PSYCHOSOCIAL WELLBEING SERIES

Mainstreaming Psychosocial Care and Support
Facilitating Community Support Structures

Lessons learned in Uganda about community-based psychosocial and mental health interventions

TPO Uganda
Transcultural Psychosocial Organisation

REPSSI
Psychosocial Wellbeing For All Children

REPSSI

Psychosocial Wellbeing For All Children

REPSSI is a regional non-governmental organisation working with partners to promote psychosocial care and support (PSS) for children affected by HIV and AIDS, poverty and conflict in East and Southern Africa.

THE REPSSI PSYCHOSOCIAL WELLBEING SERIES

Through this series, REPSSI strives to publish high quality, user-friendly, evidence-based manuals and guidelines, all characterised by subject matter that can be said to address the issue of psychosocial wellbeing. Within the series, different publications are aimed at different levels of audience or user. This audience includes: 1) community workers, 2) a variety of social actors whose work is not explicitly psychosocial in nature, but in which it is felt to be crucial to raise awareness around psychosocial issues, 3) caregivers, parents, youth and children, 4) specialised psychosocial and mental health practitioners. Apart from formal impact assessments, towards further developing the evidence base for our tools and approaches, we welcome user feedback around our materials. The standardised feedback form and a full list of all the titles in the series can be downloaded from www.repssi.org

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Acknowledgements

This guide was prepared by:

Foreword

This guide represents an important contribution to the REPSSI mainstreaming series. Readers will find that they can utilise the practical information shared in this guide by TPO Uganda about its lessons learned along with descriptions of actual community-oriented interventions to inform them in their design and implementation of psychosocial and mental health support in the aftermath of emergencies. While the guide focuses on lessons learned about community-based psychosocial and mental health interventions in the aftermath of emergencies, many of the principles apply equally to non-emergency or developmental contexts.

REPSSI (Regional Psychosocial Support Initiative) along with TPO (Transcultural Psychosocial Organisation) and GPSI (Global Psycho-Social Initiatives) joined together to produce this guide. As historical leaders in the field of psychosocial and mental health support in developing countries, they decided to pool their resources to produce a series of materials that can be used to inform individuals and organisations about effective methods of response in emergency situations.

REPSSI is a regional non-governmental organisation working with partners to promote psychosocial care and support for children affected by HIV and AIDS, poverty and conflict in East and Southern Africa.

TPO is a non-governmental organisation based in Uganda. Its interventions empower local communities, civil society organisations and government to meet the psychosocial and mental health needs of communities - especially in conflict, post-conflict and disaster-affected areas.

GPSI is a global initiative that facilitates training programmes from which its learners implement culturally relevant individual, family and community interventions in developing countries affected by conflict and other emergencies.

The REPSSI mainstreaming series also includes:

Mainstreaming Psychosocial Care and Support Trainer's Guide for Training Teachers in Conflict and Emergency Settings:
An Edited Anthology of Global Teacher Training Materials to Facilitate the Integration of Mental Health and Psychosocial Support into Education

Mainstreaming Psychosocial Care and Support Trainer's Guide for Training Health Workers in Conflict and Emergency Settings:
Guide to Recommended Training Materials to Facilitate the Integration of Mental Health and Psychosocial Support into Health Care

Mainstreaming Psychosocial Care and Support Through Child Participation:
For programmes Working with Children and Families Affected by HIV and AIDS, Poverty and Conflict

Mainstreaming Psychosocial Care and Support Within Early Childhood Development:
For ECD Practitioners Workers Working with Children and Families Affected by HIV and AIDS, poverty and conflict

Mainstreaming Psychosocial Care and Support Into Economic Strengthening Programmes:
For Practitioners Working with Children and Families Affected by HIV and AIDS, Conflict and Poverty

Mainstreaming Psychosocial Care and Support Within the Education Sector:
For School Communities Working with Children and Families Affected by HIV and AIDS, Poverty and Conflict

Mainstreaming Psychosocial Care and Support Within Food and Nutrition Programmes:
For Practitioners Working with Children and Families Affected by HIV and AIDS, Poverty and Conflict

Mainstreaming Psychosocial Care and Support Into Home Based Care Programmes:
For Practitioners Working with Children and Families Affected by HIV and AIDS

We trust that this guide will assist your efforts to provide support to individuals, families and communities affected by emergencies.

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REPSSI
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TPO Uganda
Transcultural Psychosocial Organisation

GPSI
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Introduction

Issues affecting psychosocial wellbeing and mental health are important to all populations.

In particular, populations affected by armed conflicts and other emergencies struggle significantly with psychological and social issues.

"Emergencies create a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies erode normally protective supports, increase the risks of diverse problems and tend to amplify pre-existing problems of social injustice and inequality." (IASC MHPSS Guidelines 2007).

"One of the priorities in emergencies is thus to protect and improve people's mental health and psychosocial well-being." (IASC MHPSS Guidelines 2007).

An international effort to provide this support comes from the Inter Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support (MHPSS) in Emergency Settings. These guidelines provide a *"multi-sectoral, inter-agency framework that enables effective coordination, identifies useful practices and flags potentially harmful practices, and clarifies how different approaches to mental health and psychosocial support complement one another."* (IASC MHPSS Guidelines 2007).

The term MHPSS is used within the IASC 2007 guidelines. "The composite term mental health and psychosocial support (MHPSS) is used in this document to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder."

"They reflect the insights of practitioners from different geographic regions, disciplines and sectors, and reflect an emerging consensus on good practice among practitioners."
(IASC MHPSS Guidelines 2007).

"The psychological and social impacts of emergencies may be acute in the short term, but they can also undermine the long-term mental health and psychosocial well-being of the affected population. These impacts may threaten peace, human rights and development."
(IASC MHPSS Guidelines 2007).

Thereby the IASC MHPSS guidelines propose the need for psychosocial and mental health response during three stages of an emergency:

1. **Emergency preparedness** to "*enable rapid implementation of minimum responses.*"

2. In the midst of the emergency with "**minimum responses** *defined as high-priority responses that should be implemented as soon as possible in an emergency. These responses may be seen as providing the minimum supports to which affected populations are entitled.*"

3. "**Comprehensive" response** in the aftermath which includes interventions which "*should be considered only once it is clear that the vast majority of communities are engaged in/are receiving the locally-defined minimum response. These interventions are most often implemented during the stabilised phase and early reconstruction period following an emergency.*" (IASC MHPSS Guidelines 2007)

Though the Transcultural Psychosocial Organisation of Uganda provides intervention at all three stages of emergency, in this guide they specifically share important **lessons learned** in the provision of "**comprehensive**" **psychosocial and mental health responses via community-oriented interventions in the aftermath of emergencies.** Within its core principles the IASC MHPSS recommends 4 layers of intervention at each stage of the emergency:

Community support is provided differently at different stages of response.

This guide is specifically directed at providing readers with examples of interventions in layer 2: ie community and family support, as well as in community responses that support interventions covered by layers 1, 3 and 4.

The interventions presented by TPO in this guide are those that begin once the emergency has settled, the situation is safe, and the population ready for rebuilding.

This guide includes:

Chapter 1: A history of the Transcultural Psychosocial Organisation (TPO) of Uganda's lessons learned in the development of its "comprehensive" psychosocial and mental health interventions in the aftermath of emergencies.

Layer 4:
Specialised
Services

Layer 3:
Focused Supports

Layer 2:
Community and family supports

Layer 1:
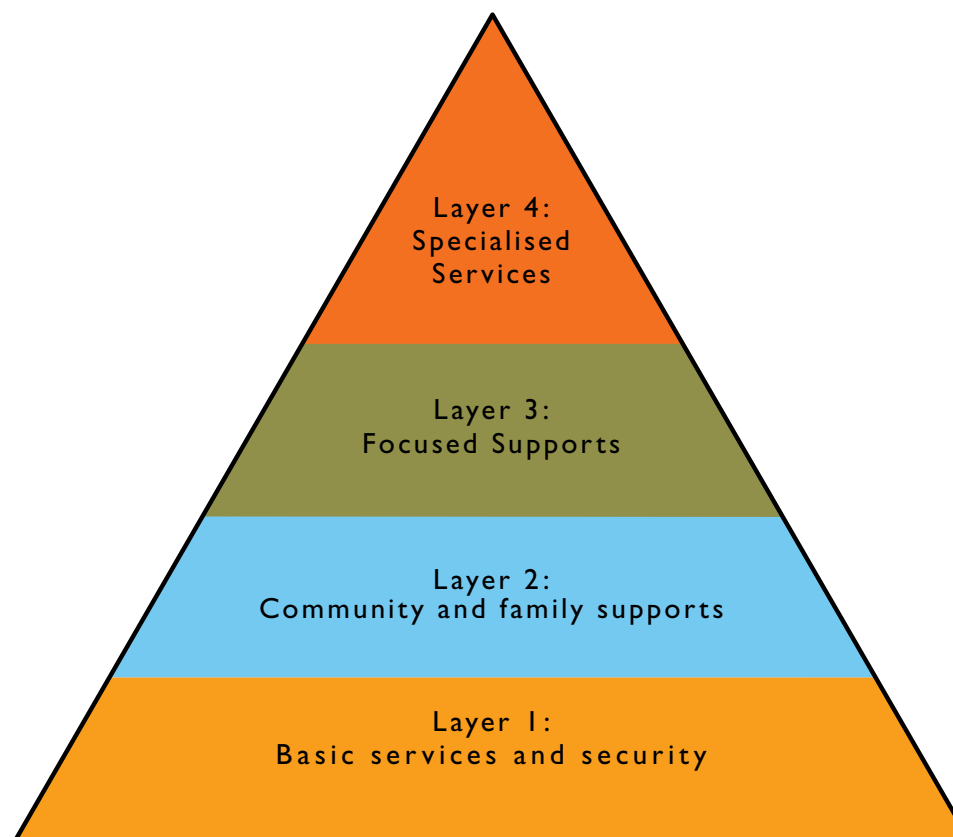Basic services and security

Figure: IASC MHPSS (2007) Intervention Pyramid for Emergencies.

Chapter 2: An overview of the international guidelines and research corroborating TPO's lessons learned.

Chapter 3: Specific case studies utilising TPO's Community Support Structure (CSS) model leading to sustainable support for psychosocial wellbeing and mental health care.

All those people involved in the design and implementation of psychosocial and mental health support in the aftermath of emergencies will find this practical sharing of **lessons learned** and descriptions of actual community-oriented interventions enlightening.

Through this guide, readers will understand one organisation's plan for how to utilise the guidance provided in the IASC MHPSS guidelines which state: "*Strengthening and building on existing local support systems and structures will enable locally-owned, sustainable and culturally appropriate community responses. In such an approach, the role of outside agencies is less to provide direct services than to facilitate psychosocial supports that build the capacities of locally available resources.*"

Readers can take the lessons they learn from TPO and utilise them in their work in the design of community-focused interventions that will lead to sustainable support for psychosocial wellbeing and mental health care.

Chapter **I** A History of Community Based Psychosocial and Mental Health Intervention in Uganda with Lessons Learned

The Transcultural Psychosocial Organisation (TPO) is a local Ugandan non-governmental organisation which began in 1994 with the aim of providing psychosocial support and mental health care to communities, families and individuals. Its mission is *"to empower local communities, civil society organisations and the government to meet the psychosocial and mental health needs of communities especially in conflict, post conflict and disaster affected areas."* (TPO Website 2009 / www.tpoug.org)

Based on lessons learned, TPO's present services are delivered through a community-oriented intervention model, which *"focuses on identifying existing community support structures, traditional circles of support and building their capacity to identify and participate in supporting the psychosocial and mental health needs of; children in need of protection; survivors of gender based violence; children and families infected and affected by HIV/AIDs and families whose socio-economic wellbeing has been debilitated by conflict and/or any other disaster."* (TPO Website 2009 / www.tpoug.org)

The present themes of TPO's community-oriented intervention projects include:

- Protection of the rights of the child.
- Care for HIV-AIDS affected, orphaned and vulnerable children.
- Prevention and response to gender based violence.
- Promotion of community-based peaceful co-existence.
- Food security and livelihoods improvement to enhance psychosocial wellbeing.
- Promotion of psychosocial and mental health support.
- Training and capacity building.

The following traces the history of TPO's **lessons learned** and how its services evolved to be what they are today. It begins with TPO's response to a conflict-affected refugee population living in Uganda and continues to describe the growth and development of its interventions to assist national conflict-affected populations in Uganda. The guide concentrates only on the TPO response in the aftermath of conflict and violence once the daily lives of the affected populations are somewhat stable. It is specifically directed at those responses used to mobilise communities and build their awareness, sensitisation and capacities so that they can provide sustainable support for the psychosocial and mental health issues of their community members.

