Community Based Psychosocial Support:
A Strategy for Action
© UNICEF, 2010

The opinions expressed in the current document are entirely those of the authors and they do not necessarily reflect the opinion and policies of UNICEF.

Text  Alessandro Conticini and Valérie Quéré – Play Therapy Africa

Supervision : Fatuma Ibrahim, Chief Child Protection – UNICEF Iraq
Scientific inputs and programmatic support: Susan Prosser, Regional Advisor on PSS, UNICEF MENA

Methodology, facilitation, technical support and edition:
Play Therapy Africa
www.playtherapyafrica.org
# Table of Contents

The WALL .................................................................................................................. 7  
Building Resilience: the BRICKS.............................................................................. 8  
I HAVE .......................................................................................................................... 10  
I AM ................................................................................................................................ 10  
I CAN ............................................................................................................................... 11  
Enhancing Social Capital: the MUD........................................................................ 12  
A Positive Approach: the CEMENT........................................................................ 15  
The Focus of the Programme: The Child, the Family and the Community.......... 16  
Principles and Methods ............................................................................................. 17  
CROSS-SECTORAL INTERVENTIONS ................................................................... 17  
‘SPECIAL CHILDREN’.............................................................................................. 18  
YOUTH GROUPS FOR OUTREACH WORK ............................................................. 19  
MULTIPARTNERSHIP APPROACH AND COMPLEMENTARITY OF SERVICES .... 20  
COMMUNITY DIALOGUE and LOCAL NURTURES .............................................. 20  
SPORT, PLAY and STRUCTURED GROUP ACTIVITIES........................................ 22  
GOOD PARENTING SKILLS ...................................................................................... 23  
COMMUNITY INVOLVEMENT: DESIGN, IMPLEMENTATION and MONITORING .. 23  
COMMUNITY MESSAGING ....................................................................................... 24  
WALL’s Programming Rules ...................................................................................... 24  
1. Children’s right to life, survival, and development................................................ 25  
2. Respect for the views of the child ......................................................................... 25  
3. Best interests of the child ...................................................................................... 25  
4. Non-discrimination of any kind ........................................................................... 25  
5. Child-centeredness ............................................................................................... 25  
1. Gender equity and age sensitivity ....................................................................... 26  
2. Sustainability ......................................................................................................... 26  
3. Scaling up ............................................................................................................. 26  
4. Measurable impact ............................................................................................... 26  
The Steps of the Project and possible Timeframe ................................................... 27  
STEP 1: Develop a Conceptual Framework and Strategy for the provision of community based PSS interventions ....................................................................................... 27  
STEP 2: Support the establishment of an Interministerial working group to supervise and coordinate the programme .................................................................................. 28  
STEP 3: Develop capacity building and training tools for the implementation of the programme ...................................................................................................................... 28  
STEP 4: Provide the different types of capacity building and training for youth, parent/caretakers and community leaders ........................................................................... 28  
STEP 5: Support the development of community plans, goals and activities .............. 29  
STEP 6: Implement identified community based PSS activities starting from the IASC minimum standards for community mobilization and support ................................... 29  
STEP 7: Strengthen collaboration and coordination with all existing actors working in identified communities .................................................................................................................. 29  
STEP 8: Oversee and supervise community facilitators and provide them with ongoing mentoring and training (Quality Assurance) ........................................................................ 30
STEP 9: Assess the initial outcomes of intervention on children, families and communities...... 30
STEP 10: Present communities and partners the outcomes of the First Phase ..................... 31
Quantifying and Qualifying Impact .................................................................................. 31
Ethical Conduct of Psychosocial Workers and Community Facilitators for the Implementation of
the WALL Programme ................................................................................................. 33
1. Relationship to Clients and Service Users ..................................................................... 33
2. Relationship with Colleagues ....................................................................................... 34
3. Upholding the Credibility of the Agency ....................................................................... 34
4. Upholding the Credibility of the Psychosocial Sector ................................................ 35
5. Responsibility to Service Users ..................................................................................... 35
6. Responsibility to Psychosocial Workers and community facilitators .......................... 36
7. Maintaining the Best Interests of Children ...................................................................... 36
8. The Limits of Confidentiality ......................................................................................... 37
9. Legal and Civic Duties of Psychosocial Workers and Community Facilitators .......... 37
10. Transparency in Work .................................................................................................... 38
11. Time Keeping ............................................................................................................... 38
12. Record Keeping ............................................................................................................. 39
13. Handing Over Services ................................................................................................. 39
14. Self-Awareness ............................................................................................................. 40
15. Responsibilities of Psychosocial Supervisors ............................................................. 40
16. Responsibilities of Peer Supervisors ............................................................................ 41
17. Preparing for Supervision ............................................................................................. 41
18. The Role of Supervision ............................................................................................... 41

Annex 1 ............................................................................................................................... 43
Fundamental Psychosocial competencies among children and adolescents ......................... 43

ANNEX 2 ............................................................................................................................ 45
Emotional and Social Assessment of the Child using Ages and Stages Questionnaire, Strengths and
Difficulties Questionnaire, and indicators based on Erickson, Piaget, Freud and Bowlby’s theories 45

Annex 3 ............................................................................................................................... 48
Ethnographic Indicators used to assess PSS programming’s Outcomes at the Child, Family and
Community level .............................................................................................................. 48

Source: Adapted from Prewitt-Diaz (2006).ANNEX 4 ....................................................... 49

ANNEX 4 ............................................................................................................................... 50
Evaluation of increased Resilience and Social Capital at the Individual, Family, and Community
Level using the I AM, I HAVE, I CAN framework................................................................. 50
“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

‘Childhood is measured out by sounds and smells and sights, before the dark hour of reason grows’

John Betjeman
Winning-back happiness for ALL (WALL)

Introduction

Once the basic structures of life are re-established as much as possible, and the acute emergency has evolved into a situation of chronic insecurity or recovery, explicit community based psychosocial programmes can be designed and put into place. These programmes can assist children in coping with the effects of the sudden or recurrent violence that they have experienced. Crucial in this regard is the restoration of culturally accepted means for the integration and symbolization of events. This integration and symbolization must be achieved not only by individual children and adolescents, but also by the community as a whole. As institutions and adults are able to manage this they can best assist their children.

The hallmark of best practice in psychosocial programming is the restoration of coping mechanism in the home, community and society that support families to raise their children well, and create new mechanisms where none can be found to address the situation at hand, or where old mechanisms are thought to be harmful (CARE 2005). These measures are critical during emergencies and recovery, as they insure the promotion of the protective factors for children.

The current Strategy is the operationalisation of the Framework for community-based PSS in Iraq. As such, it cannot be considered in isolation from the theoretical frameworks and conceptual challenges that have been presented and explained within the Framework. Rather than being a policy document, the Strategy answers the need to have evidence-based, programmatic suggestions for future interventions.

The Strategy is a strategic document that aims at providing programmatic guidance and setting boundaries for the implementation of the Framework. As such, it is a document whose content is not set in stones, but very much open for revision and modifications as the need arises, and as initial implementation suggests diversion from the original ideas here presented.

The Strategy has been written trying to reach a difficult balance between centralized and uniform programming approaches, and decentralized and heterogenic ones. Find the right compromise between a centralized program at the national level (with substantial degrees of regional uniformity), and carefully decentralized implementation modalities (with substantial degrees of heterogeneity), is a difficult task. The Strategy is designed around the belief that carefully conceived balance between national uniformity and regional heterogeneity leaves the door open for adapting the program’s objectives to culturally and geographically relevant issues, consider local authorities’ priorities, and strengthen communities’ involvement in tailor-making the intervention according to the specific needs identified. As such, this Strategy only provides the boundaries, principles, and rules of programming for community-based psychosocial support in Iraq, yet it doesn’t go as far as identifying fixed activities because it would deny the very nature of community programming and self-help promotion. Where possible, examples on ‘how to do’ are provided, but those examples are mere suggestions for participatory review instead of guidelines.

The Strategy has been developed with the participation and suggestions received from a number of civil society and government actors that have helped in reviewing current practices and gaps in PSS services in Iraq, as well as setting realistic targets for intervention. While the Strategy ambitions to guide the future collaboration between UNICEF, the Government of Iraq, and UNICEF’s partner NGOs working on community based service delivery and PSS, it is a document accessible to all civil society actors that intend to review their current practices on the field.
The Strategy’s main beneficiaries and implementers are children, youth and selected communities. As presented in the Framework, good practices in community based PSS support have shown that the role of external agencies, while important, can only be the one of facilitating, building capacities and fostering community mobilization, as opposed to substitute for it. This is why while external aid will be important in providing for the suitable programmatic and policy framework for the intervention to successfully happen, only the buy in by communities and community-based associations will allow for the programme to be successful.

