The International Federation Reference Centre for Psychosocial Support

# Coping with Crisis

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International Federation of Red Cross and Red Crescent Societies

Hosted by Danish Red Cross

Editorial

# No more brand new wheels

*- It is time to stop reinventing the wheel!* How many times have we heard this? We talk, write and feel very seriously about this, but how can we go from words to action? What are the practical things that must be in place in order for us to stop reinventing? What do we have to do to learn how to improve the wheel, and how to adapt it to our vehicles and our roads? This is something we discuss a lot at the PS Centre these days.

It has long been a goal for the PS Centre to collect and share knowledge, however, in our new strategy we have set a more specific aim. It is our goal to be a global centre of excellence within community-based psychosocial support. In order to more systematically learn from the success of others, and in order to improve the overall performance of psychosocial programmes, we aim to be a clearing house which links theory and practice in psychosocial support for people living through critical events. This will entail the development of quality standards of information, the formation of a review board and a systematized process for the sharing of good practices. To achieve it, we will need a lot of time, effort and additional resources yet to be identified. However, it is our hope that such a clearing house will in the long run facilitate better services to the people whose lives we aim to improve.

Learning from experiences is not a new idea, we are all constantly learning from our own experiences and those of other people. In this issue of Coping with Crisis, you can read about how the American Red Cross improved its hurricane response from Katrina in 2005 to Gustav and Ike in 2008, precisely by looking at the previous response and analyzing how to make it better. What we want to do is to systematize this type of learning. We want to accumulate and apply knowledge about what works and what doesn't in different contexts. We also want this learning to be evidence-based and to provide useable solutions. This is why we are currently spending time looking forward, trying to see where we want to go and find out how we are going to get there. We are discussing what services we should deliver and how this would best be done, in order to develop a capacity building plan, and we look forward to sharing more details with you later on.

In the meantime, we hope that you will all enjoy this last issue of Coping with Crisis for 2008, where you, in addition to the hurricane response in the United States, can read about research done with children in West and Central Africa, psychosocial support in Bangladesh after Cyclone Sidr and sport in post-disaster interventions. Finally, all of us here at the PS Centre would also like to wish you all the best as the year comes to an end.

Warm regards,

Nana Wiedemann

*Nana Wiedemann*
*Head, International Federation Reference Centre for Psychosocial Support*

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**Front page photo:** *Participants in sports activity in post-disaster interventions in Germany, November*
*Photo: Christof Schwager / Swiss Federal Institute of Technology*

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# Support to children in difficult circumstances in West and Central Africa

*By Alice Behrendt, Project manager, researcher and clinical psychologist*

## Introduction

Despite the difficult living conditions of many children in West Africa, little research has been conducted on their psychosocial needs and on the efficiency of existing psychosocial support. In order to close this gap and to learn more about the impact of poverty, armed conflict, political instability and HIV/AIDS on children's development, Plan and the USAID funded the project AWARE-HIV/AIDS of Family Health International and have implemented a five country research entitled "Psychosocial support to children in difficult circumstances".

## Objectives and methods

The study was implemented from January 2007 to July 2008. The overall objectives were to improve the offer of psychosocial support services to children in West Africa and to stimulate and support a network of providers (individuals and organisations) by means of two strategies:
(1) The assessment of the mental health state and psychosocial needs of children in five different high risk contexts;
(2) The analysis of existing services in the West African region in order to identify best practices and lessons learned.

We conducted field studies in five countries, investigating different high risk contexts: child trafficking in Togo, war affected communities in Sierra Leone and Liberia, communities with high HIV prevalence in Cameroon and communities with repatriated families from Côte d'Ivoire in Burkina Faso. The work with the children included individual interviews, focus group discussions and case studies, and was carried out by a local team of either child psychologists or psychosocial workers.

Furthermore, we carried out onsite institutional analysis with organizations providing psychosocial support in 10 West African countries in order to explore best practices and lessons learned. After a process of pre-selection, seven Anglophone and 16 Francophone institutions in 10 different West African countries were selected for on-site visits.