Western mental health ideas are introduced to Uganda

TPO began as an arm of an international organisation based in the Netherlands. It began its work with the extremely large numbers of Sudanese refugees who fled to Uganda and lived within refugee camps. Its early model tried to create a balance between local cultural and traditional methods of individual, family, community and societal self-help and western directed psychological and psychiatric practices.

City educated psychology students as rural psychosocial workers

In the beginning, TPO hired a group of graduates from national university psychology departments. They were trained and supervised by western professionals to provide western-oriented counseling.

In a short time, it became clear that this model was inadequate. There were many reasons. The psychology graduates lacked a depth of understanding about the culture, traditions and language of the refugees and as a result few refugees could relate to them or sought their services. The graduates were unhappy living and working in the rural location of the refugee camps. They wanted counseling offices to which people in need would come to seek their help. The basic needs of the refugees remained unsatisfied and as a result they were seeking food not counseling.

African proverb *"A hungry stomach has no ears."*

Lessons learned:
- In-depth understanding and utilisation of culture, tradition and language is essential for providing psychosocial and mental health support.
- People affected by emergencies have many natural resources and capacities to help themselves. Outside interventions need to facilitate their natural resources and activate them for effective self-help.

Indigenous community based psychosocial workers

PHASE 1: Recognising the limitations of their model, TPO changed their working team. They selected refugees, knowledgeable about their own culture, traditions and language, who were known leaders and helpers, and hired them as "counselors". Western professionals trained them to provide counseling. They emphasised that the refugees had experienced traumatic events during their displacement and thereby suffered from psychological and psychiatric symptoms of distress and mental health disorders. The counselors set up mud-hut offices in the camps to provide counseling and with the support of local psychiatric nurses set up mobile outreach mental health clinics.

PHASE 2: It was clear after the first year that some very vulnerable and desperate refugees received support from the counselors and their situations improved. Clearly, refugees helping refugees was a better model.

The issues confronting the refugees however were different than initially expected and the "counselors" needed more knowledge and skills. Requests for TPO assistance were recorded as:

- *Help a family find a confused, naked man who ran into the bush talking to himself and threatening to harm anyone in his way.*
- *Assist a family after the rebels abducted their daughter and*

stole the family's food supply and the children are starving.
- *Calm a violent quarrel between a drunken man and his wives.*
- *Mediate a dispute between neighbors due to one believing the other "cursed" his family.*
- *Find a home for a mother and her retarded child after being abandoned by her husband and family.*
- *Speak to a parent who is not paying a child's school fees.*
- *Advocate to the United Nations for a community whose donated seeds for planting did not germinate.*
- *Rush to a home where a child is dying and help them secure medical care.*
- *Help a depressed widow with seven children and no extended family.*
- *Assist a suicidal childless woman.*
- *Assist a man charged with defilement and locked in prison without a trial.*
- *Provide assistance to a person suffering from the cultural stigma placed on people with epilepsy.*
(Baron, N. 2002)

Lessons learned:
- It is essential for helpers to go to the people and meet with them in their homes and communities and not expect the people to come to them.
- The issues disturbing people affected by emergencies are most often related to their present lives and not to the traumatic events of their displacement.

- Many people affected by emergencies have some symptoms of distress including feelings of anxiety, sleep disturbances, periodic nightmares and in particular psychosomatic pain. People may show normal post traumatic stress responses, signs of depression and excessive alcohol use. Care should be taken to avoid using stigmatising labels such as Post Traumatic Stress Disorder.
- Specific vulnerable groups i.e,: people with psychological, cognitive and physical challenges, people with chronic and serious health problems - like epilepsy and HIV-AIDS, survivors of gender based violence, unaccompanied and orphaned children, widows and elderly without adequate family support may benefit from additional specialised support.

For more information read: Baron, N., Jensen, S. & de Jong, J. (2001). The Mental Health of Refugees and Internally Displaced People In *Guidelines for Psychosocial Policy and Practice in Social and Humanitarian Crises: Report to the United Nations* (Eds. J. Fairbanks, M. Friedman, J. de Jong, B. Green & S. Solomon). United Nations, New York.

PHASE 3: Based on the **lessons learned**, the training of the refugee "counselors" was expanded since many psychosocial workers began to work with TPO with little understanding of psychosocial and mental health issues.

During training one TPO psychosocial worker reported: "I remember when I was young. A relative became mentally ill. He was locked in the house and the meat of an elephant was burned. The smoke successfully chased away the demons." (Baron, N. 2001).

The expanded training provided the "psychosocial workers" with a broader range of knowledge and capacity for intervention. They learned about bio-psycho-social consequences, how to identify people with mental disorders, health disorders and psychosocial issues and how to provide them with an appropriate range of interventions at individual, family, community and societal levels. They were taught social work skills, case management, family counseling and preventative interventions - especially how to facilitate community awareness raising, problem solving and conflict resolution. More emphasis was placed on the importance of their supporting and not replacing natural traditional and cultural beliefs and methods of self-help and working cooperatively with community leaders, elders and traditional healers. More time was spent on personal development, especially since the TPO workers were also refugees who had difficult lives, and who were managing the stress and challenges of their new responsibilities.

Balancing the integration of traditional methods of helping with effective modern treatment models was complicated. Time was spent on determining which traditional methods prevented effective helping and actually violated human rights since it was only these that needed to be modified.

> For example, "ostracizing, neglecting and abusing people with epilepsy because it is believed that they are cursed rather than providing effective medication had to be changed so that all people are equitably provided access with their human rights." (Baron, N. 2001)

The overall goals of the TPO-Uganda program at that time included:

- *"Culturally sensitive community-based interventions utilising indigenous "helpers".*
- *Provide curative psychosocial and mental health assistance through mid- and long-term supportive problem solving assistance.*
- *Prevent psychosocial and mental health problems through crisis intervention, psychosocial education and community, youth and child activities.*
- *Increase community awareness and sensitisation of psychosocial and mental health issues to assist in preventing problems and empowering communities and families to help their needy members.*
- *Encourage empowerment of individuals to help themselves within the context of family.*

- *Work cooperatively with all community, NGO or government leaders and helpers.*
- *Promote human rights, peace and reconciliation." (Baron N. 2002).*

TPO continues to have active teams of indigenous psychosocial workers providing community oriented support throughout Uganda today.

Lessons learned:
- Respect for community beliefs and practices and understanding of those that are beneficial and necessary is essential to helping individual, families and communities.
- Only those traditional helping or healing practices which are dangerous and violate human rights need to be modified.
- Determining which traditional practices are dangerous or violate human rights is difficult but essential. The goal is to empower communities to help their members with psychosocial and mental health issues. If an outside source takes over the support of vulnerable community members and is not sustainable it can damage essential self-help structures that might never be reinstituted.

For more information read:
Chapters on TPO Uganda's work in: Baron, N. (2001). Community based psychosocial and mental health interventions for southern Sudanese refugees living in long term exile in Uganda. In *War and Violence: Public Mental Health in the Socio-Cultural Context.* (Ed: J. de Jong), New York: Plenum Publications.

Baron, N. (2002). Southern Sudanese Refugees: In Exile Forever? *A Psychosocial Approach to Innovative Multicultural Interventions* (Ed: F. Bemak, Chung R. C.-Y. & Pedersen P.). New York: Greenwood Press.

Facilitating the capacity of community leadership to provide psychosocial and mental health support

Life in the refugee camps in Uganda was difficult and stressful. There were many issues with psychosocial consequences that were new to the people.

> As example: The men living in the camps had little constructive daily activity and many increased their use of alcohol use. Increased alcohol use and high frustration over the inability to care for their children lead to increased family quarrels and violence.

The refugee camps for the Southern Sudanese in Uganda most often replicated their previous community village structures, and had community leaders who were delegated

by the communities with the responsibility for problem resolution. This leadership assisted with many issues but few understood psychosocial and mental health issues, human rights, basic health care etc. The TPO workers realised that the community leadership had the respect of the people and many important skills. In order to facilitate them in providing psychosocial and mental health support, TPO provided them with capacity-building workshops. This led to increased sensitisation and awareness and mobilised them to help their vulnerable members.

"To be effective community education needs to flood the entire community so TPO developed a community education approach that reaches throughout the communities. Community Participation in Psychosocial Helping (CPPH) workshops target community leaders and the overall goal is to increase community sensitization and awareness and mobilise these leaders to help their vulnerable members and activate their communities to help themselves and know when and how to make referrals to TPO and other helpers. In 1998 and 1999, counselors held 360 training sessions in which they trained more than 8000 community leaders, religious leaders, teachers, health workers, youth leaders, women leaders, traditional healers, government officials and NGO workers. Building awareness promotes the referral of people with problems to the available services but also provides a "preventive" function. Educating people about potential problems can prevent their occurrence or exacerbation." (Baron, N. 2001).

One specific outcome of this training was the initiation of Community Crisis Intervention Teams (CCIT). Due to a large number of suicide attempts and deaths, teams of Community Leaders were trained in each settlement about how to facilitate an emergency response. Community Leaders along with TPO made presentations to the refugee communities to increase their understanding of the risks and methods of response and referral.

'About one month after the training, a community member rushed to the Crisis Team and asked for assistance for her neighbor. The neighbor a 32 year old woman had a misunderstanding with her brother. He accused her of leaving a plate unwashed and beat her. She became very upset and purchased 25 chloroquine tablets. She took all of the tablets and was sick shaking and unable to speak. The CCIT ran to the woman's home and brought her to a health center. She was treated successfully. The next day the CCIT held a meeting with the suicide victim, her brother and parents and resolved the conflict. Afterward, they informed the TPO worker who will continue to follow-up the case with the CCIT.'
(Baron, N. 2001).

TPO continues to provide training and capacity building via awareness-raising workshops to community leaders today.

Lessons learned:
- **The usual capacities of individual, family and community self-help may be damaged or limited in an emergency. Therefore it is important that they are facilitated to regain and strengthen their capacities.**
- **With awareness raising and capacity building, community leaders can provide psychosocial and mental health support as well as referral to suitable services to their community members.**
- **community leaders can provide immediate and effective crisis intervention including response to people with the risk of suicide.**
- **Community leaders knowledgeable on basic human rights can provide a sense of stability and normalcy in times of adversity.**

Building community awareness and sensitivity about psychosocial and mental health issues

The TPO psychosocial workers recognised that the people could benefit by greater awareness, discussion and new skills for living with the stress and psychosocial consequences of living in the camps. As a result, they began to provide short community-based workshops with topics of interest identified by the communities. These awareness-raising workshops included: understanding alcohol use and abuse; protecting women against gender-based violence;

skills for parenting children; methods to control family violence; alternatives to early marriage; prevention and treatment of HIV-AIDS, etc.

TPO also utilised awareness-raising workshops as a means to introduce new ideas that challenged existing dangerous attitudes and practices and lead to community support of vulnerable members. In particular, awareness raising took place about the causes and treatment of epilepsy and mental illness, and how families and communities could best care for children with disabilities.

Most importantly, awareness-raising workshops brought people together to discuss vulnerable groups and agree on ways to offer them needed support.

TPO continues to provide awareness-raising workshops to communities throughout Uganda today.

Lessons learned:
- **Awareness raising can positively influence the health seeking behavior of local people, as health-related myths are demystified and people become more informed of existing options.**
- **Greater community awareness leads to greater understanding and empathy so that people with psychosocial and mental health issues needing support are identified.**

- **Psychosocial workers, who are part of the community and have their trust and respect, are able to present new ideas that challenge dangerous cultural and traditional attitudes and practices in ways that get people's attention and stimulate some to try the new ways.**
- **Over time, as the new methods prove to be effective more people are willing to try and attitudes and practices slowly change.**

Community outreach mental health clinics

Uganda has the same needs for treatment for mental health disorders as any other country around the world. Therefore, approximately 2-3% of the population is in need of mental health treatment. Additionally, there is likely to be an increase of approximately 1% of the population needing mental health treatment due to ongoing conflicts (IASC MHPSS Guidelines 2007).

TPO worked with the Ministry of Health to design Mobile Mental Health Clinics initially within the refugee settlements. Each day Ugandan psychiatric nurses moved on motorbikes from settlement to settlement with a backpack of psychiatric medications. TPO's mud hut offices served as the site for mental health clinics.

TPO psychosocial workers provided awareness-raising workshops to community leaders and members about mental health issues and the availability of treatment. After the workshops, people with mental illness and epilepsy came to the TPO office clinics. They were diagnosed by psychiatric nurses and received medication, if needed. The nurses received ongoing supervision from monthly visits by a national psychiatrist.

During the clinics, the TPO workers oversaw the administration of the clinic, ensured that the patients, nurses and medication arrived, provided psychosocial support to patients and their families as needed during the clinic.

In between clinic sessions, the TPO workers provided follow-up to patients to offer support and ensure follow-through with medication schedules. They also provided ongoing support and awareness raising to families and communities to deal with the stigma, discrimination and fears around mental illness.

