

Coping with Crisis

Federation Reference Centre for Psychosocial Support



Psychosocial support as a platform for an integrated development program

Looking back at my first year in the PS Centre

Psychosocial needs of the elderly Kashmir earthquake survivors

The power of knowledge and support

14 communities, 14 ways to understand resilience

Social support and trauma – a review



International Federation
of Red Cross and Red Crescent Societies

Danish Red Cross 

Apologies for spamming

Some of our readers have received the last issue of Coping with Crisis by email several hundred times. We are very sorry for the inconvenience this has caused. Our IT department and their suppliers have been through all our systems with a fine tooth comb but unfortunately the problem lies somewhere outside of our systems. This means that we have not been able to stop the email from resending over and over again.

In order to avoid this problem in the future, we have bought a new it-solution for distributing the newsletter in a more safe way. We sincerely hope that this problem never occurs again.

Looking back at my first year in the PS Centre

By Nana Wiedemann, Head of the International Federation Reference Centre for Psychosocial Support

In the beginning of March 2007 I met Grandmother Leon on a beach in Phuket, Thailand. When the tsunami hit the coast, her house was washed away and she lost relatives and friends. She is still wearing the same blouse she did on that horrible day more than two years ago.

Grandmother Leon suffers from diabetes, high blood pressure and a bad liver. She tells me that things are better now and that she has a home. But before the tsunami she sold food, now she has nothing to do. She tells me that most people in the village have nothing to do. She would like to work again because she has no money.

I met Grandmother Leon on a technical visit with the aim to support the Thai Red Cross (TRC) in their efforts to apply for funding to the American Red Cross (ARC) Tsunami Recovery Fund, to provide input for their monitoring and evaluation systems and to consult with the ARC and TRC and the health unit in the regional delegation on the enhancement and prolongation of a three year psychosocial programme to support the tsunami affected population.

On this one mission I covered all three elements of the mission of the PS Centre: Support to National Societies, technical support to programmes, and documentation and dissemination. I had yet again seen how psychosocial support is relevant not only immediately after the disaster, but also in the long-term.

Support to National Societies and Networks

A little over a year ago, I took up the daunting task of maintaining and improving the good reputation of the PS Centre and to continue to provide support to National Societies, Regional Delegations and others who work with enhancing the psychosocial well-being of vulnerable people around the world. With a great effort from the entire team we have come a long way.

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Grandmother Leon still wears the same blouse she wore on the day the tsunami washed away her house and she lost friends and relatives.

Photo: Nana Wiedemann, International Federation Reference Centre for Psychosocial Support

In the last year the PS Centre has supported National Societies and international programmes in Pakistan, Sri Lanka, Indonesia, Somalia, Palestine, Lebanon and Syria, Thailand, Kosovo, Serbia and Montenegro and Beslan, Russia, providing assessments, trainings, consultations and evaluations all with the aim of promoting psychosocial well-being in beneficiaries, staff and volunteers. The PS Centre has also supported and participated in network meetings and international trainings in Grenada, the European Network for Psychosocial Support, and the South East Asian Network for Psychosocial Support, and in Canada we facilitated a working group on PSP in health Emergency Response Units. We contributed substantially to the development and field testing of WHO's Inter-Agency Standing Committee guidance for mental health and psychosocial support in emergencies. The PS Centre also conducted several trainings on PSP in emergencies for delegates and staff from National Societies in order to raise their awareness of psychosocial stress and well-being and how to prevent normal emotional reactions from turning into long-term chronic disorders.

Documentation and Dissemination

Documenting lessons learned and develop-

ing guidelines has also had a high priority in the past year. We have therefore worked on developing guidelines for PSP in emergencies, for assessment and for monitoring and evaluation, including development of useful and meaningful qualitative indicators. Furthermore, there is an ongoing collaboration with the European Commission Humanitarian Office (ECHO) to support their development of policies and guidelines for the funding of international psychosocial interventions in emergencies. Together with the Danish Red Cross we have conducted two lessons learned workshops and more are in the pipeline with stakeholders from the IFRC and relevant stakeholders from National Societies such as Canadian Red Cross, American Red Cross and Turkish Red Crescent.

The newsletter *Coping with Crisis* underwent close scrutiny as we carried out a survey to assess the needs of the readers and we have adjusted the newsletter accordingly. In the beginning of May our new information material will be ready and our toolkit for psychosocial delegates in the field is being distributed all over the world. We have developed visibility fundraising strategies in order to obtain visibility and raise awareness of and advocate for the need for psychosocial support and the facilitating of resilience in beneficiaries, staff and volunteers.