*Drawing as a means of expressing feelings in Sierra Leone*

### Follow-up project of the research: Assistance to severely affected children

The first, and very dramatic, results of the field studies were the high incidence of suicide risk and of physical and sexual abuse among the interviewed boys and girls. In total, about 20 per cent of the interviewed children were in acute danger of committing suicide when interviewed, and needed immediate assistance, as they had been exposed to war atrocities, exploitation and maltreatment.

While we expected to be confronted with difficult findings, the dramatic nature of the results compelled us to look for immediate support for the most affected children. In order to fulfil our ethical

commitment and due to lack of referral possibilities, Plan West Africa set up, in each participating country, mobile psychosocial support units which have been providing the necessary support to all interviewed children identified as being subjected to ongoing severe physical or sexual abuse and/or assessed with a high risk of suicide. The activities put into practice by the psychosocial mobile units include counselling, suicide prevention, trauma healing exercises, traditional healing ceremonies, fairy tale sessions and family mediations, medical and social assistance.

In the first three study countries, Togo, Burkina Faso and Cameroon, the projects teams have provided assistance to about 30 children per country, a number which represents approximately 15 per cent of the interviewed children. In the post-conflict countries, however, the number of severely affected children encountered during the research was much higher: the project teams in Sierra Leone and Liberia were obliged to include more than 35 per cent of the interviewed children in the follow-up project.

## Results

More than 1,000 Children aged 8-18 years participated in individual interviews, case studies and group discussions conducted in local languages.

*High rates of domestic violence in all study countries*

The rates of different forms of domestic violence are alarmingly high in West Africa. More than 80 per cent of the interviewed children had experienced physical abuse, verbal violence and neglect in their lives. Fostered children are more often exposed to maltreatment than children staying with one or both of their parents. The repeated exposure of many children to severe forms of domestic violence did not only result in high suicide risk, low self-esteem and limited social competence, but also lead to risky behaviour such as running away from home, spending entire days in the street, and engaging in transactional sex or child trafficking. The results of this study demonstrate how the high rates of domestic violence make children more vulnerable to HIV in West Africa.

*Severe impairment of mental health*

Mental disorders, including affective or emotional instability, behavioural deregulation, and cognitive dysfunction, severely impair the development of many children in the West African region. The findings for Sierra Leone and Liberia were particularly alarming. More than 25 per cent of all interviewed children in Sierra Leone and Liberia, for example, stated a high risk of suicide, meaning that they had recently attempted to kill themselves and/ or that they had elaborated a plan on how to kill themselves. In vulnerable groups, such as war orphans, the numbers of high suicide risk were even more alarming and attained rates above 65 per cent.

*Low capacity of institutions*

The number of institutions implementing activities under the label of psychosocial support is high in West Africa. There are very few, however, that retain adequately trained human resources and that have the technical and financial capacity to work successfully with vulnerable children. Most institutions are operating in cities and serve a few hundred children at best.

*Children particularly vulnerable to HIV*

The characteristics of children particularly vulnerable to HIV differ from region to region. They usually have little visibility and are not targeted by HIV-prevention and assistance programmes. Our research showed, for instant, a high HIV vulnerability of trafficked girls in Togo. Action research is crucial for the identification of these children in different contexts.

*Community responses to AIDS* community coping mechanisms to AIDS vary from country to country and represent important resources for the support of orphans and vulnerable children. Our study in a high prevalence area in North Western

***Akissi's story***

Akissi is 15 years old. She was given by her father to an intermediary at the age of 9 years. The intermediary brought her to Benin where she worked over four years as a housemaid. She returned to her village at the age of 13 years. She lives in the house of her husband's family and has one daughter.

"Two times my mistress put hot pepper in my vagina as a punishment….another time I lost 1500 FCFA (US$ 4) after selling for her on the market. To punish me, she tied up my hands and feet and locked me up for an entire day without food or water. When she finally let me out, my hands and feet hurt a lot, you can still see the scars. I was very scared and it hurt so much. Until now I have very bad nightmares and wake up screaming. And what added up to my despair was that one night when I was sleeping, I was woken up all of a sudden because someone entered my room. It was the son of my boss who came in order to take off my skirt and to sleep with me. He forced me and all I could do was try to push him away and to scream. But it was only when my boss came that his son got off me and left to go to bed. Now back in Togo, it is the wife of my husband's brother that maltreats me…she also tells my husband that I am bad and he beats me as well. I can't go on anymore and I bought a chemical product to end my life."

