Settings workshops, held in Sierra Leone, Liberia, Guinea and Côte d'Ivoire, suggested during these exercises.

You might want to share them with participants after each group work session (as handouts) as they illustrate the wealth of experiences collected within the sub-region. They exemplify the cultural and economic obstacles that often impede effective implementation of the MHPSS Guidelines in the West Africa Region. However practitioners also provide practical recommendations for how to overcome these obstacles.

By sharing the constraints occurred during operations, we believe that agencies will draw on lessons learned and will develop projects in the future that address the affected populations' needs in line with the recommendations outlined in the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings.

Facilitator's instructions

Each of four group work sessions has the same instruction.

Begin the working session by asking participants to turn to their *Handout 3.1 "Action Sheets with key actions from the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings".*

- Explain to participants that for each Key Action they will be asked to use their experiences from the emergency to provide operational responses. This means how was and how should these Key Actions actually be implemented in the local context. They should provide explanations and examples that specifically relate to the particular Key Action and to the emergency setting.
- Divide the participants into groups of four or five and provide them with equal proportions (one or two Key Actions each depending on the Action Sheet).
- Tell participants that they should take a few minutes to read through all of the content of Key Actions assigned to their group. You can suggest that that every group's chairman read them aloud.
- Ask them to study the Key Actions carefully and to provide their own Operational Responses to each one. Remind them that they must respond in relation to the Emergency Setting.
- Ask groups to respond to the following questions:

    1. **How did you or your organizations implement the respective Key Actions during the emergency?**
    2. **What were the constraints?**
    3. **What were the resources?**
    4. **How could it have been done better?**

Allow approximately 60 minutes to this activity. Provide each group with flipchart sheets and markers and ask them to nominate one presenter.

Ask the groups to fill in the template for each Key Action that looks like this:

Example:
Group 1
Minimum Response: i.e. *4.2 Enforce staff codes of conduct and ethical guidelines.*
Key Action number: i.e. *All humanitarian actors must be informed of and regularly reminded about the agreed minimum standards of behavior.*
Answers:
1.
2.
3.
4.

As the groups work, move around the room to ensure that they are discussing specific operational responses in relation to the Key Action they have been assigned.

If the groups are having difficulties, give examples shown in the matrix for facilitators (at the end of this session - *Operational Response Matrix (CCF-WA, August 2006) – Mental Health and Psychosocial Support in Emergency Settings*) to help them get started. Do not share this information unless the groups are having trouble.

After 60 minutes, ask a representative from each group to present their work; after each plenary presentation allow participants to ask questions, recap and analyze the major points illustrated by the groups.

After each session, distribute a handout (at the end of each group work session - *Examples of Operational Reponses suggested by participants of MHPSS in Emergency Settings workshops held in West Africa Region, 2006*) to participants which contain a set of examples that illustrate the kinds of operational responses that participants from the MHPSS in Emergency Settings workshops, held in Sierra Leone, Liberia, Guinea and Côte d'Ivoire, suggested during these exercises. These materials might be a good tool to compare their work with their colleagues from previous workshops.

Repeat the group work exercise for each Action Sheet, making four group-work sessions.

After all group work and plenary presentations and discussions, summarize key points from all of the group work and brainstorm with participants on concluding results of the exercise

Operational Response Matrix (CCF-WA, August 2006) – Mental Health and Psychosocial Support Minimum Responses in Emergency Settings

Minimum Response	Key Action	Example Operational Response
4.2 Enforce staff codes of conduct and ethical guidelines.	All humanitarian actors must be informed of and regularly reminded about the agreed minimum standards of behavior.	Find necessary resources and trainer to conduct an initial code of conduct and ethical guidelines training of trainers. Participate in initial training and train others working in field office and area of operation. Continue to provide training to new staff and refresher courses to those who were already trained. Participate in field level training that spells out implications for people in various roles such as volunteer, INGO staff member and CBO worker. Read the policy and remind other co-workers about their related roles and responsibilities.
	Establish an agreed mechanism (e.g. Focal Point Network proposed by the UN Secretary General) to ensure compliance beyond simply having a code of conduct.	Work with government, UN and NGO partners at the national level to establish network. Share lessons learned, best practices and Country Director with partners. Work with government, UN and NGO partners at the provincial/ county/ district level to establish network. Invite partners to participate in trainers. Participate in camp level network meetings and exchange information about codes of conduct, reporting, etc.
	Establish accessible, safe and trusted complaints mechanisms.	Inform and remind staff about open and confidential reporting. Provide alternative contacts in and out of the country for reporting. Nominate focal persons in each office that receive reports and communicate them to the Country Director. Inform and remind staff about open and confidential reporting. Provide alternative contacts in and out of the country for reporting. Train focal persons in each office that receive reports and communicate them to the Country Director. Serve as focal people to receive reports from co-workers and beneficiaries. Send reports directly to the Country Director or alternative senior staff in the region or headquarters.
	Inform communities about the standards and ethical guidelines, and of how and to whom they can raise concerns confidentially.	Instruct field staff to orient community members about ethical guidelines and confidential reporting. Organize orientation with Field Management Organize community orientation with Field Management. Hold community orientations with all stakeholders on ethical guidelines and confidential reporting.

Ensure all staff understand that they must report all concerns as soon as they are raised.	Instruct central office staff and field management in staff meetings about mandatory reporting of Code of Conduct violations. Write and circulate memo to all staff about mandatory reporting. Circulate the memo and instruct field office staff and field practitioners about the mandatory reporting. Remind co-workers about the mandatory reporting.
Use investigations protocols that comply with an agreed standard, such as the IASC Model Complaints and Investigations Procedures.	Review the IASC Model Complaints and Investigations Procedures and relevant policies to develop investigation procedures. Train a selected investigation team to carryout impartial and confidential investigations when instructed. Take part in an investigation team. Only investigate when instructed by senior management. Fully support investigations processes.
Take appropriate disciplinary action against staff for violations of the code of conduct or ethical guidelines that are substantiated.	Develop a policy for appropriate disciplinary action for various types of offenses. Use policy as a guide for assessing appropriate actions. Take disciplinary action when offenses have been substantiated. Comply with agreed disciplinary actions.
Establish an agreed response in cases where the alleged behavior constitutes a criminal act in either the host country or the home country of the alleged perpetrator.	Assess whether the alleged perpetrator will receive fair treatment under the law of the host country. If yes, inform the police. However, if not suspend the work of alleged perpetrator, take steps to insure that the alleged perpetrator has no access to the victim and inform their embassy about the criminal act. Assume a monitoring role (e.g. if there is an allegation of a rape, and the field manager sees the alleged perpetrator coming to the home of a person who had issues a complaint., Assume a monitoring role.
Select competent trainers.	Develop HR policy and recruitment procedures. Conduct panel interviews, which require candidates to do training simulations. Assist senior staff in developing job description and necessary qualifications. Participate in panel interviews.
Utilize training methodologies that ensure the immediate, practical application of learning.	Collect appropriate participatory training methods from HQ, other programs and partners. Organize TOT with field staff. Conduct TOT or facilitate visit of an external trainer. Invite participants from other organizations. Facilitate TOT. Train field practitioners. Provide follow-up support. Participate in TOT.
Match the needs of trainees with the appropriate modes of learning (e.g. brief orientation seminars varying in length as needed, consecutive short modules)	Work with field management to assess the learning needs of field staff. Work with senior management to assess the learning needs of field staff and conduct appropriate training. This means appropriate training format, timely, etc. Participate in learning needs assessment.

Arrange seminar content directly related to the expected emergency response of trainees.	Use learning needs assessment and relevant emergency policies and procedures to develop training content with field management
	Work with senior management to develop relevant training curriculum. Participate in training.
Consider establishing Training of Trainers (TOT) seminars to enable knowledge and skills to cascade to more trainees.	Organize training of master trainers workshop. Participate in or identify good trainers to take part in the TOT.
Establish a follow-up system for monitoring, support, feedback and/ or supervision of all trainees, as appropriate to the situation.	Assign trained master trainers to provide refresher training, mentoring, follow-up on the job training. Assign trained master trainers to provide refresher training, mentoring, follow-up on the job training to field practitioners. Participate in on-the-job training and mentoring.
Identify human resources in the community such as elders, traditional healers, midwives, teachers, existing psychosocial workers, youth groups, women's groups and religious groups.	Plan with field staff to identify local human resources. Facilitate logistical resources for field practitioners to meet with elders, community leaders, etc. Work with communities and key informants to identify local human resources, who can assist work to reach emergency-effected residents.
Facilitate the process of community identification of priority actions through participatory rural appraisal and other participatory methods.	Develop plan with field practitioners to hold community consultations using participatory methods. Hold community consultations using participatory methods to identify priority actions.
Support community initiatives, activities encouraging those that promote family and community support for all emergency-affected community members, including people at greatest risk.	Secure funds for community support for emergency affected residents. Work with staff on developing and using appropriate support methods. Plan and encourage field practitioners to support community-driven initiatives and mechanisms that assist people at greatest risk. Through the community consultations, identify locally-driven efforts that assist people at risk. Encourage and support these practices in a sustainable manner.
Encourage and support additional activities that promote family and community support for all emergency-affected community members and, specifically, people at great risk.	Secure funds for community support for emergency affected residents. Work with staff on developing and using appropriate support methods. Plan with field practitioners to implement community-driven initiatives and mechanisms that assist people at greatest risk, such as child-friendly spaces, training on peace building, FTR. Work with community members to implement the support activities (e.g. Peace education training, FTR, Child Centered Spaces, etc.)

7.1 Strengthen access to safe and supportive education	Promote safe learning environments	Education serves an important protection role by providing a forum for disseminating messages on and skills in protection within a violence-free environment. Immediate steps include: ■ Assess needs and capacities for formal and non-formal education, considering protection issues as well as how to integrate and support local initiatives. ■ Maximize the participation of the affected community, including parents, and appropriate education authorities (e.g. Education Ministry officials if possible) in assessing, planning, implementing, monitoring and evaluating the education programme. ■ Evaluate safety issues in the location and design of spaces, learning structures or schools. ■ Monitor safe conditions in and around the learning spaces/schools (e.g. by identifying a focal point in the school) and respond to threats to learners from armed conflict. ■ Make learning spaces/schools zones of peace. ■ Identify key protection threats external to the educational system (e.g. armed conflict) and those that are internal (e.g. bullying, violent punishment). ■ Organise quickly informal education such as child- and youth-friendly spaces ('centres d'animation') or informal community-based educational groups.
	Make formal and non-formal education more supportive and relevant	Supportive, relevant education is important in promoting learners' mental health and psychosocial wellbeing during an emergency while simultaneously promoting effective learning.
	Strengthen access to education for all	Immediate steps include: ■ Rapidly increase access to formal and/or non-formal education which may require creative and flexible approaches, such as opening schools in phases, double-shifting or using alternative sites. ■ Temporarily ease documentation requirements for admission and be flexible about enrollment . Emergency-affected populations may not have certificates of citizenship, birth/age certificates, identity papers, or school reports. Age limits should not be enforced for emergency-affected children and youth. ■ Support the specific needs of particular learners – e.g., provide child-care services for teenage mothers and siblings tasked with caring for younger children; provide school materials to learners in need. ■ Make educational spaces accessible to and appropriate for different groups of children, especially marginalised children
	Prepare and encourage educators to support learners' psychosocial well-being	Educators can provide psychosocial support to learners both by adapting the way they interact with learners, creating a safe and supportive environment in which learners may express their emotions and experiences, and by including specific structured psychosocial activities in the teaching-learning process. However, they should not attempt to conduct therapy, which requires specialized skills. Providing support for educators' own psychosocial well-being is an essential component of supporting learners.

Handout 3.1 – Action Sheets with key actions from the IASC Guidlines on Mental Health and Psychosocial Support in Emergency Settings

Action sheet 4.2:	**Enforce staff codes of conduct and ethical guidelines**
Function:	**Human resources**
Phase:	**Minimum Response**

A. Background

The potential for humanitarian actors to cause harm, either by abusing positions of power, or as an unintended consequence of an intervention, must be explicitly recognized, considered and addressed by all humanitarian agencies. Both situations have the potential to negatively affect the overall functioning of the affected population, in ways that range from causing physical harm to reinforcing a sense of dependence and lack of control among affected individuals and communities, which have negative implications for their psychosocial well-being.

During emergencies, large numbers of people rely on humanitarian actors for assistance to address basic needs. This reliance, together with disrupted or destroyed protection systems (e.g. family networks), contributes to inherently unequal power relationships between those delivering and those receiving services. Accordingly, the potential for abuse or exploitation of the beneficiary population is high, while the opportunities for detection and reporting of such abuse tend to diminish.

An example of agreed standards for staff conduct is the *Secretary-General's Bulletin on Special Measures for Protection from Sexual Exploitation and Sexual Abuse*. This bulletin applies to all UN staff, including separately administered organs and programs, to peacekeeping personnel, and to personnel of all organizations entering into cooperative arrangements with the UN. Donors increasingly require aid organizations to enforce these measures .

The *Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief* outlines the approaches and standards of behavior that promote the independence, effectiveness and impact to which humanitarian NGOs and the International Red Cross and Red Crescent Movement aspire. As of 2006, it had been agreed by 373 organizations.

Wider issues of ethical standards that guide the professional behavior expected of staff need to be agreed, made explicit and enforced, sector by sector. In all interventions, the potential for causing harm as an unintended, but nonetheless real, consequence must be considered and weighed from the outset. One critical example relates to the collection of data, which is both essential for the design and development of effective services and also requires the careful weighing of benefits and risks to individuals and communities. Consideration of how not to raise expectations, how to minimise harm how to obtain informed consent, and how to provide additional safeguards when working with children and youth, is an essential minimum first step in any assessment, monitoring or research.

The existence of a code of conduct or of agreed ethical standards does not in itself prevent abuse or exploitation. Accountability requires that all staff and communities are informed of the standards and that they have a sense of ownership of them. There must be an organizational culture that supports and protects 'whistle-blowers' and complaints mechanisms that are accessible and trusted through which people, including those who are most isolated and/or most vulnerable (and thus often most at risk of abuse), can report concerns confidentially. There need to be investigation procedures in place and staff who have been trained to investigate in a sensitive but rigorous manner. Systems need to be in place that support individuals wishing to take legal action against alleged perpetrators. Throughout, systems need to take into account the safety and protection needs of everyone concerned in such incidents: victims, complainants, investigators and the subject(s) of the complaint.

B. Key actions

1. **All humanitarian actors, both current and newly recruited staff, must be informed of and regularly reminded about the agreed minimum required standards of behavior**. This applies to all levels of staff, international and national, volunteers and consultants, and to those recruited from the affected population.

2. **Establish an agreed inter-agency mechanism (e.g. Focal Point Network proposed by the United Nations Secretary General) to ensure compliance beyond simply having a code of conduct.** This mechanism will:
    a. Share information and lessons learned, to improve the functioning of the systems;
    b. Jointly disseminate information about codes of conduct to communities;
    c. Coordinate other activities, including staff training, monitoring mechanisms, investigation procedures, etc. to prevent and respond to sexual exploitation and abuse;
    d. Establish systems that respond appropriately when the allegation concerns staff from a number of different organizations, or where the individual and/or organization cannot be identified immediately.

3. **Establish accessible, safe and trusted complaints mechanisms that:**
    a. Demonstrate commitment to confidentiality;
    b. Are age- and gender-sensitive;
    c. Take into account the safety and well-being of the survivor as the paramount consideration;
    d. Ensure referral of the victim/survivor to appropriate services, including medical and legal services and those offering psychosocial support;
    e. Preserve the complainant's confidentiality.

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

5. **Ensure all staff understand that they must report all concerns as soon as they are raised.** Their obligation is to report in good faith, not to investigate the allegation.