Lessons learned:
- There are many misperceptions due to traditional beliefs and lack of medical knowledge by communities about mental illness. Community-based awareness-raising workshops are an excellent means to educate and sensitise people about the causes and treatment of mental illness.
- Discrimination, stigma and fear may exist about mental illness and often leads to risks for affected people. Community-based awareness-raising workshops can be a forum to discuss these issues and promote modifications leading to informed attitudes and beliefs and reduced risks.
- Many people with mental illness do not follow through consistently with their medication. They either do not take their medication even if it is available, or cannot access medication due to lack of funds or lack of availability of drugs or lack of family support. It is essential to have supportive workers with the responsibility to follow through and visit patients regularly.

- The greatest downfall of community based mental health clinics is often the lack of consistent availability of medication. This is essential to the successful running of any clinic.

TPO works with the Ministry of Health in Uganda today to facilitate community outreach mental health clinics. In these clinics, Village Health Teams provide outreach support to people with mental illness. (See description in Chapter 3.)

Volunteers offering community based psychosocial support

TPO increased its work sites from the refugee camps to also include national locations in which people were affected by violence. They trained nearly 300 unpaid community volunteers to work with their paid psychosocial workers to provide support to their communities. This expanded the number of people available to provide support for psychosocial issues and build community awareness. Initially the gains for the volunteers were the opportunity to attend training and acquire knowledge, topped up with a bicycle and a TPO t-shirt. At first, the volunteer role held prestige and the volunteers were enthusiastic. However as time progressed, there were many problems. The most serious was the sustainability of the volunteers.

The concept of volunteer intervention was that the volunteers would not be paid and that they were selected by their community and were providing a community service. The volunteers both in the camps and in the national communities were poor. They needed to spend their time earning an income and their free time helping their families. Though they were told at the time of the volunteer training that there was no payment, most hoped for more and when it was not forthcoming there were high dropout rates. The support offered by those that did continue was unfortunately neither consistent nor reliable.

TPO stopped their volunteer program and revised their approach to focus on building the capacities of existing Community Support Structures (CSS), a model that they continue to use today.

Lessons learned:
- It takes a great deal of time to build the capacities of volunteers to competently provide mental health and psychosocial support and referral. It is not efficient or effective to train volunteers to do this role if they are not willing and able to become a sustainable source of support.
- It is difficult for poor people, who need to spend their time earning an income, to volunteer their time.

Facilitating existing community structures

All Ugandan communities consist of formal and non-formal structures that offer support to their members.

The formal structures include local government councils, teachers, police as well as women and youth councils and more.

The informal structures include clan elders, religious groups, women and youth support groups, associations of traditional healers, burial and bereavement support associations, community-based organisations, midwives' associations, war widows' associations, councils of elders, Mother's Unions, child protection committees, school management committees and more.

These groups are already mobilised and motivated and have established long standing "helping" roles within their communities. They have a leadership structure and there is a certain prestige in belonging.

TPO developed a Community Support Structures (CSS) Model. In this model, they identify existing formal and informal structures with a commitment to helping their people. TPO works with them to enhance their capacities so that they can provide effective psychosocial and mental health support and referral to their communities. TPO does not establish new groups. Rather, it takes advantage of the existing structures and builds their capacities to meet the needs of their communities.

The CSS Model works like this:

Step 1: Identification of a community and/or target population in need of psychosocial and mental health support.

- A community and/or target population is identified that is in need of psychosocial and mental health support services. This community can be identified via donors, government officials, NGOs or due to its people being a target of violence or other emergency.
- TPO conducts a rapid assessment with the identified community to identify the needs, problems and resources.
- TPO identifies the priorities and determines how they match with the support that TPO can provide. If it is believed that TPO can offer needed support, it moves on to Step 2.

Step 2: Identification of a CSS group

- TPO meets with the formal and informal leaders of the community to learn about its CSS. The leaders identify which CSS provide some kind of related support services.
- TPO conducts a mapping exercise to determine the positive impact and limitations of the CSS. This data is analysed and used as the baseline measure from which the progress of the CSS helping services can be measured over time.
- TPO meets the CSS groups and learns about their activities. They discuss the needs, problems and gaps in

resources of the community. TPO asks specifically about the support offered to people with psychosocial and mental health issues. If there are gaps in this support, they discuss how these gaps might be met. If a CSS group is interested in meeting this gap, then TPO asks if they would like its support in so doing. If they respond positively, then they move on to an assessment of that CSS group.

Step 3: Needs assessment of the capacities of a CSS group

- TPO works with a CSS to assess its knowledge, attitudes and skills specifically in relation to its capacity to meet the gaps in the provision of psychosocial and mental health support. For example, a women's group could have the aim to support orphans to attend school but might not be aware of the importance of providing psychosocial support to orphans.

Step 4: Development of a capacity building plan for a CSS group

- TPO works with a CSS group to develop a plan for how it will utilise Interactive Learning Sessions to provide them with the desired knowledge, attitudes and skills.

Step 5: Facilitate Interactive Learning Sessions with a CSS group

The TPO Interactive Learning methodology is a non-didactic training method suitable for all communities - particularly rural communities with low literacy levels. Sessions are facilitated by TPO workers for 90 minutes and are held in a community setting (not a hotel or conference site) at a time set by the CSS. Sessions are conducted in local language with about 15 CSS members sitting in a circle. The CSS with TPO identify topics for interactive discussion based on the role of the CSS, the issues of the people seeking its support and the gaps in the members' knowledge and skills. During the sessions, TPO facilitates the group to talk about topics of interest often including discussions about actual people needing assistance. The TPO worker adds in new information and skills as needed. A cycle of interactive learning sessions continues with TPO until the CSS feels it is no longer needed.

The typical format of an Interactive Learning Session includes:

- CSS members along with the TPO facilitator agree in advance to certain topics of discussion for the Interactive Learning Sessions. These topics can change and grow depending on the experiences and needs of the members.
- Commonly, CSS member facilitate discussion about topics by presenting examples of people in their community with problems related to this topic. Alternatively, the TPO facilitator presents case examples to open discussion which leads to CSS members sharing their community's cases.
- Groups explore attitudes, traditional or cultural beliefs, and traditional helping or healing methods related to the topic of discussion.
- TPO facilitator presents new information ie: knowledge and skills about the topic.
- Groups discuss if this new knowledge and skills could be useful to their communities and if so, they discuss how to use it to help specific people in their communities.
- Groups practice practical skills related to the topic.
- Groups discuss previous learning from previous sessions and its direct impact on people they are trying to assist. They examine the reasons for success, lessons learned and work together to formulate new plans when problems continue.
- Group discussion and support to manage the stress of their helping role.

Topics for Interactive Learning Sessions are selected based on the interests and needs of a CSS group.

Some of the topics discussed with CSS groups include:

Basic Community Health Issues

- Alcohol/drug abuse.
- HIV and AIDS.
- Mental illness.
- Psychosocial problems.
- Family planning.
- Sanitation and hygiene.
- Epilepsy.
- Food and nutrition.

Basic Human Right Issues

- Family violence.
- Child rearing practices.
- Child abuse and neglect.
- Girl child education.
- Gender issues.
- School dropouts.
- Early marriage.

Community Helping Structures

- Positive use of traditional and cultural helping methods.
- Integration of traditional and cultural helping with western medicine.
- Team building.
- Communication skills.
- Steps in psychosocial helping.
- Life skills.
- Facilitation skills.
- Problem solving skills.
- Use of social support networks.
- Safe schools.
- Basic proposal writing skills.
- Monitoring and evaluation.
- Record keeping / reporting.
- Advocacy / lobbying.

The following is an example of the format of an Interactive Learning Sessions:

The topic chosen by the group was about understanding common mental illnesses in the community.

The TPO facilitator presented the case of a 55 year old female believed to be possessed by the spirit of her stepson whom she and her deceased husband were reported to have killed. The woman was confused, wandered and talked to herself. She had a history of alcohol abuse and a family with a history of mental illness. She had been to witch doctors for cleansing but showed no improvement. Finally, she was brought to a mental health clinic, started on treatment and responded positively within two weeks.
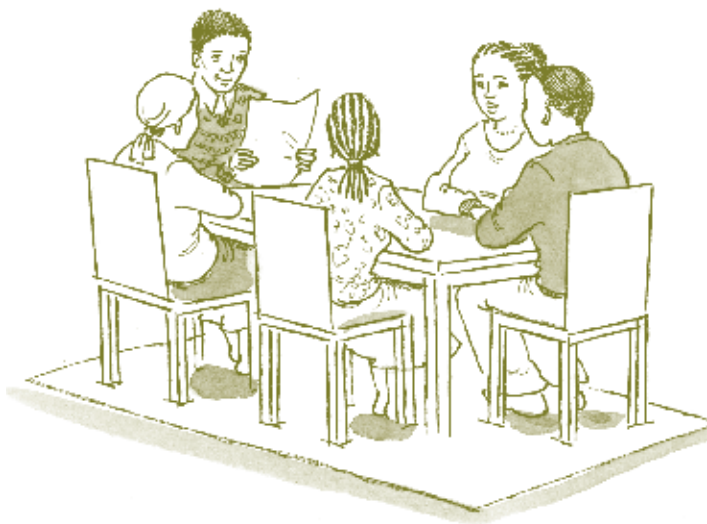
The CSS members were asked to discuss why the family and community had not gone for medical treatment as the first treatment method.

Through the interactive discussion, the CSS members discussed their community's beliefs that "curses by elders caused mental illnesses when individuals had committed acts of disgrace to the community." They discussed the community belief that cleansing through rituals would heal mental illness. However, they acknowledged that cleansing was rarely effective in terms of healing serious mental health illness.

The TPO facilitator used this opportunity to educate them about the causes of mental illness and effective forms of medical treatment.

During the discussion, the group presented many similar cases of people within their community with untreated mental illnesses.

TPO works with Community Support Structure groups throughout Uganda today. Examples of this model are provided in Chapter 3.

Lessons learned:
- All communities have support structures with a commitment to assisting their communities.
- With capacity building these CSS can provide effective psychosocial and mental health support and referral.
- Existing CSS can be a sustainable source of social support as they simply rejuvenate and build the capacity of traditional community support roles.
- CSS can act as safety nets and provide a protective fabric around vulnerable individuals and households in communities where traditional governance structures have been debilitated as is common in emergency situations.

Chapter 2 provides international guidelines and research that corroborate the CSS Model developed by TPO.

It is followed by Chapter 3 which provides actual examples of how CSS facilitated by TPO staff provide sustainable psychosocial and mental health support.

Chapter 2 International Guidelines and Research in Support of Community-Based Psychosocial and Mental Health Response

Lessons learned by TPO led them to the design of their model of Community Support Structures. This model is supported by international guidelines on mental health and psychosocial support in emergencies as well as independent research about models of community intervention. The following reviews the international guidelines and research and how they corroborate TPO's model.

IASC MHPSS Guidelines for Community Response

The Inter Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support (MHPSS) are the standards that "*..reflect the insights of practitioners from different geographic regions, disciplines and sectors, and reflect an emerging consensus on good practice among practitioners."*

The guidelines for community response are specifically found within:

- Action Sheet 5.1: Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors.
- Action Sheet 5.2: Facilitate community self-help and social support.

- Action Sheet 5.3: Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices; strongly advocate for the type of model of community intervention used by TPO. (See Appendix 1).

The Guidelines state:

"Affected groups have assets or resources that support mental health and psychosocial wellbeing. The nature and extent of the resources available and accessible may vary with age, gender, the socio-cultural context and the emergency environment. A common error in work on mental health and psychosocial wellbeing is to ignore these resources and to focus solely on deficits – the weaknesses, suffering and pathology – of the affected group."

"Affected individuals have resources such as skills in problem-solving, communication, negotiation and earning a living. Examples of potentially supportive social resources include families, local government officers, community leaders, traditional healers (in many societies), community health workers, teachers, women's groups, youth clubs and community planning groups, among many others. Affected communities may have economic resources such as savings, land, crops and animals; educational resources such as schools and teachers; and health resources such as health posts and staff. Significant religious and spiritual resources include religious leaders, local healers, practices of prayer and worship, and cultural practices such as burial rites."

"To plan an appropriate emergency response, it is important to know the nature of local resources, whether they are helpful or harmful, and the extent to which affected people can access them."

"All communities contain effective, naturally occurring psychosocial supports and sources of coping and resilience. Nearly all groups of people affected by an emergency include helpers to whom people turn for psychosocial support in times of need. In families and communities, steps should be taken at the earliest opportunity to activate and strengthen local supports and to encourage a spirit of community self-help. A self-help approach is vital, because having a measure of control over some aspects of their lives promotes people's mental health and psychosocial wellbeing following overwhelming experiences."

TPO, in agreement with the guidelines, recognised that community intervention at the beginning of emergencies had risks:

"The political and emergency aspects of the situation determine the extent of participation that is most appropriate. In very urgent or dangerous situations, it may be necessary to provide services with few community inputs."