Cameroon showed us, for example, that orphans are well supported by the communities and do not require more assistance than children living with one or both parents. In many low and high prevalence countries in Africa, AIDS and orphan specific responses are contra-indicated because they are likely to undermine and subdue more efficient and adapted community responses.

*Transactional sex as a catalyst for the spread of sexually transmitted infections including HIV in Sierra Leone and Liberia*
Our study showed that the armed conflicts in Sierra Leone and Liberia have had long lasting effects on the sexual behaviour of young girls. The massive exposure to sexual violence during the war and the destruction of family networks have lead to high rates of transactional sex among young girls: in Liberia, for example, almost 50 per cent of the interviewed girls had already been pregnant although not married. In other study countries, such as Burkina Faso or Cameroon, rates of girls having been pregnant were below 5 per cent. Girls having lost their parents during the war and girls formerly associated with the fighting forces were especially probable to be engaged in transactional sex. There is a strong need in post conflict countries to support the numerous young girls who have undergone non-assisted abortions or who are raising children without fathers and who are suffering from or are at risk for sexually transmitted infections.

## Conclusion and recommendations

As a result of the exposure to violence, abuse, neglect, discrimination and exploitation; many children in West Africa are vulnerable to HIV, suicide and mental disorders. They lack self-esteem and energy to engage with their environment and to actively learn about the world. The level of psychosocial impairment and distress vary considerably from country to country, highlighting the importance of operational research and locally specific knowledge in both advocacy and programming. In many settings, girls are more vulnerable than boys. The reduced mental health of children living in communities recovering from long periods of civil war is particularly disquieting. Without adequate psychosocial assistance, many of the children living in such areas will fail to integrate in society, and they are very likely to reproduce the endured violence on others, thus endangering the peace building processes of their countries. At the present time, there is only very limited technical and financial capacity to respond to the psychosocial needs of thousands of severely affected children in West Africa. Governments, child protection and rights agencies as well as development organisations are confronted with a very serious situation of ever growing numbers of children, vulnerable to HIV and unable to contribute to the development of their countries due to mental health impairments. We propose the following strategies to African governments, the African Union, the ECOWAS as well as the United Nations agencies and the non-governmental organisations to improve the existing conditions/ circumstances:

*A child describes his life with the help of flowers symbolizing happy moments and stones symbolizing difficult experiences.*

- To integrate a mental health component in public health programmes and national health agendas that takes into account the psychosocial needs of children and parents.
- To build up the capacity of the concerned ministries and non-governmental organisations on how to develop and implement effective psychosocial support programmes to severely affected children.
- To set up permanent psychosocial mobile units that can mitigate the impact of political crises or unrest, natural disaster, armed conflicts and

of political crises or unrest, natural disaster, armed conflicts and displacements.

- To incorporate psychological support activities in child protection and support to vulnerable children projects.

**The way forward**

To disseminate the findings of the research, Plan, FHI, USAID and AWARE-HIV/AIDS have organised a four-day bilingual dissemination workshop in Ouagadougou, from May 13 to 16, 2008. The workshop brought together a wide range of participants: government representatives of several West African countries as well as members of local and international NGOs. The immediate outcome of the workshop was the "declaration of Ouagadougou", elaborated by the participants. The declaration designs a way forward on how to address psychosocial needs of children in West and Central Africa.

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*Teenage mother photographed with her daughter, Liberia.*

# Preparing for hurricanes: the importance of a safe place

*By Diane Ryan and Michael Cronin*

After Hurricane Katrina in 2005, coastal cities in the United States began to look at hurricane preparedness in a new way. For example, in New York City, governmental and non-governmental groups in disaster management are now coordinating a plan that involves opening shelters throughout the city to receive 600,000 hurricane evacuees.

In preparation for the 2008 hurricane season, another new model was developed. The American Red Cross in Greater New York (ARC-GNY) formed a Rapid Response Team, which consisted of 47 paid and volunteer staff specifically trained to support a hurricane response in the southern United States. In the storms of 2005, major facilities were integral in saving lives and for providing shelter to thousands of displaced hurricane evacuees who lost everything and who relied on fellow citizens for life-saving aid. Facility managers and their staff responded to the calls for help, and for the first time in American history they were asked to operate "mega-shelters." Arenas, stadiums, convention centers and performing arts theaters became temporary homes and medical facilities for extended periods of time.