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

7. **Take appropriate disciplinary action against staff for violations of the code of conduct or ethical guidelines that are substantiated.**

8. **Establish an agreed response in cases in which the alleged behavior constitutes a criminal act in either the host country or the home country of the alleged perpetrator**. As a minimum this requires that no administrative action is taken that jeopardizes legal proceedings, other than those instances in which it is impossible to ensure fair or humane treatment.

Action sheet 4.3:	**Organize orientation and training of aid workers in mental health and psychosocial support**
Function:	**Human resources**
Phase:	**Minimum Response**

A. Background

All national and international aid workers share the responsibility for delivering an emergency mental health and psychosocial support (MHPSS) response. **Orientation and training seminars** are recommended to assist humanitarian workers in accessing local, traditional and cultural resources within families and communities as well as resources from professional sources. Such seminars should teach only the essential skills, knowledge, ethics, guidelines, practical instruction, support and supervision necessary for effective emergency response. Seminars should be participatory, should be adapted to the culture and context and should utilise adult learning models in which participants are both learners and educators.

Brief orientation seminars are recommended to immediately provide basic essential functional knowledge and skills about psychosocial needs, problems and available resources to everyone working at each level of response.

Training seminars teaching more extensive knowledge and skills are recommended for those involved in focused or specialized MHPSS (see pyramid in preamble). To ensure effective practical application of the learning, training seminars should be followed by continuing monitoring, support, feedback and/or supervision.

The content of seminars should be appropriate for the culture, context and capacities of the situation, and thus cannot be automatically transferred from an emergency in one country to another. Decisions about who participates and the mode, content and methodology of learning must vary according to the conditions of the emergency. Workers who are inadequately oriented and trained can be harmful to the affected population they are seeking to assist.

B. Key actions

1. **Select competent trainers.** The knowledge and skills of trainers should include:
   - Comprehensive up-to-date knowledge of emergency response
   - Practical field-based experience in previous emergencies
   - Cultural knowledge and sensitivity
   - Experience in teaching skills that immediately lead to conduct interventions.

   Local trainers with prior experience and/or knowledge about the affected location are preferred when they have the necessary knowledge and skills.

2. **Utilize training methodologies that ensure the immediate, practical application of learning.**
   - Aim to include staff from a range of partner organizations and from government as participants in seminars, in order to facilitate inter-agency cooperation, collaboration and networking for support and referral.
   - Include local university staff and professionals, as appropriate.
   - Train participants in local languages or, when this is not possible, provide translations.
   - Use audio/video/reference materials adapted to local conditions (e.g. avoid the need for Powerpoint presentations if electricity supply is unavailable).
   - Use a participatory teaching style, with active student participation.
   - Use classrooms for didactic learning and practice of skills (e.g. role-plays among other techniques).
   - Use field-based training (i.e. training in or very near to the emergency-affected area).
   - Distribute written reference materials, as appropriate.

3. **Match the needs of trainees with appropriate modes of learning (e.g. brief orientation seminars vs. training seminars).**
   - **Brief orientation seminars** (e.g. half-day or full-day seminars) should be provided for:
   - All aid workers (in all sectors, whether or not specialising in MHPSS), including paid and unpaid national and international NGO employees and staff from donor agencies and from government. Orientation seminars should, as far as possible, be organized before workers begin their mission.
   - Elected or volunteer men, women and youth community leaders, including clan, religious, tribal and ethnic group leaders.

   - **Training seminars** should be provided for people involved in focused or specialized MHPSS support.
   - Training seminars vary in length and content, according to trainees' needs.
   - The use of consecutive, short modules for cumulative learning is recommended, because (a) it limits the need to remove staff from their duties for extended periods and (b) it allows staff to practice skills between training sessions. Using short modules means that each module lasts only a few hours or days (according to the situation). Also, each module is followed by support and supervision of practice in the field, before new educational material is introduced in the next module a few days, weeks or months later.
   - Inexperienced staff hired to implement focused or specialized MHPSS tend to require longer periods of training, with content specifically designed for the activities that they will undertake.

4. **Arrange seminar content directly related to the expected emergency response of trainees.**
   - Content of **brief orientation seminars** (provided to all aid workers) includes:
   - Review of safety and security procedures
   - Coping with work-related problems (stress/substance abuse/identity crises/homesickness, etc.)
   - Codes of conduct and other ethical considerations (see Action Sheet 4.2)

- Human rights and rights-based approaches to humanitarian assistance (see the Sphere Project's Humanitarian Charter)
- Importance of empowerment and involving the local population in relief activities (see Action Sheet 5.1)
- Psychological first aid (see Action Sheet 6.1)
- Methods to promote the dignity of the affected population, using lessons learned from previous emergencies
- Providing knowledge for non-local people about the local socio-cultural and historical context, including:
    a) Basic knowledge about the crisis and the world view(s) of the affected populations
    b) Basic information on cultural attitudes, practices and systems of social organization
    c) Basic information on appropriate behavior, including identifying behavior that might be seen as offensive in the local culture.
- Information about available sources of referral (e.g. tracing, health and child services, traditional community supports, legal services, etc.)
- Information on relevant inter-agency coordination mechanisms.
- The content of training seminars includes:
- All information covered in the orientation seminars
- Response techniques that are based on the existing capacities, contexts and cultures of trainees, allowing content to be taught quickly
- Knowledge and skills necessary for implementing interventions that are part of the minimum response and are identified as necessary through assessment (see Action Sheet 2.1). This applies to:
    a) Health workers (for content, see Action Sheets 6.1, 6.2, 6.3 and 6.5)
    b) Social protection workers (see Action Sheet 3.2)
    c) Formal and non-formal community workers (see Action Sheets 5.2 and 5.4)
    d) Teachers (see Action Sheet 7.1).

5. Consider establishing Training of Trainers (TOT) seminars to enable knowledge and skills to 'cascade' to more trainees. TOT seminars educate future trainers on how to use effective and practical participatory training techniques. TOT seminars must only be done with careful planning and taught by experienced and skilled master trainers. Poorly prepared TOTs – in particular those that involve (a) future trainers without any previous experience in training or (b) future trainers with limited experience in the interventions that are to be taught and implemented – tend to fail and may cause harm to the population.

6. Establish a follow-up system for monitoring, support, feedback and/or supervision of all trainees, as appropriate to the situation. Follow-up should be provided by the trainer or, alternatively, by experienced professionals, well-trained colleagues, a collegial network of peers or related professional institutions, as available. After TOT, follow-up support should not only be provided to the future trainers but also to their subsequent trainees, in order to ensure the accuracy of training and the quality of the aid response.

Action Sheet 5.2: Facilitate community social support and self-help
Domain: Community mobilization and support
Phase: Minimum Response

A. Background

All communities contain effective, naturally occurring psychosocial supports, but in most emergencies these supports are under-utilised. Nearly all groups of people affected by emergency have, for example, healers, religious leaders, women's and youth groups, and traditional birth attendants to whom people turn for help in times of need. In families and communities, steps should be taken at the earliest phase to activate and strengthen local supports and to encourage a spirit of self-help.

A self-help approach is vital, because having a measure of control over some aspects of their lives promotes people's mental health and psychosocial well-being following overwhelming experiences. An emphasis on self-help also contributes to sustainable, culturally appropriate support. A useful emergency response is to strengthen and build on existing local supports, which are appropriate to the local culture and context and likely to endure after any externally funded programs have ended. In such an approach, the role of outside agencies is less to provide direct services than to facilitate psychosocial supports that build on locally available resources.

B. Key actions

1. Identify human resources in the community such as elders, traditional healers, religious leaders, midwives, teachers, existing psychosocial workers, youth groups, women's groups and religious groups.

A valuable strategy is to map local resources (see Action Sheet 2.1) by asking community members about the people they turn to for support at times of crisis. Particular names or groups of people are likely to be reported repeatedly, indicating potential helpers in the affected population. Meet and talk with the identified helpers, asking whether they are in a position to help.

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

Promote a collective process of reflection and visioning with key actors or community groups, discussing:

- organizations that were once working to confront crisis and that may be useful to reactivate
- mechanisms (rituals, festivals, women's discussion groups, etc.) that have helped community members in the past to cope with tragedy, violence or loss
- how the current situation has disrupted social organization and coping mechanisms
- how people have been affected by the crisis
- how people would like to see their situation change in several years' time

- what priorities people should address in moving towards their vision of the future
- what actions would make it possible to achieve their priority goals
- what successful experiences of organization have been seen in neighboring communities.

This process, though it is not comprehensive and forms only part of ongoing planning, sets the stage for a community-initiated psychosocial response.

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

- Determine what members of the affected population are already doing to help themselves and each other, and look for ways to reinforce their efforts. For example, if local people are organizing educational activities but need basic resources such as paper and writing instruments, support their activities by helping to provide the materials needed. Ask regularly what can be done to support local efforts.
- Support community initiatives suggested by community members during the participatory assessment, as appropriate.

4. Encourage and support additional activities that promote family and community support for all emergency-affected community members and, specifically, people at greatest risk. In addition to supporting the community's own initiatives, a range of additional relevant initiatives may be considered. Facilitate community inputs in (a) selecting which activities to support, and (b) designing, implementing and monitoring the selected activities. Examples of potentially relevant activities include:

- Organising access to information about services, missing persons security, etc. (see Action Sheet 11.1)
- Group discussions on how the community may help at-risk groups identified in the assessment as needing protection and support
- Activities that facilitate the inclusion of isolated persons (orphans, widows, widowers, people with severe mental disorders or those without their families) into social networks
- Structured activities for children and youth (including non-formal education, as in child-friendly spaces: see Action Sheet 7.1)
- Women's support and activity groups, where appropriate
- Sports and youth clubs, e.g. for adolescents at risk of substance abuse or of other social and behavioral problems
- Re-establishment of normal cultural and religious events for all
- Ongoing group discussion about the mental health and psychosocial effects of the crisis on community members
- Activities that promote non-violent handling of conflict: discussions, drama and songs, joint activities by members of opposing sides, etc.
- Organising foster care rather than orphanages for separated children, whenever possible
- Tracing and family reunification (see Action Sheet 3.2)
- Organization of community child protection committees (see Action Sheet 3.2)
- Protection of street children and children previously associated with fighting forces, and their integration into the community
- Communal healing practices (see Action Sheet 5.3)
- Other activities that help community members gain or regain control over their lives.

5. Provide short, participatory training sessions where appropriate, coupled with follow-up support. Where local supports are incomplete or are too weak to achieve particular goals, it may be useful to train community workers, including volunteers, to perform tasks including, possibly, the following:

- Understanding the special needs of community members who are not functioning well
- Developing appropriate mental health/psychosocial responses that are culturally appropriate
- Very basic support, i.e. psychological first aid, for those acutely distressed after exposure to extreme stressors (see Action Sheet 9.0)
- Creating mother-child groups for discussion and to provide stimulation for smaller children (see Action Sheet 5.4)
- Assisting families, where appropriate, with knowledge about child rearing and problem-solving

strategies for families

- Protecting and tracing the families of separated children
- Including people with disabilities in various activities
- Supporting survivors of gender-based violence
- Recovery and integration of boys and girls associated with fighting forces
- Setting up self-help groups
- Engaging youth, e.g. in positive leadership, organising youth clubs, conflict resolution dialogue, education on reproductive health and other life skills training
- Involving adults and adolescents in concrete, purposeful, common interest activities (e.g. constructing/organising shelter, organising family tracing, distributing food, organising vaccinations, teaching children)
- Referring affected people to relevant legal, health, nutrition and social services, if appropriate and if available.

6. When necessary, act as the voice of more vulnerable communities, urging others to bring services that are needed to the community or enabling access to services outside the community.
Typically, those who were already marginalised before a crisis began receive scant attention and remain invisible and unsupported, both during and after the crisis. This marginalisation and invisibility causes significant distress. Humanitarian workers may address this problem by linking their work to social justice, speaking out on behalf of people who may otherwise be overlooked.

Action Sheet 7.1

Domain: Strengthen access to safe and supportive education
Phase: Minimum Response

A. Background

In emergencies, education is a key psychosocial intervention – it provides a safe and stable environment for learners and restores a sense of normalcy, dignity and hope by offering structured, appropriate and supportive activities. Many children and parents regard participation in education as a foundation of a successful childhood. Well designed education also helps the affected population to cope with their situation by disseminating key survival messages, enabling learning about self-protection, and supporting local people's strategies to address emergency conditions. It is important to (re)start non-formal and formal educational activities immediately, prioritizing the safety and well-being of all children and youth, including those who are at increased risk (see preamble) or have special education needs.

Loss of education is often among the greatest stressors for learners and their families, who see education as a path toward a better future. Education can be an essential tool in helping communities rebuild their lives. Access to formal and non-formal education in a supportive environment builds learners' intellectual and emotional competencies, provides social support through interaction with peers and educators, and strengthens learners' sense of control and self-worth. It also builds life skills that strengthen coping strategies, facilitate future employment and reduce economic stress. All education responses in an emergency should aim to help achieve the *INEE Minimum Standards for Education in Emergencies, Chronic Crises and Early Reconstruction.*

Educators – formal classroom teachers, instructors of non-formal learning and facilitators of educational activities – have a crucial role to play in supporting the mental health and psychosocial well-being of learners. Far too often, educators struggle to overcome the challenges that they and their learners face, including their own emergency-related mental health and psychosocial problems. Training, supervision and support for these educators enable a clear understanding of their roles in promoting learners' well-being and help them protect and foster the development of children, youth and adult learners throughout the emergency.

B. Key actions

1. Promote safe learning environments

Education serves an important protection role by providing a forum for disseminating messages on and skills in protection within a violence-free environment.

Immediate steps include:

- Assess needs and capacities for formal and non-formal education, considering protection issues as well as how to integrate and support local initiatives. Formal and non-formal education should be complementary and established concurrently where possible.
- Maximize the participation of the affected community, including parents, and appropriate education authorities (e.g. Education Ministry officials if possible) in assessing, planning, implementing, monitoring and evaluating the education programme.
- Evaluate safety issues in the location and design of spaces, learning structures or schools.
  – Locate schools away from military zones or installations
  – Place schools close to population centers
  – Provide separate male and female latrines in safe places.
- Monitor safe conditions in and around the learning spaces/schools (e.g. by identifying a focal point in the school) and respond to threats to learners from armed conflict.
- Make learning spaces/schools zones of peace.
  – Advocate with armed groups to avoid targeting and recruiting in learning spaces/schools
  – Ban arms from learning spaces and schools
  – Provide escorts to children when traveling to or from education activities/school.
- Identify key protection threats external to the educational system (e.g. armed conflict) and those that are internal (e.g. bullying, violent punishment).
  – Identify key protection threats from within the educational system such as gender based violence, child recruitment, or violence in educational settings.
  – Incorporate messages on how to prevent and respond to these and other protection issues (such as separated children and community-based protection measures - see Action Sheet 3.2) in the learning process.
  – Set up education/protection monitoring efforts of individual children to identify and support the learners at risk of or experiencing protection threats.
  – Use the IASC *Guidelines on Gender-Based Violence Interventions in Humanitarian Settings* to prevent gender-based violence in and around learning spaces and schools.
- Organise quickly informal education such as child- and youth-friendly spaces ('centres d'animation') or informal community-based educational groups. Community members, humanitarian aid workers and educators may help organize these without infrastructure such as centres while the formal education

system is being (re)established or reactivated. The staff of child friendly spaces should have strong interpersonal skills, the ability to utilise active learning approaches and experience of working with non-formal education or community programmes. A background in formal education is not necessary in these settings.

2. Make formal and non-formal education more supportive and relevant.

Supportive, relevant education is important in promoting learners' mental health and psychosocial wellbeing during an emergency while simultaneously promoting effective learning.