The Roster

Roster members have supported the PS Centre in its development of psychosocial indicators. They have written articles, conducted assessments and trainings, and have advocated the psychosocial needs of beneficiaries. The annual Roster meeting in October covered the development of indicators and we worked with the training manual and PS programme management.

Collaboration with the Secretariat

In the past year, we have worked purposefully on improving cooperation and lines of communication with the Secretariat in the Geneva. This has been frustrating sometimes because there is no focal person for PSP in Geneva. The information flow between Geneva and Copenhagen has been greatly improved. Recently we have taken up a collaboration project on working with prisoners' health in order to mainstream

and ensure the psychosocial component in the programmes.

Our Partners

Being based in Copenhagen within the Danish Red Cross has proved to be both very valuable and challenging at the same time. There is a lot to learn from being so close to a National Society which is very active in psychosocial support, but we must also at all times prioritize our resources and maintain our identity as a reference centre for the entire Red Cross / Red Crescent Movement. The work with the other partner National Societies has also been very fruitful. The Icelandic Red Cross has often supported the centre with delegates and given support to the development of our new training manual. Norwegian Red Cross has

supported a Spanish speaking roster member and we have had continuous communication with our other partners.

The Future

Ahead of us we have several missions to National Societies; Israel, South Africa and Zimbabwe and Estonia organising lessons learned workshops, collaboration with international stakeholders, trainings and a PSP School. We are working our way into Southern Africa to support the psychosocial needs of beneficiaries and volunteers in relation to HIV, we plan to finalize several training modules, and to work more with the concept of worker care. We want to engage more deeply in post-conflict programmes and we are planning to compile and revise the approaches to working with children. ■

Psychosocial Support as a Platform for an Integrated Development Program

By Dr. Joseph O. Prewitt Diaz, Head of Program; Dr. Subhasis Bhadra, Director, Behavioral Health; Dr. Preethi Krishnan, Director, School Health, American Red Cross—India Delegation, New Delhi, India

Following the Turkey earthquake (1996) and the Kosovo crisis (1999), the American Red Cross (AmCross) initiated the delivery of disaster mental health. However, these efforts were short-lived and were not institutionalized. In fact, there is only one impact study on record; a joint effort by AmCross and the Danish Red Cross coordinated by the International Federation of the Red Cross and Red Crescent Societies (IFRC) (Dodge 1999) in Kosovo.

The present psychosocial support program evolved out of experiences gained in Central America following Hurricane Mitch, using a description of 'sense of place' (Fullilove 1996) and the sub-clinical consequences of losing place, as a theory base. Prewitt Diaz and Saballos (1999) conducted a qualitative study to evaluate the disaster mental health response to a landslide in the Las Casitas Volcano in Nicaragua. The lessons learned included the value of community consultation, contextualized activities, non-formal schooling, and identification and use of human capital as a tool for recovery and reconstruction.

The El Salvador Earthquakes (13 January and 13 February 2001) provided an opportunity to bring together mental health intervention in the form of psychological first aid (Prewitt Diaz, 2001) and psychosocial interventions (IFRC 2001). The community-based psychosocial model was unveiled in conjunction with the Guatemala Red Cross (Prewitt Diaz and Bernal Ramirez 2002) during a one-day workshop in the Latin American Psychiatric Association Conference. The psychosocial support model described here serves as the model for the Central and South America psychosocial interventions in disasters.

Disaster Mental Health

The development of the program was impacted by a request from USAIS Office of Foreign Disaster Assistance – Latin America and Caribbean and the Emergency Management Agency from Guatemala to the Guatemalan Red Cross, asking for the development of a course of study that would be given to non-mental health emergency workers. As a result, an 80-hour program of study was developed, field-tested, and utilized (Prewitt Diaz, Escorcia Delgadillo, and

Morales 2002) during the visit of the Pope in 2002.

Following the Gujarat Earthquake of 2001, the Indian Red Cross Society and AmCross developed what became known as the Disaster Mental Health (DMH) and Psychosocial Support Program (PSP). Psychological first aid (Dayal and Dash 2003) became the basic tool for intervention after a crisis or disaster and the training process was systematized, materials contextualized, documentaries developed, and teams of crisis intervention specialists trained and deployed. Following the 2004 Asia tsunami, the Indian Red Cross DMH teams were ready to intervene. In Maldives (Ibrahim and Hameed 2006), Sri Lanka, and Indonesia, these teams moved quickly to develop PSP contextualized to the realities of those countries.