*The new mega shelter is designed to host thousands of people.*

On 29 August 2008, the new ARC-GNY Rapid Response Team was deployed to open and staff a recently built mega-shelter in Alexandria, Louisiana in advance of Hurricane Gustav. This team consisted of personnel in operations management, mass care and sheltering, material support services, staff services, information management services, partner services and disaster mental health including psychosocial support. The mega-shelter was one of 35 facilities opened in Central Louisiana to receive evacuees from the Gulf Coast.

## New mega-shelter after Katrina

This article will highlight changes that were put into place in the years since Hurricane Katrina by illustrating the operation in the Alexandria mega-shelter for Hurricane Gustav. The recent American Red Cross response to Hurricanes Gustav and Ike in Louisiana and Texas between 1 September and 22 October 2008 provided over 434, 000 overnight stays in 916 shelters, using 22,455 workers. In those seven weeks there were over 52,000 client contacts made by disaster mental health workers.

The mega-shelter in Alexandria, about five hours north of the city of New Orleans and the American Gulf Cost, costs US$ 28 million. Built by the State of Louisiana after Katrina as a hurricane evacuation center, it spans five acres, can accommodate 3,500 people and is able to withstand a Category 5 storm. Construction was completed only two weeks before it was activated for Hurricane Gustav. The facility serves as a Critical Needs Transportation Center (CNTC), a government initiative, to receive residents by bus from the Gulf Coast who had no means of evacuating on their own. The plan to evacuate residents by bus to a mega-shelter was created to avoid the fatal and non fatal tragedies that occurred with Katrina when people had no means of escape. In keeping with the Fundamental Principals of the International Red Cross and Red Crescent Movement, evacuees who arrived on their own by car after traveling for many hours were also accepted into the shelter, rather than being referred to another shelter. While mega-shelters have been used in other hurricane relief operations, the construction of a facility specifically designed to be an evacuation center is a new concept in the United States.

The Rapid Response Team arrived in Louisiana on 29 August and spent their first evening at a Boy Scout Camp, arriving at the mega-shelter on 30 August to prepare the facility for thousands of evacuees. In the first six hours of preparation, 1,700 cots were assembled in the resident dormitory and staff dormitories were also arranged. The first evacuees were expected to arrive the next afternoon, however, ten buses unexpectedly arrived at midnight. Over the next few days, Red Cross workers from other parts of the country were assigned to the mega-shelter and the team grew to 108 paid and volunteer staff.

Ultimately 2,700 evacuees and about 300 staff resided in the mega-shelter. Residents were diverse in cultural, ethnic and socio economic status and ranged in age from a nine-days-old infant to adults 86 years old. 43,000 meals were served in the 12 days of occupation and 1,102 psychosocial support contacts were provided.

The components of the mega-shelter were designed to house thousands of individuals and families for a prolonged stay. A kitchen capable of distributing tremendous quantities of food was staffed around the clock by Red Cross workers trained in mass care. A separate medical station was located in a discreet area for emergency medical workers could conduct triage and provide treatment. Within this area there was a place for those needing to be medically monitored. A multitude of toilets and showers for shelter residents were located near the dormitories on the first floor.

A staff shelter with separate toilets and showers was built on the second floor. A special medical needs shelter, staffed by physicians and nurses from the U.S. Public Health Service, was set up in a separate area for those that required oxygen, dialysis, or other medical services.

A pet shelter was designed next to the mega-shelter for animals that were evacuated with their owners. This is another new concept in hurricane planning in the United States, as it has become clear that many individuals will not evacuate without their pets, which ultimately may contribute to additional loss of life. The pet shelter was staffed by a local veterinarian and volunteers from several animal care groups. The pet owners were expected to visit each day to care for their animals, including walking, feeding and providing fresh water.

