Community Based Psychosocial Support in Iraq: A Framework to move from emergency recovery to development
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“State Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of ... armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self-respect and dignity of the child”
CRC, Article 39
Foreword

Community based psychosocial programming strongly recalls what is at the very heart of a human rights based approach to development: human dignity, the ability and freedom to plan and make choices that are uniquely your own, and to act on them in order to seek fulfillment. It directly leads to an enhanced capability of duty bearers to fulfill their duties vis-à-vis the psychosocial and caring rights of children as stated in Article 39 of the Convention on the Rights of the Child. On the other hand, community based psychosocial programming also directly improves the capacities of claim holders to demand rights fulfillment: to fully realise your own creative potential, entitlements, and capabilities, and with others shape the future you would value within your family and community.

Psychosocial support programming is a set of interventions designed to protect the ‘human spirit’, the capacity of people to claim their rights, to claim happiness, to have entitlements and services. Sudden or recurrent shocks such as war and the inevitable grief and loss might hamper the capacity of people to plan, to make choices, to relate with others in a positive way, to play, to have dreams for the future. Everything that makes you uniquely human, and everything that human rights were designed to protect and enable (Thomson 2006).

Psychosocial programming is at the very core of human rights based approach to programming: communities and individuals are the principal actors for their own development, children are empowered to take better care of themselves; parents and families are enabled to provide increased quality care to their children, but also to find a renewed sense of normalcy; communities are encouraged to plan and act on their own priorities, strengthening bounds and ties that might had been disrupted as a consequence of shocks. Empowering communities simply means empowering the individual members of a community to better rely on individual and collective capabilities and strengths. It is a process of changing consolidated patterns, it can only happen through a change that comes from inside the mind of people, it can only be facilitated by external actors, but not imposed by those.

You have to draw together ‘inner healing’, the provision of immediate needs, and the political processes of seeking rights into one (Thomson 2006). But you also have to trigger the understanding that relief starts from inside each one of us, using our mind and feelings as the greatest asset available to communities that have been affected by emergency situations (moral, spiritual and mental dimensions). And the collective use of these strengths creates synergies within communities that in turn allow for expanded individual empowerment – a virtuous circle. Psychosocial programming brings people back to a position of inner strength, confidence, and trust.
Introduction

Community based psychosocial support means many things to many people. The concept is often used to refer to a panacea of interventions that relate to psychological and social wellbeing of children, their caretakers, and the community at large. The concept is traditionally used in such a broad sense that its capacity to clearly identify a set of commonly agreed interventions results to some extent compromised. As the vulnerability situation in Iraq continues, gradually evolving into a context of chronic emergency and insecurity, intervention for the psychosocial support of children and their families have multiplied, making the need for an overarching framework of intervention compelling.

‘Psychosocial’ is here used as a shorthand for describing the stress affecting people, and the programmes that seek having an impact in people’s overall sense of wellbeing. It places attention not just on the individual’s mental processes, but its interaction with other people as a vital aspect of wellbeing (Tolfree 1999). Psychosocial wellbeing is a process of transition towards greater meaning, balance, connectedness and wholeness, both within the individual and between individuals and their environment. Both the psychological and social components are essential to the normal developmental process, and evolve with physical growth and maturation. This means that psychosocial needs change as boys and girls grow and develop (UNICEF 2003). The nature of psychosocial programming directs attention to the totality of people’s experiences, and the importance of the whole person inserted into a network of relationships that conditions personal satisfactions and feelings. This is particularly important for children, whose emotional and intellectual development is a direct consequence of the social environment within which they grow up. This applies to a greater extent to societies - such as the Iraqi one – where negative events and shocks are experienced in a shared rather than in individualistic terms. Psychosocial activities build upon a child’s natural resilience and family and community support mechanisms, and attempt to provide additional experiences that will promote coping and positive development, despite the adversities experienced.

The progressive development and dissemination of the Guidelines on Mental Health and Psychosocial Support in Emergency Settings by the Inter-Agency Standing Committee (IASC) has greatly helped in enabling humanitarian actors to plan, establish and coordinate a set of minimum multi-sectoral responses to protect people’s mental health (MH) and psychosocial (PSS) well-being in the midst of emergencies, thus contributing in clarifying the contents of PSS approaches to emergency programming (IASC, 2007). The focus of the guidelines is on implementing minimum responses, which are essential, high-priority responses that should be implemented as soon as possible in an emergency. They lay the foundation for the more comprehensive efforts that may be needed (including during the phases of stabilization and early reconstruction). To complement the focus on minimum response, the guidelines also list concrete strategies for mental health and psychosocial support to be considered mainly before and after the acute emergency phase. These ‘before’ (emergency preparedness) and ‘after’ (comprehensive response) steps establish a context for the minimum response and emphasize that the minimum response is only the starting point for more comprehensive support.

Among others, the guidelines identify ‘Community Mobilization and Support’ as one of the core MH and PSS domains. Yet, the use of community based PSS services to support affected populations to gradually move from an emergency phase to a mid and longer term recovery phase remains to many extents an area were knowledge is limited and successful programs still rare and scarcely documented. In the last few years this has dramatically changed with land-mark documents and commitment at a global level to support field emergency psychosocial interventions, but the impact...
of this is still being assessed (UNICEF 2007). Despite renewed efforts in the sector, major bottlenecks still remain. Looking at the consequences of the chronic emergency affecting Iraq, strategies for field support in psychosocial interventions have tended to be vertical and spontaneous in the best spirit of humanitarian response, but with very little integration of sectors (and services). Overall coordination mechanisms are still very much absent but strongly demanded from the field, and common frameworks of work and conceptualization of interventions are simply not existing in the country. Another area of concern is the fact that due to a lack of PSS preparedness strategies prior to the emergency, the country and its institutions are gradually developing strategies for actions based on processes of learning lessons by doing, with weak national integrated vision to lead this process.

The present document responds to the need of UNICEF Iraq Country Office in its collaboration with the Government to create an evidence-based framework for community based psychosocial support interventions in the country, using the critical actions and principles as stated in the IASC Guidelines as the starting point. The document should be used in conjunction with the Strategy of key actions to be undertaken for the progressive implementation and roll-out of the Framework. The Framework is a document designed to provide UNICEF staff and UNICEF partners with principles, concepts and a strategy that can assist them to respond to the psychosocial needs of children in emergencies in Iraq and subsequent programmatic responses post-emergency.

Due to the competing theoretical approaches that inevitably shape PSS work, the Framework deals not just with issues of programming, but also with issues of theoretical paradigms within which interventions take place. In doing so, the Framework does not intend to have a normative value for interventions already existing in the country. On the contrary, it provides suggestions for the rationalization of UNICEF new interventions in the area of PSS services, and a guideline for programmatic purposes. It also provides agencies in the field with some ‘tools’ for making decisions about the type of interventions they can implement.

In line with the above, the current Framework advocates for community based psychosocial programming that is rights-based, child-friendly, gender and age responsive, and culturally sensitive and sustainable. It takes full account of the best interests of the child, and includes communities as partners in decision-making processes.

The users of the Framework will be all concerned stakeholders involved in promoting child centered programs with a psychosocial component. In particular, the primary duty bearer for children in Iraq: the Government in its specialized line Ministries (with a focus on MoLSA and MoYS). UNICEF and its partners will adopt the Framework to guide current and new contract agreements with specialized agencies and non-government organizations. Additionally, local and international NGOs could also use the Framework to review existing interventions or to draw on new ideas for future actions. Community based organizations, religious and civil society groups are also among the possible users of the current Framework for its implications on community based work.

Rationale

The necessity for assisting children with psychosocial and mental health problems is a clearly documented mandate of the State Parties signatories of the CRC. The Government of Iraq made substantial public commitment to increase the protection of children including reducing community and family based violence affecting the lives of the majority of its citizens. Over the years, efforts have been modified depending on needs, security and resources. The efforts made to assist the children of Iraq are to be commended. Yet, the current situation in the country continues to burden the coping resources of communities, families, and individuals. The level of insecurity, displacement,
poverty, and restricted access to essential services remains high. Ongoing violence, insecurity and collapse of law and order have become the norm in the daily lives of Iraqis with a devastating impact on the overall living conditions of the population especially for children and women.

The impetus to develop a community based psychosocial support programme arose from the need to respond to the ongoing insecurity which continues to impact the lives of children and young people. Children’s lives are characterized by fear, anxiety and stress. Many children are exposed to violence in more than one way. Thousands of children have lost one or both parents in the violence, while many are exposed to fear of darkness and anxiety linked to the threats of war, bombs, weapons, and fighter planes. Regrettably, most parents/guardians and teachers, who have themselves been traumatized by the consequences of years of a repressive regime, wars, insurgency and social violence, are unable to fully support their children and students and to provide the protective environment required for their development and well-being.