Finally, experience has shown the many flows of PSS interventions in terms of monitoring and evaluation. PSS is still, by large, considered a ‘soft’ intervention as opposed to ‘hard’ and more visible interventions such as schooling, health services, and alike. Donors and professionals have increasingly advocated for strong evidence-based monitoring frameworks to be established to be able to quantify and qualify the outcomes of PSS interventions, possibly leading to further and larger investments in the sector. While the Strategy recognizes that genuine participatory processes will lead to shifts in practices only through time (overnight achievements are by definition the outcome of interventions implemented for communities but not with communities), it is firm belief that a strong monitoring and evaluation framework associated to the Strategy will allow to document the changes that the programme will bring about in caring practices for children.

Objectives:

Support Iraqi children and youth, their families and communities in selected Governorates to re-establish a state of well-being and normality that is necessary for and promotes the healthy emotional and psychosocial development of child.

Specific Objectives:

1. Promoting psychosocial skills, such as common functioning in life-tasks, continuity and normalization of community based structures.

2. Support parents, caretakers and community members in reaching a deeper understanding of children emotional and development needs to provide for better care practices.

3. Empower selected communities to enhance internal (resilience) and external (social capital) protective factors for Iraqi children and youth.

4. Strengthen community initiatives and foster processes of community mobilization, participation and empowerment for increased psychosocial support of Iraqi children.

5. Develop communication and problem solving skills to obtain concrete help, while ensuring adequate connections and referral with service providers and relevant professionals.

The WALL

Winning-back happiness for ALL (WALL) is the proposed title of the community based PSS programme to be implemented by UNICEF and its partners in Iraq. Restoring happiness and regaining playfulness are concepts that immediately suggest that the focus of the programme is not on addressing problems but rather building on strengths and positive attitudes to promote a change.
Additionally, the inclusion of ALL people in a community suggests that while child focused actions will be an important component of intervention, the programme will not be confined to an exclusive focus on children. As presented in the Framework, a child’s overall perceived and real sense of wellbeing critically depends on his internal strengths, his family environment, and his community (what we could refer to as ‘meaningful others’). Including ALL people as a part of the community based PSS programme will guarantee that interventions will partner at the same time the Child, the Family, and the Community. Children will thus be direct beneficiaries of the project, but they will also benefit out of the social changes promoted by the programme in the ‘meaningful others’.

The use of the term ‘WALL’ is also a handy analogy to provide the idea of enhancing protective factors that can place the child and his surrounding social environment into full security from external risk factors. The taller and thicker the WALL, the more protected the child and his social environment are from de-stabilizing external shocks. The wider is the area around the child protected by the WALL, the broader is the social ecology of the child, the system of interpersonal relationships and networks that provide for a safe promotive environment. While natural barriers exist in nature, a WALL is the outcome of an active effort to create something that was not there before. It is the outcome of personal resolution and joint efforts. It is something that requires anticipated planning, it demands commitment over time, and most importantly provides the ground for a progression through time (it is not a given). This last point is particularly important because it highlights the idea of a community based programme that places particular emphasis on positive processes through time, as opposed to immediate outcomes.

In Iraqi tradition, a WALL requires BRICKS and CEMENT to be built, MUD is useful to consolidate the foundation. ‘BRICKS’ is an acronym for Building Resilience for Iraqi Children/Communities and Knowledge Strengthening. ‘MUD’ is a shorthand for Mobilising Unity and Development. ‘CEMENT’ stands for Communication, Encouragement, Mentorship, Education, Non-Judgemental, and Team-building.

**Figure 1: Summary of Programme’s Philosophy and Working Model**

![Diagram of WALL, BRICKS, MUD, and CEMENT]

**Building Resilience: the BRICKS**

The ‘BRICKS’ component reminds us of the Resilience theory upon which the programme must be built. Building Resilience for Iraqi Children/Communities and Knowledge Strengthening is a
shorthand to remind practitioners to focus on the positive strengths identified in children and their communities. It serves to direct attention to children and people’s strengths rather than their weaknesses. It underlines the need to identify and use existing support networks within the community, both formal and informal. It reminds to place emphasis on strengthen protective factors through a careful understanding of children’s capacities and needs. Children’s internal resiliency can be strengthened according to age-appropriate interventions, thereby creating a more protective and conducive environment for child development.

Knowledge strengthening is a vital component of building resilience. Using the framework developed by Grotberg on behalf of the Bernard Van Leer Foundation (1995) presented below, building resilience in children/families/communities and ‘restoring the human spirit’ lies on their knowledge and progressive understanding about three domains grouped under three headings: I HAVE, I AM, I CAN.

To overcome adversities, children and people draw from three sources of resilience features labelled: I HAVE, I AM, I CAN. What they draw from each of the three sources may be described as follows:

I HAVE
- People around me I trust and who love me, no matter what
- People who set limits for me so I know when to stop before there is danger or trouble
- People who show me how to do things right by the way they do things
- People who want me to learn to do things on my own
- People who help me when I am sick, in danger or need to learn

I AM
- A person people can like and love
- Glad to do nice things for others and show my concern
- Respectful of myself and others
- Willing to be responsible for what I do
- Sure things will be all right

I CAN
- Talk to others about things that frighten me or bother me
- Find ways to solve problems that I face
- Control myself when I feel like doing something not right or dangerous
- Figure out when it is a good time to talk to someone or to take action
- Find someone to help me when I need it

A resilient child does not need all of these features to be resilient, but one is not enough. A child may be loved (I HAVE), but if he or she has no inner strength (I AM) or social, interpersonal skills (I CAN), there can be no resilience. A child may have a great deal of self-esteem (I AM), but if he or she does not know how to communicate with others or solve problems (I CAN), and has no one to help him or her (I HAVE), the child is not resilient. A child may be very verbal and speak well (I CAN), but if he or she has no empathy (I AM) or does not learn from role models (I HAVE), there is no resilience. Resilience results from a combination of these features.

These features of resilience may seem obvious and easy to acquire; but they are not. In fact, many children are not resilient and many parents and other care givers do not help children become resilient. On the contrary, too many adults crush or impede resilience in children or give mixed messages, and too many children feel helpless, sad and not fully loved. This is not the situation necessarily out of intent; it is more the fact that people do not know about resilience or how to promote it in children. Children need adults who know how to promote resilience and are, indeed,
becoming more resilient themselves. Adults that promote resilience make family and institutional supports available to children. They encourage children to become increasingly autonomous, independent, responsible, empathetic, and altruistic and to approach people and situations with hope, faith and trust. They coach them how to communicate with others, solve problems, and successfully handle negative thoughts, and behaviours. This coaching is provided by caregivers through their words, actions, and the environment they provide.

I HAVE

The ‘I HAVE’ factors are the external supports and resources that promote resilience. Before the child is aware of who she is (‘I AM’) or what she can do (‘I CAN’), he needs external supports and resources to develop the feelings of safety and security that lay the foundation, that are the core, for developing resilience. These supports continue to be important throughout childhood. The resilient child says ...

- I HAVE trusting relationships
Parents, other family members, teachers, and friends who love and accept the child. Children of all ages need unconditional love from their parents and primary caregivers, but they need love and emotional support from other adults as well. Love and support from others can sometimes compensate for a lack of unconditional love from parents and caregivers.

- I HAVE structure and rules in the family
Parents who provide clear rules and routines, expect the child to follow them, and can rely on the child to do so. Rules and routines include tasks the child is expected to perform. The limits and consequences of behavior are clearly stated and understood. When rules are broken, the child is helped to understand what he or she did wrong, is encouraged to tell his or her side of what happened, is punished when needed, and is then forgiven and reconciled with the adult. When the child follows the rules and routines, he or she is praised and thanked. The parents do not harm the child in punishment, and no one else is allowed to harm the child.

- I HAVE role models
Parents, other adults, older siblings, and peers who act in ways which show the child desired and acceptable behavior, both within the family and toward outsiders. These people demonstrate how to do things, such as dress or ask for information, and encourage the child to imitate them. They are also models of morality and may introduce the child to the customs of their religion.

- I HAVE encouragement to be autonomous
Adults, especially parents, who encourage the child to do things on her own and to seek help as needed, help the child to be autonomous. They praise the child when he or she shows initiative and autonomy, and help the child, perhaps through practice or conversation, to do things independently. Adults are aware of the child’s temperament, as well as their own, so they can adjust the speed and degree to which they encourage autonomy in their child.

- I HAVE access to health, education, welfare, and security services
The child, independently or through the family, can rely on consistent services to meet the needs the family cannot fulfill — hospitals and doctors, schools and teachers, social services, and police and fire protection, or the equivalent of these services.