Immediate steps include:

- Make education flexible and responsive to emergency-induced emotional, cognitive and social needs and capacities of learners. For instance: offer shorter activities if learners have difficulty concentrating; establish flexible schedules to avoid undue stress on learners, educators and their families by offering variable hours/shifts; revise exam timetables to give learners additional time to prepare.
- Aim to provide education that helps to restore a sense of structure, predictability and normality for children; creates opportunities for expression, choice, social interaction and support; and builds children's competencies and life skills. For instance: establish activity schedules and post these visibly in the education facility/learning space; avoid punishment of learners whose performance in class suffers due to mental health and psychosocial problems; use collaborative games rather than competitive ones; increase the use of active, expressive learning approaches; use culturally appropriate structured activities such as games, song, dance and drama that use locally available materials.
- Include life skills training and provision of information about the emergency. Life skills and learning content that may be particularly relevant in emergencies include hygiene promotion, non-violent conflict resolution, interpersonal skills, prevention of gender-based violence, prevention of sexually transmitted diseases (e.g. HIV/AIDS), mine or explosive awareness, and information about the current situation (e.g. earthquakes, armed conflicts etc.). The content and facilitation of life skills training should be informed by a risks assessment and prioritization of need.
- Utilise participatory methods that involve community representatives and learners in learning activities. Adolescent and youth participation in conducting activities for younger children is particularly valuable. Peer-to-peer approaches should also be considered.
- Use education as a mechanism for community mobilisation (see Action Sheet 5.1). Involve parents in the management of learning and education and engage the community in the (re)construction of education facilities (may be temporary and/or permanent structures). Organize weekly community meetings with child/youth/community representatives to facilitate activities that are appropriate to the local context and utilise local knowledge and skills.
- Ensure that any education coordination or working group takes into account mental health/psychosocial considerations. Designate a point person to link the mental health/psychosocial coordination group (see Action Sheet 1.1) to the education coordination mechanism.
- Include opportunities in child- and youth-friendly spaces for children and young people to learn life skills and to participate, for example, in supplementary education, vocational training, artistic, cultural and environmental activities and/or sports.
- Support non-formal learning such as adult education and literacy and vocational training to provide learners with skills that are relevant for the current and future economic environment and that are linked to employment opportunities. For children under 15, non-formal education should serve as a complement to, not a substitute for, formal education.
- Use food for education programmes to promote mental health and psychosocial wellbeing, where appropriate. Providing food (on-site or as take-home rations) in educational settings can be an effective strategy for increasing attendance and retention, which in itself contributes to mental health and psychosocial wellbeing (see Action Sheet 7.1). In addition, food in education can directly benefit psychosocial well-being by increasing concentration, reducing social distinctions between "rich" and "poor", etc. The provision of food or feeding programmes in educational settings should occur only when this can be done efficiently, does not harm the nutritional status of the learners and does not significantly undermine social traditions (e.g. the role of the family in providing appropriate nutrition for children).

3. Strengthen access to education for all.
Immediate steps include:

- Rapidly increase access to formal and/or non-formal education which may require creative and flexible approaches, such as opening schools in phases, double-shifting or using alternative sites.
- Temporarily ease documentation requirements for admission and be flexible about enrollment . Emergency-affected populations may not have certificates of citizenship, birth/age certificates, identity papers, or school reports. Age limits should not be enforced for emergency-affected children and youth.
- Support the specific needs of particular learners – e.g., provide child-care services for teenage mothers and siblings tasked with caring for younger children; provide school materials to learners in need.
- Make educational spaces accessible to and appropriate for different groups of children, especially marginalised children (e.g. disabled or economically disadvantaged children, or ethnic minorities). Develop separate activities for adolescents and youth, who often receive insufficient attention.
- Where appropriate, provide catch-up courses and accelerated learning for older children (e.g., those formerly associated with armed forces or groups) who have missed out on education.
- When appropriate, conduct back-to-school campaigns in which communities, educational authorities and the humanitarian community promote access for all children and youth to education.

4. Prepare and encourage educators to support learners' psychosocial well-being.
Educators can provide psychosocial support to learners both by adapting the way they interact with learners, creating a safe and supportive environment in which learners may express their emotions and experiences, and by including specific structured psychosocial activities in the teaching-learning process. However, they should not attempt to conduct therapy, which requires specialized skills. Providing support for educators' own psychosocial well-being is an essential component of supporting learners.
Immediate steps are to:

- Adapt interaction with students by:
  – integrating topics related to the emergency in the learning process,
  – addressing the cause of problem behaviours in the class (e.g. aggressivity),
  – helping the learners to understand and support one another.
- Provide educators with continuous learning opportunities, relevant training and professional support for the emergency, rather than through one-off or short-term training without follow-up (see Action sheet 4.3). Key topics may include:
  - Encouraging community participation and creating safe, protective learning environments
  - Effects of difficult experiences and situations on the psychosocial well-being and resilience of children, including girls and boys of different ages; ethics of psychosocial support (See Action Sheet 4.2)
  - Life skills relevant to the emergency (see key action item #2 above for suggestions)
  - Constructive classroom management methods that explain why corporal punishment should not be used and which provide concrete alternatives to the use of violence
  - How to deal constructively with learners' issues such as anger, fear, and grief
  - How to conduct structured group activities such as art, cultural activities, sports, games and skills building
  - How to work with parents and communities.
  - How to utilise referral mechanisms to provide additional support to learners who exhibit severe mental health and psychosocial difficulties (see Key Action 5 below);
  - How to develop plans of action for implementing psychosocial support in educators' work
  - Helping educators to better cope with life during and following the emergency, including the effects of stress on educators, coping skills, supportive supervision and peer group support.
- Use participatory learning methods adapted to the local context and culture. Ensure that educators have opportunities to share their own knowledge and experience of local child development and helping practices and to practise new skills. The appropriateness and usefulness of training must be evaluated periodically. Ongoing support including both professional supervision and materials should be provided to educators.
- Activate available psychosocial support for educators. For instance, bring educators together with a skilled facilitator to start talking about the past, present and future, or put in place a community

support mechanism to assist educators in dealing with crisis situations.

5. Strengthen the capacity of the education system to support learners experiencing psychosocial and mental health difficulties.
Immediate steps are to:

- Strengthen the ability of educational institutions to provide support to learners experiencing particular mental health and psychosocial difficulties
  - Designate focal points to monitor and follow-up individual children
  - If school counselors exist, provide training on dealing with emergency-related issues
- Help school staff such as administrators, counselors, teachers, and health workers understand where to refer children with severe mental health and psychosocial difficulties (this may include children who are not 'affected' but may have pre-existing difficulties) to appropriate mental health, social services and psychosocial supports in the community (see Action Sheets 5.2) and to health services, when appropriate (see Action Sheet 9.1, including the criteria for referral of severe mental health problems). Ensure that learners, parents, and community members understand how to use this system of referral.

3.2: Selected Action Sheet – (4.2) Enforce staff codes of conduct and ethical guidelines

Learning Objectives

At the end of this session participants will

- Understand the importance of enforcing staff codes of conduct and ethnical guidelines into their work practices.
- Gain an understanding of the approaches and standards of behavior that promote the independence, effectiveness and impact to which humanitarian NGOs and agencies aspire.
- Be familiar with wider issues of ethical standards that guide the professional behavior expected of staff.
- Gain a solid understanding of the core principles prohibiting sexual exploitation by humanitarian agencies staff, community workers and educators, and the implications of these principles for the behavior and the behavior of colleagues.
- Be able to identify potential vulnerabilities to sexual abuse and exploitation within multi-sectoral programs, and are able to suggest concrete strategies to prevent and respond to these vulnerabilities.

3.2.1: Group work – Operational Response

Time needed: Approximately 1.5 hours
Resources needed: *Handout 3.1 Action Sheets with key actions from IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, copy with a work assignment for groups, *Handout 3.2.1 Examples of Operational Reponses suggested by participants of MHPSS in Emergency Settings workshops held in West Africa Region, 2006,* flipchart, markers and wall tape.

Facilitator's notes

This session is built on a group work on analyzing the Key Actions from the Minimum Response *4.2: Enforce staff code of conduct and ethical guidelines.*
Handout 3.2.1 Examples of Operational Reponses suggested by participants of MHPSS in Emergency Settings workshops held in West Africa Region, 2006 is to be distributed at the end of the session.

Key Messages

Conflict and displacement inevitably erode and weaken many of social and political structures that are designed to protect members of the community. The resources available to affected populations, and to the humanitarian community that is there to assist them, are frequently insufficient to meet basic needs. All too often, mechanisms for protection are not given sufficient priority.

Sexual exploitation and abuse occur in many different environments. However, in humanitarian crisis, the dependency of affected populations on humanitarian agencies for the basic needs creates a particular duty of care on the part of humanitarian workers and peacekeepers, when present.
Managers have an additional responsibility to ensure that there are proper mechanisms to prevent and respond to sexual exploitation and abuse.

Humanitarian agencies must make every effort to create an environment where sexual exploitation and abuse are not tolerated. The question of who constitutes a humanitarian worker highlights another layer of complexity. The group is much more broadly defined than the internationally engaged staff of humanitarian aid organizations. Thousands of staff are engaged in a variety of work ranging from volunteers, casual laborers, drivers and workhouse guards to decision makers at the country, regional and international levels.

Many of these staff are drawn from beneficiary communities themselves. This can blur distinctions between what constitutes professional and private relationships with other members of the beneficiary community. However, by accepting work with humanitarian agencies, humanitarian workers also have to accept the special responsibility of humanitarian care that goes with the job.

Humanitarian standards of behavior: There is, as yet, no common code of conduct governing the individual behavior of humanitarian workers. The problem of sexual exploitation and abuse has highlighted the need for clear standards of behavior for humanitarian workers. It raises additional questions as to who should be responsible for enforcing standards of behavior, and whether that responsibility should be individual or collective and lie at the country, regional or international levels. At present, such issues are dealt with on daily basis, from agency to agency, which limits the effectiveness of common plan of action.
All humanitarian agencies must clearly define the principles and standards of behavior that they expect of their staff.

Training at all levels of humanitarian agencies was identified as an important element. However, there is a risk of fragmentation unless efforts are coordinated.
However, there is a real commitment on the part of agencies to address this problem and take responsibility for necessary management changes.

Facilitator's instructions

Review the learning objectives for this session.
Introduce an Action Sheet that: focuses on enforcement of staff code of conduct and ethical guidelines, calls for minimum standards of behavior required from staff, deals with sexual abuses of beneficiaries and mechanisms of complaints and outlines the role of sensitization of communities about the standards and ethical guidelines.
For the group work, follow the procedure laid out step by step in the ***Section 3 – Review of the Selected Action Sheets, Facilitator's instructions.***

Read all eight Key Actions aloud. Divide participants into 4 groups. Assign two Key Actions to each group. Distribute the instructions for groups. Read the instructions, paraphrasing and repeating as necessary until everyone understands the assignment.

4.2 Enforce staff codes of conduct and ethical guidelines - Operational Responses

Nominate a chair to lead the group through the steps and a presenter to record the group's output and feedback in plenary.
Chair will read aloud Key Actions assigned to your group.
For each Key Action assigned to your group use your experiences from the emergency to define how to provide operational responses showing how these Key Actions should be implemented in the local context.
Study the Key Actions carefully and provide explanations and examples that specifically relate to the particular Key Action and to the emergency setting.
Respond in relation to the Emergency Setting to the following questions:

1. **How did you or your organizations implement the respective Key Action Point during the emergency?**
2. **What were the constraints?**
3. **What were the resources?**
4. **How could it have been done better?**

Write the points about the group's analysis on flipchart paper for feeding back in 5 minutes in plenary. Use the template for recording on flipchart:

Group: i.e. 1
Minimum Response: i.e. 4.2
Key Action number: i.e. 1
Answers:
1.
2.
3.
4.

You have 60 minutes for this exercise

3.2.2: Case Study Exercise – Code of conduct and ethical guidelines in emergencies

Time needed: Approximately 1.5 hours
Resources needed: *Handout 3.2.2 Case study - Code of conduct and ethical guidelines in emergencies* for groups, flipchart, markers and wall tape.

Facilitator's instructions

Divide participants into small groups of 5 people. Distribute case study to the groups.
Read the case study aloud, paraphrase and repeat as needed until everyone understands the scenario and the assignment.
Stress that they are to design the policy and procedures to the case study.
Give groups 60 minutes to discuss.
After 60 minutes, reconvene the groups and ask a representative from one group to report, noting the main points on a flipchart. Ask the rest of the groups if they had any additional points to note. There may be discussion and disagreement on points.
Finally summarize the main issues raised during the discussion.

Handout 3.2.1 – Examples of Operational Reponses suggested by participants of MHPSS Minimum Responses in Emergency Settings workshops held in West Africa Region, 2006

5.2 Enforce staff codes of conduct and ethical guidelines

Minimum Response	Key Action	Example Operational Response
4.2 Enforce staff codes of conduct and ethical guidelines.	1. All humanitarian actors must be informed of and regularly reminded about the agreed minimum standards of behavior.	Liberia: Reporting system for SEA was put into place; Code of conduct was reinforced , There was orientation of the COC; Interagency training was conducted in Child Protection agencies in SEA, SEA training for all staff and partners; Training of military observers/Peace keepers in SEA Sierra Leone: Organizations during emergency either had no/little time to educate their staff about the standard required for humanitarian workers. Their concentration was on helping the vulnerable without acquainting their staff about the codes of conduct Guinea: Sensitization about existence of COC and its enforcement, training in COC Côte d'Ivoire: COC signed by staff, conducted induction sessions, focal points appointed; COC adapted and disseminated among agencies' staff; Constraints: Due to the workload, lack of sufficient time to organize the seminars on COC; Recommendations: Ensure that code of conduct is in job advertisements; Publication of COC in local languages; COC must be in the staff contract upon recruitment; Training of staff on policy matters especially on COC upon recruitment; Monitor the staff on the effectiveness of the COC; Regular/ frequent focus group discussion with staff on COC.; Ensure that COC is adhered to beyond working hours; At the end of the year, hold workshop to review COC by all staff; Make a quarterly review to share lessons learned; Regular awareness raising campaign with stakeholders (children, women, and men); Community to produce their own COC.
	2. Establish an agreed mechanism (e.g. Focal Point Network proposed by the UN Secretary General) to ensure compliance beyond simply having a code of conduct.	Guinea: Inter-agency collaboration to obtain standardized approach; regular Meeting in the field Côte d'Ivoire: COC produced by UN adopted; interagency task force established Constraints: Lack of time and logistics, Problem of getting staff together, Sending representatives who cannot influence the policy, Lack of commitment of the agencies heads Recommendations: There should be a sharing of lessons and or joint trainings conducted; There is need for having designated focal persons as thus: Country Director/ President/Director - Senior Management , Field Coordinator/ Field Officer - Field Management , Protection Officer-Practitioners; Having regular, interagency meetings; There must be: effective monitoring by senior management at all levels, sharing of lessons and or joint trainings undertaken and effective reporting mechanism by the field management; Awareness raising campaigns and training workshops conducted including local authorities and community members; Establish COC committees in which committees should address the issues of violation on the code of conducts by staff in the various agencies; Monthly committee meetings and experience sharing; Involving practitioners to the reflection on establishment of the mechanisms.