The 2006-7 Iraq Family Household Survey concluded that overall, 35.5% of the adult population can be "considered as having significant psychological distress and are potential psychiatric cases", with 40.4% of women and 30.4% of men reporting telltale symptoms such as tension/worries, tiredness, frequent headaches, unhappiness, poor appetite, and sleeping problems. A psychosocial assessment carried out by the International Medical Corps (IMC) and UNICEF in Sadr City in May 2008, in the aftermath of military operations, found that 77% of children and families showed signs of psychosocial distress and as many as 60% of mothers reported severe psychological and behavioral problems in their children. In addition, parents and caregivers acknowledged feelings of helplessness and an inability to help children to cope. Teachers also reported increased levels of aggression and fear among students, mainly boys.

Several statements from local NGOs indicate that there is continuous use of children to carry out suicide attacks. Media, police, military sources and community members reported the continuing recruitment of children and young adults by armed groups for acts of terrorism. Some of the children used as suicide bombers are girls. To ensure that the girls will carry out the attacks, the girls can be sexually abused or raped so that they never can return to their family and are considered without value. Since the systematic implementation of the Monitoring and Reporting Mechanism (MRM) started in April 2009; there have been 142 violent incidents where there are strong reasons to believe that children have been killed or injured. Reports of abduction and kidnapping are increasing in Iraq. The alleged perpetrators vary between armed groups that demand ransom as a way of financing their insurgent activities and criminal elements that demand ransom for their own benefit (UNCT, 2009).

Iraq remains volatile but there are opportunities to address and respond to the situation of children, their families, and their communities through the provision of a strengthened and systematized psychosocial care programme. To build on the gains made so far, the Government of Iraq and UNICEF intend to increase the decentralization of the CRC implementation at the community level through community based psychosocial programming. This in turn will directly impact on the level of violence experienced by children within their families and communities.

Confusion still exists about what psychosocial interventions are and what they are not, about whether they achieve their goals, whether they do harm rather than good and about what principles should guide good practice of agencies. The absence of a common framework that agencies can refer to when they want to initiate psychosocial interventions has meant that agencies often find themselves alone in their decision-making. In order to gain clarity on some of these questions and to help agencies who want to work in Iraq in the field of PSS, the current Framework was developed. Above all, the Framework remains an initial attempt by the GoI and its partners to bring the CRC
closer to children, families and communities through a process of decentralization of services that will help in translating policies into practice.

**Clarifying the concepts of ‘psychosocial’, ‘psychosocial work’ and ‘psychosocial well-being’**

Based on an initial working definition developed during a 1995 Conference in Nairobi organised by UNICEF, psychosocial work in conflict/post conflict situations has been further defined as part of the 1997 “Capetown Principles”\(^1\) that agreed upon best practices in work with child soldiers, and reinforced by the Oxford Refugee Study Centre’s Psychosocial Training Module (1999). This definition states:

- The term “psycho-social” underlines the dynamic interrelationship between the psychological and social effects of armed conflict, with each continually influencing the other.

- “Psychological effects” refers to those experiences which affect emotions, behaviour, thoughts, memory and learning ability, as well as capacity to perceive and understand everyday situations (i.e. mind, thoughts, emotions, feelings and behaviours).

- “Social effects” refers to how the diverse experiences of war alter people’s relationships to each other, changes in the workings of the community as well as personal change, for example through death, separation, estrangement and other losses. “Social” may be extended to include an economic dimension, as many individuals and families become destitute through the material and economic devastation of war, thus losing their social status and place in their familiar social network (i.e. environment, culture, traditions, spirituality, and interpersonal relationships with family, community and friends and life tasks such as school or work).

The social influences the psychological and vice versa, as violent events affect many aspects of children’s development, from the messages that their parents transmit to them to the way in which violence affects cognition, to disruptions of care-giving and loss of those they love. Conversely, the point of view of growing children and their families and their capacity to affect the world around them is influenced by their psychological development and its disruptions (CPiE 2008).

Psychosocial components are essential to the normal human biological-psychological-social developmental process. In emergency and post-emergency contexts, PSS problems can include:

- **Psycho:** Problems related to emotional distress, sadness, loss, frustration, fear, despair, anxiety etc.
- **Social:** Problems related to insecurity, violence, lack of opportunities; separation from families, friends or communities; poor physical living environment; inadequate economics; family neglect or abuse, alcohol or drug use etc.

During an emergency, many people are likely to be simultaneously affected by the crisis. The nature, degree and magnitude of the crisis’ impact on individuals vary enormously according to individual strengths and capacities to face adverse circumstances (resilience), as well as the nature of social

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\(^1\) The Capetown Principals adopted by the participants in the Symposium on the Prevention of Recruitment of Children into the Armed Forces and Demobilization and Social Reintegration of Child Soldiers in Africa, organized by UNICEF in cooperation with the NGO Sub-group of the NGO Working Group on the Convention on the Rights of the Child, Cape Town, 30 April 1997 They define psychosocial work, and the parameters for intervention with children and their families associated with fighting forces.
relationships surrounding the individuals (social capital). It comes without say that as individuals are affected by the crisis, so are their families, communities and the society at large. Again, the degree and magnitude of the damages that a crisis might bring to social environments depends on the consequences that the crisis had on individuals’ capacity to cope.

The psychological and social wellbeing of a person are inextricably interconnected. For example, a child who is displaced and separated from family and friends is likely to experience intense feelings of loss and fear, while community efforts to respond and protect others may increase feelings of solidarity and optimism.

Psychosocial work therefore focuses on the aspects of an environment or situation which impact on both the social and psychological well-being of affected populations. This is achieved via working with the local community, sectors, and organisations to advocate for improved access to community supports and basic services and restore everyday recreational, social and vocational activities in order to promote psychosocial well-being.

When we think about psychosocial work we are focusing on activities to promote the well-being of affected populations. Such well-being can be thought of having 3 core domains, all of which will affect a person’s ability to function:

- **The individual capacity of a person.** This is a person’s physical and mental health, their coping abilities, their position in society, and their ability to access resources such as food and water, social services, education, and health provisions. For children, this would include their level of resilience and developmental stage.

- **Family and community functioning.** This is the degree to which a person can engage in ordinary social roles and carry out everyday activities, such as attend school or go to work, and the availability of essential services. Effective functioning requires having networks of support from family and friends, and wider groups within the community e.g. religious groups, colleagues and peers. For children, this includes the existence of supportive caregivers, and other social resources such as family members, school friends, and teachers.

- **Societal Culture and Values.** These are the beliefs, values, and practices that give a sense of meaning, unite communities, and contribute to a person’s identity e.g. religion, spirituality, and traditions. For children, this will be significantly influenced by the beliefs held by their family members and community, and the perceived relevance of these to their own life.

**Figure:** The Domains of Child Well-Being

![The Domains of Child Well-Being](image)

*Source: Child Protection in Emergency Training Manual*
How is psychosocial well-being affected in complex emergencies?

Complex emergencies are linked with a range of differing events, including armed conflict, terrorist attacks and displacement. Communities can continue to feel the effects of such events for many years after they have occurred as they can bring about physical, material and economic losses. The common feature of these events is that they challenge communities by disrupting or depleting their resources.

Psychosocial well-being can be affected by war and displacement in a number of different ways. The Psychosocial Working Group (2005) has identified three key domains through which these effects can be understood. Firstly, human capacity may be reduced when people become depressed, withdraw from social life or become physically disabled. The death of people usually leads to a loss of skilled labour in household and communities. Even the feeling of having less control over events and circumstances may contribute to people feeling less able to meet the challenges they face.

Secondly, wars and natural disasters also lead to a disruption of the social ecology of a community, where relations between families and peers change, or where religious and civic organisations find it difficult to function.

Thirdly, the culture and values of communities may also be disrupted when common values are challenged and human rights are violated. It may become more difficult for people to follow cultural traditions that have previously provided a sense of unity and identity to communities. Conflict may also increase or reinforce negative images of other political, religious or ethnic groups which may lead to an escalation of violence and hatred.

The issues outlined above are not the only factors that impact on well-being in complex emergencies. The loss of material and economic resources of households, the disruption of infrastructure on communal and regional levels, and the degradation of the environment all have an important impact on psychological well-being. Such issues form part of the broader context within which individuals, families and communities begin to engage with the events that have affected their lives (PWG 2005).

Figure: The Impact of Emergencies on Child’s Ecology and Mitigating Factors


A core programming principle: people and communities have resources

All communities respond to the events that affect them in some way. This is captured by the term ‘resilience’ which refers to the ability of people and communities to ‘bounce back’ and deal with the difficulties they face. They do this by drawing on the skills and knowledge available in the communities, as well as on social networks and support and common values (social capital) to
rebuild their lives (see following sections of this document). The extent to which communities are able to draw on resources is an indication of their capacity to cope.