"Facilitating community social support and self-help requires sensitivity and critical thinking. Communities often include diverse and competing sub-groups with different agendas and levels of power. It is essential to avoid strengthening particular sub-groups while marginalising others, and to promote the inclusion of people who are usually invisible or left out of group activities.

Thereby, the TPO model presented in this guide is activated during the aftermath of an emergency, and managed and implemented by local teams who know the environment and its challenges. Lessons learned have shown that this is a safe and effective way to enter communities and find and begin to build the capacities of sustainable sources of support.

TPO's plan, like that recommended within the IASC MHPSS Guidelines, is not to start new community structures, but rather to build onto existing community support structures.

"Affected groups of people typically have formal and informal structures through which they organise themselves to meet collective needs. Even if these structures have been disrupted, they can be reactivated and supported as part of the process of enabling an effective emergency response."

"Strengthening and building on existing local support systems and structures will enable locally owned, sustainable and culturally appropriate community responses. In such an approach, the role of outside agencies is less to provide direct services than to facilitate psychosocial supports that build the capacities of locally available resources."

Research into community-based support

There is little research that evaluates the impact of working with communities to provide mental health and psychosocial support. Evaluations of TPO's work continually report the strengths and assets of their work with communities but no controlled research has been done.

An evaluation that synthesised "a review and summary of the available global evidence on community-based child protection groups and their impact on children's protection and well-being" had some draft findings that support the efficacy of TPO's work. This evaluation focused "specifically on community-based groups that work on child protection and wellbeing, with an emphasis on groups that had been externally initiated or supported." (Wessels, M. 2009)

Though these groups are not the same as the groups that evolve via the TPO Community Support Structures programme, the findings in the evaluation about the strengths of these groups seem interesting and relevant.

The evaluation selected 160 documents including evaluation reports and published papers that reviewed programs or community groups from 60 countries. The documents included groups at the community and district level but excluded groups at the national level; they focused on children's (under 18 years) protection issues; whose role consists wholly or in part of caring for and protecting children; supporting broader wellbeing outcomes for children; community-based child protection approaches involving volunteers as well as on larger community groups.

The review states that "a significant limitation of this review is the lack of rigorous, high caliber evidence regarding child-focused community groups. The absence of a strong evidence base makes it inappropriate to draw firm conclusions about effectiveness, cost, scalability, sustainability or other aspects of child protection groups. Since this review is based largely on anecdotal evidence, its findings, lessons learned, and recommendations are best regarded as provisional."

"Despite these limitations, numerous themes and trends arose consistently and frequently across a wide array of regions, agencies, and evaluators. These themes pertained more

to the initiation and activities of child-focused community groups than to outcomes for children and the sustainability of those outcomes beyond the period of funded projects. Regarded with appropriate caution, the themes and the findings presented below are useful sources of learning about the current state of practice and can help guide efforts to improve it." Seven factors were identified as influencing the effectiveness of child-focused community groups. These factors and their relevance to TPO community group work follow.

1**. "Community Ownership:** Community based groups that felt collectively responsible for addressing locally defined child protection issues and experienced a sense of ownership over the group's process and activities were more effective than were groups that had less or no sense of ownership…"

The groups used by TPO in its CSS initiatives are solely owned by the community. These groups provided support to their communities prior to TPO and might well be there after TPO.

2. "**Building on Existing Resources**: A concerning pattern was the tendency of many programs to facilitate the formation of child-focused community groups without first learning what protection mechanisms or supports for children were already present in the local context. Many programs were initiated without a careful assessment of existing capacities and assets, and some were implemented in a top-down manner that

left people feeling disrespected and that marginalised local culture. Numerous evaluations attributed programmes' limited effectiveness to their failure to work in partnership with religious leaders and important cultural resources…"

The TPO Model builds onto existing structures. It identified these structures with the help of the communities. It discusses the psychosocial and mental health needs of the people with the CSS and together they assess what services meet the needs and problems and where there are gaps. The CSS group decides if it wants to meet this gap. If it does, then TPO works with them to do so. TPO provides capacity building and support as the CSS learns to meet these needs and address the problems.

3. "**Support from leaders:** The support of non-formal and formal leaders such as traditional leaders, elected community officials, religious leaders, and respected elders enabled effective work by child protection groups since it built trust and legitimacy and provided positive role modeling within the community…"

Community Leaders are an integral component of the TPO CSS initiative.

4. "**Child participation**: In general, the level and quality of children's participation were low to modest. Although children were often members of child-focused community groups, their participation was either tokenistic or limited by the tendency of adults to dominate meetings and decision making. Where children did participate more fully, their activities, creativity, and resourcefulness tended to increase the effectiveness of the child-focused community groups…"

Some CSS are youth and/or peer groups offering support within their community.

5. "**Management of Issues of Power, Diversity, and Inclusivity**: Effective child-focused community groups tended to be ones that included representatives of diverse subgroups within the community, including women and men and very poor and marginalised people, who shared power in the discussions, decision making, and the work of the child protection group…"

This is reported as a difficult issue for many programs and also for TPO. Traditional structures commonly give men a louder voice than women, and adults overshadow the voice of children. Many of the existing structures that TPO support follow traditional structures. TPO promotes human rights and equity but traditions are hard to change. TPO ensures that it works with a wide range of CSS groups who are representative of all the various community groups. They will facilitate the capacity building of all the voices but sometimes need to do so in separate women and children's groups so that their voices are clearly heard.

6**. "Resourcing**: To be effective, child-focused community groups needed a mixture of human and material resources…"

By working with existing ongoing structures and not creating new structures, TPO deal with this issue. The CSS groups are long standing and work out these issues themselves.

7. **"Linkages**: Linkages with formal systems were instrumental both in supporting the work of community-based groups and in expanding their reach and scope of impact…"

TPO works with formal and informal structures and links these together to form a collaborative network of support. As an example, it works with groups of community leaders, traditional healers and parents as well as with teachers, police and government officials. It works to create links between them so that they form a sustainable network of support.

Wessells, M. (2009). What Are We Learning About Community-Based Child Protection Mechanisms? An Inter-Agency Review of the Evidence From Humanitarian and Development Settings.
(Provisional Draft Inter-Agency Report).

TPO's CSS Model utilises many of the key features of the IASC MHPSS Guidelines as well as the key ideas identified in the research on child protection groups.

The next chapter provides case examples of CSS groups and how they work to provide psychosocial and mental health support and referral to their communities.

Chapter 3   Community Support Structures: case examples

This chapter provides examples showing how the Community Support Structures (CSS) model is implemented by TPO in Uganda to provide comprehensive support in the aftermath of emergencies.

Examples are provided to show how strategically selected CSS groups facilitate family and community support at all the layers of intervention described in the IASC MHPSS (2007) Guidelines.

The first example is of a CSS working at Layer 1. This is followed by examples of CSS working at each layer.

LAYER 1:
Basic services and security intervention
CSS mediation of rural community conflicts due to witchcraft

The following is an example of a CSS group working at **Layer 1: Basic services and security intervention.** It describes how TPO worked with a CSS group in rural Uganda to enhance its capacity to support community conflict mediation to sustain security and peaceful coexistence.
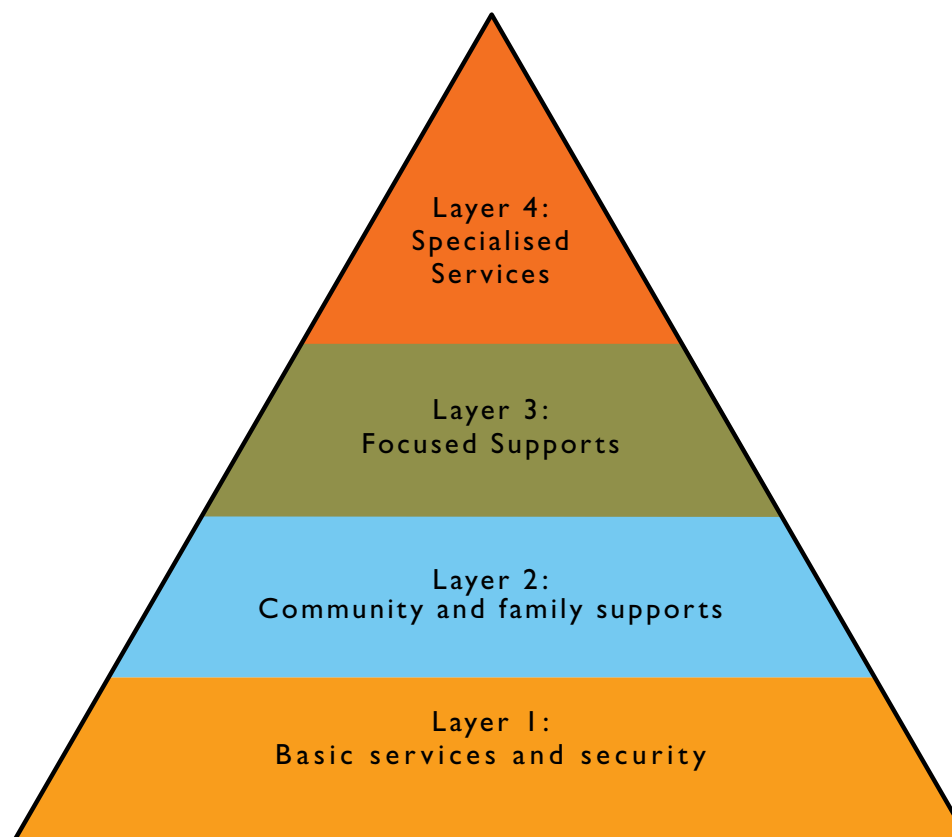
Figure: IASC MHPSS (2007) Intervention Pyramid for Emergencies.

"The wellbeing of all people should be protected through the (re)establishment of security, adequate governance and services that address basic physical needs (food, shelter, water, basic health care, control of communicable diseases)… An MHPSS response to the need for basic services and security may include: advocating that these services are put in place with responsible actors; documenting their impact on mental health and psychosocial wellbeing; and influencing humanitarian actors to deliver them in a way that promotes mental health and psychosocial wellbeing. These ways that protect local people's dignity, strengthen local social supports and mobilise community networks." (IASC MHPSS 2007).

Step 1: Identification of a community and or target population in need of psychosocial and mental health support

A baseline study on traditional conflict mediation and peace building mechanisms was completed in one district which had ongoing communal violence. This study revealed that community elders historically had a strong role in managing community conflicts. Yet, this community continued to have problems with violence seemingly due to its beliefs in witchcraft.

Step 2: Identification of a CSS group

TPO invited a CSS that consisted of a group of elders (20 men and 10 women) who had an informal traditional group alliance for 8 years to work with them as a CSS. The group was respected by their community and traditionally played a peace building role. The group agreed to work with TPO since they knew and appreciated its work and believed that learning more skills about conflict mediation to manage the community violence would be beneficial to their community.

Step 3: Needs assessment of the capacities of a CSS group

The needs assessment showed that the community and the CSS held beliefs about witchcraft which hindered peaceful co-existence. Continual acts of violence, even death, were due to random accusations about witchcraft. Though traditional methods including ritual cleansing and restitution were used to resolve many conflicts, the root causes of the communal violence due to traditional beliefs about witchcraft were not effectively addressed.

Step 4: Development of a capacity building plan for a CSS group

The CSS group agreed to a capacity building plan in which it would increase its role so that in addition to managing conflicts due to land disputes, which were its usual role, it would also mediate communal conflicts and violence due to accusations of witchcraft.

Step 5: Facilitate Interactive Learning Sessions with a CSS group

TPO facilitated 10 Interactive Learning Sessions with the CSS about these topics:

- Identification of community problems and understanding of cause and effect.
- Traditional beliefs and attitudes about witchcraft and how it can cause distrust and intrigue among families.
- Identification of conflict trigger points and early warning signs and how to create immediate response plans.
- Methods to facilitate community dialogue meetings.
- Effective skills for mediating conflicts.
- Methods for working with traditional healers and communities to minimise dangerous traditional practices.
- Methods to manage the stress resulting from their role as elders especially given their difficult living circumstances.

Example of this CSS group's assistance to their community

A 43 year old man was alleged to be a witch. The community became violent and fearful and wanted to expel him. The elders with the knowledge and skills from their Interactive Learning Sessions reacted quickly. They met with the man and assessed the reasons he was accused of witchcraft. They encouraged the community to perform a traditional cleansing ritual. Afterwards they facilitated discussions with the man and strategic members of the community and his neighbors. All agreed to live peacefully.

LAYER 2:
Community and family support

The following two examples show how selected CSS groups activated **Layer 2: Community and Family Support.** The first describes how Interactive Learning enhanced the capacities of a women's group's to provide psychosocial support to their community. The second explains how the capacities of a youth group were enhanced to facilitate community awareness about child protection through music, dance and drama.