	3. Establish accessible, safe and trusted complaints mechanisms.	Liberia: Questionnaire response, Field staff reported to the senior manager the issues raised Guinea: Legal Clinics established to serve refugees, social workers appointed Constraints: Some cases not properly reported; some matters were not reported due to ignorance and poverty; Some services only provided for refugees Recommendation: legal services for all affected population, not only target groups, improve confidentiality.
	4. Inform communities about the standards and ethical guidelines, and of how and to whom they can raise concerns confidentially.	Liberia: Sensitization and awareness raising on staff ethical guidelines to their community leaders: Town/ Paramount chiefs, Women leaders, Elders Teachers, Youth; Government: Police, Immigration officers, LRRRC, Staff/Beneficiaries Côte d'Ivoire: Focal Points appointed; Persons recourse within the communities identified to sensitize their communities; Community sensitization on reporting system; Constraints: Referral system was excellent but lacks confidentiality; Agencies' duplication of roles was causing confusion to survivors; Lack of confidentiality/trust in reporting system; Senior staff failing to serve as role models; No actions taken on report; Poor supervision; Traditional barriers; Poverty in victims homes/ ignorance; Family/ community and authority intervention; Bribery and corruption; Poor judicial/ medical system; Recommendations: Effective follow-up and monitoring of practical application by leaders; Proper coordination to avoid duplication of roles.
	5. Ensure all staff understand that they must report all concerns as soon as they are raised.	Liberia: Followed the chain of command; Immediate senior management meetings were held including the filed workers; Staff that was found out to be involved in the violation of the COC was dismissed after investigation. Côte d'Ivoire: Focal Points appointed. Constraints: Funding withdrawal; Mistrust; Befitting punishment to defaulters; Due to the workload, staff concentrated on their job; Culture of silence; Stigmatization; Intimidation; Scarce human resources; Arbitrary use of power; Weak legal system; Compromise/ compensations; Condoning due to close relationship with perpetrators; Lack of confidentiality; Fear to report your superior; Favoritism. Recommendations: Monitoring and evaluation of staff; Constant feedbacks from target groups; Establishing committees to serve as watch dogs; Ensure distribution of COC to staff; Protection of the source of information on violation of the COC, Refreshment workshops on COC.

	6. Use investigations protocols that comply with an agreed standard, such as the IASC Model Complaints and Investigations Procedures.	Liberia: Reporting procedure was followed by to field managers; Investigations were carried out Côte d'Ivoire: Incident Report Form used in practice; Training for staff/volunteers who completed Incident Report Forms Constraints: Lack of feedback, Lack of commitment to confidentiality Recommendations: Conduct workshops and organize training for staff, Follow up and review procedures/proposal
	7. Take appropriate disciplinary action against staff for violations of the code of conduct or ethical guidelines that are substantiated.	Liberia: Immediate senior management meetings were held including the filed workers; Staff that was found out to be involved in the violation of the COC was dismissed after investigation; Provided SEA training to all staff, to communities, Military observer/peace keepers and focal points; Contract termination/dismissal Sierra Leone: After 2001, SC UK report breach on the codes of conduct, investigations were carried and perpetrators were dismissed; In cooperating other agencies e.g. SC UK, FSU, and other Child Protection agencies to work out modalities on how to pursue the matter. Côte d'Ivoire: Management team took disciplinary actions against staff violations of COC Recommendations: Train focal points in different communities to report cases; Improve information sharing among staff and other agencies; Solicit additional funding for SEA projects.
	8. Establish an agreed response in cases where the alleged behavior constitutes a criminal act in either the host country or the home country of the alleged perpetrator.	Recommendations: Summary dismissal of perpetrators. Deportation of perpetrator (s) if it is an international staff. Ensuring that home country takes appropriate action. Fast track court for investigation of reported cases. Result should be made public. Reported incident immediately to top management for appropriate action to be taken.

Handout 3.2.2 – Case Study – Code of conduct and ethical guidelines in emergencies

There are two thousand Liberian refugees living in a transit camp in Tabou, Cote d'Ivoire near the border of Liberia and the sea. There are approximately another 10 thousand refugees living in host communities in close proximity to the border. In the town of Tabou there are several international and local NGOs partnering with UNHCR and UNICEF to provide services for these refugees.

You are newly hired as a program manager for a local NGO that is providing water and sanitation services to refugees in the host communities. Part of your NGO's mandate is to provide hygiene training to the community residents. Your program is just starting and your staff are mostly young men who are from the capital, Abidjan.

There are rumors that NGO workers are sleeping with Liberian girls. None of these rumors name specific people or NGOs. However, you discover that your NGO has no policy on the issue of sexual relations between staff and beneficiaries.

- What should you do?
- What policy is needed?
- Please be specific in describing the details of this policy?
- How will the policy work?
- How and by whom will it be implemented?
- Does the policy conform to the Minimum Responses?

You later learn through a friend at another NGO that one of your male field workers has a girlfriend in one of host-communities. Your friend will not reveal his source of this information but says it was a volunteer in one of the communities that told him this story.

- What actions, if any, should you take?
- What partnerships, if any, do you need with other agencies? How will these partnerships work?
- When, if ever, should you inform other agencies about this incident?
- Will the policy that you've designed provide sufficient guidance? Why? Why not? What needs to be added/ changed with your policy?

Upon further investigation you later hear from another female staff member that the male staff member in question is having a sexual relationship with a 15-year-old Liberian refugee girl. She also says that the girl's family is fully supportive of the relationship since your staff member occasionally provides the girl's family with money. When confronting the male staff member about the issue, he denies the accusation.

- What actions should be taken based on this information?
- Will the policy that you have designed provide sufficient guidance in solving this issue? How?

You have 60 minutes for this activity.
Select one person in your group to present the answers to your questions in plenary. This should include a summary of the policy and procedures that you have designed together.

3.3: Selected Action Sheet – (4.3) Organize orientation and training of aid workers in mental health and psychosocial support

Learning Objectives

At the end of this session participants will

- Be familiar with one of the selected Action Sheets related to the domain of human resources in emergencies.
- Identify aid workers' training needs in emergency settings
- Identify relevant training resources, gaps, and explore ideas for filling those gaps in participants working area

3.3.1: Group Work – Operational Response

Time needed: Approximately 1.5 hours
Resources needed: *Handout 3.1 Action Sheet with key actions from IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings,* copies with a work assignment for groups, *Handout 3.3.1 Examples of Operational Reponses suggested by participants of MHPSS in Emergency Settings workshops held in West Africa Region, 2006,* flipchart, markers and wall tape.

Facilitator's notes

This session is built on group-work on analyzing the Key Actions from the Action Sheet 4.3: *Organize orientation and training of aid workers in mental health and psychosocial.*
Handout 3.3.1 Examples of Operational Reponses suggested by participants of MHPSS in Emergency Settings workshops held in West Africa Region, 2006 is to be distributed at the end of the session.

Key Messages

All national and international aid workers share the responsibility for delivering an emergency mental health and psychosocial support (MHPSS) response. If humanitarian workers are not properly trained they may cause further harm.

Orientation and training seminars are recommended to assist humanitarian workers in accessing local, traditional and cultural resources within families and communities as well as resources from professional sources. Such seminars should teach only the essential skills, knowledge, ethics, guidelines, practical instruction, support and supervision necessary for effective emergency response. Seminars should be participatory, should be adapted to the culture and context and should utilise adult learning models in which participants are both learners and educators.

Brief orientation seminars are recommended to immediately provide basic essential functional knowledge and skills about psychosocial needs, problems and available resources to everyone working at each level of response.

Training seminars teaching more extensive knowledge and skills are recommended for those involved

in focused or specialised MHPSS. To ensure effective practical application of the learning, training seminars should be followed by continuing monitoring, support, feedback and/or supervision.

The content of seminars should be appropriate for the culture, context and capacities of the situation, and thus cannot be automatically transferred from an emergency in one country to another. Decisions about who participates and the mode, content and methodology of learning must vary according to the conditions of the emergency. Workers who are inadequately oriented and trained can be harmful to the affected population they are seeking to assist.

Facilitator's instructions

Review the learning objectives for this session.
Introduce an Action Sheet that: focuses on capacity building and training for humanitarian aid staff, outlines appropriate type and training content, and follow-up for staff working in emergency.

For the group work, follow the procedure laid out step by step in the ***Section 3 – Review of the selected Action Sheets, Facilitator's instructions.***

Read all six Key Actions aloud. Divide participants into 3 groups. Assign two Key Actions to each group. Distribute the instructions for groups. Read the instructions, paraphrasing and repeating as necessary until everyone understands the assignment.

4.3 Organize orientation and training of aid workers in mental health and psychosocial support – Operational Responses

Nominate a chair to lead the group through the steps and a presenter to record the group's output and feedback in plenary.
Chair will read aloud Key Actions assigned to your group.
For each Key Action assigned to your group use your experiences from the emergency to define how to provide operational responses showing how these Key Actions should be implemented in the local context.
Study the Key Actions carefully and provide explanations and examples that specifically relate to the particular Key Action and to the emergency setting.
Respond in relation to the Emergency Setting to the following questions:

1. **How did you or your organizations implement the respective Key Action during the emergency?**
2. **What were the constraints?**
3. **What were the resources?**
4. **How could it have been done better?**

Write the points about the group's analysis on flipchart for feeding back in 5 minutes in plenary. Use the template for recording on flipchart:

Group: i.e. 2
Minimum Response: i.e. 4.3
Key Action number: i.e. 4
Answers:
1.
2.
3.
4.

You have 60 minutes for this exercise

3.3.2: Case Study Exercise – Organize orientation and training of aid workers in mental health and psychosocial support

Time needed: Approximately 1.5 hours
Resources needed: *Handout 3.3.2 Case study - Organize orientation and training of aid workers in mental health and psychosocial support,* for groups, flipchart, markers and wall tape.

Facilitator's instructions

Divide participants into small groups of 5 people. Distribute case study to the groups.
Read the case study aloud, paraphrase and repeat as needed until everyone understands the scenario and the assignment.

Stress that they are to design a training program, which will address the entire selected training subject, with specific sub-topics in each subject, methods that will be used and the time required for each training. In addition, include a plan for following-up with on-going technical support of staff.

Give groups 60 minutes to discuss.
After 60 minutes, reconvene the groups and ask a representative from one group to report, noting the main points on a flipchart. Ask the rest of the groups if they had any additional points to note. There may be discussion and disagreement on points.

Conclude the session with a summary of the main issues raised during the discussion.

Handout 3.3.1 – Examples of Operational Reponses suggested by participants of MHPSS Minimum Responses in Emergency Settings workshops held in West Africa Region, August-December 2006

4.3 Organize orientation and training of aid workers in mental health and psychosocial support

Minimum Response	Key Action	Example Operational Response
4.3 Organize orientation and training of aid workers in mental health and psychosocial support	1. Select competent trainers.	Liberia: Criteria/guidelines developed for the selection of trainers by agencies; Selected persons trained in different subjects; The deployment of trainers in the field; Involvement in the selection of competent trainers; Provided supervision and on the job training; Participated in field level decision making process. Guinea: Job offers for trainers advertised; Constraints: The lack of resources to maintain trained staff on the field; Close monitoring, mentoring and follow up of staff; Lack of staff commitment and job insecurity; To hire consultancy outside is expensive; Local staff may have cultural knowledge, practical experiences and skills but lack comprehensive or up-to-date knowledge of emergency response; Random selection - emphasis was on availability not competence; Improper scrutiny; Limited support from senior management staff; Inaccessibility of some project areas. Recommendations: Improve management support to field team; Longer contract agreement for national staff; Advertisement over the radio; Proper scrutiny; Emphasize on competence and not availability; Collaborative network existing among agencies, the practitioners should be involved in recruitment process.
	2. Utilize training methodologies that ensure the immediate, practical application of learning.	Liberia: Conducted field based training Côte d'Ivoire: Participatory training methods and local language recognized and incorporated to the trainers profile; Exchange of experiences among agencies; Studied practical case studies; Constraints: Community acceptance and ownership of training; Participants asking for sitting fees; Language barriers; Time and availability of trainers; Translators might not be available; Logistical problem e.g. accessibility to infrastructures, inadequate training materials, accommodation; Difficulties/costly to take trainers to remote areas;. Recommendations: Secure more funding; Involvement of resource person from communities (teachers, pastors, nurses); Use of audio/ visual aids; Provide adequate logistics

3. Match the needs of trainees with the appropriate modes of learning (e.g. brief orientation seminars varying in length as needed, consecutive short modules)	Constraints: Lack of funds and expertise,; Difficulties for people to volunteer. Recommendations: Have in place a contingency plan prior to emergency; Emergency preparedness training on MHPSS prior to emergency for staff and stakeholder; Integration of MHPSS in all programs of intervention; Select the target group according to the training needs; Organize training seminars for specialized and non specialized personnel; Follow up training by specialized staff to aid workers; To match existing documents/ experience from other communities/ agencies to the context; Recruit competent staff; Empower and involve local people in relief activities; Provide information about source of referrals; Promote dignity for the affected people
4. Arrange seminar content directly related to the expected emergency response of trainees.	Recommendations: Organization/planning of seminar and trainings; Ensure human rights/rights based approach during humanitarian assistance; Information on relevant interagency coordination mechanisms; More awareness, monitoring and follow-up for field staff
5. Consider establishing Training of Trainers (TOT) seminars to enable knowledge and skills to cascade to more trainees.	Liberia: Many organizations selected senior staff for TOT level based on their past training experiences; Overseas trainers were brought in also; Training plans were developed (short and long terms); Facilitated training for practitioners; Monitored and evaluated the effectiveness of training and its impact on staff Sierra Leone: CCF raised awareness on Psychosocial Support to Parliamentarians, Ministry of Social Welfare Gender and Children's Affairs; Handicap International organized Psychosocial training for social workers; Incorporated Psycho social counseling in institutions curriculum at Secondary and Tertiary levels-MMCET, IPAM, Polytechnique. Constraints: Short term training duration; Adjustment of newly trained staff to handle the task; Poor training venues; Time involvement (planning, recruitment and implementations in emergency settings); Accessibility and availability of funds; Incentive constraints Recommendations: Identify qualify trainers for TOT; Make provision for training and capacity building; Refresher courses should be done; Clearly explain objectives of training to avoid participant's expectation to be raised
6. Establish a follow-up system for monitoring, support, feedback and/ or supervision of all trainees, as appropriate to the situation.	Field managers participated in the training; Monitored and evaluated the effectiveness of the training; Prepared checklist to follow up training that was conducted. Constraints: Unavailability of human resource; Difficulty in bringing pool of trainers together for information sharing due to other commitment; Finance/ logistics; The commitment of the trainer to carry out other trainings; Migration of trainers and inconsistency; Job insecurity-termination of contract Recommendations: Improve method of feedback; Inform trainers about funds available for training; Formation of trainers and pool active committee e.g. CWCs, SGBV Psychosocial groups that could organize groups; More plans on follow-up trainings/ implementation

Handout 3.3.2 – Case Study – Organize orientation and training of aid workers in mental health and psychosocial support

You are a program manager for a new project that has recently received funding. The project is to address the psychosocial support needs of children in an IDP camp in Guiglo, Cote d'Ivoire. Because of renewed fighting between militias in the area approximately 4,000 people have grouped into the camp to escape the violence. Most of the camp residents are Burkinabé. Approximately half of the camp residents are under the age of 18. Many of these children have experienced horrific events in the villages where they fled. Formal education has not yet been made available in the camps. Most of the children help their parents with their makeshift shelter construction; collect firewood and cooking rations provided by WFP.

Your new project will be targeting three different age groups with activities that will foster children's natural resilience to the distress that they may be experiencing. You will be targeting 2 to 6 year olds with early childhood activities, 7 to 12 year olds with middle childhood activities and 13 to 18 year olds with activities for adolescents.

You have to hire new staff to implement the project. You choose to hire local staff from the Burkinabé community. However, none of your candidates have any training in psychosocial support. Therefore you will need to arrange training for all of your field staff.

1. What training subjects are required?
2. How do you ensure that the training is culturally and contextually relevant and useful?
3. What specific methods should be used?
4. How do you assess the training needs of your staff?
5. How do you follow-up to ensure that staff is properly applying their new knowledge and skills?

Please design a training program, which will address the entire selected training subject, with specific sub-topics in each subject, methods that will be used and the time required for each training. In addition, include a plan for following-up with on-going technical support of staff.