## Needs for psychosocial support

There were many clients in need of psychosocial support in a wide range of categories. There were many “worried well” who were physically and emotionally healthy but concerned about how their homes would fare in the storm, particularly if their homes had previously been affected by Hurricane Katrina. Some evacuees arrived with pre-existing dementia and became more disoriented in an unfamiliar environment. Several evacuees with mental illness arrived without their medications. There was a


group of evacuees who were anxious as their pets were expected to arrive to the adjacent pet shelter but had instead arrived to a pet shelter in a different city. Some evacuees were survivors from Hurricane Katrina and had family members or others in their town that suffered fatalities. Many of these people reported difficulty sleeping and having nightmares. Evacuees who had been in the Superdome in New Orleans during Hurricane Katrina were terrified to be in a shelter environment due to the atrocities they experienced or witnessed there.

Shelter residents received a range of psychosocial interventions. There was a need for psychological triage and mental health assessment followed by the need to hospitalize those with serious physical and emotional conditions such as cardiac conditions, anxiety, unstable mentally illness. There was also a need to develop a plan to manage chronic medical and emotional illness that did not require hospitalization such as diabetes, renal disease, and severe trauma.

Promotion of safety is essential in any shelter situation. The presence of security personnel in the mega-shelter provided the perception of safety, as well as the highly structured environment. A daily routine was strongly encouraged, schedules were posted that indicated time periods for coffee, meals and snacks, shower use, children's activity periods, and twice daily information sessions for clients. Disaster mental health workers were present in the dormitories before lights were dimmed in the evening in order to provide comfort, reduce anxiety and answer questions. Those who had previously experienced living in the Superdome and were frightened were given less active areas of the dormitory to sleep.

### Access to information

The importance of clients having access to information in disaster situations is well known. Mega-shelter resident information

meetings were held twice daily, providing information on shelter updates, the status of storm, municipality plans for return to communities. The Chief Executive Officer of the American Red Cross served as a team member and conducted these information sessions. This became an important factor as the shelter residents knew that information and concerns passed between themselves and shelter leadership were handled consistently by someone with authority to make decisions on their behalf. These meetings were an ideal forum for mental health workers to provide coping information and to dispel rumors of children being molested or abducted, which did not occur but concerns regarding this came up and seemed to be related to experiences in the Superdome.

Advocating for the needs of the clients has always been a role for disaster mental health workers. Residents with disabilities in the mega-shelter needed considerations regarding negotiating meal lines and discreet times for toilet and shower use so that assistance from different sex family members could be facilitated. Disaster mental health workers assisted the federal government to determine the location of pets that were supposed to arrive at our pet shelter. Much anxiety was reduced once these pets were identified in another pet shelter and their owners were assured of their safety and the plan to reunite them after the storm passed.

To promote a sense of community within the mega-shelter, adults and children assisted with chores such as cleaning and distributing snacks. The children were particularly happy to assist and were wonderful at reminding everyone about the shelter rules. They proudly wore their Red Cross pins that they received for their hard work.

Disaster mental health workers and other staff trained in psychological first aid provided emotional support and validated thoughts and feelings by being visibly available and approachable as needed. Disaster mental health staff participated in the daily informational meetings which made it easier for clients to request assistance since they had become known to them. Crisis intervention and normalizing stress reactions were techniques provided to individuals and families as needed, along with information on ways of coping.

All workers supported shelter residents in practical tasks such as connecting to their support systems, obtaining medications, and arranging for pet care, offering support and advice, and providing the use of telephones.

## Helping the helpers

Staff support is a vital mental health service in disaster, particularly in the hardships created by working long hours in a shelter situation. Staff resided in the same facility as the evacuees and this added to the hardship. Hurricane Gustav passed 20 miles to the west of the mega-shelter, and this made it necessary to stay on location for a few days until the storms and tornado watches ended. Fresh food was not available during this period and staff and evacuees had to eat military rations and heater meals. Staff began to work many additional hours, as there were no options for respite until the storms passed. The shelter experience may cause increased fatigue and stress related symptoms such as irritability when staff are in constant contact with each other. Acknowledging this hardship in staff meetings, asking personnel to be patient with each other and providing information on coping seemed to be helpful for staff. There was much support, encouragement and recognition of the valuable work being done by shelter leadership, which was essential to maintaining staff morale.

A quieter area of the shelter was designated for staff to try to get some alone time. Disaster mental health workers were constantly available to offer support and had contact with each staff member in the closing days of the shelter. Once the bad weather passed, the staffing team began to schedule workers for a much needed day off.