Standards and Guidance

The inclusion of social and psychological support within the SPHERE Standards (2004) and INEE (2004) has guided the development of inclusive formal and non-formal school activities. The emerging standards of the IASC Task Force MHPSS (2007) that evaluates the signs of distress, community planning, and implementation has become a guideline in planning and implementing community-based psychosocial support activities.

The Integrated Model

The integrated model, which is currently being planned by the IRCS and AmCross relies on activities such as community mapping, listening to the language of distress (identifying intensity, duration), and finding out from the community how to resolve the external stimuli that cause stress. Imbedded in the PSP core are community, school health, water, and sanitation issues. The strategies include community participatory assessment and program development, capacity building, development of contextualized materials and community radio as a tool for timely dissemination of information. The tools consist of community and school participatory processes (such as community mapping, identification of human capital, and solution-focused activities).

Once consultations are completed in schools and communities, different groups plan various projects to enhance their sense of 'place'. As a result, the survivors and the

new community are able to mourn losses and identify their support systems through the networks that develop. These activities result in enhanced health, hygiene, and emotional status. The output from this model is that the community generates an information base resulting from previous experiences, brain storming, and identification of human capital.

Through the resilience-building projects, the community applies the new knowledge base by undertaking projects that improve community health, the environment, and the capacity for decision-making. By the end of the project, survivors develop a positive attitude towards the process, themselves - individually and collectively, and their new 'place'; and have impacted the development of their environment, psychosocial and physical well-being. The health, water, and sanitation elements of the model eventually change survivors' perceptions from a position of reclaiming a sense of 'place', to that of achieving a healthy and safe community.



*Women reading information from a poster on "Safe Home" in a community participatory session.
Photo: American Red Cross*

Components of the Psychosocial Program

Capacity Building: A continuum of capacity building has been formulated to guarantee a progression from participating in operational training sessions, to becoming a crisis intervention professional with basic knowledge about responses to disaster-related stress, conducting a rapid assessment, psychological first aid, self-care activities, and a core of stress-releasing activities for teachers to conduct with children.

Material Development Center: The Material Development Center is involved in the development of training materials which are



*Women teachers participating in the development of creative & expressive activities for children
Photo: American Red Cross*

used for the implementation of the program.

Formal School Activities: Experience in disaster-affected areas showed the potential of schools to be a hub for rehabilitation and support activities in the communities. This formed the basis for Amcross' school-based PSP - 'Resilient School Program'.

Non-Formal School Activities: These schools work with children below five, out-of-school youth, and marginalized groups of handicapped individuals, elderly, and widows. Each of these informal schools is provided with recreation kits and other psychosocial support materials.

Community Activities: The program identifies community volunteers and provides capacity building, so that they can become community facilitators (non-paid volunteers). These facilitators assist in the development of community-owned and managed psychosocial support activities by promoting positive coping, individual and group behaviors, and strengthening networks that lead to psychosocial competence.

Enhancing Proactive Coping through Resilience Activities: Built upon sets of core choices, it must include necessary details of timing, budget, and phasing. In emergency settings, the surrounding chaos, suffering, and time pressures push humanitarian agencies to act quickly, without learning about local beliefs and practices.

Participatory Assessments: The qualitative and quantitative 'Participatory Assessment' technique identifies the response mechanism of the community, determines risks, and sets the stage for the resilience project.

Before implementing community-based psychosocial support, program planners, implementers, and beneficiaries should set up clear goals. Subsequently, various psychosocial support activities are taken up.

- A) Use of human capital. The willingness of survivors volunteering free services and time for their community leads towards the development of the community. The greater involvement of community members increases their sense of ownership and hastens the recovery process.
- B) Holding meetings to strengthen networks is another crucial activity to re-establish the eroded support system. The mutual support and bonding among the members of a group depends on their level of comfort and feelings of security. When they are given knowledge on PFA and self-care strategies are extended, they develop support for themselves.
- C) Strengthening networks of the community is usually facilitated by ensuring participation of all underrepresented groups of a community. There are various cultural programs, community festivals, or community projects in which people take part. As their inclusion becomes a part of the PSP, people develop trust with their new neighbours, adapt new rituals, develop attachments, and a common platform of sharing.
- D) A functional community centre is an important part of PSP, as people come



The community gives input to the development of informational material to Dr. Joseph Prewitt.

together to plan their activities. It does not mean a physical space of interaction, but rather a psychological place where people join together without any apprehension or socio-cultural barrier.