You have 60 minutes for this activity.

3.4: Selected Action Sheet – (5.2) Facilitate community social support and self-help

Learning Objectives

At the end of this session participants will

- Understand that care and protection of children ultimately lies with the families and communities
- Understand that the helpers are catalysts; they assist but do not direct local community members
- Be aware that effective psychosocial services require that helpers collaborate with local community organizations
- Advocate for implementation of community development principles that promote local ownership and sustainability
- Gain deeper understanding of necessity of capacity building of community members

3.4.1: Group Work – Operational Response

Time needed: Approximately 1.5 hours
Resources needed: *Handout 3.1 Action Sheets with key actions from the IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings,* copies with a work assignment for groups, *Handout 3.4.1 Examples of Operational Reponses suggested by participants of MHPSS in Emergency Settings workshops held in West Africa Region, 2006* ,flipchart, markers and wall tape.

Facilitator's notes

This session is built on group-work on analyzing the Key Action Points from the Action Sheet 5.2: *Facilitate community social support and self-help.*
Handout 3.4.1 Examples of Operational Reponses suggested by participants of MHPSS in Emergency Settings workshops held in West Africa Region, 2006 is to be distributed at the end of the session.

Key Messages

Communities, even affected by emergencies, have structures and capacities for coping according to their ideals, values and community relationships. Although their resources for coping may be undermined by the emergency, they do not lose their capacity for developing solutions and recreating functioning structures of community life. In families and communities, steps should be taken at the earliest phase to activate and strengthen local supports and to encourage a spirit of self-help.

A useful emergency response is to strengthen and build on existing local supports, which are appropriate to the local culture and context and likely to endure after any externally funded programs

have ended. In such an approach, the role of outside agencies is less to provide direct services than to facilitate psychosocial supports that build on locally available resources.

Psychosocial interventions should be based on an assessment of existing services and an understanding of the socio-cultural context. They should include use of functional, cultural coping mechanisms of individuals and communities to help them regain control over their circumstances.
Collaboration with community leaders and indigenous healers is recommended when feasible.

Community-based self-help groups should be encouraged. Community workers should be trained and supervised to assist health workers with heavy caseloads and to conduct outreach activities to facilitate care for vulnerable and minority groups

The following are essential elements in the process of facilitating community self-help:

- Identification and involvement of community leaders or influential persons
- Establishment of a sense of ownership by the community and the engagement of different sub-groups within the community
- Identification of community resources
- Promotion of psychological well-being
- Mobilization of resources
- Joint decision-making and consensus.

A self-help approach promotes people's mental health and psychosocial well-being following overwhelming experiences. People working together in groups in an emergency setting, are less likely to suffer feelings of helplessness and dependency.

Facilitator's instructions

Review the learning objectives for this session.
Introduce a Selected Action Sheet that: focuses on community empowerment and self-help, on building on and strengthening existing social supports, on the human resources in the community, points out the facilitation of community's ability to organize psychosocial support and emphasizes the role of community initiatives and activities.
For the group work, follow the procedure laid out step by step in the Section 3 – Review of the selected Action Sheets, Facilitator's instructions.

Read all six Key Actions aloud. Divide participants into 3 groups. Assign two Key Actions to each group. Distribute the instructions for groups. Read the instructions, paraphrasing and repeating as necessary until everyone understands the assignment.

5.2 Facilitate community social support and self-help – Operational Responses

Nominate a chair to lead the group through the steps and a presenter to record the group's output and feedback in plenary. Chair will read aloud Key Actions assigned to your group.
For each Key Action assigned to your group use your experiences from the emergency to define how to provide operational responses showing how these Key Actions should be implemented in the local context.
Study the Key Actions carefully and provide explanations and examples that specifically relate to the particular Key Action Point and to the emergency setting.

Respond in relation to the Emergency Setting to the following questions:

1. **How did you or your organizations implement the respective Key Action Point during the emergency?**
2. **What were the constraints?**
3. **What were the resources?**
4. **How could it have been done better?**

Write the points about the group's analysis on flipchart for feeding back in 5 minutes in plenary.
Use the template for recording on flipchart:

Group: i.e. 3
Minimum Response: i.e. 5.2
Key Action number: i.e. 3
Answers:
1.
2.
3.
4.

You have 60 minutes for this exercise

3.4.2: Case Study Exercise – Organize orientation and training of aid workers in mental health and psychosocial support

Time needed: Approximately 1.5 hours
Resources needed: *Handout 3.4.2 Case study - Organize orientation and training of aid workers in mental health and psychosocial support,* for groups, flipchart, markers and wall tape.

Facilitator's instructions

Divide participants into small groups of 5 people. Distribute case studies to the groups.
Read the case study aloud, paraphrase and repeat as needed until everyone understand the scenario and the assignment.
Give groups 60 minutes to discuss.
After 60 minutes, reconvene the groups and ask a representative from one group to report, noting the main points on a flipchart. Ask the rest of the groups if they had any additional points to note. There may be discussion and disagreement on points.
Finally summarize the main issues raised during the discussion.

Handout 3.4.1 – Examples of Operational Reponses suggested by participants of MHPSS Minimum Responses in Emergency Settings workshops held in West Africa Region, 2006

5.2 Facilitate community social support and self-help

Minimum Response	Key Action	Example Operational Response
5.2 Facilitate community social support and self-help	1. Identify human resources in the community such as elders, traditional healers, midwives, teachers, existing psychosocial workers, youth groups, women's groups and religious groups.	Liberia: Team set up to carry out rapid assessment; Joint and individual agency assessment; Coordination meetings to present and share findings; Identification of resources/relief assistance; Côte d'Ivoire: Human resources in the community identified; encouragement community's members; Constraints: Inaccessibility to certain areas; Funding problems; Lack of human resources; Not enough time to identify all stakeholders during emergency; Duplication of efforts (too much NGO's doing the same program in the same community); Much attention wasn't paid to psychosocial support; Inadequate expertise; Unwillingness of the community to participate fully; Limited time for planning; Unavailability of facilities e.g. recreational centers, Insecurity of staff and beneficiaries. Recommendations: Familiarize with local authorities and outline your purposes; Authorities to help to identify existing individuals/ groups in the emergency situation; Assessment of individuals/groups capabilities and competencies e.g. knowledge, skills and experiences; Catch- up training (capacity building)
	2. Facilitate the process of community identification of priority actions through participatory rural appraisal and other participatory methods.	Conducted PRA to identify community priority; Documented and submitted outcomes of the PRA to senior management. Côte d'Ivoire: Planned activities based on communities' needs. Constraints: Language barriers; Misinformation and tribal barriers (sometimes certain groups and/or leaders influenced community priority), insecurity threats; Recommendations: Assessment, interview observation and focus group discussion (assessment on the knowledge of psychosocial support issues); Identification of community support structures

3. Support community initiatives, activities encouraging those that promote family and community support for all emergency-affected community members, including people at greatest risk.	Liberia: Planning and assessment of community capacities was based on initiatives and resources; Sierra Leone: Had spontaneous meetings; Community contribution (i.e. food, local materials and farming tools); Responsibilities were assigned to people in the community; Identified materials to be used; Worked within a stipulated time. Côte d'Ivoire: Work with community leaders, Community sensitization, Advocacy ; Supervision of the community based committees; Material support to the community committees; Guinea: collaboration in the refugee camps with religious leaders to gain community's approval for infant immunization.; Constraints: High expectations by the community hindered management support Recommendations: Total involvement of community by management before intervening; Provide local materials and initiatives i.e. blocks, sticks ideas etc before the provision of other materials - such as zinc, roofing nails etc; Search for local foodstuff e.g. bush yams, potatoes, cassava etc.
4. Encourage and support additional activities that promote family and community support for all emergency-affected community members and, specifically, people at great risk.	Recommendations: Community sensitization on services provided by agencies; Peace building workshop; Support traditional ceremonies e.g. cleansing ceremonies; Recreation center space for children; Leadership trainings; Formation of reconciliation committees; Provision of cultural materials to revive entertainment
5. Provide short, participatory training sessions where appropriate, coupled with follow-up support.	Liberia: Conducted training needs assessment in communities, IDPs camps through focus group discussions; Identified potential community members; Conducted training, Supervised/monitored training,; Developed training assessment checklist; Provided funding; Provided technical support during training/ project implementation; Built relationship with community members; Established and worked with existing community structures, Observed community norms and values; Conducted training in prenatal care, child rights and protection, sanitation, personal hygiene etc; Network with other agencies Constraints: Lack of competent community members; Community volunteers demanded salary/ incentives; Lack of incentives for volunteers for effective implementation, No TOR for community volunteers; Limited time for monitoring; Community's unwillingness to take initiatives; Poor collaborative networking; Community members not unite. Recommendations: Field managers should be a part of the checklist development,; Management needs to increase visitation at project sites; Clear TOR for community volunteers; Incentives for volunteers; Practitioners to encourage and motivate community members to take ownership of the initiatives and projects; Community to be involved at all levels of activities (e.g. planning, organizing, implementing, monitoring and evaluating); Community to be informed about existing services for referral purposes; Traditional healers to be identified; Strengthen collaboration amongst community structures.

Handout 3.4.2 – Case Study – Organize orientation and training of aid workers in mental health and psychosocial support

You're a program manager in a NGO that specializes in psychosocial support programming. Your NGO is responding to recent severe flooding in a community in the southeast corner of Sierra Leone. As a result of the flooding all of the 560 families in community have lost their homes and six people lost their lives. In addition, cropland has been flooded and some of the livestock were lost. The province, with the support of UNICEF, has established a camp with 10 large tents and WFP has begun providing emergency food rations.

Through your initial assessment of the conditions of the camp, you and your assessment team interview community leaders, parents and children. Your team's initial findings are that many of the camp's residents are overwhelmed by their recent experience of the floods. Many parents express concern because their children are having frequent bad dreams and crying at night. Some children are afraid to leave their tents. Your assessment also finds that the adults in the community, whom were once very busy with farming are now idle. Many of the adults are lethargic and speaking fatalistically about the catastrophe.

1. How should your NGO respond to the psychosocial needs of the community?
2. How will you identify the priority actions?
3. What are the potential local resources/ resource people in the camps?
4. How can these local resources/ resource people be directed to assist the community?

Please design a project that will respond to the needs of the community by completing the following table.

Log-frame for Project Response			
Project Goal: *(overall project goal that will be achieved through this project)*			
Objectives	Outcome	Activities	Outputs
What are the intermediate objectives to achieve the goal?	*What do you expect to achieve through these objectives?*	*What activities will be required to achieve the objective?*	*What do you expect to achieve with the activities?*
1.	1.	1.1 1.2 1.3	1.1 1.2 1.3
2.	2.	2.1 2.2 2.3	2.1 2.2 2.3
3.	3.	3.1 3.2 3.3	3.1 3.2 3.3

How does this project meet, or fail to meet, the minimum responses as indicated in the Action Sheet?

You have 60 minutes for this activity.

3.5: Selected Action Sheet– (7.1) Strengthen access to safe and supportive education

Learning Objectives

At the end of this session participants will

- Gain deeper understanding of teachers contribution to the mental health and psychosocial well-being of learners
- Understand the need to support the educators' work

3.5.1: Group Work – Operational Response

(this is a productive well organized exercise related to minimum response under the education sector – you could just change the minimum response wording on this)

Time needed: approximately 1.5 hours
Resources needed: *Handout 3.1Action Sheets with key actions from IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings,* copy with a work assignment for groups, *Handout 3.5.1 Examples of Operational Reponses suggested by participants of MHPSS in Emergency Settings workshops held in West Africa Region, 2006,* flipchart, markers and wall tape.

Facilitator's notes

This session is built on group work on analyzing the Key Actions from Action Sheet 7.1: *Organize psychosocial support in educational settings.*
Handout 3.5.1 Examples of Operational Reponses suggested by participants of MHPSS in Emergency Settings workshops held in West Africa Region, 2006 is to be distributed at the end of the session.

Key Messages

Educators have a crucial role to play in supporting the mental health and psychosocial well-being of learners. As key supports for learners, they are well placed to help strengthen their resilience and capacity to overcome adversity.

Educators can communicate critical messages to children, youth and adult learners; serve as models of caring adult behavior; help to re-establish learners' trust in others; and create a positive learning environment that helps learners to develop psychosocial skills. They can do this through the way they interact with the learners in the learning environment and by facilitating specific, structured activities. Educators who can provide these supports include formal classroom teachers, instructors of non-formal learning and facilitators of educational activities.

They commonly struggle to understand the behavioral and emotional changes in their learners and to find constructive ways to deal with them. Too often, children who exhibit normal reactions to an

emergency are punished for misbehaving.

Educational institutions (pre-schools and schools) cannot substitute for therapeutic treatment, but they are almost always the best place to deal with the problems, fears and losses of children. Children often express themselves through play or talk about their experiences when conversing with a trusted the children to feel more relaxed and perhaps develop ideas of how to solve their problems. When teachers and educators contain the experiences of children, their families and communities, they are contributing to the development of collective structures of understanding and working through these experiences without individualizing or pathologizing them.

Teachers and educators in conflict situations need a minimum of knowledge of the effects of fear, trauma and loss on children. Purposeful training of teachers does not seek to impart knowledge on psychosocial issues in isolation, but helps teachers to integrate these issues into their regular lesson plans and educational activities. How, for example, can one talk to students about a sibling who has been kidnapped? How can one structure lessons so that children with weak concentration powers do not lose the thread? Which learning methods further the children's ability to manage conflicts etc.? The teachers need help so that they can link the contents with appropriate teaching methods. Purposeful further training, however, not only conveys the correct contents and participatory methods, but also offers space where values can be questioned and teachers can gain personal experience in democratic decision-making and interaction.

Zwedru, Grand Gedeh County, Liberia, facilitator's report:
On the last day of our discussion on the Action Sheets, was Teacher's day at which we were also discussing the minimum response "Strengthen access to safe and supportive education". During this time all participants agreed to pause and recognize about 5 teachers present. This was a happy and sad moment for some of the teachers present; it was the first time for someone to recognize and honour them for their tremendous effort and they stressed that the day will forever be remembered their life. They thanked the facilitators for creating a time within their schedule for acknowledgement.

Zwedru, Grand Gedeh County, Liberia, facilitator's report:
On the last day of our discussion on the Action Sheets, was Teacher's day at which we were also discussing the minimum response "Strengthen access to safe and supportive education". During this time all participants agreed to pause and recognize about 5 teachers present. This was a happy and sad moment for some of the teachers present; it was the first time for someone to recognize and honour them for their tremendous effort and they stressed that the day will forever be remembered their life. They thanked the facilitators for creating a time within their schedule for acknowledgement.

Not only students suffer in conflict. Teachers and educators experience the same daily events as everyone else and are often, as influential members of the community or as opinion leaders, under additional pressure to obey the dictates of the conflict parties. Also, educators may struggle with their own emergency-related mental health and psychosocial problems. Every meaningful educational program must above all invest in the support and further training of teachers so that they can perform their duties. Teachers must be given the opportunity to consider their own experiences in the conflict and find better ways of protecting themselves. They will then be able to react more adequately to the needs of their students.

They must co-operate closely with the parents, since on the one hand the children's welfare and learning success depends to a great extent on the psychosocial situations of their parents, and on the other hand the educational institutions can only function well with the active participation of the families. The goal should always be a relationship of mutual support between the teaching staff and the parents.