I AM

The ‘I AM’ factors are the child’s internal, personal strengths. These are feelings, attitudes, and beliefs within the child. The resilient child says ...
• I AM lovable and my temperament is appealing
The child is aware that people like and love him or her. The child does endearing things for others that help make him or her lovable. The child is sensitive to the moods of others and knows what to expect from them. The child strikes an appropriate balance between exuberance and quietness when responding to others.

• I AM loving, empathic, and altruistic
The child loves other people and expresses that love in many ways. He or she cares about what happens to others and expresses that caring through actions and words. The child feels the discomfort and suffering of others and wants to do something to stop or share the suffering or to give comfort.

• I AM proud of myself
The child knows he or she is an important person and feels proud of who he or she is and what he or she can do and achieve. The child does not let others belittle or degrade him or her. When the child has problems in life, confidence and self-esteem help sustain him or her.

• I AM autonomous and responsible
The child can do things on his or her own and accept the consequences of the behavior. There is the feeling that what he or she does makes a difference in how things develop and the child accepts that responsibility. The child understands the limits of his or her control over events and recognizes when others are responsible.

• I AM filled with hope, faith, and trust
The child believes that there is hope for him or her and that there are people and institutions that can be trusted. The child feels a sense of right and wrong, believes right will win, and wants to contribute to this. The child has confidence and faith in morality and goodness, and may express this as a belief in God or higher spiritual being.

I CAN

The ‘I CAN’ factors are the child’s social and interpersonal skills. Children learn these skills by interacting with others and from those who teach them. The resilient child says ...

• I CAN communicate
The child is able to express thoughts and feelings to others. He or she can listen to what others are saying and be aware of what they are feeling. The child can reconcile differences and is able to understand and act on the results of the communication.

• I CAN solve problems
The child can assess the nature and scope of a problem, what he or she needs to do to resolve it, and what help is needed from others. The child can negotiate solutions with others and may find creative or humorous solutions. He or she has the persistence to stay with a problem until it is indeed solved.

• I CAN manage my feelings and impulses
The child can recognize his or her feelings, give the emotions names, and express them in words and behavior that do not violate the feelings and rights of others or of himself or herself. The child can also manage the impulse to hit, run away, damage property, or behave otherwise in a harmful manner.

• I CAN gauge the temperament of myself and others
The child has insight into his or her own temperament (how active, impulsive, and risk-taking or quiet, reflective, and cautious he or she is, for example) and, also, into the temperament of others. This helps the child know how fast to move into action, how much time is needed to communicate, and how much he or she can accomplish in various situations.

• I CAN seek trusting relationships
The child can find someone — a parent, teacher, other adult, or same-age friend — to ask for help, to share feelings and concerns, to explore ways to solve personal and interpersonal problems, or to
discuss conflicts in the family. As children grow older, they increasingly shift their resilience from outside support (‘I HAVE’ factors) to their own skills (the ‘I CAN’ factors) while continually building their personal attitudes and strengths (‘I AM’ factors). In PSS interventions the child is supported through a path of personal healing and strengthening, but the factors and resources that promote healing should be facilitated by outside actors (i.e. peers, family or community members).

Increasingly, as they grow, they themselves become active in promoting their own resilience. This process involves being able to engage fully in relationships with others, look towards the present and the future, rather than the past.

Each of the I HAVE, I AM, and I CAN factors suggests numerous actions children and their care givers can take to promote resilience. No one child or parent will use the entire pool of resilience factors, nor need they. Some use many; others use few. However, the larger the pool of possibilities before them, the more options children, parents, and care givers have and the more flexible they can be in selecting appropriate responses to a given situation. The I HAVE, I AM and I CAN model proves very useful and practical in guiding practitioners in identifying activities to develop resilience.

**Enhancing Social Capital: the MUD**

The ‘MUD’ component reminds us of the Social Capital, justice and trust theories presented in the Framework. Mobilising Unity and Development highlights the need for having the intervention firmly grounded on community mobilization and participation techniques that look at how to strengthen resources and social networks available to a given community at any given time. MUD directs actions toward social networks of peers, household and community members to increase the reciprocal level of knowledge, understanding and trust. The stronger the MUD, the higher the trust the members of that same community might place in their own strengths to overcome adversities, promoting reciprocal support and mutual solidarity. Mobilising Unity and Development leads to communities progressively better equipped to support the child and its ‘meaningful others’ in their respective and interdependent PSS needs.

The concept of unity also applies to children at risk of separation. Ensuring children remain with their families and primary caretakers is one of the most important ways to promote their resilience. Continuous, stable and supportive family-based care for children is essential to protect children from the possible negative psychological and social impacts of emergencies.

The MUD component also ensures the fulfillment of IASC minimum response standards for community mobilization and support:

- Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors.
- Facilitate community self-help and social support.
- Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices.
- Facilitate support for children and their care-givers.

In the IASC on MH and PSS services, the term ‘community mobilisation’ refers to efforts made from both inside and outside the community to involve its members (groups of people, families, relatives, peers, neighbours or others who have a common interest) in all the discussions, decisions and actions that affect them and their future. As people become more involved, they are likely to become more hopeful, more able to cope and more active in rebuilding their own lives and communities. At every step, relief efforts should support participation, build on what local people are already doing to help themselves and avoid doing for local people what they can do for themselves.
Building on social capital theories, a self-help approach is vital, because people’s mental health and psychosocial well-being are strengthened by having a measure of control over some aspects of their lives. Affected groups of people typically have formal and informal structures through which they organise themselves to meet collective needs. Even if these structures have been disrupted, they can be reactivated and supported as part of the process of enabling an effective emergency response. Strengthening and building on existing local support systems and structures will enable locally owned, sustainable and culturally appropriate community responses. In such an approach, the role of outside agencies is less to provide direct services than to facilitate psychosocial supports that build the capacities of locally available resources (IASC 2007).

Understanding and, as appropriate, enabling or supporting cultural healing practices can increase psychosocial well-being for many survivors, thus the importance placed by the IASC standards on cultural, religious and traditional healing practices. Ignoring such healing practices, on the other hand, can prolong distress and potentially cause harm by marginalizing helpful cultural ways of coping. In many contexts such as Iraq, working with religious leaders and resources is an essential part of emergency psychosocial support.

The combination of interventions aiming at strengthening social capital and interventions aiming at increasing resilience will result not just in an enhanced protective environment for children, but also in an environment which is promotive of child development (see the developed Framework for the distinction between protective and promotive environments).
Figure 2: Summary of the Link between Programme’s Philosophy and Programmatic Activities

WALL
Winning-back happiness for ALL

CEMENT
Communication, Encouragement, Mentorship, Education, Non-Judgemental Team Building

BRICKS
Building Resilience for Iraqi Children/Communities and Knowledge Strengthening

MUD
Mobilising Unity and Development

FOUNDATIONS

CHILD
I HAVE
I AM
I CAN

FAMILY
WE HAVE
WE ARE
WE CAN

COMMUNITY
WE HAVE
WE ARE
WE CAN

ACTIVITIES
:-
:-
:-

ACTIVITIES
:-
:-
:-
A Positive Approach: the CEMENT

‘CEMENT’ is a useful shorthand to remind practitioners of the positive attitudes and practices needed to develop Social Capital and Resilience. Communities and Families will not be the ‘beneficiaries’ of the project, but veritable partners and implementers. Communication, Encouragement, Mentorship, Education, Non-Judgmental, and Team-building are among the most significant skills that good community facilitators should have in order to be successful in bringing about a positive change for children. Experience has shown that social change processes require time, but most importantly, agencies have a far bigger probability in being successful in triggering social changes if they are promoted from within the community through facilitators, role models, ‘champions’, ambassadors and spokespersons. The ‘teaching’ and ‘preaching’ approach has resulted un-successful and interventions based on social change communication, positive encouragement, mentorship, participative education, and team-building are on the contrary better placed to gradually bring the community to re-consider practices detrimental to children, youth and women.

*Communication for development and social change* can be defined as the use of communication to promote social development. More specifically, it refers to the practice of systematically applying the processes, strategies, and principles of communication to bring about positive social change. It is the art of human communication linked to a society’s planned transformation from a state of vulnerability to one of dynamic socio-economic growth that makes for greater equity and the larger unfolding of individual potential (Quebral 2001).

*Positive encouragement* is a well known good parenting skill for positive discipline that can greatly help children through all development stages. Positive encouragement by peers, parents, teachers or community members focuses on releasing child’s positive energy in front of adversities or shortfalls as opposed to focusing on everything that is wrong. It helps in building self-confidence, trust, and feeling of empowerment. It provides the basis for an open dialogue between the child and the social actors that surround him/her.