- E) A 'sense of place project' allows people to look at their problems and develop a project with available resources and support. After a disaster, loss of attachment, familiarity, and identity is very common. Therefore, a 'sense of place project' allows re-establishing the bonds, attachments, and identity of the survivors. It ensures the cultural, historical, physical, psychological, environmental, and spiritual sense of place, as it is based on local cultural beliefs and practices.

Support to Host Governments: In collaborating closely with the affected countries' governments, the psychosocial programs gain institutional acceptance and sustainability. In the immediate aftermath of a disaster, AmCross Psychosocial Support Programs, as a matter of policy, promptly begin coordination efforts with government and non-government groups through the Host National Society (HNS). The coordination groups usually have representation from key government ministries such as Health, Social Welfare, and Education, UN agencies, and national and international non-governmental organizations.

In most cases, the National Society utilizes technical assistance provided by AmCross to participate in psychosocial programs with key government ministries. This is an important element not only with ministries but also with National Universities, Schools of Social Work, and Teachers' Colleges. This activity has high impact, wide reach, high visibility, and because it is co-sponsored by the government, high acceptance by the public. ■

The references mentioned in this article can be found on the last pages of this newsletter.

Psychosocial needs of the elderly Kashmir earthquake survivors

By Gordon R. Dodge, PH.D, Consulting disaster psychologist and Naeem Sarwar, MA., Psychosocial Coordinator, Helpage International and Merlin NGOs

On 8 October 2006 a massive earthquake hit northern Pakistan and Indian administered Kashmir killing an estimated 80,000 people and resulting in more than 3 million homeless. Because of the mountainous nature of the area rescue, recovery, and rehabilitation efforts were seriously hampered.

In early 2006 Helpage International determined that the needs of the elderly earthquake survivors in the Pakistan administered Kashmir area were not being adequately met, and funded three posts to be seconded to Merlin, an NGO that had been

providing services in the area since shortly after the earthquake occurred. The three posts were a public health trainer, a protections officer and a psychosocial coordinator. The three positions were promptly filled but a turnover occurred in the psychosocial position, and Gordon Dodge was subsequently contracted to conduct an in-depth needs assessment, develop and initiate the intervention programs, recruit Pakistani mental health personnel, and provide an initial series of trainings during a 10 week period from the end of August to the first part of November 2006. The project has been continued since early November under the

leadership of Naeem Sarwar, a Pakistani psychologist, and is slated to be completed in late May when funding likely will end. In addition to Naeem Sarwar, a female psychologist was also employed with the project. This gender balance is especially useful in effectively working with both male and female segments of the population being served.

Needs Assessment and Program Plan

The needs assessment, while focusing on the elderly, also included assessment of the general survivor population. The assessment approach was community participatory-based in nature, conducted on the premise that by doing so the assessment process itself can be empowering and healing, as well as the most accurate method in terms of determining what approaches are needed and will help the most.

Clinical findings were generally consistent with those of other studies of post-natural disaster effects, with a few important qualifications. It was found to be critical to differentiate the types and likely contributors to the emotional difficulties identified, especially relative to current living circumstances, since this makes a significant difference in the most likely effective interventions. Also, indications were that there was somewhat less PTSD present than found in some studies, this perhaps at least partially

due to the psychosocial work already having been provided by other organizations. Functional limitations were also identified, with the effects of disappointment, frustration, and hopelessness being especially prevalent in the camps, and complications of fear and anxiety being more prevalent back up in the valleys and villages where people had returned to their home settings. Significant residuals of grief and loss continued to be present in the entire earthquake affected areas and populations.

Many community and other sociological strengths were back in place, especially in Muzaffarabad, the major regional city in the earthquake area, and in the villages. These included essential social and civic structures and activities, a strong sense of family and concern for neighbor and community, cooperative problem-solving, social support, an identified sense of purpose, and opportunities for mobilization. However, those strengths were less present in the IDP camps, with the exception that informal social support was occurring more easily because of the closer proximity of people with each other. The greatest impediment to the overall emotional well-being of the affected people in the camps especially was the absence of sufficient opportunity for gainful employment.

The elderly had most of the same difficulties as well as strengths as others. However,



A common activity of the women is to collect water for the household by the river. Fetching water is the women's time to socialize.

Photo: Gordon Dodge

additional psychosocial concerns that were somewhat more predominant included increased isolation, feelings of being a burden more than an asset, distress over being alive while children and young adults had died, intergenerational conflicts, and the reality that the major losses they experienced would not be able to be restored in their lifetime. The loss of family members, friends, home, and community also more deeply affected many of the elderly. Given the needs assessment findings and the identified resources and constraints, the overall model of intervention chosen was psychosocial in principle, and emphasizes capacity-building methods of community organization, prevention, and education. The community organizational objects are to establish, maintain, and improve social structures and activities that are primarily mental health preventive as well as healing for those needing such.