Often people do not want to re-establish the same social order and conditions they had prior to the emergency situation. This is particularly important in those contexts where social conditions and power relations between different groups in place prior to the eruption of an emergency are also partially responsible for the commencement of the crisis itself (PWG 2005).

The diversity of PSS Interventions in Iraq

Like in other well documented humanitarian situations (i.e. for instance Galappatti 2003), a number of initiatives have been conducted in recent years in Iraq to map regional or national projects that have a more or less explicit component of PSS. A rapid desk review of existing projects being implemented has allowed for the identification of the following key strategies as being central to particular projects:

Provision of explicitly psychological or medical therapeutic services, such as psychological counseling, befriending (i.e. supportive listening and allowing for the sharing of emotions), art and drama therapy, assessment for PTSD and referral for medical or counseling services. This may also include providing children with tools for exploring their feelings related to conflict and insecurity, or visiting families in their homes to talk about their feelings.

Awareness raising and psycho-education, through providing information on trauma and methods of coping with symptoms, or discussions on issues related to violence and conflict, training parents and caregivers to help children manage stress, or exhorting persons with particular symptoms or problems to seek out local service providers.

Interpersonal skills development for community members, often in the form of guidance for conflict mediation, communication, listening and problem solving.

Social activities to support the expression of feelings and thoughts, such as providing opportunities for interaction, dialogue, trust-building and sharing of experiences.

Mobilization of existing social networks in the community, through promoting sharing of work between community members, establishing children’s clubs, supporting effective traditional coping strategies, running workshops to mobilize children’s own resources in relation to specific problems.

Supportive practices for child development, in the form of recreational activities, creating positive social and physical environments, meeting early childhood developmental needs for stimulation, skill building and socialization.

Skills training to improve material security and sense of self-efficacy, in the form of vocational training for young adults, educational activities, business skills development and motivational workshop for single women, or child focused child awareness programmes.

Provision of material and other support to remove structural threats to well-being, such as provision of food and aid supplies, prevention of sexual abuse and injury by landmines, accommodating children in foster care settings, facilitating economic support, public campaigning to protect children from the effects of conflicts or instability, rehabilitation for ex-combatants and offenders, implementation of integrated rural development projects.
Strengthening of spiritual, religious and moral dimension, through involvement in religious activities and religious education that is not fundamentalist. In some cases human rights education is also undertaken with the aim of strengthening moral views and human dignity, so that principles such as gender equality could be for instance reinforced by using religious values.

 Provision of psychology-oriented skills training for personnel such as counselors, teachers operating in emergency areas, midwives, child care and social service officers, health care workers, social researchers, social workers, on issues such as counseling for trauma, early childhood development needs and strategies, PSS, psychological treatment of torture survivors, and alike.

 Improving the linkages and exchanges between resources and support services through networking initiatives such as the establishment of a steering committee for emotional stimulation programmes run in schools, an inter-agency working group in PSS and MH, or a collaboration between foreign universities and local universities.

 Yet what is also to be noticed is the striking absence of traditional healing, spiritual and cultural practices from formal humanitarian coordination initiatives. Another important issue noticed in Iraqi programmes promoted in the area of PSS is their explicit emergency nature. Only a minimum number of existing programmes has well defined links between an emergency and a transition or development component, and very few of them have been designed from the onset as developmental, with a strong emphasis on capacity building of local actors and the delivery of services through the use of already existing channels.

 The diversity of the mentioned initiatives and strategies for PSS intervention in Iraq, while celebrated by someone as a testimonial of multisectoral work, it has also been the basis of regular disagreements within the humanitarian communities and weakened a common ground of work. Particular interventions often draw insights –consciously or unconsciously- from important bodies of knowledge. The traditional opposition between biomedical and anthropological approaches has also been characterised as a clash between the discourse of ‘trauma’ and ‘resilience’ (Galappatti 2003). While the resilience discourse is deemed as more suitable for human rights approaches, the trauma discourse has been more often associated with the application of western, medically oriented interventions (Agger 2000). The review of the literature conducted for the development of the current Framework has found no programme actively looking at building resilience as major programme objective.

**Box:** Multi-layered supports

In emergencies, a key to responding to MH and PSS needs of the different groups affected is to organise a layered system of complementary supports. People are affected in different ways and require different kinds of supports. All layers are important and should ideally be implemented concurrently.

**i. Basic services and security.** The well-being 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). In most emergencies, specialists in sectors such as food, health and shelter provide basic services. 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 well-being; and influencing humanitarian actors to deliver them in a way that promotes mental health and psychosocial well-being. These basic services should be established in participatory, safe and
socially appropriate ways that protect local people’s dignity, strengthen local social supports and mobilise community networks.

**ii. Community and family supports.** The second layer represents the emergency response for a smaller number of people who are able to maintain their mental health and psychosocial well-being 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.

**iii. Focused, non-specialised supports.** 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.

**iv. 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.

The uniqueness of each emergency and the diversity of cultures and socio-historic contexts make it challenging to identify universal prescriptions of good practice. Nevertheless, experience from many different emergencies indicates that some actions are advisable, whereas others should typically be avoided.

*Source: IASC 2007.*


Recent work by UNICEF Iraq has placed importance to situating the current focus on community based PSS, within a broader path of PSS work undertaken in the country. Tracing back the history of psychosocial programming of UNICEF Iraq is important for two reasons. First, it is important to know where the programme is coming from and on what foundations a future Strategy can be built. In the context of Iraq Country Office it also serves the purpose of preserving institutional knowledge, as this was a problem over the past years due to changes within counterparts and government structures, staff departure, and lack of consistent filing system.
The following section traces back as far as possible the projects, partnerships and initiatives, which were started by UNICEF Iraq and which focused partially or entirely on psychosocial support. The documented initiatives were grouped into four categories:

- Research, Coordination, Strategy Development;
- Child Friendly Spaces and organized child/youth activities;
- Drop-in Centers for Children and Youth;
- Capacity Building, including support to government institutions.

**Research, Coordination, Strategy Development**

There has been a marked concentration of efforts regarding research, coordination, and strategy development in 2003. No systematic follow-up activities could be identified in the files until 2007, when UNICEF Regional Advisor for PSS work looked at strategic options for PSS interventions in Iraq.

In March 1999, a report was published by UNICEF with the title: Assessment of the Implementation of the Humanitarian Programme (SCR 986): the psychosocial well-being of children in Iraq. Two major recommendations were made by the report:

- ‘... an expansion of present humanitarian programmes to respond in an exhaustive manner to Iraqi children’s psychosocial and developmental needs...’;
- ‘... the establishment of a comprehensive monitoring system that allows to document changes of their psychosocial and development status through valid and reliable data’.

In late 2002, UNICEF embarked on the task of developing a national strategy for psychosocial interventions and started to work on a national psychosocial programme. But due to the worsening of the crisis in Iraq, the strategy was only achieved at the level of developing the teachers training methodology and the ‘Safe to Play’ approach, never going beyond these initial stages.

During the same period, UNICEF was also chairing an intersectoral child protection coordination group. Under this umbrella, a number of sub-committees had been formed to cover PSS work or children at risk. The work of this committee was stopped during 2003, after the UN blast.

During 2007, UNICEF Regional Office also contributed in strengthening Iraq Country Office’s recommendations to PSS work by:

- Design and launch a large broad based community messaging campaign for the distribution of public information on UNICEF sectoral issues (education, health, protection, WESH), as well as psychosocial/educational information, cross-cutting into the health, education and WESH sectors;
- Using some of the existing institutions as access point for PSS for some of the most vulnerable groups of children/youth, and a point from where to access the community, schools, families, and other children later in the process;
- Support PSS that is done through public health campaigns.

In 2009, a family brochure was produced for national coverage, with the aim of helping parents in supporting the coping capacities of their children, and to gradually increase focus on the psychosocial needs of children.

**Child Friendly Spaces and Organised Child and Youth Activities**

Between the year 200 and 2004, UNICEF supported a number of child friendly spaces especially in the Kurdish region. Between 2000 and 2002, UNICEF also carried out a number of summer camps in
collaboration with the Directorate of Social Affairs. Most of the children attending the camps were children living in institutions such as orphanages. The project aimed at enhancing the child’s ability to express their problems and emotional needs, gain self-esteem, and confidence through recreational and educational programmes, role play and peer activities. The programme also worked towards the reintegration of the children into foster care families.

Following this initial experience, Save the Children Alliance and UNICEF started in the year 2001 and 2002 school based summer camps for psychosocial support. Several activities were organized to cater for the psychosocial and emotional needs of reached children. The main group targeted during the initiative were children that had experienced some form of destabilization within their families or communities.