An advantage of the Rapid Response Team concept is that most of the team members had previously worked with each other, trusted each other, and were able to provide support when colleagues became stressed. This mutual support is critical to maintaining a vital work force, and much more difficult when team members are working to get to know each other.

There were no negative incidents at the Alexandria Mega-shelter, in marked contrast to the New Orleans Superdome that was used for Hurricane Katrina. A valuable lesson learned from this experience is that providing a safe and structured environment in which residents take part in ownership can increase their confidence and capability. Our greatest lesson learned was that mass evacuation and providing emergency shelter can be done in a compassionate environment that meets the needs for safety, security and well-being.

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# Psychosocial support in Bangladesh in the aftermath of Cyclone Sidr

*By Dr Satyabrata Dash, Psychosocial Support Programme Delegate and Dr Mohammed Fazlul Quader, Psychosocial Support Programme Manager*

## Introduction

The southern and western parts of Bangladesh were hit by Cyclone Sidr at approximately 6:30 pm on the evening of 15 November 2007. At landfall, Sidr was a category 4 storm, with a diameter of nearly 1,000 km and sustained winds of up to 240 km per hour. Sidr was the second most destructive disaster of the 14 to hit Bangladesh in the past 15 years. Sidr affected nearly the entire western and southern coastal plains of the country.

The three hardest hit divisions were: Barisal (six districts), Khulna (three districts), and Dhaka (four districts). An estimated 15.95 million people in 3.17 million households were affected. One-third of the affected population is from the four worst affected districts in coastal areas.

Cyclone Sidr claimed 3,406 lives and 1,001 people are still missing. More than 55,000 were injured and close to nine million people in 30 districts were affected. As Sidr struck during the late evening, many families were caught inside their homes.

The government of Bangladesh, in collaboration with the UN, the Bangladesh Red Crescent Society (BDRCS), and the International Federation of Red Cross and Red Crescent Societies, undertook several humanitarian assessment missions and started the relief operations. Both the international and national aid community responded quickly to the crisis. The International Federation and World Vision launched relief operations in the most affected districts on 18 and 16 November, respectively. A number of other UN organizations and other NGOs also distributed relief packages.

## Assessment

In the beginning of December 2007, a two-member team supported by the Danish Red Cross conducted a psychosocial assessment. The team collected secondary information from a number of relevant Movement partners and other stakeholders, made field visits to one of the worst affected districts, and conducted interviews with key informants and focus group meetings with volunteers working in relief operations and community members. The team also introduced psychological first aid to 19


*An estimated 15,95 million people in 3,17 million households were affected by cyclone Sidr.*

students from Dhaka University, and held initial discussions with the department of clinical psychology for liaison in recovery programmes.

## Programme design

Based on the recommendations of the assessment team the programme has two objectives, firstly to provide psychosocial support to the BDRCS volunteers who were exposed to the traumatic events during the relief operations and secondly to provide psychosocial support to affected communities (20,000 households in four districts).

The first objective is designed to serve multiple purposes, and will involve BDRCS units in nine affected districts. The training sessions are planned to be delivered by trainers from the department of clinical psychology at Dhaka

University. Through three days of interactive training sessions and individual psychological support to the BDRCS volunteers, it is expected that they will be able to provide psychosocial support to others. Secondly, through this capacity building, the volunteers will be better able to manage their own stress as well as that of fellow volunteers and survivors of future disasters. Finally, the awareness on psychosocial support will increase in the targeted communities and in the country as a whole.

Best practices and lessons learned will be shared with the BDRCS senior management and other disaster management authorities in the country to advocate for the inclusion of psychosocial interventions in the disaster response framework of Bangladesh. Involvement of the Dhaka University will help validate the cultural and contextual appropriateness of the interventions.

The programme will help in the development of linguistically, culturally and technically appropriate information for dissemination- and training materials in the form of leaflets, posters, training booklets etc.