*Mentorship for children* refers to a developmental relationship in which a more experienced or more knowledgeable person (parent, teacher, community volunteer of peer educator) helps a less experienced or less knowledgeable person (child or youth) to develop in a specified capacity. There are several definitions of mentoring in the literature. Foremost, mentoring involves communication and is relationship based. It is a process for the informal transmission of knowledge, social capital, and the psychosocial support perceived by the recipient as relevant to development (Bozeman and Feeney 2007).

*Positive education* implies the use of alternative education techniques that allow for principles of child participation to be implemented in the social environments most relevant to children: peer groups, family, school and community. Positive education helps in expanding children’s set of safe choices, civic engagement (i.e. voluntarism), a deeper understanding of the social constructions around them, and positive thinking. Self-confidence and a lack of fear to attempt to achieve tasks without negative reprisals due to temporary lack of achievement is a must for the building blocks for both leadership and innovation. Without consistent positive reinforcement the child’s chances of realizing this self-confidence to persevere, to develop and initiate new ideas and methodology is greatly restricted. Positive education has a crucial impact on psychosocial wellbeing as it provides the possibility for restoring a sense of normalcy, dignity and hope for the future. It also enhances the formation of healthy peer relationships, acquire key life skills and knowledge, and build self-esteem.

*Non-Judgmental – complete here*
Team-building is important not for the immediate experience of the activities performed by the team (group of peers, family or community members), but also for the group skills, communication and bonding that result. Team-building approaches provide realistic experiences that empower individuals to contribute to common goals. Some of the benefits of team-building include: improves morale and leadership skills, finds the barriers that thwart creativity, clearly defines objectives and goals, improves processes, identifies a team’s strengths and weaknesses, and improves the ability to problem solve. Activities of team-building motivate people to pool their talents, children and community members discover that diversity is their greatest asset and trust, cooperation and effective communication are the key to a group’s success. Structured activities not only encourage individual development, but bring all members together for a common cause.

The skills grouped under the acronym of CEMENT are the skills that UNICEF and the Government will promote for the community facilitators that will help in managing the project at the child, family, and community level. It might be appropriate to stress that the presented skills can be developed in children and youth themselves, their peers, parents, teachers, and community members at large. Like cement, they will serve to glue together the different conceptual and programmatic pieces promoted by the Strategy.

The Focus of the Programme: The Child, the Family and the Community

The Strategy, as it results from what presented so far, will facilitate the development of activities that focus on a set of three social environments: the child, the family, and the community. The child, the family and the community are the foundation of the protective and promotive WALL. For each of these social environments the Strategy will support the planning and development of activities that will help the development of Resilience and Social Capital following the I HAVE, I AM, I CAN goals of intervention.

Interventions focusing on the child and his group of peers will be interventions aiming at developing child’s psychosocial competencies (see Annex 1), the personal and interpersonal strengths of the child, his capacity of building positive relationships, his sense of self-esteem, restore confidence and competence in the child, express grief when needed, the capacity of nurturing feelings and emotions, helping the child in grounding his feelings within cultural and religious values, supporting his personal internal working model, and alike. This set of interventions will also enable the child to better conceive his role vis-à-vis the family and the community, building on the child’s pro-social behaviors, feeling of security and trust that will be further enhanced by interventions at the family and community level. Child focused interventions on the above themes will be age/gender specific, recognizing the different needs of children and youth according to age and gender.

Interventions focusing on the family or primary caretakers will be designed to enhance good caring practices, good parenting skills, positive discipline, information on the development needs of the child according to his/her age and gender. This programme component will also deal with issues such as parents-to-child communication, intra-household power relationships, quality time with children. As for the interventions focusing on the child, activities that will be developed at the family level will be built using a WE HAVE, WE ARE, WE CAN module that leads the family to recognize its strength and reciprocal and complementary capabilities and roles. Once the family has recognized the resources they can rely on, they will move towards the recognition of ‘what they are’, meaning an understanding of the kind of family they have built, with its strengths and weaknesses, the current caring practices adopted, the role/importance given to children, the space given to children inside the family, the ways used to interact with them. In the ‘we can’ stage, the family will take stock of their strengths and weaknesses to take commitments in building a better family
environment for children, addressing negative practices through the use of strengths that are internal to the family itself. This set of interventions will also greatly support the development of attachment, trust, and security between children and their primary caretakers. For separated children, the group of peers will be considered as the basis for intervention.

*Interventions focusing on the community at large or sub-groups of it are interventions that aim at increasing the spirit of mutual support, reciprocity, and altruism, helping the community in realizing that joint efforts usually lead to bigger achievements than individual undertaking. This set of activities will support a participatory dialogue among community members to review their ideas, feelings and perceptions on topics that the community itself has identified as important, with a special attention to caring practices. The typical tool that will be used for this set of activities will be community dialogue techniques and they will follow the same model of WE HAVE, WE ARE, WE CAN presented in the family section. It will also be an important programme component to review the role given to children by a community, participatory and discipline practices, public spaces for children, and alike.*

While the current *Strategy* is designed to go beyond the initial emergency response implemented in Iraq to support a recovery phase, it also recognizes that general PSS services for community mobilization and support have been by large overlooked during the acute emergency phase in the country so far. Therefore the *Strategy* also suggests to include, but not to be confined to, IASC minimum response activities for this important domain. Part of the activities implemented at the child, family and community level will therefore also include the following minimum standards:

- Facilitate conditions for community mobilisation, ownership and control of emergency response in all sectors.
- Facilitate community self-help and social support.
- Facilitate conditions for appropriate communal cultural, spiritual and religious healing practices.
- Facilitate support for children and their care-givers.

**Principles and Methods**

**CROSS-SECTORAL INTERVENTIONS**

Psychosocial wellbeing requires that children and families’ basic needs for security, health, clean water, shelter, food, livelihoods, education are being met. As such, the entire humanitarian response in emergencies contributes to psychosocial wellbeing. In addition, the way in which humanitarian response is conducted can have a huge impact on the psychosocial wellbeing of children and their families. Psychosocial programming recognises these facts while also acknowledging that it is not the role of a psychosocial programme itself to address all these issues. Rather a psychosocial programme needs to work closely with all the other sectors of the humanitarian response (CPIE XXX).

The WALL programme aims at establishing meaningful collaborations, links and sharing of experiences and practice with complementary sectors, starting from the education and health sectors where initial PSS and better parenting interventions have been promoted (Better Parenting project and In-School PSS project respectively, see below). Children that will be identified in need for a more specialized and focused MH or PSS intervention, will be referred to professional or paraprofessional services available, although it is recognized the scarce availability of those services. Referral will work in the two ways: from less specialized to more specialized service providers and the other way around.
The Better Parenting project is a project implemented by the Ministry of Health in collaboration with UNICEF, in the Kurdistan regions aiming at promoting 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. This information is usually given to the prime caretaker during the first week after delivery, when parents attend the primary health care center to register their newborn. The coverage of the project is very limited (only 3 primary health care centers) and its effectiveness not yet independently assessed, yet the initial assessments available show that the project has helped families in improving their child care and nurturing practices, thus providing for a good collaboration opportunity for the WALL programme.

The in-school PSS project’s main objective is to promote children’s psychosocial support in 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. Reports from teacher trainers and field supervisors have substantiated observations that the project has been having a positive effect in promoting children’s psychosocial support, preventing violence in schools, and establishing partnerships between schools and families in support of children.

‘SPECIAL CHILDREN’

Following MOLSA suggestion, the WALL programme will have a positive discrimination approach for ‘special children’, children that are likely to fall between the cracks of the programme due to their status of vulnerability unless specifically targeted. MOLSA’s priority in this sense are homeless families, street children, orphans, children with disabilities, and children in institutions. MOLSA directly runs a number of Open day Centers for homeless children and their families, but the capacities of relevant staff in the centers appear to be limited and no minimum standards for foster care are available.

A positive focus on ‘special children’ is justified by the condition of special vulnerability affecting them. The literature review, as well as a number of consultations with partners, have highlighted that the greater the condition of vulnerability, the higher the risk of children and adolescents been recruited by extremist and terrorist groups. The lack of a positive supportive network has also been presented as a cause for vulnerable children and youth being recruited into organized crime and fight.

The WALL programme proposes to address the special needs of these children and youth through a twofold approach: on one side by building a supportive network of peers and community members that are enabled to pay more attention to these groups of excluded minors, and on the other side by strengthening the services directly available for these children.

Consequently, as a part of the tools to be developed for the WALL programme, each training and capacity building component will have a special section on how to adapt developed tools also to the
most excluded and hard to reach beneficiaries, making sure that part of the indicators reflect outcomes for this group of 'special children'.