In 2002, UNICEF, Diakonia and the Directorate of Education in the KRG organized a child-to-child programme for 5,000 children and youth aged 10 to 16 in several districts in Erbil and Koya. The main objective of the intervention was to strengthen children and community participation to ensure intellectual, physical and emotional needs of children. Furthermore the project trained peer educators to increase knowledge on child rights and life skills, including health/hygiene promotion and landmine awareness.

During the war of 2003, in Kurdistan, UNICEF and MoLSA trained social workers to provide psychosocial support to children in conflict with the law, children in orphanages, and children with disabilities. In the same year, UNICEF together with the Directorate of Culture and Social Affairs also opened a child friendly space for youth and children involved in scavenging and collecting dump material, with the aim of providing stabilization, foster education and social reintegration. Likewise, a programme for youth was started in collaboration with the Kurdish Youth Union in Erbil to establish a center for 600 youth at risk of exploitation, school drop-out and engaged in hazardous working conditions.

In 2008, UNICEF started to re-focus more strongly on PSS through the design and implementation of an in-school PSS project whose main objective was to promote children’s psychosocial support in selected Iraqi schools, to reduce the use of violent teaching methods, and to establish partnerships between schools and families. Heartland Alliance, in collaboration with UNICEF, worked with the Iraqi Ministry of Education (MoE), the Ministry of Higher Education (MoHE), relevant Directorates of Education (DoE), and the Ministry of Labor and Social Affairs (MoLSA), to foster governmental support for the project and integration into the MoE national training curriculum for teachers. The project targeted 105 schools selected based on the vulnerabilities of the students in six governorates: Baghdad, Wassit, Missan, Thi Qar, Basra and Erbil.

Drop-in Centers for Children and Youth

Starting from 2003, UNICEF followed up on the recommendations made in the inter-agency child protection assessment, through supporting a number of drop-in centers for children and youth. The number of centers supported reached a pick in 2004, to then gradually decrease and phase out at the end of 2006. Main target groups of these initiatives were working children, children that had drop-out from school, and street children. The project provided non-formal education, recreational activities, as well as basic forms of psychosocial support.

Capacity Building and Support to Government Institutions

UNICEF’s training and capacity building efforts has been more steady and stable than programming in the other areas described above. Starting from 1998, three ‘psychological guidance centers’ were
established in Erbil, Dohuk and Suleimaniya in collaboration with Save the Children. The centers were subsequently supported with capacity building by Save the Children UK, UNICEF and the Swedish Diakonia. The centers were originally established under the MoH and had the purpose of improving the wellbeing of children and families affected by severe stress, with a focus on medical and diagnostic interventions. In 2001, the centers have changed their name and became the ‘Psychosocial Education, Treatment, and Consulting Centers’, or more simply ‘the Mental Health Centers’, and they are still working today, with a special emphasis on good parenting skills to promote maternal care during pregnancy, neonate and infant care including exclusive breastfeeding, vaccination and growth monitoring, infant and child feeding practices, infant/child mental and socio development needs, the importance of playing for child physical growth, development and learning, communication and stimulation skills during infancy.

Between 2003 and 2007 UNICEF and its partners have spearheaded a number of initiatives that in most of the cases had a regional focus depending on the capacities and coverage of implementing partners. Local and international institutes and universities were routinely partnered to influence not just the capacities of in-service personnel, but also the contents and quality of curricula in pre-service training. This effort culminated in 2008 and 2009, with a major project of increasing teachers’ capacities within primary schools to address the psychosocial needs of children².

Starting from 2009, and based on the positive outcomes of the in-school PSS programme, UNICEF launched the design of a nation-wide framework for community based PSS programming.

**Overarching Objective : A Promotive Environment for Children**

The objective of a nation-wide community based PSS system in Iraq is the one of building emotional and behavioural strengths in boys and girls to promote and enhance their inner resilience through the mobilization of peers, families and communities.

It is not just a matter of responding to problems, but to also gradually promote positive changes in the surrounding environment. By focusing on problems, pathology or symptoms, an unintended consequence may be to highlight the individual’s sense of abnormality and difference instead of building on strengths and individual or common resources.

Looking at the case for a renewed effort in facilitating and expanding child focused community based PSS schemes, psychological and social interventions jointly implemented are an effective tool not just by virtue of their traditional *protective* and *preventive* role (risk prevention and risk mitigation), but also in light of their growing *promotive* and *transformative* role (risk reduction). While interventions on MH and PSS should be framed within a broader public health and protection discourse, general PSS interventions also have a too often overlooked promotive role vis-à-vis the emotional and intellectual capacities of the child. Adapted from the theories of social protection (Devereux and Sabates-Wheeler 2004, Conticini 2009), the current framework argues that a comprehensive community based PSS system should include four broad sets of interventions:

- **Protective interventions** that offer relief from economic and social deprivation, including alleviation from chronic and extreme poverty or stress;
- **Preventive interventions** that are put in place before a shock occurs and are designed to avert or mitigate the impact of negative shocks. These interventions seek to prevent further

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² For a full account of UNICEF PSS programming in recent years in Iraq, please refer to the document ‘UNICEF PSS programming in Iraq 1998-2008’. 
psychosocial deterioration, strengthen individual and community coping mechanisms, and rebuild protective social networks. This will usually include targeted work with the “at-risk” population. Examples include identifying foster families for unaccompanied children, establishing life skills and education programs for former child combatants, and providing day care for adolescent mothers;

- *Promotive interventions* to enhance existing strengths, human and social capital and income generation capacities. These are programmes that generally support and reinforce positive activities within the generally-affected population, by providing children opportunities to engage in educational, social, and spiritual activities.

- *Transformative interventions* are those aiming at addressing structural imbalances of power, inequality and vulnerabilities. These include equitable policy promotion, social change and social justice interventions, addressing social exclusion, legal and judicial reforms.

**Figure:** Components of Community Based PSS Programming

<table>
<thead>
<tr>
<th>Protective : RISK COPING</th>
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<tbody>
<tr>
<td>- Community based PSS services help in recovery from shocks and offer relief from stress that are perceived at the individual, family and community level. These interventions usually take place in a continuum that ranges from MH to general PSS activities according to the magnitude and severity of traumatisms. They are traditionally framed within a public health and protection sectoral approach and include the 3 top layers of the Intervention Pyramid for MH and PSS in Emergencies (IASC 2007):</td>
</tr>
<tr>
<td>a. community and family support,</td>
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<tr>
<td>b. focused non-specialised support, and</td>
</tr>
<tr>
<td>c. specialized services.</td>
</tr>
<tr>
<td>A community with stronger social networks and emotional/behavioural stability is a community that copes better with current shocks and recovers quicker.</td>
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<tr>
<th>Preventive : RISK MITIGATION</th>
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<tr>
<td>- Community based PSS services can also have a role in preventing the negative impacts from shocks and emergencies, mitigating their adverse consequences. Most of the interventions at this level refer to the layer “Basic Services and Security” presented within the Intervention Pyramid for MH and PSS in Emergency (IASC 2007). Preventative approaches are characterised by an attempt to anticipate risk and put in place actions considered likely to reduce the likelihood of the onset of difficulties.</td>
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<tr>
<td>A community with stronger social networks and emotional/behavioral stability is a community that is more resilient to shocks.</td>
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<th>Promotive and Transformative : RISK REDUCTION</th>
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<tr>
<td>- Community based PSS services contribute (greatly) to strengthen the self-resilience and inner strengths of individuals/households/groups, potentially enabling people to reach social norms and attitudes of a higher power. Transfers support accumulation of assets, particularly human and social capital. This is likely to reduce the real or perceived intensity of shocks.</td>
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*Source:* Author

While the protective and preventive components address the problem of current impact and consequences of shocks, community focused PSS schemes have also the potential to promote a sustained decrease in future vulnerabilities by improving the emotional and physical environment of boys and girls. This might also play a key role in breaking the intergenerational transmission of
adverse care practices (Conticini and Epstein 2009). By placing concerted attention on children, households and communities, these programs combine social assistance with social development and help in graduating from clinical and preventive approaches (currently dominating the scene in Iraq) to ones that emphasize promotion in the context of holistic community development.

Conceptual Foundations for a Community Based PSS Programme in Iraq

The community based PSS programme for Iraq will be based upon two complementary theoretical pillars:

1- Theories of Individual and Community Resilience upon Adversities, and
2- Theories of Social Capital and Social Trust.

Theories of Individual and Community Resilience upon Adversities

Children’s cognitive and affective processes can be damaged by emergencies, imprinting emotional, psychological and physiological scars. This may lead to behavior characterized by distrust and hostility and can prevent the child from developing into a fully realized adult and citizen. Under the right circumstances, a child’s cognitive and affective processes can also serve as a source of strength, building resilience and increasing the ability to “bounce back” from unusual stress or trauma. This is especially the case when a child can count on continuous support from parents, family, friends and/or other community members and social institutions. Research into resilience has shown that most children can cope fairly well with low levels of risk. Most of the time, their development and ability to reach their full potential will only be jeopardized when risk accumulates (Boothby 1998, Arafat 2003). Iraq represents an example of an environment where risk factors accumulate for many children and young people.