Training and Consultation

An extensive training and training of trainers series was conducted as the first part of the project intervention activities. The educational objectives were to integrate community psychology principles and practices as well as to upgrade the counseling and other intervention skills of the primary caregivers in the settings being served. The trainings were presented in English and Urdu, depending on the participants' language skills. The training modules included:

- Psychosocial Consequences of Disasters on Individuals and Communities; methods of identification and assessment
- Psychosocial Intervention Methods for Disaster Related Circumstances; effective ways of helping individuals and communities
- Psychosocial Disaster Preparedness and Capacity Building, principles and methods of psychological first aid and resilient community building
- Principles and Methods of Staff Care, how staff can address the critical incident and cumulative stress of disaster response work

Approaches effective with the elderly were emphasized. Participants in the trainings and follow-up consultation included Merlin medical staff who provide services in the IDP camps and outreach sites, other Helpage staff, administrative and leadership mental health and social service staff from

eight other local and international NGOs still providing services in the catchment areas, Pakistani District Health Office staff, and most importantly, local camp and village leadership persons, religious leaders, teachers, home visitors, health care workers, and other indigenous caregivers.



Photo: Gordon Dodge

Examples of Community Interventions

As mentioned in the section describing the needs assessment results, there were two primary settings that the project addressed; namely the IDP camps, and the villages. The first example described below is typical of a psychosocial activity conducted in an IDP camp. The second example describes a psychosocial outreach effort in a village setting. It is important to note, however, that similar activities have been conducted in both settings, and the skills developed in such activities serve to both address existing recovery needs as well as build resiliency and capacity to better handle future disasters and other major stressors.

A group for ten elderly men and women (ages 60 – 73, equal male and female) was conducted in one of the IDP camps. Selection was based upon results of initial screenings with a series of instruments (BDI, IES-R, GHQ, & SET), and camp doctor referral. Primary psychological difficulties of concern included depression, psychosomatic complaints, generalized anxiety, and panic attacks. All were taking prescribed medications for these difficulties, and had associated functional impairments.

The group progressed in a typical fashion, with gradual increase in trust, sharing of concerns, problem solving, desensitization, cognitive restructuring, and interpersonal support. The earthquake experiences were

processed and the group moved on to addressing current living difficulties and future challenges. Sixty-six percent of the participants reported that as a result of the sessions they were feeling much better, with particular reduction in restlessness and hopelessness. A corresponding significant reduction in use of medications was reported.

This group demonstrated the benefit of how mutual support and opportunity to talk with each other especially in a guided manner can be of significant benefit, and also that such opportunities don't often spontaneously occur even more than a year after a disaster. The provision of the group experience also improved trust and skills in the population to continue to provide such a community-based, self-help experience as necessary, without needing professional



Women participating in an assessment. The assessment approach was community participatory-based in nature, conducted on the premise that by doing so the assessment process itself can be empowering and healing, as well as the most accurate method in terms of determining what approaches are needed and will help the most.

Photo: Gordon Dodge

presence. Another interesting finding is that men and women can be brought together, even the elderly, and can comfortably discuss personal significant matters of concern with each other, this with a conservative rural population with limited formal education and of strong Islamic ties. The authors of this article, however, have found that IDP and refugee camps, as disruptive and limiting as they may be in many ways; do often offer opportunities for the residents to establish new and helpful social interaction activities and structures.

The second example is from work conducted by one of the Merlin staff pharma-

cists working out of what are termed "P sites", which are outreach self-standing medical clinics in the Lower Neelum Valley, a rural mountainous area severely affected by the earthquake. This pharmacist was trained by and provided follow-up consultation from the project psychological staff. A group of seven elderly men and seven elderly women who had significant remaining psychosocial concerns were convened for three sessions, and the same basic educational and therapeutic processes as were provided in the camp groups also occurred here. Having increased socialization and problem-solving opportunities with other persons of the same age was especially beneficial, and 76% of the group expressed feeling and functioning significantly better in a short-term follow-up.