**YOUTH GROUPS FOR OUTREACH WORK**

Youth groups and youth community volunteers will be major partners for the WALL programme. Throughout the country there are already a number of youth centers and youth groups that are actively engaged in supporting children and peers through recreational, sport and advocacy activities. Most of these clubs, however, do not have sufficient skills for engaging in community facilitation activities. This is why investing in building the skills of these groups of youth will further enhance the community work already promoted.

Youth groups are particularly well placed to promote peer education programs, basic PSS interventions with younger children, as well as facilitating community dialogues with parents, communities and children. Directly engaging youth and adolescents can also help them to find meaningful ways to contribute constructively to their communities, preparing them for parenting, and allowing them to carve a positive role within society. Strengthen life skills and options for livelihood are also important component of working with youth in this programme.

Ideally, youth facilitators and peer educators will come from the same communities where the programme is run. Yet, this *Strategy* acknowledges the need to find a balance between participatory processes (requiring commitment and investment over time) and enhanced service delivery. Thus this *Strategy* proposes to start by training selected youth groups that will facilitate the implementation of the WALL programme not just in their own community, but also in the neighboring ones, using an outreach approach.

At the moment, there are over 130 youth centers active throughout Iraq and an undefined additional number of youth centers active in Kurdistan region. 85 youth NGOs, 10 of them working exclusively with girls, have also been registered in addition to 17 welfare centers for youth censed by the Ministry of Youth and Sport. MOY&S strongly supports the idea of having youth engaged in a community based PSS programme because it will greatly enhance their skills, but also the role that these clubs can play within their respective communities. The activities undertaken by these centers vary greatly according to the competencies and skills of member youth, but overall, the areas of engagement are recreation and sport, informal education and tutoring, art, festivals and basic concepts of community development. Life skills is partially included in the training and peer education of these centers at a superficial level but it is an area for great improvement.

Specific activities are designed in these centers for children 14 to 17 but there are not separate clubs for younger adolescents. Age composition of the youth centers varies, but it would appear that young adults or adults are also part of these centers and that leadership is not rotated or renovated easily. Roughly, the 25% of youth centers’ members are girls and there are 3 youth educational centers that are exclusively focusing on girls and women. The growing number of senior members of these centers and the low degree in changes in leadership within these clubs is directly connected to lack of employment opportunities for youth. The centers thus become a natural form of aggregation that provides with some basic opportunities for them to engage in activities for their communities.

As it stands, no voluntarism programme is undertaken in Iraq and it would appear not part of local culture to freely devote part of personal time to community work and development. Another possible constraint in the collaboration with youth centers is that currently the centers do not undertake any outreach work and services are all provided inside the centers themselves. This
approach is not ideal for a community based PSS programme, and the Strategy will need to see how youth centers could gradually start delivering outreach services.

From the information gathered, the current Strategy considers youth and youth groups in Iraq as a major untapped opportunity that could provide a strong basis for the implementation of a community led PSS support programme.

MULTIPARTNERSHIP APPROACH AND COMPLEMENTARITY OF SERVICES

The Strategy proposes to create a multi agency and multi-governorate collaboration starting from 4 programmes that seem particularly relevant for complementing the proposed community based PSS interventions: the Parenting Education project by the Ministry of Health (run in the primary health care centers of Erbil, Suleimanyiah, and Dahuk), the School Based PSS project by Heartland Alliance and Ministry of Education (run in Erbil, Thi Qar, Basra, Misan, Baghdad, and Wasit governorates), the Child Centered Mental Health project by the Ministry of Health and several NGOs partners (implemented in Dahuk, Basrah, Baghdad, and Misan) and the Open Centers for Special Children project by the Ministry of Labor and Social Affairs (run in Baghdad, Al Nassiryah, and Basrah).

Looking at the coverage of the above presented projects, the following Governorates are proposed as strategic starting points for the programme:

<table>
<thead>
<tr>
<th>Governorate</th>
<th>Parenting Education Project</th>
<th>School Based PSS Project</th>
<th>Child Centered Mental Health Project</th>
<th>Open Centers for Special Children</th>
<th>Phase of Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Misan</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>First Phase</td>
</tr>
<tr>
<td>Basrah</td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
<td>Second Phase</td>
</tr>
<tr>
<td>Baghdad</td>
<td></td>
<td>✓</td>
<td></td>
<td>✓</td>
<td>First Phase</td>
</tr>
<tr>
<td>Dahuk</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>Second Phase</td>
</tr>
<tr>
<td>Erbil</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td>First Phase</td>
</tr>
</tbody>
</table>

Within the proposed governorates there is already available a critical mass of professionals, institutions and organization that, if mobilized, will form the basis for the programme's supporting network. In Addition, Erbil, Baghdad and Misan are proposed to be the Governorates to be reached in phase one of the programme, while the remaining Governorates will be reached in the second phase of the programme (year two), after tools and approaches have been tested and validated.

COMMUNITY DIALOGUE and LOCAL NURTURERS

Community Dialogue is an approach of Community Development that emphasizes the various voices in the community and how these voices can impact the community. Community Dialogue is useful when the best way to tackle a community issue (need/conflict or opportunity/asset) is through a dialogue process among the community voices, in order to make better decisions and better community action. Basic principles of community dialogue are: shared responsibility (solidarity, partnership, and ownership), participatory decision making (transparency, profound listening, informed decision making), and openness.
The methodology proved successful in many countries and areas of intervention due to its simplicity and effectiveness in promoting inter-generational understanding of common issues and themes. As a methodology, Community Dialogue does not have a pre-defined set of topics presented to the communities, on the contrary communities are free to identify for themselves the most relevant issues they want to discuss in a shared forum. It is a toll particularly indicated for communities highly patriarchal and male dominated (i.e. Iraqi society), because it provides a safe and constructed space for everyone to express views, ideas and to be listened to. It is also a tool particularly effective for communities that have high levels of intrafamilial violence because it provides a safe space to start reflecting upon social norms that are so widely practiced that are often necessarily considered as ‘normal’. It is a non-judgemental tool, meaning that the ultimate decision regarding for instance the appropriateness of certain caring practices only lies with the community itself, and the facilitators only plays a role of mediator of the discussion.

Community Dialogue fosters individual accountability. Decisions and resolutions taken by groups or individuals during public dialogues entail the loss of reputation in case of non-respect of commitments taken. This is why personal resolutions taken in front of other community members are more likely to be respected and enforced by social pressure attitudes.

The tool is based on a set of modules that will be discussed over time by members of the community in the effort to reach shared understanding and common commitments. The contents of the modules and the main topics vary according to community priorities, but in the Iraqi context they could include:

- Emotional, Physical and Sexual Violence,
- Female Genital Mutilation and Cutting,
- Early Childhood Development,
- Good Parenting,
- Child Rights,
- Civic engagement,
- Conflict mediation,
- Mine risk Education, etc.

The best facilitators to introduce community dialogue techniques can vary. In the preparatory phase for the design of the current Strategy no main informal network at the national level has been found that could play a leading role in community facilitation interventions. A number of players such as Mokhtar, tribal leaders, paramedical personnel within health posts, traditional healers, and religious leaders have been identified as natural partners for the project, but their availability, proactiveness, capacities, and desire to get involved might vary from community to community, and it will be assessed as the programme is tested and gradually rolled out. As a general rule, the programme will start by identifying and seeking out local ‘nurturers’: individuals who have a natural desire and capacity to help others as they go about their everyday life. It will discuss their insights on how local people cope and on the existing strengths that adults and children already have. It will seek their suggestions for activities that could further promote the positive elements in their culture to help in their community’s healing and recovery. The identification of these nurturers will be a joint effort between local government, NGOs, and communities themselves. Another suggestion received and considered as an innovative idea is the one of training the owners of coffee and tea shops to sensitize their clients (mostly men) in community dialogue topics, or using traditional attractions such as mobile shows and belly dance to also pass on relevant messages.

An innovative possibility would also be the one of considering the methodology of invisible theater to run spontaneous sessions of community dialogue. Through this methodology, trained artists start
involving people in crowded places by discussing about specific issues, inviting other people to join in the discussion and express different views. Participants in the dialogue are not aware of the facilitation role of those who started the discussion. This method allows for the participation of people that usually would not participate in a structured community dialogue run by nurturers.

SPORT, PLAY and STRUCTURED GROUP ACTIVITIES

Play, sport and art are recognized to be among the most effective tools for building community PSS interventions (see IASC 2007). It is important to create opportunities for organized non-violent play, sports, art and other forms of recreation according to different age groups. Different activities may be appropriate for boys and girls, depending on the culture, age, interest and skills of the children. The current Strategy proposes to use a toolkit of well developed and tested set of play and creative art methods. The Play Therapy TOOLKIT (see Play Therapy International 2007), is composed of:

1. Creative visualization techniques;
2. Storytelling;
3. Art, drawing and painting;
4. Puppetry and role playing;
5. Sandtray;
6. Music;
7. Dance, singing and movement;
8. Drama and theatre;
9. Clay and modeling;
10. Masks and toys.