The second objective is directed towards providing psychosocial support to 20,000 households in four affected districts: Bagerhat, Pirojpur, Barguna and Patuakhali. The activities under this objective will aim at improving the psychosocial well-being in the affected communities. This will be done by training community volunteers in psychosocial support to prepare them to work in their comities with the support of BDRCS unit volunteers who are qualified as trainers of trainers. The community volunteers will do psychosocial assessments of their communities and provide credible information on psychological reactions following disasters and basic measures at household level. They will also provide psychological first aid and facilitate referrals, and conduct activities to build the psychosocial resilience in the communities.

The community based psychosocial support training includes sessions on psychological first aid, self care and community social recovery. This will ensure that personnel and volunteers get information on traumatic stress and psychological reactions, basic non-technical psychological support intervention (psychological first aid), identification of individuals requiring referral services, phases of psychosocial response of communities to disasters, and the interventions for community psychosocial recovery. Some trained volunteers will be selected and provided a trainer of trainers session to help in programme implementation – training community volunteers, facilitating meetings with community volunteers, disseminating information and monitoring implementation by community volunteers - in the target communities. (See below) Volunteers from the target communities will be chosen through a participatory method. There will be one volunteer for every 25 household, meaning around 18-20 volunteers per village. The volunteers will be trained in community-based psychosocial support through three days of interactive sessions, includes sessions on psychological first aid, self care and community social recovery. They will get information on traumatic stress and psychological reactions, basic non-technical psychological support interventions (psychological first aid), identification of individuals requiring referral services, phases of psychosocial response of communities to disasters, and the interventions for community psychosocial recovery. The information given and the training process itself will help the volunteers overcome their own stress and enhance their ability to provide services in their communities

As a result, the communities will have credible information on psychological reactions, access to psychological first aid, knowledge on identification of referrals and support for facilitating referrals. The communities will also develop strong social cohesion, which can be utilised to enhance recovery efforts and improve preparedness to respond to various challenges.

As of mid-November 2008, one year after the disaster, 49 target communities have been selected by the BDRCS; liaison with the Dhaka University is in place and trainers from the university are facilitating the psychosocial training developed by the International Federation and BRDCS in the districts. More than 300 BDRCS district unit- and community level volunteers from seven districts have been trained. The trainer of trainers manual and reference booklets for volunteers are being finalized in the local language and context; and psychosocial activities have started in the target communities.

## Conclusion

Bangladesh faces natural disasters, especially cyclones, every now and then. The country has in place an extremely effective Cyclone Preparedness Programme (CPP) that includes early warning and evacuation and emergency response. However, the country does not have a psychosocial support programme. The current programme can be a model for replication in other areas in the future and can be complimentary to the existing CPP. Additionally, development of social cohesion and social capital will strengthen developmental initiatives in Bangladesh

# Coping with crisis through sport

*By Katrin Koenen*

Rheinsberg, Germany, generally attracts tourists to its quaint town for leisurely walks along the lake or for tours of its historic castle. But for seven days in early November, Rheinsberg played host to a different breed of tourist.


*Participants from 28 countries had an active seminar in Rheinberg, Germany*

Inside the gym of Haus Rheinsberg, Germany's first barrier-free hotel, 68 participants listened attentively to a session led by Dr. Claire Colliard of the Centre for Humanitarian Psychology. But this wasn't just any ordinary psychology workshop – the participants are here for the Sport in Post-Disaster Intervention seminar, organised by the International Council of Sport Science and Physical Education (ICSSPE).

ICSSPE President Prof. Dr. Gudrun Doll-Tepper explained, "Following the devastating tsunami in South East Asia, we knew we had a responsibility to involve the fields of sport, physical activity, and sport science into disaster relief efforts. This training seminar is designed to communicate the importance of sport as an essential part in the rehabilitative process of physiologically and psychologically traumatised people, and to convince representatives of non-governmental organisations, governments, and the private sector to integrate sport into their work in conflict areas."

The reason why sport and physical activity should be chosen as a relief tool is that the benefit of sport and physical activity goes beyond increasing fitness, endurance, and strength. Using group activities properly can allow development in:

- Emotional skills - the ability to cope with emotions such as frustration and aggression;
- Social skills - solidarity, handling conflict, communication; and
- Cognitive skills - discipline, problem solving, strategic thinking.

In addition, implementing a sport programme within a community that has been affected by a disaster can help the population before they develop post-traumatic stress disorder. Therefore, it acts as a preventative tool instead of a reactionary one if implemented immediately after the disaster instead of the late phases of recovery.