This intervention activity demonstrated that new and helpful interactions can be introduced and established in affected rural areas by community resource persons, and such approaches can continue without the ongoing professional mental health guidance. Natural, non-clinical yet therapeutic and preventive community-based structures and activities can be established in a cost-efficient, culturally acceptable manner. Many similar activities and interventions were initiated in the camps as well as in the villages with the elderly as well as other age groups. Also, many community caregivers who were trained by the project are carrying out one on one interventions as part of their on-going responsibilities, with resulting daily improvement in the persons they serve. This capacity and these skills will likely be retained in the communities long after the project is terminated. Similarly, expanded approaches undertaken by the other NGOs that availed themselves of the trainings and consultation provided by the project staff suggests that those organizations have increased skills, commitment, and capacity to carry out improved and increased psychosocial activities especially for the elderly.

Program Evaluation

A thorough evaluation design was developed at the beginning of the project. This was to determine how effective the trainings, follow-up consultations, community interventions, and capacity-building would prove to be, especially to the benefit of the elderly. Baseline data relative to these pro-

ject activities have been gathered during the course of the project. How thoroughly the follow-up activities of the evaluation design will be carried out will depend principally on whether or not the project is funded beyond the end of May. If the project is extended then follow-up data of significance should be able to be gathered. In

any event, a final report will be written even if the project does not go beyond the end of May, and the authors will make the findings and conclusions of that available to the disaster mental health community and others as interested. ■

The power of knowledge and support

By Tapiwa Gomo, Regional Senior Information Officer, International Federation of Red Cross and Red Crescent Societies in Southern Africa

It is a hot afternoon, in Makohliso village of Chivi district in Masvingo province, about 300 km south of Harare, Zimbabwe. It looks green all over but the crops in the fields show signs of wilting due to a prevailing dry and hot spell. This is supposed to be a rainy season in this sub-Saharan Africa country, where everyone hopes the rains will bring good harvests, a source of survival for many.

Three kilometres off the main road through the narrow and meandering path, is Isaac Masvanike's homestead, a former mine worker for 22 years who retired due to illness. As you come closer to the homestead, six graves lie right in front of the entrance. For Isaac, this is a reminder of what the AIDS pandemic can do.

Isaac tested positive in 2005 after he was admitted in hospital for two days. "I felt sick and I was bedridden for two days. The doctor asked my family to pray as I had less than 24 hours to recover," he said. "It was a sad moment in my life and I hope it will never happen again. The doctor was very quick to advise me to go for a HIV test and be prepared to accept my status," he opened up. That was the turning point for Isaac's life as he was immediately put on antiretroviral treatment, however his wife tested negative even after going for the test three times.

Isaac is one of the lucky few who have access to treatment. His nephew pays approximately ZW\$50 00 for the drugs from a private medical centre. Today he is a strong man, fit enough to work for his four children and send them to school.



*Isaac Masvanike with his wife. Through the home-based care programme and with the right medicine they have learnt to manage Isaac's positive HIV status. Instead of preparing to die, Isaac is now looking forward to seeing his children grow up.
Photo: Tapiwa Gomo*

Turning point

The 2nd of October 2006 marked a turning point for the millions of people infected and affected by HIV and AIDS as the International Federation in collaboration with the World Health Organization Africa Regional Office (WHO/AFRO) and the Southern Africa HIV and AIDS Information Dissemination Service (SAfAIDS) joined forces and launched a generic HIV prevention, treatment, care and support training package for community-based volunteers.

This is the first package to be developed which empowers people living with HIV like the millions of people such as Isaac Masvanike, their family members and care givers, to provide care and support with minimal external support.

"This package is unique as it is client-centred and community-based with linkages to clinical, nursing and health services and it provides a link between community programmes and organisations involved in the work of HIV and AIDS," says Dr Evelyn Isaacs, of the World Health Organization (AFRO). "It also falls in line with the principle of Universal Access to prevention, care and treatment as defined in the Millennium Development Goals which will eventually change the dynamics of the epidemic in all countries across the world."



Priscilla Makambe (to the right) is a care facilitator in the Zimbabwe Red Cross. She calls Isaac's story a "miracle". He is no longer bedridden and his ability to face realities and accept his status has helped him to manage his condition. Here she is seen with Tendai, who is also a client of the home-based care programme.

Photo: Tapiwa Gomo

We are proud that the package was pre-tested in Zimbabwe on our volunteer care facilitators and with experts from the Ministry of health and child welfare, National AIDS Council, CONNECT, The Centre, two colleagues from Kenya Red Cross society and our own officers," say Mrs. Janet Muteiwa, the Health/HIV and AIDS coordinator for Zimbabwe Red Cross society. "Our care facilitators now feel confident in assisting people living with the HIV and AIDS, especially those on ART." Zimbabwe Red Cross is running one of the best home based care programmes in Africa.