This set of methods can be either used in a structured way, as well as in a non-structured way. The Strategy recommends to use the TOOLKIT in a non-structured manner for the purpose of community based PSS support. The TOOLKIT can be used in a structured and therapeutic way by professionals properly trained in the use of those techniques for children that will manifest mid or severe emotional and behavioral problems and that will be referred to complementary services with a higher degree of specialization, outside the scope of the current programme.

Additionally, the TOOLKIT results particularly flexible for its use in individual as well as group settings. Individual one-to-one use of the TOOLKIT is particularly indicated for peer-education or good parenting purposes. An older child/youth playing with a younger child or a parent/caretaker playing with his son/daughter provide a suitable environment for individual and focused support, and are appropriate to build personal resilience and overcome individual difficulties. The one-to-one use of the TOOLKIT is particularly useful to generate individual trust and reinforce attachment. The use of the toolkit in a group is particularly indicated to create trust in group members, friendship, shared values and understanding, develop lifeskills, team spirit, and a supportive network among others.

Similarly to play, sport can be used for pure recreational finalities (recreational sport), but it can also be used for achieving identified objectives (educational sport). Educational sport as well as other structured group activities are designed to achieve specific goals that are not therapeutic but are, however, oriented to strengthen coping mechanisms such as managing emotions, dealing with fears, conflict resolution, decision making, assertiveness, communication skills, etc. The inclusion of life skills, social skills and corrective thinking in sport curricula and activities can be a fun way to gain youth and children involvement when promoting PSS services at the community level.
Sport, play and structured group activities are also given priority due to their non-talking nature, particularly adapted for children (specially younger ones), and for the Iraqi tradition of expressing feelings through chanting, dancing and playing.

GOOD PARENTING SKILLS

Good parenting and positive discipline education are techniques that are similar to life skills for youth, but apply to parents or parents to be. This set of skills can easily be inserted into community based programs and can also be introduced or discussed during community dialogue modules. The theoretical justification for the use of this set of tools is that parenting comes naturally, yet it does not necessarily come naturally the way we would like to, it comes naturally the way we learnt it from our parents. And the way we learnt it is not necessarily the most conducive way to nurture children. Good parenting techniques help parents in reflecting upon the physical and emotional needs of children, and support them in taking consequent decisions and commitments.

Good parenting skills are learnt in groups because it is easier to change consolidated caring attitudes and practices towards children when there is a supportive network around the individual family.

COMMUNITY INVOLVEMENT: DESIGN, IMPLEMENTATION and MONITORING

As presented in the Framework, in each emergency, it is important to identify which aspects of the environment are having the greatest impact on psychosocial wellbeing e.g. lack of security, food, livelihood. This should be done as a part of the initial assessment before starting a programme.

The WALL programme will attribute 3 main roles to communities being reached:
- Design of community led interventions,
- Implementation of designed interventions,
- Monitoring of achievements (see Fig.3).

The design of community led interventions will be guided and facilitated by trained facilitators and nurturers (youth, parents and selected members of the community) and will be guided by the I AM, I HAVE and I CAN framework for participatory appraisal (refer to ‘the child, the family and the community’ section of the Strategy). These interventions will be implemented by the communities themselves with the external facilitation of the support network created (see section on ‘multipartnership approach and complementarity of services’). Once the interventions will be designed, external facilitation will also support the development of specific indicators both at the process and outcome level. Indicators will refer to the activities undertaken by facilitators, as well as activities and outcomes undertaken by communities.

Fig.3: The Role of Communities in Implementing the WALL
COMMUNITY MESSAGING

Community messaging is a technique used in some Western societies to link communities with security services. The concept of community messaging is presented by the Strategy as a possible way to increase child protection within communities. Families gradually learn to take responsibility not just for their children but also for the children of their neighbors. An example where this method was successfully used in less developed countries comes from Guatemala, where the level of intrafamilial violence, abuse and impunity was extremely high. Communities decided to take a stand against violence and every time they heard a woman shouting because beaten by her husband they would gather outside the hut of the victim with pots and metal sticks starting making as much noise as possible until the perpetrator stops the beating. The programme was assessed as having substantially reduced violence and increased community cohesiveness.

But community messaging is also about finding the best ways to communicate and disseminate child protection principles to communities. Messaging, using modern technologies or traditional forms, is a dynamic process of increasing communities understanding of child rights and the role that duty bearers have to play for the promotion of child protection principles. Managing communications with communities is key to successful community-driven development. Knowledge is power: without information, communities cannot participate, make choices, or ask questions. Good communication is also about trust and partnership, and is thus at the heart of successful community partnerships.

The WALL advocates for efforts to be made to both supply information and create space for dialogue between communities, local government, and aid agencies: a two way information flow that is beneficial to all parties. Good communication and messaging will only happen if dedicated attention and resources are placed upon this critical element of interaction with and among community members. Good community messaging also relates to the need to prevent expectations of community members to be different from what the programme can realistically deliver, or facilitators to break previously made promises (commitments made that are not fulfilled). Transparency and accountability are greatly facilitated by good communication techniques.

WALL’s Programming Rules

In accordance with international good practices (see for instance Save the Children 2004, or Regional Emergency Psychosocial Support Network 2006) the WALL programme intends to adopt basic rules to guide and strengthen planning and service delivery at the community level:
1. **Children’s right to life, survival, and development.** The Strategy’s overall objective for psycho-social interventions is to re-establish a state of well-being that is necessary for and promotes the healthy development of the child. This also means that where children are facing life-threatening situations, psychosocial interventions should consider what practical steps can be taken to protect the children from further harm and exposure to violence.

2. **Respect for the views of the child.** Psycho-social interventions implemented under the WALL Strategy must ensure that children’s views are acknowledged and respected so that they participate in their own healing and development, and so that their dignity is preserved.

3. **Best interests of the child.** In all decisions affecting the psychological and social well-being of the child, primary consideration should be given to the child’s healthy development. Psychosocial programmes and their outcomes should not be used for any purpose other than the psychosocial development of the children—in particular, such activities should not be used for political, media, economic or social gain for the implementing organisation or individual. The long-term development of the child and the indirect consequences of any short-term intervention should be taken into account when implementing programmes. For instance, short-term interventions that undermine the trust between the children and their caregivers or that make children more aware of their problems without helping them to find solutions for these problems can be harmful for the children.

4. **Non-discrimination of any kind,** including on the basis of sex, age, religion, socio-economic status, ethnicity, and disability status (particularly regarding availability and appropriateness of services). Psychosocial workers should also minimise the positive or negative stereotyping of children who have experienced psychological or social distress or been exposed to or involved in violence.

5. **Child-centeredness.** Children are central to the WALL programme objectives and are the primary beneficiaries of community based PSS programming. As presented in the Framework, psychosocial programme design starts with children as the core, surrounded by family, community and social structures as part of the their “social ecology” which is essential to recovery and resiliency. The WALL recognizes that the psychosocial wellbeing of children cannot be addressed in isolation from their family and community environment. Yet, the principle of the best interest of the child will guide choices in case of a conflict of priorities between the psychosocial wellbeing of the child and the one of their surrounding social ecology.

6. **Integration of psychosocial approaches to peace and development efforts (holistic approach).** Recognizes that psychosocial interventions need to be linked to individual and social quests for peace, justice and respect for human rights. The rebuilding of communities and reconnecting people to their sources of livelihood cannot be separated from the psychosocial recovery and healing process.

7. **Informed consent.** Where children are participants of development processes, the consent of the parent or adult guardian should be secured before any discussion begins with a child. Introducing the programmes objectives, the facilitators, explain to the parent or adult guardian what the programme will lead to, what information is being sought, what methods will be used, how the information collected will be used and the possible consequences of a child’s participation are vital starting points in interacting with children.

8. **Respect a community’s capacities and strengths.** The Wall will not presume children and communities in situations of conflict and emergencies as passive, helpless, weak and vulnerable
victims. Typically, the reality is more complex: communities can be resourceful and resilient; they can find ways of protecting and helping themselves in the midst of adversity. Too often people, especially children, are characterized as "traumatized victims" rather than regarded as survivors who most likely have assumed responsibility for their self and possibly others. The challenge for the WALL is to identify and respect a community’s capacities and strengths and determine how they can be used to further help and protect children’s interests. If need be, the WALL also may have to inform the community about children’s rights and their ability to be strong, resourceful and resilient rather than passive victims, applying the principles presented in the previous points.