7.1 Strengthen access to safe and supportive education – Operational Responses

Nominate a chair to lead the group through the steps and a presenter to record the group's output and feedback in plenary. Chair will read aloud Key Actions assigned to your group.
For each Key Action assigned to your group use your experiences from the emergency to define how to provide operational responses showing how these Key Actions should be implemented in the local context.
Study the Key Actions carefully and provide explanations and examples that specifically relate to the particular Key Action and to the emergency setting.
Respond in relation to the Emergency Setting to the following questions:

1. **How did you or your organizations implement the respective Action Point during the emergency?**
2. **What were the constraints?**
3. **What were the resources?**
4. **How could it have been done better?**

Write the points about the group's analysis on flipchart for feeding back in 5 minutes in plenary. Use the template for recording on flipchart:

Group: i.e. 1
Minimum Response: i.e. 7.1
Key Action number: i.e. 2
Answers:
1.
2.
3.
4.

You have 60 minutes for this exercise

3.5.2: Case Study Exercise – Strengthen access to safe and supportive education

Time needed: Approximately 1.5 hours
Resources needed: *Handout 3.5.2 Case study - Strengthen access to safe and supportive education* for groups, flipchart, markers and wall tape.

Facilitator's instructions

Divide participants into small groups of 5 people. Distribute case studies to the groups.
Read the case study aloud, paraphrase and repeat as needed until everyone understand the scenario and the assignment.
Give groups 60 minutes to discuss.
After 60 minutes, reconvene the groups and ask a representative from one group to report, noting the main points on a flipchart. Ask the rest of the groups if they had any additional points to note. There may be discussion and disagreement on points.
Finally summarize the main issues raised during the discussion.

Handout 3.5.1 – Examples of Operational Reponses suggested by participants of MHPSS Minimum Responses in Emergency Settings workshops held in West Africa Region, August-December 2006

7.1 Strengthen access to safe and supportive education

Minimum Response	Key Action	Example Operational Response
7.1 Strengthen access to safe and supportive education	**1. Promote safe learning environments**	Education serves an important protection role by providing a forum for disseminating messages on and skills in protection within a violence-free environment. Immediate steps include: • Assess needs and capacities for formal and non-formal education, considering protection issues as well as how to integrate and support local initiatives. • Maximize the participation of the affected community, including parents, and appropriate education authorities (e.g. Education Ministry officials if possible) in assessing, planning, implementing, monitoring and evaluating the education programme. • Evaluate safety issues in the location and design of spaces, learning structures or schools. • Monitor safe conditions in and around the learning spaces/schools (e.g. by identifying a focal point in the school) and respond to threats to learners from armed conflict. • Make learning spaces/schools zones of peace. • Identify key protection threats external to the educational system (e.g. armed conflict) and those that are internal (e.g. bullying, violent punishment). Organise quickly informal education such as child- and youth-friendly spaces ('centres d'animation') or informal community-based educational groups. Community members, humanitarian aid workers and educators may help organize these without infrastructure such as centres while the formal education system is being (re)established or reactivated. The staff of child friendly spaces should have strong interpersonal skills, the ability to utilise active learning approaches and experience of working with non-formal education or community programmes. A background in formal education is not necessary in these settings.

	2. Make formal and non-formal education more supportive and relevant.	Supportive, relevant education is important in promoting learners' mental health and psychosocial wellbeing during an emergency while simultaneously promoting effective learning. Immediate steps include: ▪ Make education flexible and responsive to emergency-induced emotional, cognitive and social needs and capacities of learners. ▪ Aim to provide education that helps to restore a sense of structure, predictability and normality for children; creates opportunities for expression, choice, social interaction and support; and builds children's competencies and life skills. ▪ Include life skills training and provision of information about the emergency. Life skills and learning content that may be particularly relevant in emergencies include hygiene promotion, non-violent conflict resolution, interpersonal skills, prevention of gender-based violence, prevention of sexually transmitted diseases (e.g. HIV/AIDS), mine or explosive awareness, and information about the current situation (e.g. earthquakes, armed conflicts etc.) ▪ Utilise participatory methods that involve community representatives and learners in learning activities. Adolescent and youth participation in conducting activities for younger children is particularly valuable. Peer-to-peer approaches should also be considered. ▪ Use education as a mechanism for community mobilisation (see Action Sheet 5.1). Involve parents in the management of learning and education and engage the community in the (re)construction of education facilities (may be temporary and/or permanent structures). ▪ Ensure that any education coordination or working group takes into account mental health/ psychosocial considerations. ▪ Include opportunities in child- and youth-friendly spaces for children and young people to learn life skills and to participate, for example, in supplementary education, vocational training, artistic, cultural and environmental activities and/or sports. ▪ Support non-formal learning such as adult education and literacy and vocational training to provide learners with skills that are relevant for the current and future economic environment and that are linked to employment opportunities. For children under 15, non-formal education should serve as a complement to, not a substitute for, formal education. ▪ Use food for education programmes to promote mental health and psychosocial wellbeing, where appropriate.

	3. Strengthen access to education for all.	Immediate steps include: • Rapidly increase access to formal and/or non-formal education which may require creative and flexible approaches, such as opening schools in phases, double-shifting or using alternative sites. • Temporarily ease documentation requirements for admission and be flexible about enrollment . Emergency-affected populations may not have certificates of citizenship, birth/age certificates, identity papers, or school reports. Age limits should not be enforced for emergency-affected children and youth. • Support the specific needs of particular learners – e.g., provide child-care services for teenage mothers and siblings tasked with caring for younger children; provide school materials to learners in need. ▪ Make educational spaces accessible to and appropriate for different groups of children, especially marginalised children (e.g. disabled or economically disadvantaged children, or ethnic minorities). Develop separate activities for adolescents and youth, who often receive insufficient attention. ▪ Where appropriate, provide catch-up courses and accelerated learning for older children (e.g., those formerly associated with armed forces or groups) who have missed out on education. • When appropriate, conduct back-to-school campaigns in which communities, educational authorities and the humanitarian community promote access for all children and youth to education.

	4. Prepare and encourage educators to support learners' psychosocial well-being.	Educators can provide psychosocial support to learners both by adapting the way they interact with learners, creating a safe and supportive environment in which learners may express their emotions and experiences, and by including specific structured psychosocial activities in the teaching-learning process. However, they should not attempt to conduct therapy, which requires specialized skills. Providing support for educators' own psychosocial well-being is an essential component of supporting learners. Immediate steps are to: • Adapt interaction with students by: – integrating topics related to the emergency in the learning process, – addressing the cause of problem behaviours in the class (e.g. aggressivity), – helping the learners to understand and support one another. • Provide educators with continuous learning opportunities, relevant training and professional support for the emergency, rather than through one-off or short-term training without follow-up (see Action sheet 4.3). Key topics may include: • Use participatory learning methods adapted to the local context and culture. Ensure that educators have opportunities to share their own knowledge and experience of local child development and helping practices and to practise new skills. The appropriateness and usefulness of training must be evaluated periodically. Ongoing support including both professional supervision and materials should be provided to educators. • Activate available psychosocial support for educators. For instance, bring educators together with a skilled facilitator to start talking about the past, present and future, or put in place a community support mechanism to assist educators in dealing with crisis situations.
	5. Strengthen the capacity of the education system to support learners experiencing psychosocial and mental health difficulties.	Immediate steps are to: • Strengthen the ability of educational institutions to provide support to learners experiencing particular mental health and psychosocial difficulties - Designate focal points to monitor and follow-up individual children - If school counselors exist, provide training on dealing with emergency-related issues • Help school staff such as administrators, counselors, teachers, and health workers understand where to refer children with severe mental health and psychosocial difficulties (this may include children who are not 'affected' but may have pre-existing difficulties) to appropriate mental health, social services and psychosocial supports in the community (see Action Sheets 5.2) and to health services, when appropriate (see Action Sheet 9.1, including the criteria for referral of severe mental health problems). Ensure that learners, parents, and community members understand how to use this system of referral.

Handout 3.5.2 – Case Study – Strengthen access to safe and supportive education

You are a program manager in an NGO in N'zerekore, Guinea. Recent fighting of militia troops in Cote d'Ivoire has meant that there is a large influx of refugees fleeing into Guinea. Many of these refugees have witnessed horrific events as the militias have massacred residents of their communities. Approximately five thousand refugees have crossed the border and assimilated into six local neighboring host communities in Guinea. Among the six host communities there are only two primary schools. One of the primary schools only has three teachers who teach more than one class. There are 150 Guinean students attending this school. The other primary school has six teachers and 250 students. However, only four of the teachers were formally trained. Only 50% of the primary-school aged Guinean boys attend school in the host-community. Girls' school attendance in the six host communities is only 30%. Among the five thousand Ivorian refugees 40% are between the ages of 5 and 15 years of age.

- What are the immediate needs of the refugee children in the host communities?
- What should your NGOs response be to their needs?
- Should you try to integrate the refugee children into Guinean schools?
- What training, if any will the teachers need?
- What additional support will the teachers need?
- Should you only target the refugee population with interventions? Why/ why not?
- How do the Action Sheets help you to respond?

Please complete the following table to provide details on your response to the problem outlined above. Please be as Specific, Measurable, Attainable, Realistic and Time-bound with your responses.

Log-frame for Project Response			
Project Goal: *(overall project goal that will be achieved through this project)*			
Objectives	Outcome	Activities	Outputs
What are the intermediate objectives to achieve the goal?	*What do you expect to achieve through these objectives?*	*What activities will be required to achieve the objective?*	*What do you expect to achieve with the activities?*
1.	1.	1.1 1.2 1.3	1.1 1.2 1.3
2.	2.	2.1 2.2 2.3	2.1 2.2 2.3
3.	3.	3.1 3.2 3.3	3.1 3.2 3.3

How does this project meet, or fail to meet, the Minimum Responses?

You have 60 minutes for this activity.

SECTION 4: Training Simulation on MHPSS Action Sheets

Learning Objectives

This section aims to help participants reinforce their understanding of adult education and to provide them an ongoing opportunity to practically apply their didactic learning in delivering a workshop session on the four selected Action Sheets. It builds on the content from the previous Sections and prepares participants to conduct follow up workshops and orientations on issues of mental health and psychosocial support in emergency settings.

4.1: Overview of Adult Learning and Experiential Learning Cycle

Learning Objectives

In addition to familiarizing participants with the Minimum Responses to Mental Health and Psychosocial Support in Emergencies, this training should provide them with the tools to train their colleagues. This section of the manual provides participants with a basic understanding of the principles of adult learning and allows them to practice using training tools through training simulations.

At the end of this session participants will

- Examine principles of Adult Learning, Experiential Learning cycle, participatory training and participatory methods as an important tool for adult education.
- Be able to apply these concepts in the training sessions.

Time needed: Approximately 45 minutes
Method: Brainstorming**,** lecture**,** discussion in plenary
Resource needed: Flipchart, markers, *Handout 4.1 – Principles of Adult Learning. Experiential Learning Cycle*

Facilitator's instructions

Review the learning objective for this session. Explain that in order to help participants reinforce their knowledge about the adult learning it is good to examine its principles and approaches.

Brainstorm with the participants on how the adults learn. List the answers on the flipchart, the following principal issues should emerge from the brainstorming:

- Learning is a life-long activity. Adults can and do learn throughout their lifetime.
- Adults use their personal experience for learning. All previous experiences affect an adult's ability to learn.
- Adults learn best when the knowledge or skill they are trying to acquire can be used directly in meeting a present need or responsibility.
- Adults tend to learn faster whenever the subject under study relates to specific problems drawn from actual experiences.

- Adults learn through involvement and participation.
- Adults are more apt than children to learn from each other and from sharing their experiences.
- Adults learn best in settings where they are treated as competent persons.
- Enthusiasm and commitment of the facilitator help motivate the trainee.
- Adults may feel agitated, tense, confused or frustrated by the learning process.
- A single adult can learn in many ways, and different adults learn differently.

Summarizing these key points, explain that it is important to know these principles if we are to train adults. Briefly introduce the Participatory Training Approach:

In the past, the approach to training was often trainer-centered. The trainers decided what to deliver and how to deliver it. While many trainers still follow this approach, it has been replaced in many parts of the world with approaches that are more participant-centered.

Emphasize that the participatory training process is based on the principles of adult learning. The trainer or facilitator does not determine what the participants should learn but tries to find out real needs by investigating with participants their interests. How to deliver training is also based on needs, level and social characteristics of participants. The participants judge the results of the training in terms of its usefulness to them.

Participatory approaches also benefit the trainer/facilitator who can modify the activities in the next training session. In this way training is constantly being adjusted and becomes ever more effective.

Therefore, this is a process in which both the participants and facilitators learn from each other. The term "training" is regarded as "facilitation," rather than "teaching."

The role of trainer/facilitator is to manage or guide the learning process rather than to manage the content of learning. Adult learners need to be able to share the responsibility for learning with the facilitator. The experience of adult learners should be viewed and used as a rich resource in the learning environment and they should be encouraged to contribute to the learning environment whenever possible.

Brainstorm with participants on characteristics of participatory training. List the answers on the flipchart, the following principal issues should emerge from the brainstorming:

- **Participant Centered.** Participatory training arises from the needs, interests and objectives of all participants, not those of the trainer.
- **Experience Based Learning.** Participatory training is learning that builds on the experiences of participants. Equal value is placed on the life experience of women and of men.
- **Dialogue and Learning Together.** Dialogue among trainees and between trainees and the facilitator is central to trainees acquiring new knowledge and skills. Trainees share their experiences, analyze them collectively, and draw insights.
- **Responsible for Own Learning.** In participatory training, trainees generate their own knowledge through active participation. They take responsibility for their own learning.
- **Interpreting and Understanding Information.** Trainees debate options and ideas, and accept or reject these on an informed basis. They do not merely accept what is told to them.
- **Practical.** Participatory training is practical in day-to-day life and living. Clear and conscious attention is paid to the transfer of learning from the training event to the real life situation.
- **Safe Learning Environment.** Participatory training requires the creation of a suitable learning environment. Trainees are accepted as they are and feel psychologically safe to experiment and take risks.

After summarizing the key points of characteristics of participatory training, move to the review of the Experiential Learning Cycle:

This learning approach is based on experiential learning theory (Kolb and Fry 1975; McCaffery 1986) and is participatory by design. It is a learner-centered approach involving experience followed by a process of reviewing, reflecting, and applying what has been learned. Participatory methods keep learners active in the learning process. They are involving and interactive, and they encourage communication and group work. They are action oriented and experience based.

This experiential and participatory approach was chosen to enhance effective skill transfer, to facilitate conceptual and attitudinal development, and to encourage appropriate changes in learners' behavior. The experiential learning cycle is especially useful for skill training because most of its techniques are designed to involve the learners in practicing the skill. The experiential model helps people assume responsibility for their own learning because it asks them to reflect on their experience, draw conclusions, and identify applications. Learners ground the lessons in their actual environment by considering the question of what can or should be done differently as a result of the learning experience.

The strength of the approach is in the completeness of its cycle, which consists of four stages, each as important as the preceding or following one. The four stages are **(1) experience, (2) process, (3) generalization, and (4) application.**

Experience: The experience stage is the initial activity and data-producing part of the cycle. This phase is structured to enable learners to "do" something. "Doing" includes a range of activities, such as participating in a case study, role play, simulation or game, or listening to a lecture, watching a film or slide show, practicing a skill, or completing an exercise.

Process: In this stage, learners reflect on the activity undertaken during the experience stage. They share their reactions in a structured way with other members of the group.

They may speak individually, in small groups, or as a full learning group. They discuss both their intellectual and attitudinal (cognitive and affective) reactions to the activities in which they have engaged. The facilitator helps the learners to think critically about the experience and to verbalize their feelings and perceptions, and he or she draws attention to any recurrent themes or patterns, which appear in the learners' reactions. The facilitator must also help the learners conceptualize their reflections so they can move toward drawing conclusions.

Generalization: In the generalization stage, the learners form conclusions and generalizations that might be derived from, or stimulated by, the first two phases of the cycle. The facilitator must help the learners think critically to draw conclusions that might apply generally or theoretically to "real life." This stage is best symbolized by the following questions: "What did you learn from all this?" and "What more general meaning does this have for you?"