Integration of psychosocial support

The package is made up of eight modules and provides a wide spectrum of HIV and AIDS information covering topics on basic HIV and AIDS, treatment literacy, adher-

ence, palliative care, and care for carers, treatment preparedness, counselling, nutrition and positive living. For each of the modules, issues of concern in relation to children's needs are addressed, at the same time providing facilitators handbooks to guide them in planning, conducting and evaluating sessions and participants performance. It also caters for the needs of volunteers summarizing key issues to remember as well as a series of fliers which can be handed over by volunteers to clients at household level.

"Before the training we used to just provide psycho-social support and food parcels to our clients but after attending the training we are now more empowered than before," says Priscilla Makambe, 36, a volunteer care facilitator of the Zimbabwe Red Cross society who also participated in the training.

"This has enabled most of our clients to be open and free to their own family members thereby getting adequate support from the family members." It has also helped to support Isaac and his wife as zero discordant couple.

"The package act as a reference whenever we need some questions answered, we consult the package which is so helpful instead of waiting for officers from the head offices."

For Priscilla the care facilitator, Isaac is living examples of how knowledge can change the lives of her many clients over the past ten months. "When I look at Isaac, I see a miracle. I was always coming here when he was bedridden. I always shed tears when I looked at his children," she added.

"Isaac had lost weight, but his ability to face reality and accept his status helped a lot to manage his conditions. It was really a touching story," she said.

Beyond empowerment

"The availability of anti-retroviral therapy is changing the shape of home-based care programmes from helping people to die with dignity to positive living," explains Françoise Le Goff, the International Federation's head of regional delegation in southern Africa.

"This package couldn't have come at a better time as it empowers people living with HIV, care givers and family members who provide care and support and improves backup for their humanitarian work. As a community based organization, we are convinced that this will go a long way in making life easier for our community health workers who need support; we care for the carers."

The ground is now set and the care facilitators are now prepared to give their support. Community meetings and workshops with people living with HIV have already been conducted. This has also helped reduce stigma and discrimination associated with the pandemic.

"We have attended several meetings so far on how to manage our own conditions," says Isaac. I was happy to attend the workshop with my wife who takes care of me when I am sick."

Adherence to treatment is of paramount importance if you want to live longer, says Isaac. "Our Red Cross care facilitators emphasize on ensuring that we stick to the timetable for taking the drugs. Some were just taking the medicine randomly, while others used to share the drugs with their friends. My wife is very helpful as she always reminds me to take my medicine on time," says Isaac adding that this has kept him strong enough to work for my family. "I wish I can live longer to see my children through their education."■

14 Communities, 14 Ways to Understand Resilience

By Michael Ungar, Professor, School of Social Work, Dalhousie University, Halifax, Canada

It is a well-worn cliché to say it takes a village to raise a child. But research into the factors that predict a child's resilience, his or her healthy development and growth despite exposure to the compounding effects of multiple risks, tells us that our environments matter more than we think. A group of researchers with the International Resilience Project (IRP) from 11 countries on five continents have been working to understand resilience among children growing up in 14 different cultures and contexts.

What they share is exposure to great adversity, including, for example, war in Palestine and Israel, economic decay in Russia, violence in South Africa and Colombia, marginalization due to race or sexual orientation in Canada and the United States, internal migration in Hong Kong, sectarian violence in India and poverty in the Gambia and Tanzania.

Research by the IRP shows that resilience is not just an individual's capacity to overcome adversity. It is also the capacity of the individual's physical and social ecologies to provide what children need to be healthy. To be helpful, though, resources like education that are provided must be culturally meaningful. In other words, what we offer children from diverse cultural communities must be the kind of educational services they and their families value.

Of course, the study's findings are much more complicated than just that. For example, boys and girls show unique patterns to the personal, relational, community and cultural factors that best predict well-being. Overall, the IRP is demonstrating that the factors and processes associated with achieving resilience under stress are both dynamic and culturally-embedded.



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Social support and trauma – a review

By Peter Berliner and Stephen Regel



Immense research shows that social support promotes mental health, both directly and through buffering the effects of stress. Current research shows that the ameliorating effects of social support are more related to prevention of depression than to the core problems of traumatic stress, which is loss of control and avoidance.

Photo: Jakob Dall, Danish Red Cross

In 1988 House, Landis & Umberson reviewed research on social support and health. The research showed that socially isolated individuals are less healthy, psychologically and physically and more likely to die. An example is that mortality from all causes of death is consistently higher among the unmarried than the married. Some gender differences were found, indicating that being married is more beneficial to health for men than for women. Women seem to benefit more from relationships to friends and relatives.