1. **Gender equity and age sensitivity.** The Strategy recognises that girls and boys of different age may have different socially constructed identities and needs, and that understanding these gendered identities and age specific priorities is critical to psychosocial programming. The Strategy intends to foster age and gender specific interventions by directly involving boys and girls of different age groups into the design of the PSS activities to take place at the community level. In this way, the programme will prevent the risk of suggesting and implementing activities that will result not relevant for the children and youth to be reached.

2. **Sustainability.** The WALL programme seeks to make positive changes in institutions, behaviors and policies affecting human well-being, which last beyond UNICEF’s direct involvement. Psychosocial programming focuses on building the capacity of families and community members in order to strengthen their own care-giving skills, recognize signs of psychosocial stress, and take steps to strengthen children’s resiliency in times of crisis and beyond. The programme also focuses on increasing the capacities of governmental duty bearers for the provision of quality services at the community level. The programme will thus prefer interventions that can be progressively carried out by communities and government authorities themselves, as opposed to ideal interventions that will always require the help by external actors. Ownership being the pre-requisite to sustainability, the programme will define a specific time schedule for each intervention to prevent the risk of indefinite over dependency on external aid. Thus each activity will also be defined in terms of sharing of responsibilities between communities, government and external aid, as well as a phasing out plan for external aid.

3. **Scaling up.** The proposed approach to psychosocial programming focuses on community-based support to the generally-affected and at-risk population, rather than on the small number of children who may require individual mental health care. As such, the proposed programme seeks to provide services to the largest population possible, while ensuring that quality and impact are not compromised. Services can expand quickly through the forging of partnerships with local civil society groups such as youth groups. The aim of the WALL programme is the one of reaching communities in all Governorates in Iraq, yet in this initial phase only 5 Governorates will be targeted. The experience in these Governorates will guide and advise future policy making in the remaining Governorates;

4. **Measurable impact.** The development of clear objectives, precise indicators, and systematic analysis of program activities are key steps towards measuring these outcomes and impact. While process indicators will be adopted (i.e. number of people trained, number of communities reached, etc.), the programme also intends to develop outcome indicators that better define the scope and magnitude of the achievement (i.e. changes in knowledge, attitude and practices, increased outcomes for children, etc.). Communities and programme’s facilitators will also be supported in identifying their own indicators to define ‘success’ in the context of community based PSS services.
5. **Clarification of expectations and results.** The WALL programme will not promise anything that cannot be delivered and will deliver what has been promised.

**The Steps of the Project and possible Timeframe**

The WALL project will be based on a set of multiple and subsequent steps to be implemented according to the presented time schedule:

<table>
<thead>
<tr>
<th>STEPS for First PHASE</th>
<th>TIME SCHEDULE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-Support the establishment of an Interministerial working group to supervise and coordinate the programme</td>
<td>From Feb. 2010</td>
</tr>
<tr>
<td>3-Develop capacity building and training tools for the implementation of the programme: Curricula for Training of trainers for youth, Curricula for Training of trainers for parents, Curricula for Training of trainers for community leaders.</td>
<td>Feb-May 2010</td>
</tr>
<tr>
<td>4-Provide the different types of capacity building and training: Training of trainers for youth, Training of trainers for parents, Training of trainers for community leaders.</td>
<td>June-July 2010</td>
</tr>
<tr>
<td>5-Support the development of community plans, goals and activities</td>
<td>August 2010</td>
</tr>
<tr>
<td>6-Implement identified community based PSS activities starting from the IASC minimum standards for community mobilization and support.</td>
<td>From August 2010</td>
</tr>
<tr>
<td>7-Strengthen collaboration and coordination with all existing actors working in identified communities.</td>
<td>Throughout the Programme</td>
</tr>
<tr>
<td>8-Oversee and supervise community facilitators and provide them with ongoing mentoring and training (Quality Assurance of the Programme).</td>
<td>Throughout the Programme</td>
</tr>
<tr>
<td>9-Assess the initial outcomes of intervention on children, families and communities</td>
<td>Dec.2010</td>
</tr>
<tr>
<td>10-Present communities and partners the outcomes of the First Phase.</td>
<td>Dec. 2010</td>
</tr>
</tbody>
</table>

**STEPS for Second PHASE**

1-In line with comments received and the assessment undertaken, review the outcomes of the First Phase and improve, adapt or adopt previous steps as per outcomes achieved. | Jan.-Feb 2011 |
| 2-Scale out the programme following phase one steps. | From March 2011 |

**STEP 1: Develop a Conceptual Framework and Strategy for the provision of community based PSS interventions.**

This step will be completed with the presentation, sharing and validation of the current *Framework and Strategy* for the WALL programme.

While the *Framework* will be considered as a finalized document after its validation, the current *Strategy* will be adopted as a rolling document always subjected to adaptation and improvements as the need arises and experience gained evolves. In particular, while the *Strategy* provides solid boundaries on how to implement the WALL programme, the evolving and dynamic nature of
community participatory planning will determine the opportunity to tailor make activities to the specific needs and recognized priorities of selected communities. Activities will thus differ among communities, but will also be likely to evolve over time within selected communities.

**STEP 2: Support the establishment of an Interministerial working group to supervise and coordinate the programme**

This step will officially launch the implementation stages of the WALL programme. Based on previous successful experiences in Iraq for the coordination of PSS activities, an interministerial working group will be established, possibly as a sub-group or complementary group of already existing multisectoral task forces. Relevant Ministries that will participate to the working group are the Ministry of Labor and Social Affairs, the Ministry of Youth, the Ministry of Health, the Ministry of Education, and other relevant ministerial offices as appropriate. It is believed that MOLSA will take the leadership in chairing the working group.

As a part of this STEP, all specific orientation documents for the interministerial working group will be developed such as TOR, respective roles and accountability, monitoring and supervision responsibilities, and working modalities. Much emphasis is placed in this coordination mechanisms because, if successful, has the potential to trigger positive outcomes and ownership also in other multisectoral interventions such as GBV and justice for children.

All subsequent planning and implementation steps for the WALL project will take place starting from the coordination group, and external staff can effectively be seconded to MOLSA to help in its coordination role.

**STEP 3: Develop capacity building and training tools for the implementation of the programme**

This STEP will be geared around developing relevant programme tools for a-Youth, b-Parents, and c-Community leaders. The tools will include training of trainers’ material, as well as methodological tools.

Capacity building tools for youth will include: community dialogue curricula (methodology and contents), facilitation skills, educational sport and play, use of the play and creative art TOOLKIT, life skills, peace education, civic engagement and leadership.

Capacity building tools for parents and caretakers will be geared around principles of good parenting skills, positive education, conflict mediation and early childhood development. Basic principles of Filial Play coaching (for under five children), and Play Work will also be introduced into the curricula.

Capacity building tools for community leaders will be developed starting from community dialogue and facilitation tools, risk and strengths mapping, conflict mediation and civic engagement.

**STEP 4: Provide the different types of capacity building and training for youth, parent/caretakers and community leaders**

It is important to stress that the training and capacity building material developed in Step 3 will form the basis for the rolling out of capacity building activities to relevant selected community actors. Unlike other projects implemented in Iraq, the training provided will be practical and experiential, to
facilitate a better and deeper understanding of the issues presented. The training will be implemented with the aim of allowing participants to go through a process of personal change, before asking participants to become advocates for social change within the community.

The training programme should include practices and activities that encourage self-criticism and self-awareness amongst psychosocial workers, it should also include information on maintaining wellbeing of psychosocial workers and community facilitators.

The training programme should clearly communicate to the participants the limitations of the training, including where and in what contexts the knowledge and skills would be applicable. The contexts for which the training is suitable may be particular geographical areas, types of psychosocial issues or problems, and/or particular socio-cultural groups. It should ensure that participants are provided with handouts and reference or user-friendly reading materials suitable for the level of the participants.

All identified actors will also be coached and provided with a set of clearly identified monitoring tools for quantifying and qualifying the impact of the project using both qualitative and quantitative techniques. This set of data will then be inserted into a specially designed database that will allow for the production of assessment reports that will guide future policy planning.

As experience has suggested in other contexts, a cascade training starting from a master training, to training of trainers, to training of community actors will be considered, allowing for national capacities to develop and sustain the project over time without the need for external support.

**STEP 5: Support the development of community plans, goals and activities**

Selected youth, caretakers, and community leaders will be a vehicle for social change, but the real actors and partners for the programme will be communities at large. The real essence of a community based PSS programme is in the very participation of the community into the design and implementation of the activities. Trained community facilitators will help in directing communities and families to come up with realistic and feasible objectives, but the planning and conceptualisation phase will remain at community level.

**STEP 6: Implement identified community based PSS activities starting from the IASC minimum standards for community mobilization and support**

Following on the previous step, the implementation of community devised plans will be the responsibility of the communities themselves to foster ownership and accountability, with the external support and facilitation of partners. These plans can contain group commitments but can also be based on individual commitments by families and community members on how to improve care practices for children.