"The second layer represents the emergency response for a smaller number of people who are able to maintain their mental health and psychosocial wellbeing if they receive help in accessing key community and family supports. In most emergencies, there are significant disruptions of family and community networks due to loss, displacement, family separation, community fears and distrust. Moreover, even when family and community networks remain intact, people in emergencies will benefit from help in accessing greater community and family supports. Useful responses in this layer include family tracing and reunification, assisted mourning and communal healing ceremonies, mass communication on constructive coping methods, supportive parenting programmes, formal and non-formal educational activities, livelihood activities and the activation of social networks, such as through women's groups and youth clubs."

Psychosocial support to a community affected by violence by a women's CSS group

Step 1:Identification of a community and or target population in need of psychosocial and mental health support

A community affected by the violence due to the incursion by the Lord's Resistance Army rebels was identified. They had limited resources to help them to manage the psychosocial consequences of their experiences and the destruction of the social infrastructure of their communities.

Step 2: Identification of a CSS group

The Church of Uganda Mothers Union Group with 25 registered and 47 associate members was identified as a CSS partner. This group began to provide support almost 25 years ago. The group's mission was to strengthen and support families with problems due to the incursion of the Lord's Resistance Army, as well as caused by domestic violence and social injustice in the communities. They were selected as a CSS since they are a sustainable community structure with a long history of offering support. They are well respected by the community and supported by high level church authorities.

The group agreed to work with TPO because they believed that they could teach them new skills that would enhance their capacities to assist their community.

Step 3: Needs assessment of the capacities of a CSS group

The needs assessment found that this CSS implemented many effective interventions including community sensitisation about children's issues, Christian family life and the importance of prayer, and the risks of HIV/AIDS. It also facilitated marriage seminars, family counseling, early childhood education and financial and social support to widows, single mothers, orphaned and vulnerable children and disadvantaged families.

Situations of harmful intervention were also discovered due to their strong religious beliefs which led members to recommend prayer as a healing intervention rather than seek needed medical care.

Step 4: Development of a capacity building plan for a CSS group

The Mother's Union agreed to a capacity building plan that would enhance their role in the community so that they could also provide:
- Responsible methods of referral, advocacy and support that utilised medical treatment when needed.
- Family and community conflict resolution.
- Home visits to needy families.
- Expansion of community awareness workshops to include child protection and human rights issues.
- Assistance to families with issues of alcohol and substance abuse.
- Support for family and community reintegration of people who had been abducted by the Lord's Resistance Army.

Step 5: Facilitation of Interactive Learning Sessions with a CSS group

TPO facilitated 12 Interactive Learning Sessions with the CSS on these topics:

- Information about responsible medical care for pregnant and lactating women, children's health, mental illness and epilepsy and other medical conditions.
- Knowledge about child development and protection.
- Information about human rights.
- Information about responsible community support for orphaned and vulnerable children.
- Skills for how to make supportive family visits.
- Conflict mediation skills.
- Information about the risks and treatment for families affected by excessive alcohol use.
- Methods to facilitate family and community support to children and adults returning after being abducted by the Lord's Resistance Army.
- Skills for advocacy and referral.
- Methods of self-care to manage the stresses of their role as community helpers.

Example of this CSS group's assistance to their community

Prior to their involvement as a CSS with TPO, cases was reported in which the Mother's Union encouraged women needing prenatal care, children requiring immunization, people with mental illness and epilepsy and other medical conditions to pray, read the Bible and have faith instead of seeking medical care. One noted intervention was to a pregnant woman who has having difficult with her delivery. The Mother's Union members believed she was attacked by demons and evils spirits and required her to pray and fast from many days. Her condition worsened and eventually she was taken to a hospital where it was reported that she had malaria, typhoid, pregnancy complications and needed a blood transfusion.

Due to the lessons learned in their Interactive Learning Sessions, the Mother's Union changed their interventions. They became active in immunization and pre- and post-natal care programs and established a vocational training center for girls previously abducted by the Lord's Resistance Army.

Community action for child protection resulting from CSS music and drama group

Interactive Learning Sessions enhanced this creative youth group's skills to enable them to provide community awareness of key child protection and human right issues through music, dance and drama.

Step 1: Identification of a community and/or target population in need of psychosocial and mental health support

A community badly affected by the Lord's Resistance Army was selected. In assessment it was found that the adults felt that the morality of their children had been damaged due to parents losing control over their children while living long term in displacement camps.

Step 2: Identification of a CSS group

An informal group of youth who performed music and dance for 5 years and were well known and liked by the community was identified. When they were first introduced to TPO, their activities were restricted to musical entertainment during social events.

Step 3: Needs assessment of the capacities of a CSS group

The group, of mostly male youth, was musically talented. However it performed infrequently and had instruments of poor quality. The group's music was only for entertainment and had little meaning for the community.

Step 4: Development of a capacity building plan for a CSS group

TPO discussed with the group the issues of children and their protection and the concerns of adults within the community. The group became interested. It felt that an association with TPO as a CSS group was a wonderful opportunity to help the community and advance the group.

Group members agreed to a capacity building plan that would refocus the group and become an educational enterprise. To do this, they agreed that the capacity building would include:

* Formalising the group structure.
* Balancing the numbers of male and female members of the group to 14 male / 14 female.
* Acquiring knowledge about issues of children.
* Learning how to identify child protection issues in their community.
* Learning how to write and perform songs, dance and drama with informative educational messages.
* Knowing how to advocate on behalf of children.

Step 5: Facilitation of Interactive Learning Sessions with a CSS group

TPO facilitated 10 Interactive Learning Sessions with the CSS about these topics:

* Child protection issues including children's rights, importance of education, support for gender based violence etc.
* Information about the risks of alcohol/substance abuse and causes and treatment for HIV/AIDS, mental illness and epilepsy etc.
* Skills that can be used by communities to achieve greater control over their lives, resolve conflicts peacefully, engage child participation, empower people for self-help, effectively rear children and support orphans etc.
* Writing and performing educational music, dance and drama that informs communities and mobilises them to positive action.

Example of this CSS group's assistance to their community

The group became very popular. They performed at the Day of the African Child national celebration a series of songs that they wrote about how young people can avoid becoming infected by HIV-AIDS.

LAYER 3:
Focused, non-specialised support

"The third layer represents the supports necessary for the still smaller number of people who additionally require more focused individual, family or group interventions by trained and supervised workers (but who may not have had years of training in specialised care). For example, survivors of gender-based violence might need a mixture of emotional and livelihood support from community workers. This layer also includes psychological first aid (PFA) and basic mental health care by primary health care workers."

Two examples follow which show how CSS groups facilitated family and community support to maximise the benefits of Layer 3 interventions. The first describes how CSS groups combined their efforts to facilitate support for children with problems of social adjustment. The second describes how a CSS group assisted survivors of gender based violence.

CSS groups supporting children with difficulties in social adjustment
Step 1: Identification of a community and or target population in need of psychosocial and mental health support

TPO completed vulnerability ranking assessments in a district whose communities were affected by violence due to the incursion of the Lord's Resistance Army rebels. The supportive structures offered by parents and teachers to children who had
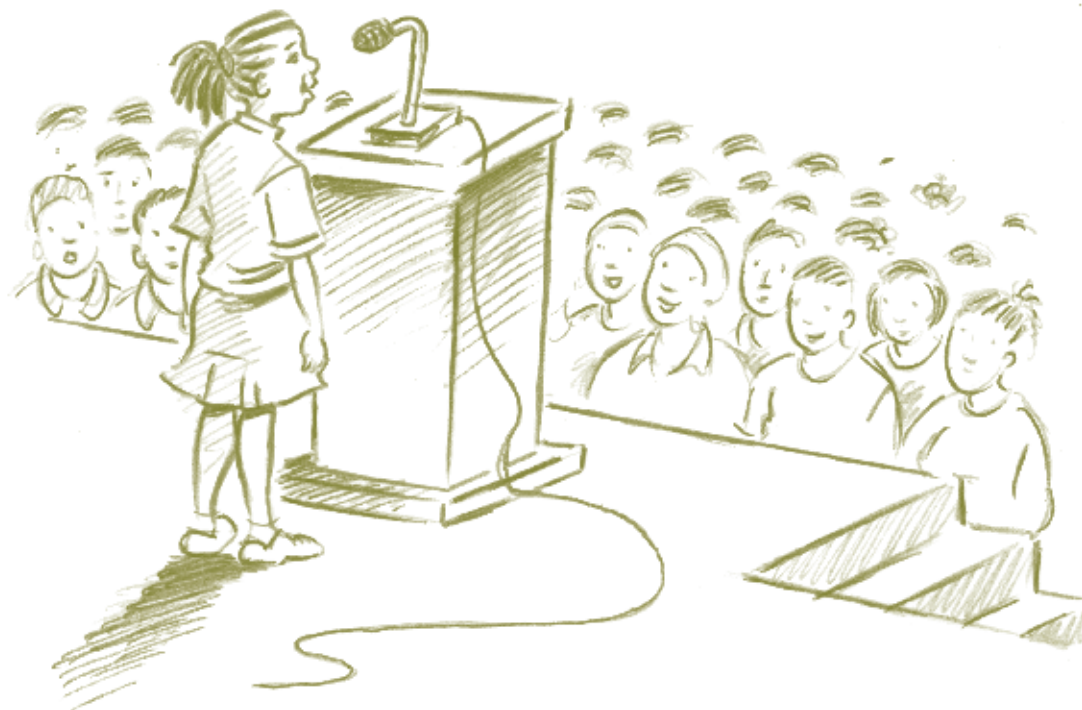
difficulties in social adjustment and had been formerly abducted, orphaned and/or affected by HIV/AIDS were found to be inadequate. Instead, parents and teachers discriminated against these children, complained about their behaviour, called them names that stigmatised them as a result of the the atrocities committed to them by the rebels, and excessively punished them.

Step 2: Identification of a CSS group

TPO chose to work throughout the district with a series of CSS groups. It believed that to assist the children it was important that all the groups received the same information and joined together to change their attitudes and behaviours. The CSS groups included: an existing Child Protection Committee whose members included local council leaders, parents, school and government representatives; a parents and teachers association, a school management committee and teachers' group. Improvement of the situation of the children, however, was not possible without the participation of the children. The schools did not have active clubs so TPO engaged with the teachers to revitalise school clubs for children's rights, recreation, peace, health, girl's education and life skills. Eighteen children's clubs, each with 20-25 members, were engaged as CSS.

Step 3: Needs assessment of the capacities of a CSS group

The parents, teachers and children's who were members of the various CSS had little knowledge about how to assist

children with problems with social adjustment and little information about children's rights.

Step 4: Development of a capacity building plan for a CSS group

The groups agreed to have their capacity built to prepare them to:

- Protect the rights of all children.
- Establish forums for positive discussion (via school

assemblies, parent-teacher meetings, school management meetings and radio talk shows) about child protection and the equitable inclusion of all children in families, communities and schools.

- Develop communal and school by-laws that support the rights of all children.
- Effectively and compassionately assist the children with difficulties in social adjustment.

Step 5: Facilitate Interactive Learning Sessions with a CSS group

TPO facilitated 9 Interactive Learning Sessions with the CSS about these topics:

- Discussion about children's right and responsibilities and how they can be practically applied in this district.
- Skills for facilitating forums for discussion.
- Discussion about what should and should not be included in by-laws.
- Skills of effective communication, offering psychosocial support, problem solving and conflict resolution.

Example of this CSS group's assistance to their community

The group members identified children at risk and maintained regular communication with those having difficulties. As an example one group was committed to keeping girls in schools and followed up on girls that dropped out of school due to problems with managing their menstruation periods in school. Another group followed a girl whose father had stopped her from attending school to tend his kiosk. This group asked the school management committee to speak to the parents of the girl and she returned to school.

A CSS group's support to survivors of gender based violence

Step 1: Identification of a community and or target population in need of psychosocial and mental health support

A population displaced by the Karamoja cattle raids found shelter in congested schools, churches and health centers. Large numbers of women and children housed in these congested shelters reported sexual abuse.

Step 2: Identification of a CSS group

A mapping of all existing community structures was done by TPO. A volunteer Crisis Response Team of 4 men and 6 women was identified by the community because of their good work.

Step 3: Needs assessment of the capacities of a CSS group

The Crisis Response Team was well respected and compassionately assisted the community. The assessment determined that they had little knowledge about problems related to sexual gender based violence (SGBV) and child protection, insufficient helping skills and little knowledge about how to make a referral and provide advocacy.

Step 4: Development of a capacity building plan for a CSS group

The group members agreed to build their capacities so that they could provide their community with:

- Identification, reporting and case management for people affected by SGBV either due to displacement or communal violence.
- Awareness to prevent SGBV.
- Support for survivors of SGBV.