In recent years and under the increasing number of man-made or natural disasters/emergencies, a number of authors have started advocating for the concept of resilience in research, policy and disaster risk reduction arenas. And most recently, the concept of disaster resilience has gained popularity after the adoption of the Hyogo Framework for Action 2005-2015 (Mayunga 2007). In several emergency contexts, but not yet in Iraq, the focus of intervention is gradually shifting from emergency risk reduction toward building community resilience, thus encompassing a limited focus on only reducing hazard and vulnerability.

The term ‘resilience’ is often used in the same manner than the notion of ‘recovery’. It is the ability of a system (including communities) to absorb changes and shocks before it changes its structure,
functions, nature, and processes that control behaviors. It is the capacity of human beings to face and respond to adversities. The quicker the recovery speed after a temporary shock, the more stable is the community in question. Some authors went further to also include the capacities to even take advantage out of adversities and reaching a status after the shock which is a stronger, less vulnerable, equilibrium. A resilient social system should be able to absorb shocks and recover so that the community remains on the same functioning state. A social system with high resilience should also be able to reconfigure itself without significant decline in the crucial functions in relation to primary productivity and economic prosperity (Pendall et al. 2007; Mayunga 2007).

The concept of resilience is not a new one, although defining it precisely remains a problem. A number of researchers have identified specific factors such as trusting relationships, emotional support outside the family, self-esteem, encouragement of autonomy, hope, responsible risk taking, a sense of being lovable, school achievement, belief in God and morality, unconditional love for someone. But there is insufficient understanding on the dynamic interaction of these factors, their roles in different contexts, their expression and their sources. Some factors that promote the psychosocial well being of children seem to be universal: safety and security; sympathetic caregivers (preferably one or both parents); familiar routines and tasks (such as school provides) and interaction with other children (e.g. in play and sports) (SCA 1996). A child’s own genetic make-up and temperament are fundamental to whether he or she will be resilient. That is, a child’s vulnerability to anxiety, challenges, stress or unfamiliarity determines his or her self-perception, how he or she interacts with others, and how he or she addresses adversities (Grotberg 1995).

A child’s resilience can be enhanced by interventions that strengthen internal and external protective factors, which buffer the effects of emergency, vulnerability and insecurity. Internal protective factors are the coping mechanisms of the child itself, described as healthy attempts to deal with an unhealthy environment. Coping mechanisms are constantly changing cognitive and behavioural efforts to deal with specific situations (Paardekooper 2002). External protective factors include the child’s contextual buffer such as social capital and support by adults and peers, daily structure and a peaceful environment (WCH 2005).

While most of the focus in the literature has been at the system and community level, individual/personal resilience, or resilience of particular sub-groups in a community such as family has also been acknowledged as an important component of the overall community performance in front of shocks. Another important strength in the use of the notion of resilience is its inextricable link to the notion of sustainability, which refers to a long term survival at a non decreasing quality of life, facilitating a more sustainable use of community resources. The concept of resilience directs attention to the fact that all people -including children- have assets and strengths and leads to program design that builds upon them.

The two trajectories presented in the below figure show a sequential change of communities over time through four phases, pre-disaster, disaster, restoration, and long-term recovery. The diagram shows that the more resilient community will often experience less disaster impacts, while the less resilient community will experience significant disaster impacts and hence greater fluctuation. It is also clear that the less resilient community will take longer to recover to come back to normal functioning. Understanding the community as a psychosocial entity permits the planners of long-term rehabilitation and sustainability programs to assist the community in identifying the factors that will enhance resilience and promote well being. It will allow the people to move beyond the loss and grief and resume normal activities.

There are interacting psychological and social factors that assist people to overcome adversity. Psychological factors include self-esteem and self-confidence, internal locus of control, and a sense
of life purpose. Social factors include social supports from family, friends, teachers, and community. These include a caring family that sets clear rules and standards, strong bonds with and attachment to the school community, and relationships with peers (Luthar, 2000). Bernard (1991) suggests the characteristics that are consistently exhibited by resilient young people are social competence, problem-solving skills, autonomy, and a sense of purpose.

**Figure:** Comparison between Communities with Different Degrees of Resilience

There has been an increase in post-disaster studies that attempt to measure why some people bounce back faster than others. The studies have identified three constructs that explain the capacity to recover: (1) a person has the support of parents, friends, and other adults or peers; (2) a person has religious, spiritual and psychological resources that will help her/him move ahead; and (3) a person has the desire to move ahead and improve his or her condition.

As a pillar for intervention, the concept of resilience is useful on a number of levels. On a general level, it serves to direct attention to gender and age specific strengths rather than weaknesses. More specifically, it underlines the need to identify and strengthen existing support networks within the community, both formal and informal. It may help in identifying existing and untapped resources which might be developed in a way that provides additional support to children.

Even in the face of extremely stressful circumstances, such as violence, loss of family members, and displacement, resilient boys and girls are able to draw on internal resources and external support to cope and adapt. Although all children react differently to stress, research has found that resilient children/youth do share certain characteristics or protective factors which seem to help them avoid long-term negative psychosocial effects. These factors include:

- Strong attachment to caring adults and/or peers;
- An ability to seek out positive, encouraging role models;

*Source: Mayunga 2007*
• Easy interaction with adults and peers;
• A level of independence and an ability to request help when necessary;
• Regular engagement in active play;
• An ability to adapt to change;
• A tendency to think before acting;
• Confidence to act or control aspects of his or her life or circumstances; and
• An active interest in hobbies or activities (SCA 2004, and Donahue-Colletta, 1992).

Table: Examples of Definitions of Resilience

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<tr>
<th>Author</th>
<th>Definition</th>
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<tr>
<td>Timmerman, 1981</td>
<td>Resilience is the measure of a system’s or part of the system’s capacity to absorb and recover from occurrence of a hazardous event.</td>
</tr>
<tr>
<td>Wildavsky, 1988</td>
<td>Resilience is the capacity to cope with unanticipated dangers after they have become manifest, learning to bounce back.</td>
</tr>
<tr>
<td>Buckle, 1998</td>
<td>Resilience is the capacity that people or groups may possess to withstand or recover from the emergencies and which can stand as a counterbalance to vulnerability.</td>
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Yet, there is still insufficient understanding on the dynamic interaction of these factors, their roles in different contexts, their expression and their sources. A child’s own genetic make-up and temperament are fundamental to whether he or she will be resilient. That is, a child’s vulnerability to anxiety, challenges, stress or unfamiliarity determines his or her self-perception, how he or she interacts with others, and how he or she addresses adversities.

By strengthening the protective factors for all children and youth, resiliency will also be strengthened. These are characteristics that can be enhanced through a careful understanding of children’s capacities and needs. Children’s inherent resiliency can be strengthened by age and gender appropriate interventions which allow children to develop or augment these characteristics even in emergency settings, thereby creating a more protective environment for the child. The protective factors listed above include internal resources, such as confidence and judgment, as well as external resources, such as an ability to seek out support and role models. This emphasizes that a resilient child is one who can call on a variety of support mechanisms when faced with new challenges (SCA 2004).

Box: Specific Suggestions for Enhancing Resilience in Children

1. A stable emotional relationship with a parent or other care-givers/s
2. Social support within and beyond the family to include relatives, neighbors, teachers, peers, etc.
3. An education climate which is emotionally positive, open, guiding and norm-oriented
4. Role models which encourage constructive coping
5. An appropriate balance of social responsibilities and achievement demands
6. Cognitive competence for skills development and realistic planning
7. A positive sense of self-esteem, self-confidence and self-control
8. An active coping style rather than a passive approach
9. A sense of structure and meaning in one’s life, often informed by religious or political beliefs, a sense of coherence, etc.

Source: Adapted from Tolfree 1999, and from Eriksson’s child development framework

Theories of Social Capital and Social Trust
All communities have mechanisms that maintain stability, decrease attrition between people, and manage adversity. When these mechanisms are in place, children are buffered from many of the difficulties of life, and parents are assisted in helping their children overcome stress. Some of these mechanisms are simply the celebrations and rituals of family life that keep people in good spirits or allow for the release of tension in difficult times. In addition there are the special provisions that a society makes for more serious difficulties. Children are protected from developmental disruption in difficult times by these means. To the extent that such mechanisms are in place, the psychosocial needs of children can be met, even in adversity. When these mechanisms are overstressed or have been abandoned, it may be important to assist the community in strengthening or restoring them in order to re-establish coping strategies for children (CARE 2005).