The participants, some who came from as far away as Iran, Qatar or Mauritius, and represented 28 countries, did not just sit and take notes either. Mr. Ken Black, from Loughborough University, separated the participants into smaller groups and led them through a range of inclusive activities that could be implemented in a disaster setting.

"I was really happy to receive an ICSSPE scholarship to be here. I am really enjoying the seminar and have learned a lot of things about how I can improve my work at my University in Pakistan", said Mr. Waheed Qureshi from Pakistan. There were four scholarship recipients from developing countries.
Participants represented a diverse range of professions, such as social work, disaster relief, sport and physical education. This mix of different backgrounds and different experiences allowed the group to exchange their ideas on culture, which is also one of the topics covered by Dr. Gary Armstrong of Brunel University.

One who knows the importance of paying attention to cultural differences is Christoph Schwager, who has been a senior officer with the Swiss Rescue Team for 15 years. Schwager has worked on relief efforts in Iran, Sri Lanka, Lebanon, Cuba, and the Ivory Coast, and has learned many lessons on what works and what doesn't. "The worst is when people from abroad come and bring their own culture with them," he explained. "To cure traumatised children, you need more than sport material - you need a lot of empathy, cultural background, knowledge about religious attitudes, and the rules and behaviour in the society."

The 2nd Sport in Post-Disaster Intervention Seminar took place from 1-7 November 2008, and was organised by the International Council of Sport Science and Physical Education. The event was held under the leadership of the International Council of Sport Science and Physical Education. It was financed with the assistance of the Federal Ministry of the Interior (Germany), and in cooperation with the Fürst Donnersmarck-Foundation, the German Red Cross, Freie Universität Berlin, and Kennesaw State University (USA).

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Christof Schwager, Swiss Federal Institute og Technology

Christof Schwager, Swiss Federal Institute og Technology

## European psychosocial network meeting (ENPS)

*By Koen Van Praet*

The two day annual forum of the European Red Cross and Red Crescent Network for Psychosocial Support (ENPS) was hosted by Swedish Red Cross in September 2008.
The theme was beyond the crisis: Psychosocial Support Programme in mid and long-term support.

It was attended by representatives from 18 National Societies, including two guests from the Red Crescent Societies of Bahrain and Iraq, representing the Middle East and North Africa (MENA) psychosocial network. In addition, two representatives from the International Federation zonal offices of Europe and MENA attended the meeting.

The Annual Forum aims to provide European Red Cross and Red Crescent National Societies, working in the domain of Psychosocial Support, with a venue and time to exchange ideas, best practices and tactics. The main themes discussed were (i) Psychosocial Support: is it ever over? (ii) Vulnerability and migration and (iii) Media: roles of the journalist.

Within the subject "Psychosocial Support: is it ever over?" three National Societies presented programmes that had been discussed in earlier fora, this time focussing on the development and closing of the programmes. The British Red Cross presented the programmes following the London bombing, the Spanish Red Cross the work after the terror attacks in Madrid, and the Russian Red Cross the Beslan programme. Finally, the Swedish Red Cross presented lessons learned during the project supporting the families of those affected by the Indian Ocean tsunami.


*Participants of the European Red Cross / Red Crescent Network for Psychosocial Support, annual forum 2008*

The second subject was "Vulnerability and migration". Migration includes a very high risk for the people affected. Families of the missing need long and ongoing psychosocial support and people have to be trained how to provide this help. Judi Fairholm from the Canadian Red Cross presented child protection, stressing the personal responsibility of all individuals who are part of an organisation to create a safe child environment.

The last topic "Media and the survivors: what are our roles?" was taken care of by Maud Fröberg, press officer of the Swedish Red Cross. She focussed on the different roles of the media, from alarm bell to investigator, and on how the role of the Red Cross and Red Crescent should change accordingly.

As always, the ENPS General Assembly took place during the forum. The assembly said goodbye to Moya Wood Heath from the British Red Cross who stepped down from the Steering Committee and welcomed, by unanimous vote, Diana Prados Sánchez, representing the Spanish Red Cross.

For a full report and downloads, *visit http://enps.redcross.at.*

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