Step 5: Facilitation of Interactive Learning Sessions with a CSS group

The topics of 12 Interactive Learning Sessions were discussed through case examples and presentations by TPO. The topics included:

- Understanding types of psychosocial problems and their causes and effects on individuals, families and communities.
- Awareness of types of SGBV; factors that contribute to incidences of SGBV; physical and psychological consequences of SGBV.
- Understanding causes, effects and treatment for HIV/AIDS
- Skills including case management, crisis response and basic counseling for assisting people with psychosocial problems and problems related to SGBV.
- Knowledge about how and where to make referrals and provide advocacy.
- Discussions about how to manage the stress and challenges of their work.

The Team offered crisis response and support to the population living in the camp. As an example, a 29 year old woman with two children was accused of adultery by her spouse. He battered her sexually. The situation was reported to the Crisis Response Team. Members of the group responded quickly and rushed her for emergency health care and accompanied her to file a police report. To protect the woman they advocated to have the husband immediately removed from the shelter. The couple was referred for marital counseling. The Team continued to offer support to their community even after they returned to live at home.

LAYER 4:
Specialised Services

The following two examples describe how CSS facilitate family and community support for people requiring treatment for mental illness.

A CSS group facilitating family and community support for the treatment of mental illness

This CSS provides the family and community support services that will maximise the likelihood of successful treatment to people needing **Layer 4: Specialised Services.**

"The top layer of the pyramid represents the additional support required for the small percentage of the population whose suffering, despite the supports already mentioned, is intolerable and who may have significant difficulties in basic daily functioning. This assistance should include psychological or psychiatric supports for people with severe mental disorders whenever their needs exceed the capacities of existing primary/general health services. Such problems require either (a) referral to specialised services if they exist, or (b) initiation of longer-term training and supervision of primary/general health care providers. Although specialised services are needed only for a small percentage of the population, in most large emergencies this group amounts to thousands of individuals." (IASC MHPSS 2007).

TPO working with the Ministry of Health and the World Health Organisation determined that certain districts in Uganda had insufficient mental health services. The populations of these districts had been seriously affected by violence due to a rebel movement. According to the Inter Agency Standing Committee Guidelines on Mental Health and Psychosocial Support 2007 (IASC MHPSS).

"It has been projected that in emergencies, on average, the percentage of people with a severe mental disorder (e.g. psychosis and severely disabling presentations of mood and anxiety disorders) increases by 1% over and above an estimated baseline of 2–3%. In addition, the percentage of people with mild or moderate mental disorders, including most presentations of mood and anxiety disorders (such as post-traumatic stress disorder, or PTSD), may increase by 5–10% above an estimated baseline of 10%. In most situations, natural recovery over time (i.e. healing without outside intervention) will occur for many – but not all – survivors with mild and moderate disorders."

Though a small percent of the population needs mental health treatment, it is a target group with extreme needs since the local population in these districts has little knowledge about the causes and treatment of mental illness commonly leading to the neglect and abuse of the affected people.

A proposal was funded for a project to build the capacities of health professionals to identify, diagnose and treat people with mental health problems and provide a consistent supply of psychotropic medication within the primary health care system.

Lessons learned by TPO with similar projects led them to seek a CSS that could provide community outreach support to the patients and their families and communities.

Step 1: Identification of a community and or target population in need of psychosocial and mental health support

Three districts with minimal mental health services which were seriously exposed to violence due to the Lord's Resistance Army rebels were identified.

Step 2: Identification of a CSS group

Village Health Teams with eight members were established by the government to provide village support for primary health care. They had no knowledge or experience in mental health treatment.

They were identified by TPO as an ideal Community Support Structure due to their sustainable infrastructure and commitment to grassroots support to community health needs.

Step 3: Needs assessment of the capacities of a CSS group

TPO along with the Ministry of Health assessed the knowledge and skills of the Village Health Teams.

They found that they were under-utilised and only active in times of crisis and epidemics e.g cholera, immunization campaigns, distributing mosquito nets etc, and They possessed good skills in community health education but were not knowledgeable in mental health care and psychosocial support.

TPO met with the Teams to discuss the needs of people with mental illness. The Teams agreed that the need existed and expressed interest to be trained so that they could support this population.

Step 4: Development of a capacity building plan for a CSS group

The Village Health Team agreed to a capacity building plan that would prepare them to:

- Recognise symptoms of mental illness and make appropriate referrals.
- Provide outreach through home visits to identify people with mental illness.
- Educate and mobilise people so that those in need will seek mental health treatment.
- Facilitate community based awareness-raising sessions to share new information and modify attitudes to fight stigma

and discrimination towards people with mental illness.
- Assist in the formation of support groups for people with mental illness and their families.
- Create effective income generating schemes.

Step 5: Facilitate Interactive Learning Sessions with a CSS group

Based on their existing knowledge and skills and what skills are known to be needed to be able to provide support to people with mental illness living in rural communities, 8 Interactive Learning Sessions were organised for them over a 6 month period.

Topics included:

- Discussion about local attitudes and traditional beliefs about mental illness and how these lead to stigma, discrimination and dangerous practices that violate the basic human rights of people with mental illness.
- Accurate information about the causes of mental illness.
- Knowledge about effective methods of medical treatment and psychosocial support for people with mental illness.
- Instruction about the importance of caregivers providing good nutrition and hygiene for all people, including those with mental illness.
- Discussion about how to implement methods of intervention that village health teams could utilise to support people with mental illness including:
  » Community outreach to identify people with mental illness.

- » Creating support groups for people with mental illness and their caregivers.
- » Establishing income generating schemes for support group members.
- » Developing a system of shared support in which support group members take responsibility to ensure that everyone in the group takes their medication, attends clinics and receives adequate care and support.
- » Agreement to assign a replacement caregiver from a support group to children in that location with mental health problems and inadequate family support to take them to the clinic, and to ensure that they abide by treatment and try to mobilise involvement of family members.
- Information about the possible mental health and psychosocial consequences to people who are survivors of gender-based violence, family violence, torture, abduction and other emergencies and how to provide emergency outreach to interview survivors, assess needs and make referrals to support services, when needed.
- Methods for passing information between the village health teams so that trained teams can assist in the training of other teams.
- Discussion about methods to identify and manage personal stress since many of the health team members had also been survivors of violence.

Example of this CSS group's assistance to their community

After their training about mental illness, one village health team decided to assist a household of a person that had been identified with mental illness. They visited the family and discussed the problems of the person identified and their attitudes and beliefs about mental illness. They informed them about the availability of treatment at the health centres and offered to accompany them to the clinic. By freely visiting this household, the village health team showed the community that they did not fear them and that they did not believe this household was cursed, nor that those who visited it would acquire bad luck. They spoke to the neighbors about the causes and treatment of mental illness. The family and patient agreed to attend the clinic. Two village health team members accompanied them to the first clinic appointment. Since then, they visit them regularly to ensure that the patient takes his medication and continues to attend the clinic regularly.

A community based CSS supporting "patients" with mental illness, their families and communities

This second example is of a community based support group and how it facilitates family and community support for people requiring mental health treatment.

Step 1: Identification of a community and or target population in need of psychosocial and mental health support

A rural community with a long history of violence due to the incursion of the Lord's Resistance Army's rebels and cattle rustling was identified. A need's assessment identified that there was little treatment available for mental disorders. TPO established an outreach mental health clinic and many people with mental disorders needing ongoing follow-up care did not follow their medication regimes and prematurely stopped attending the clinic.

Step 2: Identification of a CSS group

During its pre-intervention mapping exercise, TPO identified a "Patients" Support Group that had been in existence as a loose informal group of 2-3 families that occasionally checked on each other to talk about the challenges of supporting their household members with mental illness.

TPO discussed with this group the idea of broadening its membership to offer support to more people affected by mental illness. The group embraced the opportunity since they wanted assistance in better managing the needs of the people in their group with mental illness. They said, *'an informed mind is a powerful mind'.*

Now, two years later the group has 25 members (8 Males, 8 Females and 9 Children) who are either people with mental illness, caregivers or community member with good will.

Step 3: Needs assessment of the capacities of a CSS group

The group identified gaps in their capacity for which they requested TPO support.

Before the involvement of TPO, the group was loosely structured and only consisted of a few families periodically checking on each other. They had little information about mental illness and effective methods of treatment. Their methods of patient care included letting them wander, locking them in houses, or tying them with strong ropes and often denying basic needs such as food and proper hygiene.

Step 4: Development of a capacity building plan for a CSS group

The group agreed to a capacity building plan that would lead them to know how to:

- Facilitate community awareness raising sessions about mental health disorders.

- Identify people with mental disorders.
- Refer persons with mental health related problems to health centers.
- Provide home base care to individuals who need services.
- Promote positive attitudes towards persons with mental illness.
- Increase access to treatment for mental illness.

Step 5: Facilitate Interactive Learning Sessions with a CSS group

12 Interactive Learning Sessions focused on learning through the discussion of case examples presented by group members. The topics discussed included:

- Knowledge about the types, causes and treatment of mental illness.
- Methods for increasing the capacities of their group.
- Methods of effective home based care.
- Causes and methods of prevention for relapses.
- Skills for providing community awareness raising sessions about mental illness and methods of community support.
- Problem solving and sharing of feelings associated with difficult case situations.
- Discussion on how to manage the stress associated with their volunteer role and in working to assist people with mental illness.

Example of this CSS group's assistance to their community

The group facilitated awareness-raising sessions for many community groups. During these sessions, they explored people's attitudes towards the causes of mental illness and towards people who are mentally ill. Over time, the mental health clinic reported that more than 80 cases a month were referred as a result of the awareness raising done by the patients support group.

In appreciation, the community donated land to the group to support their farming and livelihoods activities. Some community members joined the *Patients' Support Group*; and others frequently collect and deliver drugs for mental health patients who are unable to travel to the health centers. The group has responded to the increasing number of children attending the mental health clinic unaccompanied. They act as chaperones to these children at the clinic, visit them at home to monitor their progress and talk to their guardians to ensure that they attend the clinics.

Conclusion

In this guide TPO Uganda shares practical lessons that it has learned in its years of experience facilitating interventions that activate family and community support with emergency affected populations.

TPO shares case examples describing the Community Support Structures (CSS) model that it uses as a part of its "comprehensive" services in the aftermath of emergencies once basic needs are adequately met and security is intact.

TPO selects communities to participate in this model who have been affected by emergencies and want and need added services to manage the issues affecting the psychosocial wellbeing and mental health of their population.

The community is asked to select existing organisations or groups that they trust and believe have sustainable interest in providing support.

TPO works with these Community Support Structures (CSS). Together they assess community needs, problems and available resources as well as the capacities of the CSS. Based on this assessment, a capacity building plan is developed for the CSS that will enhance their ability to assist the community.

The capacity building is accomplished through Interactive Learning Sessions. These informal information and discussion sessions are designed to maximise the learning capacities of the CSS. New knowledge and skills are acquired through discussions of cases, practical explanations and role play. When needed, traditional attitudes are explored and dangerous practices defying human rights challenged. From the Interactive Learning Sessions, the CSS capacities are enhanced so that they are able to more effectively and sustainably assist their communities.

This model has been replicated by TPO throughout Uganda as well as in other countries. You are encouraged to take advantage of the lessons learned by TPO and activate similar models in your work in the aftermath of emergencies.

References

Baron, N., Jensen, S. & de Jong, J. (2001). The Mental Health of Refugees and Internally Displaced People In *Guidelines for Psychosocial Policy and Practice in Social and Humanitarian Crises: Report to the United Nations* (Eds. J. Fairbanks, M. Friedman, J. de Jong, B. Green & S. Solomon). United Nations, New York.

Baron, N. (2001). Community based psychosocial and mental health interventions for southern Sudanese refugees living in long term exile in Uganda. In *War and Violence: Public Mental Health in the Socio-Cultural Context.* (Ed: J. de Jong), New York: Plenum Press.

Baron, N. (2002). Southern Sudanese Refugees: In Exile Forever? In *A Psychosocial Approach to Innovative Multicultural Interventions* (Ed: F. Bemak, Chung R. C.-Y. & Pedersen P.). New York: Greenwood Press.

Inter Agency Standing Committee Guidelines on Mental Health and Psychosocial Support (2007) Geneva, Switzerland.

Wessells, M. (2009). What Are We Learning About Community-Based Child Protection Mechanisms? An Inter-Agency Review of the Evidence From Humanitarian and Development Settings. (Provisional Draft Inter-Agency Report).

Transcultural Psychosocial Organisation (TPO) Uganda (2008) Harnessing Community Capacity for Self-Help: Facilitator's Guide for Community Support Structures.