Much of the contemporary discussion about emergency planning assumes that community members ‘panic’ and that strong authority is necessary. The vocabulary of ‘command and control’ suggests chaos rather than citizen adaptability and creativity. Such assumptions can be questioned by the research evidence accumulated in recent years. While we calculate damage to physical and human capital, we usually ignore the social capital available within communities to deal with emergency and recovery (Dynes 2006). Social capital is our most significant shared resource in responding to damage caused by disasters or others hazards such as terrorism.

Social capital is not located in individual people, as in human capital, but rather is embedded in social relationships and networks between and among members of a community. These relationships can be used to guide collective action in emergency situations. In other words, even with losses to physical and human capital, social capital might result less affected, might be quickly repaired, and might provide an essential resource in accomplishing critical tasks (Dynes 2006). The stronger the social network among community members, the more trust the members of that same community might place in their own strengths to overcome adversities. Social capital fosters tolerance, allowing societies and communities to overcome traditional dilemmas of opportunism and collective action by norms of reciprocity that serve to reconcile self-interest and solidarity. These norms are likely to be associated with dense networks of social exchange, and are self-strengthening and reinforcing: ongoing social relations can generate incentives for trustworthiness in future exchanges.

If a basic component of PSS services at the community level is the degree of mutual support that children can find within their peers, within the household or within the community at large, it then results clear that a community with higher degrees of social capital is also a community naturally better equipped to support the child in his PSS needs. Additionally, communities with high degrees of social capital are also communities that tend to perform better in social justice issues. Arguably, people strongly connected in networks of positive mutual relationships are also people that have a collective interest in guaranteeing that social justice is preserved and fulfilled towards all the members of the network (community). To this extent social capital and social justice have often been used in combination with the concept of social trust.

A precise definition of social trust is difficult to pin down, but it has been encapsulated as an ongoing motivation or impetus for social relations that form a basis for interaction. Social trust can entail perceived honesty, objectivity, consistency, competence, and fairness, all of which foster relationships between individuals that must be maintained by the sustained fulfillment of these standards. It has been described by several experts as a “risk judgment”: a form of cooperation that has no immediate payoff or benefit and gambles that the trusted party will act as expected. Thus in many ways, trust is a strategic game. The values that form the basis of social trust are not universal, but rather can vary among cultures, between contexts, and across time. It is a proven fact that social trust is important (Boslego 2005). The existence of social trust might signify internal peace and
stability and therefore could be correlated with freedom, democratization, modernization, or a number of other developmental benchmarks. It has also been shown to constrain immoral behavior, since knowing that another has placed his trust in a person can make that person feel responsible for upholding that burden. 

Box: Specific Suggestions for Enhancing Social Capital

The basic assumption relating to social capital is that the local social system is the logical and viable base for all stages of emergency action and recovery. Certain specific courses of action have been suggested as a guide to policy making:

1. Utilize a variety of mechanisms to increase community identification and collective responsibility. Enlist religious and other civic organizations to build disaster responsibility into routine messages about moral and civic responsibility. In particular, there is a need to remind the community that the greater the emergency, the more the community will have to depend on its own resources.

2. Involve civic organizations in planning activities. Develop an inventory of and knowledge about community resources, both people and materials. Encourage organizations to develop certain useful emergency skills. For example, groups with physical locations, such as mosques, schools, and some civic organizations, might develop skills in running mass feeding operations, shelters, information centers, etc.

3. Utilize existing habit patterns as the basis for emergency and recovery action. To do this effectively, knowledge of the patterns of social life and their routines is essential.

4. Utilize existing social units, rather than create new ad hoc ones. If families are the major point of resource allocation within the community, utilize that system.

5. Utilize the existing authority structure, rather than create new ones. The speed with which decisions are made can be increased more easily by the use of a traditional structure than by the creation of a new one. The establishment of authority, which involves not only power but the acceptance of that power, takes time and is not easily or quickly reversed.

6. Utilize existing channels of communication and increase them, rather than restrict and narrow them to “official messages.” Information about potential risk, potential threat, and potential preventative action are not disorganizing; the lack of information, in the quest for certainty, may be. Any effective emergency plan is based on the autonomous and independent decisions of many to take appropriate action. These actions are more effective when communication is enhanced than restricted. Some citizens may be socially isolated because of disabilities, age, illness, and geographical location. Attempts to reach these people can also utilize conventional methods of social capital.

Source: Adapted from Dynes (2006)

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3 Emergencies usually directly affect the child’s sense of trust in the capacity of parents and families to protect and nurture, in the capacity of the communities to provide for basic resources, in the capacity of society to provide for a sense of predictability and protection. Above all, emergency also affect the child sense for self-trust.
The Child, The Family and The Community

Role of the Family

One of the most important contributions that can be made to improve children’s psychosocial well-being is to help adults in a family re-establish their capacity for good parenting. The family is the fundamental social unit in almost all societies and plays a critical role in meeting basic human needs. Boys and girls depend on their families for their survival and for their well-being. A caretaker’s illness, death, or separation deprives the child of the many developmental benefits of parental care (SCA 2004). In general, children (and adults) who have good relationships with family and friends have fewer symptoms of psychosocial difficulties or mental traumas. In fact, there is evidence that a good social network contributes to a longer life. Additionally, the theory of attachment formulated during the 60s by J. Bowlby shed light on the fundamental role that the primary caretaker (usually the mother) has on the child at an early stage in life, and its consequences on adult behaviors. The role of the father, while important, is secondary to the one of the mother, and his influence as a role model will only start later in life. The younger the boy or the girl, the more their well-being depends on the well-being of the caretakers. If the caretaker is calm, the child is calm; if the caretaker is depressed, the child will suffer. This obviously works in reverse: when their children cope well, parents often cope better. The psychosocial well-being of adults, particularly parents and caregivers has a direct impact on that of children, and should thus be addressed through concurrent parent-focused and gender sensitive psychosocial interventions (IWG 2005). Rebuilding the child’s ability to trust is a task for everyone, but especially for those closest to children in their daily life. The most effective way to do this is by establishing good relationships with children, through play, listening, supporting, keeping promises, involving children in real tasks and giving them proper feedback (SCA 1996).

Furthermore, adults are role-models, showing through their behavior and actions how children should act – the primary role model for a boy or a girl are the father and the mother respectively. The closer the relationship between a child and an adult, the more likely it is that children will model themselves after the caretakers. Essential steps in the healing process, once security is assured, include re-building trust in others; re-establishing self-esteem; and developing a positive sense of identity and direction. Children who have been continually exposed to violence often express a significant change in their beliefs and attitudes, including a fundamental loss of trust in others. The more we support the children’s parents, family or other caretakers, the better able they will be to serve as good role-models for their children. Therefore, providing support to families allows them to offer stability and improved care to their children. Promoting normal family and everyday life also reinforces a child’s natural resilience. As a result, psychosocial interventions may provide support which targets not only children directly, but also their caretakers through parenting peer support, early childhood development (ECD) activities or livelihoods support such as skills training. Ensuring that caregivers have the time to care for themselves and their families in threatening environments is also integral to children’s psychosocial well-being, as caregivers under extreme stress will not be able to provide essential support to their children (Duncan and Arntson 2004).

Role of the Community

In all societies, families are the first to protect their children and help them grow into strong and healthy adults. But children also interact beyond the family circle through a range of social activities with friends, teachers, religious leaders, and other community members. This broad community interaction helps them build their identities and understand the cultural norms and values which enable them to become functioning members of their societies. A child’s understanding of the world is not only influenced by the direct experience of events, but also by the family, friends, and
community which help to interpret or ‘mediate’ these events. A child’s well-being and healthy psychosocial development are, then, dependent upon how he/she interacts within the broader social context of family, community, and culture. When conflict erupts, there are far-reaching consequences at the community level as traditional structures erode, authority figures weaken, cultural norms and coping mechanisms disintegrate, and traditional support relationships disappear. In times of crisis, distrust and isolation become more common, making children even more vulnerable to psychosocial harm (Duncan and Arntson 2004).

The social environment or “ecology” in which boys and girls develop plays an important role in their behavior, attitude, and sense of self. The diagram below shows the inter-related levels of support. Children interact within the nested social systems of family (including clan and kinship group) and wider society (including community institutions and religious and ethnic networks). A child’s well-being requires strong and responsive social support systems at the family and societal level. Children develop and bring their own ways of understanding and adapting to a situation, but the degree to which they can find or draw on these coping mechanisms depends on internal as well as external resources. During times of crisis, these social support systems may break down temporarily. As children try to cope with extreme violence, loss, fear, and social upheaval, it is important to understand that their usual resources may no longer be at their disposal. To promote psychosocial recovery, it is essential, therefore, to not only support the child directly, but to also restore these social and community mechanisms in order to provide the child with additional external resources and support (Duncan and Arntson 2004).