A number of large scale epidemiological studies from the 1960s through the 1980s demonstrated that the detrimental consequences of social isolation were most remarkably found in men in urban environments. In terms of post traumatic growth, both Park (1998) and Schaefer & Moos (1998) reviewed research showing that social support mostly has a positive effect on health.

Both Cassel (1976) and Cobb (1976)

showed through reviews that social relationships are protective of health. They explained that social interactions in most cases promote adaptive behaviour and/or neuroendocrine responses in stressful situations. In a 1985 review, Bovard concluded, that social contact stimulates the release of human growth hormone and inhibits the secretion of adrenocorticotrophic hormone, cortisol, catecholamines, and associated sympathetic autonomic activity. This approach has been developed in the neuroscience research showing how this may be understood as self-regulation of stress-reactions and how these processes are influenced by social interactions (Kolk *et al*, 1996; Stern, 1985), bodily activities (dancing, listening to music, eye movements and other physical activities) and mental activities (such as meditation and mind fullness) (Bessel van der Kolk, 1996).

Two perspectives can be found in the research: (1) the buffering hypothesis, and (2) the neuropsychological theory of the beneficial effects of social relations.

The buffering hypotheses explains the found correlation between perceived good social support and less symptoms of distress following potentially traumatizing events by that other people may help to determine the meaning of particular experiences and emotional reactions to these. Antonovsky (1984) explains the positive health effects of social support by promoting a sense of coherence and manageability. House, Landis & Umberton (1988) offer a related explanation with focus on that social support facilitates health-promoting behaviours such as proper sleep, diet and exercise, prevention of substance abuse, and may help the impacted person or group to seek appropriate help and support. A longitudinal of working-class women found that social support was strongly associated with a reduced risk of depression in the wake of being exposed to a severe event or major difficulty (Andrews & Brown, 1988, Joseph et al, 1997, p.102). Joseph et al summarise the research and state that there is growing evidence for the role of social support as a protective factor against emotional distress following exposure to a traumatic incident (p.103). An example of this is found in a study on UN-soldiers returning from peace-keeping service in the former Yugoslavia. The study showed a strong correlation between self-perceived social isolation (loneliness) and severe symptoms of traumatic stress (Bache & Hommelgaard, 1994). Norris & Kaniasty (1996) argued that the perception of social support was more essential than the received support, which is in line with the results of Bache & Hommelgaard. Yap and Devilly (2004) argues on a basis of a review of studies on victimised people, that a history of chronic exposure to victimization or trauma erodes victims' perceptions of the social support available to them.

House et al (1988) also reviewed the research on the socio-economic context's impact on access to social support. They found support for the conclusion that the access to social support is inhibited by social forces such as migration, refugee status, age and poverty. Cohen et al, 1986; Schultz & Decker, 1985, displayed that efforts to explain away the association of social relationships and support with health by controls for personality variables have failed so far. Thus, political decisions may play an impor-

tant part in providing a supporting environment. This is in line with Silove's current demonstration of traumatic stress provoked by receiving host community's reception of refugees (Silove, 2004, 2005).

Basoglu has made important research into the particular consequences of trauma (2006, 2005, 1994, 1993, - www.bmj.com/cgi/eletters/333/7581/1230#160313 for a recent overview). Based on solid research he concludes that social support is not directly related to traumatic stress, but to depression. The results of his research showed that different interventions may be needed for three components of survivors' traumatic experience: cognitive and behavioural strategies for treatment of PTSD symptoms, marital or family strategies for minimizing the impact of the trauma on the family, and strategies for enhancing social support to minimize post-captivity depression and anxiety.

The research on learned helplessness supports this (Peterson, *et al.* 1993). Even though both research on learned helplessness and traumatic stress focus on the loss of control, traumatic stress relates this to a particular event, which keeps on reiterating itself mentally and socially as avoidance. Basoglu states that studies on torture trauma show that lack of social support contributes to depression but not to PTSD (Basoglu et al, 1994). Refugees may feel less depressed by appropriate social support, but they may still suffer from full-blown PTSD. Social support is important for the prevention of depression but not to traumatic stress.

In conclusion, immense research shows that social support promotes mental health, both directly and through buffering the effects of stress. Current research shows that the ameliorating effects of social support are more related to prevention of depression than to the core problems of traumatic stress, which is loss of control and avoidance. ■

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