Appendix 1:

Inter Agency Standing Committee Guidelines on Mental Health and Psychosocial Support (2007) Action Sheets related to Community Support

Action Sheet 5.1
Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors

Background

The process of response to an emergency should be owned and controlled as much as possible by the affected population, and should make use of their own support structures, including local government structures. In these guidelines, the term 'community mobilisation' refers to efforts made from both inside and outside the community to involve its members (groups of people, families, relatives, peers, neighbours or others who have a common interest) in all the discussions, decisions and actions that affect them and their future. As people become more involved, they are likely to become more hopeful, more able to cope and more active in rebuilding their own lives and communities. At every step, relief efforts should support participation, build on what local people are already doing to help themselves and avoid doing for local people what they can do for themselves. There are varying degrees of community participation:

- The community to a large extent controls the aid process and decides on aid responses, with government and non-government organisations providing direct advocacy and support.
- The community or its representative members have an equal partner role in all major decisions and activities undertaken in partnership with various government and non-government organisations and community actors.
- The community or its representative members are consulted on all major decisions.
- The community acts as an implementing partner (e.g. supporting food distribution or self-help activities), while major decisions are made by government and non-government organisations.
- Community members are not involved in designing and only minimally involved in implementing relief activities.

Critical steps in community mobilisation

- Recognition by community members that they have a common concern and will be more effective if they work together (i.e. 'We need to support each other to deal with this').
- Development of the sense of responsibility and ownership that comes with this recognition ('This is happening to us and we can do something about it').
- Identification of internal community resources and knowledge, and individual skills and talents ('Who can do, or is already doing, what; what resources do we have; what else can we do?').
- Identification of priority issues ('What we're really concerned about is…').
- Community members plan and manage activities using their internal resources.
- Growing capacity of community members to continue and increase the effectiveness of this action.

Adapted from Donahue and Williamson (1999), *Community Mobilization to Mitigate the Impacts of HIV/AIDS*, Displaced Children and Orphans Fund.

It is important to note that communities tend to include multiple sub-groups that have different needs and which often compete for influence and power. Facilitating genuine community participation requires understanding the local power structure and patterns of community conflict, working with different sub-groups and avoiding the privileging of particular groups. The political and emergency aspects of the situation determine the extent of participation that is most appropriate. In very urgent or dangerous situations, it may be necessary to provide services with few community inputs. Community involvement when there is inadvertent mingling of perpetrators and victims can also lead to terror and killings (as occurred, for example in the Great Lakes crisis in 1994). However, in most circumstances, higher levels of participation are both possible and desirable. Past experience suggests that significant numbers of community members are likely to function well enough to take leading roles in organising relief tasks and that the vast majority may help with implementing relief activities. Although outside aid agencies often say that they have no time to talk to the population, they have a responsibility to talk with and learn from local people, and usually there is enough time for this process.

Nevertheless, a critical approach is necessary. External processes often induce communities to adapt to the agenda of aid organisations. This is a problem, especially when outside agencies work in an uncoordinated manner. For example, a year after the 2004 tsunami in southeast Asia, a community

of 50 families in northern Sri Lanka, questioned in a door-to-door psychosocial survey, identified 27 different NGOs offering or providing help. One interviewee stated: 'We never had leaders here. Most people are relatives. When someone faced a problem, neighbours came to help. But now some people act as if they are leaders, to negotiate donations. Relatives do not help each other any more.' As this example indicates, it can be damaging if higher degrees of community participation are facilitated by agencies with their own agendas offering help, but lacking deep bonds with or understanding of the community. It is particularly important to facilitate the conditions in which communities organise aid responses themselves, rather than forcing the community to adhere to an outside agenda.

Key actions
1. Coordinate efforts to mobilise communities.
- Actively identify, and coordinate with, existing processes of community mobilisation (see Action Sheet 1.1). Local people often have formal and non-formal leaders and also community structures that may be helpful in coordination, although care should be taken to ensure that these do not exclude particular people.
- It is important to work in partnership with local government, where supportive government services are present.

2. Assess the political, social and security environment at the earliest possible stage.
In addition to reviewing and gathering general information on the context (see Action Sheet 2.1):
- Observe and talk informally with numerous people representative of the affected community;
- Identify and talk with male and female key informants (such as leaders, teachers, healers, etc.) who can share information about (a) issues of power, organisation and decision-making processes in the community, (b) what cultural rules to follow, and (c) what difficulties and dangers to be aware of in community mobilisation.

3. Talk with a variety of key informants and formal and informal groups, learning how local people are organising and how different agencies can participate in the relief effort.
Communities include sub-groups that differ in interests and power, and these different sub-groups should be considered in all phases of community mobilisation. Often it is useful to meet separately with sub-groups defined along lines of religion or ethnicity, political affinity, gender and age, or caste and socio-economic class. Ask groups questions such as:
- In previous emergencies, how have local people confronted the crisis?
- In what ways are people helping each other now?
- How can people here participate in the emergency response?

- Who are the key people or groups who could help organise health supports, shelter supports, etc.?
- How can each area of a camp or village 'personalise' its space?
- Would it be helpful to activate pre-existing structures and decision-making processes? If yes, what can be done to enable people in a camp setting to group themselves (e.g. by village or clan)?
- If there are conflicts over resources or facilities, how could the community reduce these? What is the process for settling differences?

4. Facilitate the participation of marginalised people.
- Be aware of issues of power and social injustice.
- Include marginalised people in the planning and delivery of aid.
- Initiate discussions about ways that empower marginalised groups and prevent or reduce stigmatisation or discrimination.
- Ensure, if possible, that such discussions take note of existing authority structures, including local government structures.
- Engage youth, who are often viewed as a problem but who can be a valuable resource for emergency response, as they are often able to adapt quickly and creatively to rapidly changing situations.

5. Establish safe and sufficient spaces early on to support planning discussions and the dissemination of information.
Safe spaces, which can be either covered or open, allow groups to meet to plan how to participate in the emergency response and to conduct self-help activities (see Action Sheet 5.2) or religious and cultural activities (see Action Sheet 5.3). Safe spaces can also be used for protecting and supporting children (see Action Sheets 3.2 and 5.4), for learning activities (see Action Sheet 7.1), and for communicating key information to community members (see Action Sheets 8.1 and 8.2).

6. Promote community mobilisation processes.
- Security conditions permitting, organise discussions regarding the social, political and economic context and the causes of the crisis. Providing a sense of purpose and meaning can be a powerful source of psychosocial support.
- Facilitate the conditions for a collective reflection process involving key actors, community groups or the community as a whole regarding:
- Vulnerabilities to be addressed at present and vulnerabilities that can be expected in the future;
- Capacities, and abilities to activate and build on these;
- Potential sources of resilience identified by the group;
- Mechanisms that have helped community members in the past to cope with tragedy, violence and loss;
- Organisations (e.g. local women's groups, youth groups or professional, labour or political organisations) that could be involved in the process of bringing aid;

- How other communities have responded successfully during crises.
- One of the core activities of a participatory mobilisation process is to help people to make connections between what the community had previously, where its members are now, where they want to go, and the ways and means of achieving that. Facilitation of this process means creating the conditions for people to achieve their goals in a manner that is non-directive and as non-intrusive as possible. If needed, it may be useful to organise activities (e.g. based on popular education methodologies) that facilitate productive dialogue and exchange. This reflective process should be recorded, if resources permit, for dissemination to other organisations working on community mobilisation.
- The above process should lead to a discussion of emergency 'action plans' that coordinate activities and distribute duties and responsibilities, taking into account agreed priorities and the feasibility of the actions. Planning could also foresee longer-term scenarios and identify potentially fruitful actions in advance. It should be clearly understood whether the action is the responsibility of the community itself or of external agents (such as the state). If the responsibility is with the community, a community action plan may be developed. If the responsibility is with external agents, then a community advocacy plan could be put in place.

Key resources

1. Action on the Rights of the Child. *Community Mobilisation.* http://www.savethechildren.net/arc/files/f_commmob.pdf

2. Active Learning Network for Accountability and Performance in Humanitarian Action (ALNAP) (2003). *Participation by Crisis-Affected Populations in Humanitarian Action: A Handbook for Practitioners.* http://www.odi.org.uk/ALNAP/publications/gs_handbook/gs_handbook.pdf (English); http://www.psicosocial.net (Spanish)

3. Donahue J. and Williamson J. (1999). *Community Mobilization to Mitigate the Impacts of HIV/AIDS.* Displaced Children and Orphans Fund. http://pdf.dec.org/pdf_docs/pnacj024.pdf

4. Norwegian Refugee Council/Camp Management Project (2004, revised 2007). *Camp Management Toolkit.* http://www.flyktninghjelpen.no/?did=9072071

5. Regional Psychosocial Support Initiative (REPSSI) (2006). *Journey of Life – A Community Workshop to Support Children.* http://www.repssi.org/home.asp?pid=43

6. Segerström E. (2001). 'Community Participation' in *The Refugee Experience*, Oxford Refugee Studies Centre. http://earlybird.qeh.ox.ac.uk/rfgexp/rsp_tre/student/commpart/com_int.htm

7. Sphere Project (2004). *Humanitarian Charter and Minimum Standards in Disaster Response*, Common standard 1: participation, pp.28-29. Geneva: Sphere Project. http://www.sphereproject.org/handbook/index.htm

8. UNHCR (2002). *Guide for Shelter Planning* (chapters on Community Participation and Community Organising). http://www.unhcr.org/cgi-bin/texis/vtx/home/opendoc.pdf?tbl=PARTNERS&id=3c4595a64 (English); http://www.acnur.org/index.php?id_pag=792 (Spanish)

9. UNHCR (2006). Tool for Participatory Assessment in Operations. http://www.unhcr.org/publ/PUBL/450e963f2.html

Sample process indicators

- Safe spaces have been established and are used for planning meetings and information sharing.
- Local people conduct regular meetings on how to organise and implement the emergency response.
- Local men, women, and youth – including those from marginalised groups – are involved in making key decisions in the emergency.

Example: Mexico, 1985

- In 1985, following a devastating earthquake in Mexico City – where there were strong, pre-existing community organisations – people from the local community organised the emergency relief efforts.
- Local people did most of the clean-up work, distributed food and other supplies, organised temporary shelters and designed new living quarters.
- The local emergency response developed into a social movement that assisted people for a period of five years.
- Studies conducted three and five years after the earthquake reported no increase in the prevalence of mental health problems.

Action Sheet 5.2
Facilitate community self-help and social support

Background

All communities contain effective, naturally occurring psychosocial supports and sources of coping and resilience. Nearly all groups of people affected by an emergency include helpers to whom people turn for psychosocial support in times of need. In families and communities, steps should be taken at the earliest opportunity to activate and strengthen local supports and to encourage a spirit of community self-help.

A self-help approach is vital, because having a measure of control over some aspects of their lives promotes people's mental health and psychosocial wellbeing following overwhelming experiences. Affected groups of people typically have formal and informal structures through which they organise themselves to meet collective needs. Even if these structures have been disrupted, they can be reactivated and supported as part of the process of enabling an effective emergency response.

Strengthening and building on existing local support systems and structures will enable locally owned, sustainable and culturally appropriate community responses. In such an approach, the role of outside agencies is less to provide direct services than to facilitate psychosocial supports that build the capacities of locally available resources.

Facilitating community social support and self-help requires sensitivity and critical thinking. Communities often include diverse and competing sub-groups with different agendas and levels of power. It is essential to avoid strengthening particular sub-groups while marginalising others, and to promote the inclusion of people who are usually invisible or left out of group activities.

Key actions

1. Identify human resources in the local community.

Examples of such resources are significant elders, community leaders (including local government leaders), traditional healers, religious leaders/groups, teachers, health and mental health workers, social workers, youth and women's groups, neighbourhood groups, union leaders and business leaders. A valuable strategy is to map local resources (see also Action Sheet 2.1) by asking community members about the people they turn to for support at times of crisis. Particular names or groups of people are likely to be reported repeatedly, indicating potential helpers within the affected population.

- Meet and talk with identified potential helpers, including those from marginalised groups, and ask whether they are in a position to help.
- Identify social groups or mechanisms that functioned prior to the emergency and that could be revived to help meet immediate needs. These might include collective work groups, self-help groups, rotating savings and credit groups, burial societies and youth and women's groups.

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

- Identify available non-professional or professional supports that could be activated immediately or strengthened.
- Promote a collective process of reflection about people's past, present and future that enables planning. By taking stock of supports that were present in the past people can choose to reactivate useful supports. By reflecting on where they want to be in several years' time, they can envision their future and take steps to achieve their vision.
- Discuss with key actors or community groups:
  - Organisations that were once working to confront crisis and that may be useful to reactivate;
  - Mechanisms (rituals, festivals, women's discussion groups, etc.) that have helped community members in the past to cope with tragedy, violence or loss;
  - How the current situation has disrupted social networks and coping mechanisms;
  - How people have been affected by the crisis;
  - What priorities people should address in moving towards their vision of the future;
  - What actions would make it possible for people to achieve their priority goals;
  - What successful experiences of organisations have been seen in their and neighbouring communities.
  - Share results of this identification process with the coordination group (see Action Sheets 1.1 and 2.1).