Figure: Social Ecology of the Child

Source: Duncan and Arntson (2004).

Community Planning and Participation

The basis for a successful community based PSS programme is in the degree of participation of community members in the design and implementation of the programme itself. With the current limited access to most of Iraqi communities, and remote programming, it is even more important to facilitate ownership of the intervention by communities since the onset.

The Framework foresees external agencies as having a facilitation and supportive role, while the decision making component will remain in the hands of communities. The difference between the approach proposed and the traditional approach observed in the field can be illustrated by the figure below.
Figure: Role of communities in decision making and coordination approaches

Approaches that try to solve PSS issues in an individualistic rather than in shared terms are particularly inappropriate for the Iraqi society that possesses a ‘we’ instead of ‘I’ perception of negative events and experiences. Hence approaches that see PSS issues in individualistic terms may not only enhance the person’s sense of vulnerability, but deny or ignore the collective resources which might be more appropriately utilized. Community based PSS services place emphasis on programmes that focus on common needs within the community rather than specific needs of individuals. They promote collective solutions to shared problems, after having identified community definitions of needs and priorities rather than professional judgments about them.

A recurrent priority that has been presented as best practice is the need to understand how problems are perceived by the people themselves, and what resources are available to the culture and community to respond to identified problems (Tolfree 1999). The task of the external agency can thus be defined as the one of enhancing these resources and facilitating the decision making process, rather than proposing or implementing external solutions to healing.

Box: Rights and traditions - reconciling differences

A common opposition to community based PSS interventions echoed during initial consultation for the development of the current Framework has been that PSS services promoting the holistic development of the child must be grounded within local traditions and cultures, but these traditions might well be in direct opposition to human rights fulfillment. The perception is thus that promoting human rights as well as PSS services, while having a broad spectrum of overlapping objectives, might also present conflicting agendas. Like most areas of international law, universal human rights and especially children’s rights, are a modern achievement, relatively new to many cultures. Each of us can point to ways in which old ways, and old practices as well as new ones in our own cultures, violate human rights principles that we both respect and advocate for in every corner of the world.

Many people today grew up in a time when advocating rights meant shedding such traditions as slavery, racism, and colonialism which had led us on a path of exploitation and war. And yet, radical attempts to throw off the chains of earlier times, without attention to what those trends represented, often led to a backlash both profound and bloody. This was especially true when throwing off those chains was essentially the product of globalisation, or the imposition of the will of an outside power, announcing liberation with the help of tanks and guns (i.e. Iraq). In many
cases, the chains in question were perceived by the population as the myriad of small things that held culture together and represented resistance to colonial and neo colonial power.\(^4\)

Further, when we talk of children’s development, we talk about the most intimate part of human life: the century old ways through which human bonds are used to welcome a new generation of people into the world and give them the essential capacities necessary to live in it. Many advocates whose work is cited in this report worry that universal human rights can be intrusive and disruptive to the most essential protections that traditional societies afford to children.\(^5\) Without these traditions, it is difficult to imagine that children’s care and protection can be managed at all.

Further, the Convention on the Rights of the Child asserts that every child has the right to his or her culture, and Article 30 specifies the right of children to “enjoy their own culture, practice their own religion and use their own language.” However, the central role of culture in the protection of children’s rights is not necessarily in opposition with the view that traditional culture alone does not often provide sufficient protection, and therefore universal rights are necessary. The answers to these questions are not easy, and can only be resolved by constant attention to the dialectical tension between these two essential poles. Critical to a good solution is the view of culture, protection, and harmonious development as a compelling part of human rights fulfillment that must be protected. This view then leads us to develop programmes that strive to create an appropriate balance.

To begin to address this dilemma, we must understand, and include as a part of each initial assessment, the ways in which the traditional culture protects the well-being of children. This understanding can then help us to illustrate the common foundation of human dignity on which human rights promotion stands. It will enable us to assert the relevance of universal rights to the culture and place in which we work. Recognition and appreciation of each particular cultural context can then serve to facilitate, rather than reduce, human rights respect and observance by communities.\(^6\)

\(\text{Source: CARE 2005}\)

### Overarching Principles for Community Based PSS Interventions

From what presented above, certain key principles are important in supporting this psychosocial Framework.

*Communities are not empty terrains* but contain within them a wealth of formal and informal resources and information which can greatly contribute to the processes of healing. Many of these resources are invisible to outsiders unless outsiders explicitly look for those in consultation with communities.

*The concepts of ‘self’ and ‘us’* might be very different between external aid actors and local communities. In some cultures, problems might be seen in a collective rather than individual terms. Western societies place great emphasis on individuality, but in many more traditional societies, such as the Iraqi one, the idea of self is embedded in community and collectivity. This is an enormously

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important concept that has deep implication in the ways PSS programs should promote individual versus community commitments.

**Different cultures have different norms regarding the expression of feelings, and different rules regarding what can be discussed and with whom.** Western approaches tend to emphasise the cathartic value of expressing feelings as well as talking through difficult and painful experiences but in other cultures such as the Iraqi one, public expressions of feelings might not be judged fully appropriate for certain age/gender groups. Public discussions can thus center on events rather than directly on feelings. Children should then be encouraged to express their feelings in the forms and ways that are appropriate to the community set of norms.

**Focus on traditional mediums of communication.** Western approaches tend to be heavily oriented towards communication through the medium of talking, but this is not necessarily characteristics of all societies. In Iraqi society for instance communication approaches based on art techniques such as chanting, dancing, poetry, and playing are a culturally more appropriate medium of interaction that should be considered besides talking communication approaches.

**Approaches might be adapted in situations of continuing violence and stress.** Much of the tools and approaches used in community based PSS services have been developed, tested and researched in situations where stressful events happened in the past and had a relatively transitory nature. In this respect, Iraq represents a particular case because the acute emergency gradually shifted into a situation of chronic vulnerability, insecurity and instability. Transition towards peace and security takes place within a context of multiple and recurrent shocks that are an ever-present reality.

**It is important that existing traditions, resources and structures within the community are fully understood if programmes are to build effectively on them.** People’s reactions to stressful experiences are, to a great extent, influenced by their perception of the meaning of those events. Informal patterns of leadership might also be worth considering before aiming at empowering specific groups within the community (Baron 2005). The literature places great emphasis on political ideology in helping people to make sense of their experiences, but religion and traditional beliefs also play an important part. The point to highlight here is the need to understand the frameworks of traditional belief, religion, political affiliation, national identity, etc. through which people understand and interpret events and experiences (Tolfree 1999). The partnership with local facilitators, youth groups and social workers in Iraq will thus help in grasping better understanding of community resources.

**Cooperation with government and civil society is the backbone of good programming.** It is essential to work in close cooperation with the national government and civil society in each zone to ensure understanding, commitment and responsibility for the care and protection of children and psychosocial initiatives. Despite the ongoing insecurity and continual changes in government, it is essential to work in cooperation with the evolving government structures to ensure the development of sustainable infrastructures.

**Ethical standards and supervision is compulsory to any well designed community based psychosocial support intervention.** Ethical practices help people involved in programming to adhere to the highest quality and protection standards. While ethical standards regulate individual and group interventions and interactions, supervision helps in taking informed decisions and consistency in the best interest of the child. The two components must thus be integral part of the present Framework.

**Since psychosocial components are part of normal life, it is essential to integrate this understanding into all existing frameworks, infrastructures and levels of support.** This includes promoting the
importance of a holistic approach to child development that includes psychosocial needs and the promotion of psychosocial well-being for all people. UNICEF Iraq can promote this as part of its public media campaigns and in its initiatives in relief, health care, justice for children, education, women and youth programming etc. It can also advocate for an integrated approach with the government and other organizations.

*Investment in local capacity building ensures that efforts are viable and sustainable over time.* Capacity building is vital for developing group of national professionals who can plan, design, monitor and deliver psychosocial interventions in Iraq. Initially, capacity building can take the form of training and supervision, but as a resources are developed, emphasis can evolve to training of trainers, curricula development within education institutes, standards setting, minimum requirements for practice, and policy making.

**Box: The Ethics of PSS Workers and Community Facilitators**

**Respect for People Dignity**
Psychosocial workers and community facilitators should respect the dignity of all people. They should acknowledge, be tolerant and respect the viewpoint of all people.

**Concern for the Wellbeing and Welfare of People**
Psychosocial workers and community facilitators should protect the wellbeing and promote the rights and interests of all people. Where the rights and interests of one group conflicts with those of another, psychosocial workers should create the space for dialogue and negotiations.