Application: After learners have formed some generalizations, the facilitator must guide the learners into the application stage. Drawing upon the insights and conclusions reached during the generalization stage (and previous stages), learners can begin to incorporate what they have learned into their lives by developing plans for more effective behavior in the future. Techniques used to facilitate the application stage can include action plans, reviewing each other's action plans, formulating ideas for action, sharing action plans with the whole group, and identifying additional learning needs. The facilitator assists during this process by helping learners to be as specific as possible.

Close the session by summarizing the key points. Conclude by noting that experiential learning is an

important technique of adult education.

4.2: Simulation of training session on selected MHPSS Action Sheets

Learning Objectives

At the end of this session participants will
Strengthen participants abilities to effectively teach the four Selected Action Sheets.
Time needed: Approximately 2 hours 30 minutes
Method: Group training simulation and discussion in plenary
Resource needed: Flipchart, markers, *Handout 4.2 Participatory training methods* (that is to distributed at least one day before this exercise so each participant can familiarize with the participatory training methods) and copies with group instruction for simulation exercise

Facilitator's notes

Participant-led session provides an effective method for participants to learn some of content of the MHPSS content Action Sheets that they will have to deliver when they facilitate an MHPSS training workshop themselves. It creates space for participants to practice and provides an opportunity for peer-to-peer feedback and exchange of experiences to occur. This is also an opportune time for the facilitator to provide to participants on how to make their facilitation and training sessions effective.

Facilitator's instructions

Review the learning objectives for this session with participants. Explain that in this activity groups will participate in a competition where they will compete in simulating the best training sessions on one selected Action Sheets.

Participants will be broken up into four groups and each assigned a different Action Sheet to teach:

Group 1: Enforce staff codes of conduct and ethical guidelines

Group 2: Organize orientation and training of aid workers in mental health and psychosocial support

Group 3: Facilitate community social support and self-help

Group 4: Strengthen access to safe and supportive education

Prizes will be awarded to the winning group. The Groups will be judged by the set criteria.

The scoring grid can look like this below:

Criteria	GI	G2	G3	G4
Followed experiential learning circle stages	/10	/10	/10	/10
Creativity	/10	/10	/10	/10
Covered Action Sheet	/10	/10	/10	/10
TOTAL	**/30**	**/30**	**/30**	**/30**

Each group is asked to:

1. Follow the experiential learning cycle of Experience, Reflect, Generalize Learning, and Application of Learning in designing session.
2. Try to be as creative as possible in incorporating participatory methods and keep your audience's attention
3. Cover entire content of a selected Action Sheet.
4. Keep time.

Write these criteria on a flipchart paper and post it on the wall.
Form four groups. Have each group select one of four Action Sheets: 4.2, 4.3, 5.2, and 7.1.

Provide about 60 minutes preparation time. The presentations should be 20 minutes each. Prepare a small price prize for the winning group.

Give the groups the assignment; read it, paraphrase and repeat as needed until everyone understand the assignment:

> Prepare in 60 minutes a training session on the Action Sheet that has been selected by your group to demonstrate it before the large group.
> Assume your audience (field practitioners) has no prior knowledge on Mental Health and Psychosocial Support Action Sheets. The presentation can take any form of song, dance, lecture, drama, art, etc.
>
> Outline the sequence of the session, the content and appropriate training activities:
>
> 1. Follow the experiential learning cycle of Experience, Reflect, Generalize Learning, and Application of Learning in designing session.
> 2. Try to be as creative as possible in incorporating participatory methods and keeping your audience's attention.
> 3. Cover entire content (all key actions) of a selected Action Sheet.
> 4. Keep time.
>
> You have **60 minutes** for preparation.
> Demonstrate or role-play your session in **20 minutes** before the large group.

Assemble in plenary for presentations and scoring. Emphasize that this is intended to be a learning experience for both the presenters and the observers. The presenters are not expected to be "expert" trainers or facilitators at this point. Encourage constructive feedback and suggestions on the session demonstrated.

Reward the winning group!

Conclude the session by noting that this exercise aimed to provide participants an ongoing opportunity to practically apply their didactic learning in delivering a workshop session on the four Selected Action Sheets. This event was a good opportunity to evaluate the level of understanding of key selected Minimum Responses by participants. All participants exemplified in their display of their training skills that each time they train they must understand in depth the topics if workshops are to be success.

Lecture

In this method, an individual delivers a lecture or speech to the participants.

Strengths

- A great deal of information can be presented quickly and in an organized and systematic way.
- A good lecturer can stimulate and inspire learners, and encourage further study and inquiry.
- The lecture does not require printed materials or high literacy levels.
- Large numbers of persons can attend.

Risks

- Learners play a passive role, and there is not much scope for an exchange of ideas or participation.
- Only the lecturer's ideas or points of view are presented. Facts can be distorted.
- Dynamic lecturers are rare. It is easy to lose the audience.
- It is difficult to gauge the impact of the lecture on the learners.

Materials

Different aids can be used: charts, diagrams, pictures, overhead projectors, etc.

Steps

1. Prepare the lecture well ahead of the session, clearly linking it to learning objectives.
2. If applicable, prepare handouts and decide when they will be distributed.
3. Prepare and present a challenging and stimulating introduction.
4. Explain how the lecture is related to the learning objectives.
5. Conduct the lecture.
6. Provide an opportunity for questions from participants.

Brainstorming

Brainstorming is a method for generating ideas. It involves focusing on a word, concept, or problem, and then coming up with as many ideas or solutions as possible. Brainstorming sessions are free and open sessions in which there is no criticism of ideas. Sometimes brainstorming is used to help participants begin thinking about a particular topic or issue. Other times, brainstorming sessions are intended to result in the selection of ideas for further analysis, or the selection of "best solutions" to a problem.

Strengths

- Brainstorming is an effective way of getting participation in a non-threatening environment.
- Brainstorming is an effective means of generating lots of ideas with large groups.
- Brainstorming encourages creativity and "thinking outside the box."

Risks

- Brainstorming requires a strong facilitator who can establish a non-threatening, uncritical environment, and keep the session on course.
- One or two individuals can dominate the session. The facilitator should plan how everyone, both male and female participants, will be encouraged to participate.

Materials
Something to write on: flipchart, chalkboard, whiteboard

Steps
1. Describe the brainstorming process to participants (e.g., one idea per person, be creative, no interruptions, no evaluation of others comments, individuals may pass).
2. Define the issue or question to be brainstormed. Write out the question, and make sure everyone understands it. Give group a few minutes to jot down their thoughts.
3. Set a time limit. Around 25 minutes is about right. Larger groups may need more time so everyone can get their ideas out.
4. Everyone shouts out solutions to the problem while one person records them on flip chart paper.
5. Collectively, select five ideas or solutions that the group likes best. Make sure everyone agrees.
6. With the group, establish criteria for judging the five ideas or solutions, e.g.,
   - it should be cost effective;
   - it should be possible to finish before a specified date.
7. Score the five ideas or solutions that were selected in step #4. Select the idea with the highest score.
8. Keep a record of all ideas in case the one with the highest score is not workable.

Demonstration
In this method, a skill or technique is demonstrated by one or more individuals, e.g., facilitators, participants or outside resource persons. The demonstrator presents a method of doing something, while explaining what is being done. It may take only a few minutes, or it may take several hours.

Strengths
The learners have an opportunity to see the actual skills or techniques that they are learning.

Risks
An effective demonstration takes careful preparation and attention to physical arrangements.

Materials: Depends on what is being demonstrated.

Steps
1. Write down the steps in advance.
2. Do a test run before you meet the trainees.
3. Make sure all the necessary tools and supplies are at hand.
4. Conduct the demonstration. After each key point, check understanding.
5. When completed, ask trainees to describe what has been done. Ask leading questions about what they found to be critical steps. Provide opportunities for both women and men participants to ask questions and respond.
6. Have the trainees practice the operation with supervision from the facilitator.

Large Group Discussion and Questioning

Discussion is a way of generating ideas and sharing experiences. In a workshop setting, discussions are structured around specific topics or issues. The facilitator or one of the participants leads the discussion by posing a series of questions.

Strengths

- By posing appropriate questions, the facilitator can direct and encourage learning, leading the exploration of a subject rather than relying exclusively on telling.
- Discussion is an effective way of generating ideas and sharing experiences.
- Participants can learn from each other and take an active part in the learning process.
- Good questioning techniques can draw shy women and men into the discussion.
- The responses of participants help the facilitator assess existing knowledge and decide if additional activities are needed.

Risks

- Discussion in large groups (e.g., more than 15) is difficult.
- One or two people may dominate the discussion if they are more articulate or more aggressive than others. The group leader must provide opportunities for all to speak.
- There is a danger that all the dialogue will be between the facilitator and the trainees, rather than between and among the trainees themselves. A skilled facilitator is needed to help trainees interact with one another, not just with the facilitator.

Inexperienced facilitators can fall into the trap of posing questions to a few favourites who can be relied on to give correct answers.
Care must be taken not to embarrass anyone.

Materials: Something to write on: flipchart, chalkboard, whiteboard

Steps

1. Start with a search for basic facts that everyone is likely to know.
2. Move on to questions that are more complex and require learners to interpret facts and use knowledge.
3. If the discussion flounders, draw the attention of the group back to yourself by assuming responsibility for an unclear question.
4. If no answer is forthcoming, give a trial answer yourself and ask participants to comment on your answer.
5. Acknowledge all answers and ideas put forth by participants to let them know they have been heard.
6. Frequently summarize the group's work.

Small Group Discussions

In this methodology, participants are divided into small groups to share their experiences, opinions and ideas.
Different forms of small groups include:

- buzz groups of short duration (three to four person groups used for a specific purpose);
- task groups (usually five to nine);
- fish-bowl, where a small group discussion is observed by another group from outside, and then the outside group discusses, being observed by the first group.

Groups can be same sex or mixed, same organization or different organizations, same or different levels or positions, and so on. Homogenous groups can sometimes make it easier to discuss sensitive topics.

Strengths
If used effectively, this method stimulates thinking and actively involves all members of the group. It facilitates adult learning enabling all learners to describe their experiences and express their opinions.

Risks
- There is a danger that one or two outspoken individuals will dominate groups.
- Some participants may choose not to speak, or some may not engage seriously in group discussion.
- Small groups often require the presence of a facilitator to work effectively. An unskilled facilitator can be detrimental to the group, rather than helpful.
- This method can be time consuming, and requires space to accommodate different groups.

Materials: Flipchart for groups to record their ideas.
Steps
1. Identify spaces or areas in which groups will work.
2. During the planning process, establish the objectives of the group work.
3. At the appropriate point in the workshop, form groups using one of a variety of methods (e.g., participants number off, self-selection by participants, facilitator assigns individuals to groups, participants draw from box, etc.)
4. Give clear instructions to the groups on what they are to do, how much time they will have, provide the questions they are to consider, and explain if and how they are to report back to plenary. Instructions may be written or oral. If groups are to respond to a set of questions, these should be written either on newsprint or on instruction sheets for each group.
5. While groups carry out the designated task, circulate and provide clarification, assistance and advice.
6. If applicable, assemble in plenary for presentations and discussion.

Role-Play Technique

A role-play is a structured situation in which participants act out a situation or problem before a group of co-participants and facilitators. Roles played in real life situations are critically examined by both the actors and the observers. There are various types of role-plays, e.g.,
- simple role-plays, in which a small group performs before the observers;
- two persons role -play two different sets of characters and then interchange their roles;
- multiple role-play in which different groups enact the same situation.

Strengths
- Participants do not feel as threatened as they might in a real life situation, so they can open up, take some risks, and respond spontaneously.
- Role-plays can give actors the opportunity to practice new behaviors, e.g., male actors might practice gender-sensitivity.
- Role-plays are simple and low cost. They do not require much material or advance preparation.
- It is a good method for throwing light on crucial issues within a short period of time. It can be an effective way to confront issues, e.g., gender -related power structures in a village.

Risks
- If learners are not fully involved it can be mostly entertainment rather than learning. Role-playing can become an end in itself – players can exaggerate or distort their roles.
- If participants get too involved in their roles, they may not be able to look at themselves and the dynamics of the situation from a distance.
- Discussion and reflection require skilled facilitation in order to highlight dynamics and issues.

Materials: Written cards describing the roles or the situation can be used.

Steps

1. State the learning objective of the role-play.
2. Identify a problem or situation that is meaningful to the group, and that meets the learning objective.
3. Explain the rationale for the role-play, i.e., what is it being used for and why.
4. Assign roles to individuals or groups. (For different role -plays, either the facilitator can assign roles to different individuals or groups, or individuals can pick their own roles.)
5. Set times and carry out the role-plays.
6. Lead a sharing and analysis session, with discussion focused on observations, feelings and understandings, not on opinions or suggestions.

Case Study Methodologies

Case studies are real life experiences of individuals, groups or organizations. A case study tells a story. They can be written or oral.

Strengths

Case studies aid in the process of reflection and application of new ideas. Learners can draw parallels with their own experiences, and see differences.

Case studies can demonstrate that there are various ways of seeing and resolving problems.

Participants can draw strength from the sharing of experiences and realizing that they are not alone in their struggles. This helps give them renewed commitment and a will to go on.

The case study works well with most sizes of groups. Large groups can be divided into smaller groups.

This approach is effective with interdisciplinary groups.

Risks

Finding appropriate and relevant case studies can be difficult.

It is time consuming to collect information and prepare case studies. It requires considerable skill.

Case studies are influenced by the perceptions, ideologies, feelings and experiences of the writers, and can give distorted and subjective versions of reality.

Materials: Case studies

Steps

1. Read or hear the case study
2. Individual reflection.
3. Small group discussion or activity (e.g., preparation of a skit) to explore the issue further (May be guided by previously developed set of questions.)
4. Extract highlights.
5. Collectively, analyze the case.
6. Summarize the lessons provided by the case.

SECTION 5: Preparation of Plan of Action. Establishing MHPSS Coordination and Network

Learning Objectives

This section aims to help participants to develop Plans of Actions to transfer the learning from this workshop on MHPSS Emergency Response through a cascade of training and to establish strategies to enhance the process of coordination, networking and follow-up of psychosocial services providers at various levels, local, national and regional.

5.1: Preparation of Plan of Action

Learning Objectives

At the end of this session participants will

- Have their Plans of Action to share their new knowledge on Action Sheets after the workshop with their colleagues by facilitating training within their organizations, their communities and other NGOs.

Time: Approximately 40 minutes
Methods: individual work/small group, discussion
Resources needed: Copies with a work assignment, copies with tentative agenda for a two-day workshop for each participant (see Appendix 3).

Facilitator's instructions

Review the learning objectives for this session. The output of this session should be detailed work-plans produced by all participants with preparation and training activities with date, location, target and resources required.
Explain that this activity is set up to help participants to prepare their plan of action. They will be expected to conduct workshop sessions on Action Sheets for their colleagues from their organization, for working community members or for other NGOs.

Ask participants what they will do after the lessons and discussions and plans of actions made here. Facilitate a short discussion to bring out few action steps that will indeed carry action forward. Some examples:

- Return to my organization and conduct this kind of training
- Run this kind of training to working communities
- Run this kind of training/ Co-facilitate it to other NGOs

Ask participants to group themselves by agencies (if relevant) and prepare their plan of action based on learning from the workshop.

Give them the work assignment to prepare the plan of action. Read the instruction, paraphrasing

and repeating as necessary until everyone understands the assignment.

> Design a workshop session on key Action Sheets. Outline a detailed plan of action with preparation and appropriate training activities, with date, location, target audience and resources needed. Assume your audience (your colleagues, humanitarian field workers, and community workers) is with little or no prior knowledge of the MHPSS Guidelines.
> You have 25 minutes for this activity.