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

- Determine what members of the affected population are already doing to help themselves and each other, and look for ways to reinforce their efforts. For example, if local people are organising educational activities but need basic resources such as paper and writing instruments, support their activities by helping to provide the materials needed (while recognising the possible problem of creating dependency). Ask regularly what can be done to support local efforts.
- Support community initiatives suggested by community members during the participatory assessment, as appropriate.
- Encourage when appropriate the formation of groups, particularly ones that build on pre-existing groups, to conduct various activities of self-support and planning.

4. Encourage and support additional activities that promote family and community support for all emergency-affected community members and, specifically, for people at greatest risk.

In addition to supporting the community's own initiatives, a range of additional relevant initiatives may be considered. Facilitate community inputs in (a) selecting which activities to support, (b) designing, implementing and monitoring the selected activities, and (c) supporting and facilitating referral processes. Examples of potentially relevant activities are provided in the box below.

Examples of activities that promote family and community support for emergency-affected community members and, specifically, for people at greatest risk

- Group discussions on how the community may help at-risk groups identified in the assessment as needing protection and support (see Action Sheet 2.1);
- Community child protection committees that identify at-risk children, monitor risks, intervene when possible and refer cases to protection authorities or community services when appropriate (see Action Sheet 3.2);
- Organising structured and monitored foster care rather than orphanages for separated children, whenever possible (see Action Sheet 3.2);
- Family tracing and reunification for all age groups (see Action Sheet 3.2);
- Protection of street children and children previously associated with fighting forces and armed groups, and their integration into the community;
- Activities that facilitate the inclusion of isolated individuals (orphans, widows, widowers, elderly people, people with severe mental disorders or disabilities or those without their families) into social networks;
- Women's support and activity groups, where appropriate;
- Supportive parenting programmes;
- Sports and youth clubs and other recreational activities, e.g. for adolescents at risk of substance abuse or of other social and behavioural problems;
- Re-establishment of normal cultural and religious events for all (see Action Sheet 5.3);
- Ongoing group discussion about community members' mental health and psychosocial well-being;
- Building networks that link affected communities with aid agencies, government and various services;
- Communal healing practices (see Action Sheet 5.3);
- Other activities that help community members gain or regain control over their lives;
- Activities that promote non-violent handling of conflict e.g. discussions, drama and songs, joint activities by members of opposing sides, etc.;
- Structured activities for children and youth (including non-formal education, as in child-friendly spaces: see Action Sheet 7.1);
- Organising access to information about what is happening, services, missing persons, security, etc. (see Action Sheet 8.1);
- Organising access to shelter and basic services (see Action Sheets 9.1, 10.1 and 11.1).

5. Provide short, participatory training sessions where appropriate (see Action Sheet 4.3), coupled with follow-up support.

Where local support systems are incomplete or are too weak to achieve particular goals, it may be useful to train community workers, including volunteers, to perform tasks such as:

- Identifying and responding to the special needs of community members who are not functioning well;
- Developing and providing supports in a culturally appropriate way;
- Providing basic support, i.e. psychological first aid, for those acutely distressed after exposure to extreme stressors (see Action Sheet 6.1);
- Creating mother-child groups for discussion and to provide stimulation for smaller children (see Action Sheet 5.4);
- Assisting families, where appropriate, with problem-solving strategies and knowledge about child rearing;
- Identifying, protecting and ensuring care for separated children;
- Including people with disabilities in various activities;
- Supporting survivors of gender-based violence;
- Facilitating release and integration of boys and girls associated with fighting forces and armed groups;
- Setting up self-help groups;
- Engaging youth e.g. in positive leadership, organising youth clubs, sports activities, conflict resolution dialogue, education on reproductive health and other life skills training;

- Involving adults and adolescents in concrete, purposeful, common interest activities e.g. constructing/organising shelter, organising family tracing, distributing food, cooking, sanitation, organising vaccinations, teaching children;
- Referring affected people to relevant legal, health, livelihood, nutrition and social services, if appropriate and if available.

6. When necessary, advocate within the community and beyond on behalf of marginalised and at-risk people.

Typically, those who were already marginalised before the start of a crisis receive scant attention and remain invisible and unsupported, both during and after the crisis. Humanitarian workers may address this problem by linking their work to social justice, speaking out on behalf of people who may otherwise be overlooked and enabling marginalised people to speak out effectively for themselves.

Key resources

1. IASC (2005). *Guidelines for Gender-Based Violence Interventions in Humanitarian Settings*. Geneva: IASC. http://www.humanitarianinfo.org/iasc/content/products/docs/tfgender_GBVGuidelines2005.pdf

2. IFRC (2003). 'Promoting community self-help', in *Community-based Psychological Support: A Training Manual,* pp.57-65. Geneva: International Federation of the Red Cross and Red Crescent Societies.

Available in English, Arabic, French and Spanish at: http://psp.drk.dk/sw2995.asp

3. Norwegian Refugee Council/Camp Management Project (2004, revised 2007). *Camp Management Toolkit*. http://www.flyktninghjelpen.no/?did=9072071

4. Pretty J.N. and Vodouhê D.S. (1997). 'Using rapid or participatory rural appraisal'.FAO: New York. http://www.fao.org/docrep/W5830E/w5830e08.htm

5. Refugee Studies Centre and UNICEF (2002). 'Addressing the needs of children, their families and communities', in *Working with Children in Unstable Situations – Principles and Concepts for Psycho-social Interventions* (draft), pp.47-79. http://psp.drk.dk/graphics/2003referencecenter/Docman/Documents/1Disaster-general/WorkWithChild.UnstableSitua.pdf

6. Regional Psychosocial Support Initiative (REPSSI) (2006). *The Journey of Life* (awareness and action workshops). http://www.repssi.org/

7. Save the Children (1996). *Promoting Psychosocial Well-Being Among Children Affected by Armed Conflict and Displacement: Principles and approaches*. http://www.savethechildren.org/publications/ technical-resources/emergencies-protection/psychsocwellbeing2.pdf

Sample process indicators

- Steps have been taken to identify, activate and strengthen local resources that support mental health and psychosocial well-being.
- Community processes and initiatives include and support the people at greatest risk.
- When necessary, brief training is provided to build the capacity of local supports.

Example: Bosnia, 1990s

- In Bosnia, following the wars of the 1990s, many women in rural areas who had survived rape and losses needed psychosocial support, but did not want to talk with psychologists or psychiatrists because they felt shame and stigma.
- Following a practice that existed before the war, women gathered in knitting groups to knit, drink coffee and also to support each other.
- Outside agencies played a facilitating role by providing small funds for wool and by developing referral supports.

Action Sheet 5.3
Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices

Background

In emergencies, people may experience collective cultural, spiritual and religious stresses that may require immediate attention. Providers of aid from outside a local culture commonly think in terms of individual symptoms and reactions, such as depression and traumatic stress, but many survivors, particularly in non-Western societies, experience suffering in spiritual, religious, family or community terms.

Survivors might feel significant stress due to their inability to perform culturally appropriate burial rituals, in situations where the bodies of the deceased are not available for burial or where there is a lack of financial resources or private spaces needed to conduct such rituals. Similarly, people might experience intense stress if they are unable to engage in normal religious, spiritual or cultural practices. This action sheet concerns general communal religious and cultural (including spiritual) supports for groups of people who may not necessarily seek care, while Action Sheet 6.4 covers traditional care for individuals and families seeking help. Collective stresses of this nature can frequently be addressed by enabling the conduct of appropriate cultural, spiritual and religious practices. The conduct of death or burial rituals can ease distress and enable mourning and grief. In some settings, cleansing and healing ceremonies contribute to recovery and reintegration. For devout populations, faith or practices such as praying provide support and meaning in difficult circumstances. Understanding and, as appropriate, enabling or supporting cultural healing practices can increase psychosocial well-being for many survivors. Ignoring such healing practices, on the other hand, can prolong distress and potentially cause harm by marginalising helpful cultural ways of coping. In many contexts, working with religious leaders and resources is an essential part of emergency psychosocial support. Engaging with local religion or culture often challenges non-local relief workers to consider world views very different from their own. Because some local practices cause harm (for example, in contexts where spirituality and religion are politicised), humanitarian workers should think critically and support local practices and resources only if they fit with international standards of human rights.

Key actions

1. Approach local religious and spiritual leaders and other cultural guides to learn their views on how people have been affected and on practices that would support the affected population.

Useful steps are to:

- Review existing assessments (see Action Sheet 2.1) to avoid the risk of repetitive questioning.
- Approach local religious and spiritual leaders, preferably by means of an interviewer of the same ethnic or religious group, to learn more about their views (see key action 3 below). Since different groups and orientations may be present in the affected population, it is important to approach all key religious groups or orientations. The act of asking helps to highlight spiritual and religious issues, and what is learned can guide the use of aid to support local resources that improve wellbeing.

2. Exercise ethical sensitivity.

Using a skilled translator if necessary, work in the local language, asking questions that a cultural guide (person knowledgeable about local culture) has indicated are appropriate. It may be difficult for survivors to share information about their religion or spirituality with outsiders, particularly in situations of genocide and armed conflict where their religious beliefs and/or ethnic identities have been assaulted. Experience indicates that it is possible for humanitarian workers to talk with religious and spiritual leaders if they demonstrate respect and communicate that their purpose is to learn how best to support the affected people and avoid damaging practices. In many emergencies, religious and spiritual leaders have been key partners in educating humanitarian workers about how to support affected people. Ethical sensitivity is needed also because some spiritual, cultural and religious practices (e.g. the practice of widow immolation) cause harm. It is important to maintain a critical perspective, supporting cultural, religious and spiritual practices only if they fit with human rights standards.

Media coverage of local practices can be problematic, and should be permitted only with the full consent of involved community members.

3. Learn about cultural, religious and spiritual supports and coping mechanisms.

Once rapport has been established, ask questions such as:
- What do you believe are the spiritual causes and effects of the emergency?
- How have people been affected culturally or spiritually?
- What should properly happen when people have died?
- Are there rituals or cultural practices that could be conducted, and what would be the appropriate timing for them?
- Who can best provide guidance on how to conduct these rituals and handle the burial of bodies?
- Who in the community would greatly benefit from specific cleansing or healing rituals and why?
- Are you willing to advise international workers present in this area on how to support people spiritually and how to avoid spiritual harm?

If feasible, make repeated visits to build trust and learn more about religious and cultural practices. Also, if possible, confirm the information collected by discussing it with local anthropologists or other cultural guides who have extensive knowledge of local culture and practices.

4. Disseminate the information collected among humanitarian actors at sector and coordination meetings.

Share the information collected with colleagues in different sectors, including at intersectoral MHPSS coordination meetings and at other venues, to raise awareness about cultural and religious issues and practices. Point out the potential harm done by e.g. unceremonious mass burials or delivery of food or other materials deemed to be offensive for religious reasons.

5. Facilitate conditions for appropriate healing practices.

The role of humanitarian workers is to facilitate the use of practices that are important to affected people and that are compatible with international human rights standards.
Key steps are to:
- Work with selected leaders to identify how to enable appropriate practices.
- Identify obstacles (e.g. lack of resources) to the conduct of these practices.
- Remove the obstacles (e.g. provide space for rituals and resources such as food for funeral guests and materials for burials).
- Accept existing mixed practices (e.g. local and Westernised) where appropriate.

Key resources

1. PAHO/WHO (2004). 'Sociocultural aspects'. In: *Management of Dead Bodies in Disaster Situations*, pp.85-106. Washington: PAHO. http://www.paho.org/English/DD/PED/DeadBodiesBook.pdf
2. Psychosocial Working Group (2003). *Psychosocial Intervention in Complex Emergencies: A Conceptual Framework.* http://www.forcedmigration.org/psychosocial/papers/Conceptual%20Framework.pdf
3. Sphere Project (2004). *Humanitarian Charter and Minimum Standards in Disaster Response.* Mental and social aspects of health, pp.291-293. Geneva: Sphere Project. http://www.sphereproject.org/handbook/index.htm

Sample process indicators

- Local cultural, religious and spiritual supports have been identified, and the information is shared with humanitarian workers.
- Obstacles to the conduct of appropriate practices have been identified and removed or reduced.
- Steps have been taken to enable the use of practices that are valued by the affected people and consistent with international human rights standards.

Example: Angola, 1996

- A former boy soldier said he felt stressed and fearful because the spirit of a man he had killed visited him at night. The problem was communal since his family and community viewed him as contaminated and feared retaliation by the spirit if he was not cleansed.
- Humanitarian workers consulted local healers, who said that they could expel the angry spirit by conducting a cleansing ritual, which the boy said he needed.
- An international NGO provided the necessary food and animals offered as a sacrifice, and the healer conducted a ritual believed to purify the boy and protect the community. Afterwards, the boy and people in the community reported increased wellbeing.