**Value Diversity of People**
Psychosocial workers and community facilitators should value the diversity of people, cultures and values and should not practice any form of discrimination on the base of race, sex, sexual orientation, age, class, religion, ethnic origins, political belief, mental or physical impairment, or any other preference or condition on an individual.

**Possess Integrity and Honesty**
Psychosocial workers and community facilitators should be honest, trustworthy and reliable. Psychosocial work involves considerable physical and emotional strain; therefore psychosocial workers should ensure their own wellbeing so that they can exercise clear thinking and sound judgments, together with sensitivity and tolerance.

**Execute Responsibility to the Psychosocial Sector**
Psychosocial workers and community facilitators should uphold public trust and confidence in psychosocial services (PF 2004).

**Respect Age and Gender Diversities and Specificities**
Psychosocial workers and community facilitators should bear in mind that age and gender specificities shape the ways they interact with populations and condition the way reached population see and perceive the work promoted. A full respect, adaptation, and consideration of these two variables will allow for greater effectiveness of the intervention proposed.

**Mind Power Dynamics**
External aid and psychosocial workers can be perceived as *de facto* having some power over the reached populations. Social worker should bear this in mind and not enter into any sort of power dynamics that could compromise their role and reputation vis-a-vis the affected population.
Community Based PSS Support as a toll to enhanced policy making and decentralisation of services

Lessons learned in previous PSS work have highlighted the many opportunities that are intrinsic to community based planning under the facilitation of Government institutions. The Government of Iraq could take stock of these lessons to increase the link between child centered policy making, evidence based programme setting, and decentralization of service provision. Thus, the recommendations obtained from the Committee on the Rights of the Child, and the periodic recommendation from the Office of the Secretary General for Children in Armed Conflict could also find a channel for implementation that directly links communities to the different levels of policy making in the country.

Acknowledging Previous Best Practices and Success Stories

UNICEF has, overtime, invested in supporting a global culture of identifying best practices in PSS programming, acknowledging promising approaches, as well as highlighting strategies that have proven less successful than what hoped. The Iraqi community based PSS programme should capitalize on the lessons learned in other country programs over the past years. While a thorough literature review of global practices for community based PSS is not within the scope of the current Framework, it is useful to present, in a summary form, the main lessons from the field that have been presented by scholars. Taking stock of best practices and working models is a priority effort that helps in consolidating the analytical and conceptual foundations of the current Framework proposed for the response in Iraq. The following part thus shortly presents the key recommendations and findings that emerged over recent years from PSS programming at community and individual level in the Middle East.

Key Lessons Recently Learned in the Middle East

- IASC Guidelines as broad framework of reference is essential and compulsory.
- PSS planning and programmes need to be framed in a human rights based approach and activities defined under protection rather than service delivery.
- To capacity build PSS initiatives into regional, country, cross-border and inter-agency collaborations and coordination.
- PSS training development should incorporate ‘a description of essential workers competencies that is locally relevant’.
- Strategic plan to capacity build PSS work into other UNICEF sectors (esp. health & education) which would embrace ‘social considerations’ in all aspects child wellbeing.
- Need for pre and post-tests to assess staff training programs.
- Data collection needs to be a core priority. Develop technical assessment, monitoring, surveillance and reporting tools (stand-alone PSS tools and/or integrated into other sector tools) that are developed within a human rights and protection framework.
- Need Code of Conduct for Psycho-Social Interventions that ensures quality control and ethics.
- Problems with using medical model which exaggerate and associate mental illness, including trauma, to a large proportion of the population. This strategy is risky since it pathologizes every family or child. Medical approach can be more disempowering than empowering.
- Promoting resilience is most important and it opposes to “trauma” and individual or therapeutic models.

7 See for instance Baron 2002.
• Applying foreign/imported techniques that have not been updated and do not take into account the local realities and culture, social networks, and community and family resources are problematic.
• Interventions targeting children without families limit their effectiveness and sometimes undermine the child’s existing support mechanism (“Community focused” not just “children focused” intervention is essential).
• Interventions should build onto existing community structures.
• Best not want to single out the “vulnerable” rather pull them all together and mainstream them.
• Interventions that allow children expressing their feelings and distress but not provide a healing or problem solving process are problematic.
• Promotion of positive “life skills” seems more practical than counseling because this last is an unclearly defined set of actions and no one seems able to explain an effective “counseling” intervention.
• Although UNICEF policy is weak with regards to economic development initiatives and strengthening livelihoods these are critical issues that need to be progressively taken into consideration within national strategies.
• Dedicated budget, resources and capacity to develop and integrate models of coordination and communication and information systems into child protection and PSS (emergency) planning and programming, including inter-agency collaborations and partnerships for community messaging (public information and psychosocial education).
• Training mainly works if practical and not academic.
• The cascade training model has failed in several contexts because of poor supervision and ongoing coaching of trainers.
• Expectations for community based PSS programmes must be realistic and not too demanding: PSS interventions need to be mainstreamed into existing practices without adding on the burden of selected professionals.
• Training others is a specialized task and requires full understanding of materials. It is not successful to just teach people something and expect them to teach it to others.
• Effective training that results in parents or adults changing their attitudes, and empathetically assisting the children is difficult. Training of practitioners is most effective when the focus is on their self-understanding and personal development. Through self-awareness training, facilitators became more sensitive to children and provide a more positive environment.
• Need clear assessments, strategies, priorities and indicators leading to evaluation in psychosocial initiatives just like in other programs.
• Individual talking counseling is not a good choice of treatment. Children often distrust adults and are not ready to talk with them. Children need time and emotional space in order to adjust. Activities are to be preferred and fill the purpose of transition and normalization. Expressive methods like dance, music and drama are culturally preferred and offer indirect consolation, support and expression of feelings.
• Important to utilize traditional methods of healing, reconciliation and forgiveness in the process of reunification and reintegration (Barron 2002).

Box: Examples of Community Based PSS interventions and their link with more specialized interventions

Promote a sense of safety and security
• Make sure children are physically safe from harm and dangerous and exploitative situations.
- Ensure both the physical safety and the psychological well-being of children and their families. They should “be safe” and “feel safe.”
- Create friendly spaces to give children the possibility for play and the freedom to be themselves, unafraid and confident that nothing will happen to them.
- If applicable or appropriate to the context and if possible, provide the community with security measures, such as police presence or other law enforcement officials.

**Establish trust**
- Remain aware that under extremely stressful situations, children and their families experience a lot of pain and suffering along with various emotions, such as fear, anxiety, helplessness and hopelessness. And that in some cases, these situations destroy people’s trust in themselves, other people and the immediate environment.
- Seek strategies that will bring back people’s confidence in themselves and in others.
- Identify trusting and caring adults whom children respect, can rely on and feel comfortable with.
- As much as possible, create an atmosphere in the immediate environment that is conducive for playing and other structured or routine activities that will give a sense of normalcy to children’s lives.

**Strengthen relationships**
- Recognize the network of relationships children are a part of, starting with the family and growing to include peer groups, their neighborhood, school, religious groups and community.
- Recognize that connections between people and their environment are affected by changes in context (economic, political and social) and that strong family and community ties become protective factors that promote a sense of security, safety and trust – which are important to a child’s sense of identity and belonging.
- Recognize that in extreme cases, fear overwhelms the lives of children and can shatter their identities, causing them to withdraw from relationships, to not assume their roles and responsibilities and to stop caring for others.
- Seek strategies that address these “broken” connections – to the self, the family, friends, community and the environment.
- Recognize that crisis situations also may open up new beginnings and renew meaningful relationships.

**Enhance resilience**
- Remember that even in the midst of very stressful situations, every individual has resilience – or the capacity to cope or to engage in “self-help” and “mutual help” efforts.
- Realize that a child’s resilience needs positive elements in his or her environment, often described as protective factors or processes. The interaction of risks and resilience factors plays an important role in the development and well-being of children.
- Aim to reduce risks and increase resilience in children and their families.

**Increase awareness**
- Seek strategies that will generate a new understanding of psychosocial support and protection and promote healing and wellness in the lives of children, their families and communities.
- Identify key issues and concerns that will be raised at the level of policy and decision making.
- Include provisions for advocacy efforts in all recommendations.

**Ensure sustainability**
- Ensure that strategies stress continuity and the follow-up of plans and programmes.
- Include strategies for fostering support within the community and for communities to empower themselves to avoid creating dependency on outside help.
• Include feedback and follow-up provisions to strengthen a community’s capacities and improve on the participation of children, families and communities.

Bibliography


Boothby, N. (1996) “Mobilizing communities to meet the psychosocial needs of children in war and refugee crises”, in R. Apfel and B. Simmon (eds.) Minfields in their hearts; The mental health of children in war and communal violence (149-164), New Haven: Yale University Press;


Guiding Principles


UNICEF (2007). Emergency Psychosocial Programmes. Middle East and Northern Africa Region. Amman