Distribute to each of participants a tentative agenda for a two-day workshop as a supportive tool for preparation.
Allow 25 minutes for this activity.
After 25 minutes, reconvene participants and ask one ore two participants to report. Ask the rest of the groups if they had any additional points or suggestions to note.
Conclude the session by suggesting that when participants return to their offices that they consider applying the developed plan of action into practice to extend the information on MHPSS in Emergency Settings Guidelines to their working area.

5.2: Establishing Interagency Mental Health and Psychosocial Support Coordination and Network

Learning Objectives

At the end of this session participants will

- Commit to the development/strengthening of a well coordinated and effective interagency, multisectoral psychosocial response team
- Commit to the work on enhancing the process of coordination and networking on MHPSS
- Develop the coordination strategies involving intersectoral participation at local, national and regional level.

Time: Approximately 45 minutes
Methods: brainstorming, plenary discussion
Resources needed: flipchart papers, markers

Key messages

Coordination involves sharing information about psychosocial initiatives among working communities, discussion and problem-solving among actors and stakeholders about response activities, and collaborative monitoring, evaluation, and ongoing programmed planning and development.

Possible **Terms of Reference** that might be developed include the following points:

1. Identify network of qualified organizations and resource persons.
2. Establish and continuously review methods for reporting and referrals among and between

different actors. Referral networks should be free of bureaucratic delays focusing on providing appropriate services to children.

3. Convene regular meetings of key actors and stakeholders:
   - Quarterly local level meetings to discuss specific information, data, and activities
   - Quarterly regional (e.g., field office, sub-office, district level) meetings to discuss information, data, and activities occurring in that region.
   - Quarterly country level meetings to discuss information, data, and activities country wide.

4. Coordination meetings should serve a number of purposes:
   - Share information within and between sectors and organizations. The MHPSS coordination group is responsible for collecting, collating and disseminating relevant information to organizations. This includes information on needs and vulnerabilities, especially as identified in the assessment as well as mapping of resources, capacities and programs. It also involves documenting and sharing information on approaches, materials and lessons learned. This information should be regularly reviewed, discussed and updated.
   - On an ongoing basis, critically analyze activities by identifying gaps in services and strategies for improvement and strengthening current activities. Also, oversee the implementation of the strategies identified.
   - Provide a supportive forum for actors to seek guidance and assistance from colleagues. Also, provide an opportunity for constructive feedback, problem-solving, and debriefing after particularly complex or difficult cases.
   - Clarify the roles and responsibilities of all those involved with the planning, implementation and monitoring response activities.
   - Determine roles and responsibilities among international, national, regional and local authorities.
   - Plan, schedule, and co-ordinate activities, such as staff training, community education and awareness raising.
   - Continuously build shared ownership of psychosocial initiatives and effective partnerships between all involved.

5. The designated "Lead Agency" is responsible for encouraging participation and facilitating meetings and other methods for coordination and information sharing.

Facilitator's instructions

Review objectives for this session. Explain that this activity is set up to help participants establish new coordination mechanisms or if they already exist to, reactivate or strengthen psychosocial support coordination mechanisms.

Facilitate discussion on existing psychosocial support coordination mechanisms involving intersectoral participation, at local, national and regional levels. Existing coordination groups should be used if available.

Brainstorm with participants to bring out few action steps that will indeed carry action forward. Example:

- Convene on regular meetings of mental health and psychosocial coordination group that should have representation from, at minimum, key government ministries (such as ministries of health, social welfare and education), UN agencies and national and international non-

governmental organizations
- Agree on the date of the first meeting
- Establish the Terms of Reference of psychosocial support coordination group

Lead the discussion into participants' commitment to establish this kind of coordination if it doesn't exist within their area of operation.
Summarize the key points of discussion.
Two key points merit attention here for discussion with participants. First, the establishment of a single coordination group might be emphasized in this section since in many emergencies there are separate coordination groups established on mental health and psychosocial support, respectively. Second, the matrix is a useful tool for mapping what is being done and identifying gaps.

5.3: Closing activities

Learning Objectives

- To summarize experiences of the participants individually and as a group
- To provide written evaluation of the workshop
- To recognize the end of the group's time together

Time: Approximately 25 minutes
Resources needed: copies of Evaluation Forms, flipcharts with key points from each session, certificates, and copies of Training Manual

Facilitator's instructions

- Review objectives for this session. Explain that closing this training and planning workshop involves reviewing the workshop content and outcomes and also gaining verbal commitment from participants to carry forward the discussion from this workshop.
- Begin the closing session by announcing to participants that it is time to review what we've done together these days and clarify next steps.
- Review the key points from each module covered during workshop, topic by topic – referring to the flip charts created.
- Review the list of expectations that were developed in Section 1 on the first day. Facilitate a short discussion to verify that expectations were met. If not, ask group to identify how those expectations can be met in other ways.
- Distribute the evaluation form and allow 10 minutes for all participants to complete it. Encourage participants to be as open, honest and details in their responses as possible.
- Hand out the certificates of completion and the copies of the *Training Manual.*
- Make closing remarks and thanks to participants.

APPENDIX 1 - Agenda for four-day workshop

Suggested agenda for Mental Health and Psychosocial Support in Emergency Settings, Four-day Training of Trainers Workshop

TIME	DAY1	DAY 2	DAY 3	DAY 4
9:00-10:45	*Opening and Workshop Introduction * Interagency Regional Steering Committee * IASC Taskforce * Psychosocial Key Concepts	* Recap of Day One * Report from Observers 2) **Organize orientation and training of aid workers in mental health and psychosocial support**: Group Work Plenary Presentations	* Recap of Day Two * Report from Observers *Plenary Presentation 4) Case Study Exercise	* Recap of Day Three * Report from Observers Planning for MHPSS Coordination
Coffee/Tea break 10:45				
11:00-13:00	* Review of MHPSS Action Sheets * Exercise: Advocating for use of the MHPSS Guidelines * Exercise: Emergency context	2) Case Study Exercise 3) **Facilitate community social support and self-help**: Group Work	* Overview of Adult Learning, Experiential Learning Cycle Exercise: Simulation of a training session *Group Preparations	Closing
Lunch 13:00				
14:00-15:30	FOUR KEY ACTION SHEETS 1) **Enforce staff codes of conduct and ethical guidelines**: Group Work Plenary Presentations	Plenary Presentations 3)Case Study Exercise	*Group Presentations	
Coffee/Tea break 15:30				
15:45-17:00	1) Case Study Exercise	4) **Strengthen access to safe and supportive education**: Group Work Plenary Presentation	Plan of Action Plenary Presentations	

APPENDIX 2 – Agenda for two-day workshop

Suggested agenda for Mental Health and Psychosocial Support Minimum Responses in Emergency Settings, Two-day Training of Trainers Workshop

TIME	DAY 1	DAY 2
9:00-10:30	Opening and Workshop Introduction * Overview: • Project • Guidelines • Psychosocial Key Concepts	• Recap of Day 1 Plenary analysis of group work 3) **Facilitate community social support and self-help** Role-play
10:30 – 10:45	*Coffee/tea break*	
10:45-13:00	**FOUR SELECTED ACTION SHEETS** **1) Enforce staff codes of conduct and ethical guidelines** • Lecture Case Study / Role-play	• Plenary Analysis 4) **Strengthen access to safe and supportive education** • Lecture
13:00 – 14:00	*Lunch*	
14:00 – 15:30	• Plenary Analysis **2) Organize orientation and training of aid workers in mental health and psychosocial support** • Lecture	• Case Study/ Role-play • Plenary Analysis
15:30 – 15:45	*Coffee/tea break*	
15:45 – 17:00	• Group Work	• Way forward • Closing

ABBREVIATIONS

CAAC	Children affected by armed conflict
CCF	Christian Children's Fund
COC	Code of Conduct
CVT	the Center for Victims of Torture
ECHO	European Commission's Humanitarian Aid Office
FSU	Family Support Unit
FTR	Family tracing
ICRC	International Committee of the Red Cross
IRC	International Rescue Committee
LCIP	Liberia Community Infrastructure Program
IASC	Interagency Standing Committee
HI	Handicap International
MHPSS	Mental health and psychosocial support
MoU	Memorandum of Understanding
MSWGCA	Ministry of Social Welfare-Gender-Children's Affairs
NGO	Non-governmental organization
PSS	Psychosocial support
PTSD	Post Traumatic Stress Disorder
RSC	Regional Steering Committee
SC UK	Save the Children UK
SEA	Sexual Exploitation and Abuse
SGBV	Sexual and Gender Based Violence
TOT	Training of Trainers
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WHO	World Health Organization
WVI	World Vision International

GLOSSARY

Emergency

A serious situation or occurrence that happens unexpectedly, that threatens the lives and well-being of large numbers of people, causes widespread destruction and distress; extraordinary action being required to ensure the survival, care and protection of those affected.

Disaster

A disaster is a sudden, calamitous event that seriously disrupts the functioning of a community or society and causes human, material, economic or environmental losses that exceed the community's or society's ability to cope using its own resources. Though often caused by nature, disasters can have human origins.

Natural disasters:

- Flooding: Significant rise of water level in a stream, lake, reservoir or coastal region.
- Storms: Wind with a speed between 48 and 55 knots.
- Hurricanes: Large-scale, closed-circulation system in the atmosphere above the western Atlantic with low barometric pressure and strong winds that rotate clockwise in the southern hemisphere and counterclockwise in the northern hemisphere. Hurricanes are cyclones of tropical origin with wind speeds of at least 118 kph. A hurricane is a large, rotating storm where the winds move around a relatively calm centre called the "eye". Usually, a hurricane lasts several days.
- Volcanic eruptions: An event caused by acidic lava that flows only a short distance before cooling and solidifying. The build-up of material blocks the vent, which raises the pressure and results in a series of violent blasts where pyroclastic material is ejected.
- Droughts: A naturally occurring phenomenon that occurs when precipitation is significantly below normal levels, causing water levels to drop and vegetation to die. This extended period of dry weather usually lasts longer than expected and leads to significant losses (crop damage, water-supply shortage) in a community.

Human Disasters

- Fire: Any fire occurring in vegetation areas, regardless of ignition sources, damages or benefits.
- Death/poor health/general sickness: over and beyond expectation and directly due to a particular external cause of causes.
- Contamination of food products or water or the environment that result in deaths or injuries.
- War/conflict/terrorism. Armed conflict is defined as a political conflict in which armed combat involves the armed forces of at least one state (or one or more armed factions seeking to gain control of all or part of the state), and in which at least 1,000 people have been killed by the fighting during the course of the conflict.
- Workplace violence where the cause of the injuries and/or deaths is directly linked to the working environment of those affected.

Disaster response

Activities that occur in the aftermath of a disaster to assist victims and to rehabilitate or reconstruct the physical structures of the community

Hazard

A potentially damaging physical event, phenomenon or human activity that may cause the loss of life or injury, property damage, social and economic disruption or environmental degradation. Hazards can include

latent conditions that may represent future threats and can have different origins: natural (geological, hydrometeorological and biological) or man-made (environmental degradation and technological hazards). Hazards can be single, sequential or combined in their origin and effects. Each hazard is characterized by its location, intensity, frequency and probability.

Reconstruction

Actions taken to re-establish a community after a period of rehabilitation following a disaster. Actions include construction of permanent housing, full restoration of services and complete resumption of the pre-disaster state.

Relief

The provision of assistance or intervention during or immediately following a disaster to meet the life-preservation and basic subsistence needs of those people affected. It can be of an immediate, short-term or protracted duration.

Risk

The relative degree of probability that a hazardous event will occur. The probability of harmful consequences or expected losses (deaths, injuries, property, livelihoods, disruption of economic activity or environmental damage) resulting from interactions between natural or human-induced hazards and vulnerable conditions.

Code of conduct

A set of conventional principles and expectations that are considered binding on any person who is a member of a particular group

Perpetrator

Is a person, group, or institution that directly inflicts, supports and condones violence or the other abuse against a person or group of persons.

Victim/survivor

Refers to individuals or groups who have suffered violence

Violence

Is a means of control and oppression that can include emotional, social or economic force, coercion or pressure, as well as physical harm.

Gender-based violence

Is used to distinguish common violence from violence that targets individuals or groups of individuals on the basis of gender

Sexual violence, including exploitation and abuse (is a form of GBV)

Refers to any act, attempt or threat of a sexual nature that results, or is likely to result, in physical, psychological and emotional harm.

Abuse

Is the misuse of power through which the perpetrator gains control or advantage of the abused, using and causing physical psychological harm or inciting fear of the harm.

Humanitarian aid workers

All workers engaged by humanitarian agencies, whether internationally or nationally recruited, or formally informally retained from the beneficiary community, to conduct the activities of at agency; hold positions of great authority in affected population's settings.

Protection

Protection consists of ensuring the fulfillment of basic human rights and enabling human wellbeing, particularly in regards to vulnerable people, such as women, children and displaced people. Protection includes reducing physical, emotional and social risks; supporting emotional and social wellbeing; providing equal access to basic services; promoting the rights and dignity of individuals, families, groups, and communities.

Community

A group of individuals who are interconnected through emotional, intellectual, or physical bonds

Self-help

The act or an instance of helping or improving oneself without assistance from others; the maximizing of one's opportunities

Self-help groups

Are voluntary, small group structures for mutual aid and the accomplishment of a special purpose. They are usually formed by peers who have come together for mutual assistance in satisfying a common need, overcoming a common handicap or life-disrupting problem and bringing about desired social and/or personal change. The initiators of such groups emphasize face-to-face social interactions and the assumption of personal responsibility by members. They often provide material assistance, as well as emotional support; they are frequently "cause" oriented, and promulgate an ideology or values through which members may attain an enhanced sense of personal identity.

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5. Refugee Studies Centre/UNICEF (draft), Addressing the needs of children, their families and communities. In *Working with Children in Unstable Situations - Principles and Concepts for Psycho-social Interventions*, pp.47-79

6. UNHCR, Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons. Guidelines for Prevention and Response May 2003

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9. Kolb, D.A. and R. Fry. 1975. Toward an applied theory of experiential learning. In *Theories of group processes,* edited by Cary Cooper. London, UK: John Wiley & Sons.

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PARTICIPANT EVALUATION FORM

Date of workshop:

Trainers:

Location:

Please complete and return this form to the facilitators.
Please do **not** put your name on the form.
Please be open and honest in your evaluation.

Check (✓) the most appropriate box.
Please rate the following categories on a scale of 1 – 4, where 1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree.

	1 Strongly disagree	2 Disagree	3 Agree	4 Strongly agree
The workshop achieved its aims and objectives.				
The content of the workshop is relevant to my work.				
What I have learned will impact on the way I work.				
The methodology used in the workshop helped me to understand how the Minimum Responses can be applied.				
The quality of the learning materials and aids was useful.				
The sessions listed below were covered adequately:				
Background to Interagency Regional Steering Committee and Interagency Standing Committee Taskforce				
Review of key mental health and psychosocial support concepts				
Review of MHPSS Minimum Responses				
Emergency context exercise				
I. Enforce staff codes of conduct and ethical guidelines				
II. Organize orientation and training of aid workers in mental health and psychosocial support				
III. Facilitate community social support and self-help				

IV. Strengthen access to safe and supportive education				
The session on simulating a training session was covered adequately:				
Review of adult learning, experiential learning cycle and participatory training methods				
Training simulation session on Minimum Responses				
Preparation of Plan of Action.				
Establishing MHPSS coordination and network				
Enough time was devoted to each module				
I will advocate for the coordination and networking with colleagues from other organizations				
The facilitation and presentation during the workshop were open and helped me to learn.				
The venue was appropriate.				

What parts of the workshop were most useful for you?

What improvements/changes would you suggest for similar workshops?

What are your plans for future trainings on Minimum Responses? What support is needed to move these plans forward?

Please give any other comments/suggestions.

Thank you for taking the time to fill in this form.