**STEP 7: Strengthen collaboration and coordination with all existing actors working in identified communities**

As a part of the identification of the strengths of selected communities, families will be asked to identify major actors working or being active within the community itself. This will be the basis for gradually establishing a referral system whereby children with mid and high degrees of distress and mental health issues will be referred to the most appropriate set of service providers. As a minimum,
where geographical coverage will allow, the community based PSS system will coordinate with the better parenting project run among health professionals, and the school based PSS programme run by teachers in selected communities. Yet, the programme will remain multisectoral, non-medical and general enough to benefit the broader child population.

**STEP 8: Oversee and supervise community facilitators and provide them with ongoing mentoring and training (Quality Assurance)**

Adequate supervision of psychosocial providers, both professionals and non-professionals is a key strategy to ensure quality of services. Previous interventions have shown the importance of ongoing counseling and support for community facilitators, whether they are youth, parents or community activists. This support will start through the training provided, but it cannot be confined to it. Programme supervisors will be deployed on a regular basis to allow for the sharing of responsibilities between community facilitators and programme supervisors. This set of trained professionals will also help in gradually linking the programme up-stream with local and governorate authorities, inviting government counterparts to joint monitoring field missions, bringing relevant issues to the attention of government counterparts, and constantly updating policy making with the evidences that come from the field. Accreditation mechanisms need to be put in place to ensure adherence to the Strategy’s principles by institutions and individual practitioners.

Supervision is a process where psychosocial workers and community facilitators are given the opportunity to discuss their work so that areas of concern and difficulty are identified, and guidance given where necessary. Supervision is an important mechanism for ensuring that the interests and wellbeing of the service providers are safeguarded and that the performance of the service provider is acceptable. Supervision can be carried out through different mechanisms; discussions with either a more trained and experienced colleague (the supervisor) or with colleagues of similar and adequate competencies to one’s own (peer supervision). Although technical supervision and managerial supervision have been defined as being different from each other, it is important to recognise that in practice it is difficult to separate technical and managerial supervision concerns. Equally, it is important to recognise that technical and managerial supervision within psychosocial work and community facilitation is different from the overall monitoring of project or service progress and process.

**STEP 9: Assess the initial outcomes of intervention on children, families and communities**

Data collection and management will be a routine activity and will be led by MOLSA since the onset of the programme. In particular, MOLSA will be supported in the development and management of a quantitative database that will provide up-date information on the achievements of the project. Qualitative indicators and process indicators will also be collected by community facilitators with the support of programme supervisors. The same data and outcomes of the interventions will also be made available to community.

Indicators, part of which will be agreed through a process of community participation, will include three set of indicators:

- indicators on the changes at personal level on the child,
- indicators on the changes at the family level vis-à-vis knowledge attitudes and practices toward children and child care, and
- indicators at the community level vis-à-vis knowledge attitudes and practices towards children and child care practices.
A smaller set of indicators will also be developed regarding the degree of the use of evidences generated by the programme for policy and planning by government authorities.

**STEP 10: Present communities and partners the outcomes of the First Phase**

Too often participants and communities are excluded from learning about the outcomes of aggregated interventions run at scale or at pilot stage. Thus presenting communities the result of the first year activity stands as a reminder that the leadership of the programme stays within the community itself.

**Quantifying and Qualifying Impact**

As previously stated, each community will have the possibility to define ‘success’ through participatory methodologies of facilitation. Traditionally, assessment tools for PSS emergency programming vary according to the phase of the assessment to be carried out. Each phase requires a different focus: in phase 1 assessment is initiated immediately after a disaster or calamity strikes or after a major event in an ongoing armed conflict. It focuses on survival and protection needs and on affected people’s access to information and resources they need. Phase 2 assessment is an update of the initial assessment once basic survival needs have been met. It focuses on the return to normalcy; while phase 3 assessment is initiated once efforts are in place to address needs of rehabilitation of affected population. It focuses on strengthening and expanding existing community services and activities and establishing psychosocial approaches through local and national government services (see Fig. 4). Being Iraq in a situation of chronic emergency, where livelihoods are being rebuilt within a context of continuous vulnerability, phase 3 assessment tools would seem more appropriate at this stage.

**Figure 4: Phases in Assessing and Supporting PSS wellbeing in emergencies**

The Strategy suggests adopting two sets of indicators (process and outcome indicators) for each of the levels of interventions: child, family and community. The Strategy suggests identifying indicators that reflect increased resilience and strengthened social capital for each of the set of activities implemented. The following applies as an initial example and suggestion to be discussed and reviewed during community dialogue activities:

<table>
<thead>
<tr>
<th>Process Indicators</th>
<th>Outcome Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child</strong></td>
<td></td>
</tr>
<tr>
<td>• N. of children reached</td>
<td>• Pre and post intervention qualitative questionnaire on selected child psychosocial competencies (see Annex 1).</td>
</tr>
<tr>
<td>• Age and Sex of Children reached</td>
<td>• N. of youth effectively practicing lifeskills.</td>
</tr>
<tr>
<td>• N. of peer educators trained</td>
<td>• Increased in child resilience and strengths using Ages and Stages Questionnaire (Children 0 to 5), Goodman SDQ tools (Children 5 to 14), or other development indicators based on Erickson, Piaget, Bowlby and Freud theories (See Annex 2).</td>
</tr>
<tr>
<td>• N. of youth receiving life skills training</td>
<td>• Ethnographic observation of parents, children and</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td></td>
</tr>
<tr>
<td>• N. of families reached</td>
<td></td>
</tr>
<tr>
<td>• Household composition</td>
<td></td>
</tr>
<tr>
<td>• Number of people trained in good parenting skills</td>
<td></td>
</tr>
</tbody>
</table>
Before finalizing the suggested data collection tools, it is advisable to review them in light of their cultural and gender-appropriateness, child friendliness, possible negative effects of the assessment, and in light of the ethics for data gathering. An important element of evaluating the programme will be to give feedbacks to communities regarding the outcomes of what implemented.

**Ethical Conduct of Psychosocial Workers and Community Facilitators for the Implementation of the WALL Programme**

Psychosocial workers and community facilitators play a crucial role in the protection and promotion of the wellbeing of all people with whom they are in contact. It is the psychosocial workers and community facilitators’ responsibility to ensure that they provide high quality services that are effective and appropriate to the service users. The values and principles of psychosocial workers will inevitably inform and influence the relationship they have with service users.

1. **Relationship to Clients and Service Users**

   1.1 Psychosocial workers and community facilitators should refrain from using labels that may lead to further stigmatisation or disempowerment of service users.

   1.2 Psychosocial workers and community facilitators should encourage service users to take a primary role in their own healing and development by giving them the opportunity to express their views, feelings and ideas.

   1.3 Psychosocial workers and community facilitators should establish and maintain appropriate personal boundaries with service users. These boundaries are reflected in the personal information shared by the psychosocial worker and community facilitator, the times and places in which appointments are held, etc.

   1.4 Psychosocial workers and community facilitators should not engage in intimate relationships with service users.

   1.5 Psychosocial workers and community facilitators should be aware of the risks involved in providing emotional support services to people with whom they have a prior close relationship with, and avoid this when possible.
1.6 Psychosocial workers and community facilitators should communicate openly, accurately and appropriately with service users concerning the service being provided and the limitations of their role.

1.7 Psychosocial workers and community facilitators should be aware of the power dynamics operating in the relationship between themselves and the service user and should ensure that they do not misuse this power.

1.8 Psychosocial workers and community facilitators should avoid accepting personal gifts from service users (although on special occasions one may accept hospitality or gifts of low value).

1.9 Psychosocial workers and community facilitators should not exploit relationships with service users for personal gain, and should refrain from asking personal favours or personal work to be done by service users.

1.10 Psychosocial workers and community facilitators should promote the independence of service users.

1.11 Psychosocial workers and community facilitators who anticipate the termination or interruption of the service for service users shall notify them promptly and seek the transfer, referral, or continuation of service in relation to the service users’ needs and preferences.

1.12 Psychosocial workers and community facilitators should obtain informed consent of service users at the beginning of service provision.

1.13 Psychosocial workers and community facilitators should respect the privacy of service users by adhering to the principles of confidentiality.

2. Relationship with Colleagues

2.1 Psychosocial worker and community facilitators should treat their colleagues with respect and recognise differences of opinion, expressing criticism in a constructive manner.

2.2 Psychosocial workers and community facilitators who are concerned about the conduct of a colleague should initially approach the individual concerned. If the individual does not respond satisfactorily, psychosocial worker should inform the line-manager or their supervisor of their concerns.

2.3 Psychosocial workers and community facilitators who are concerned about the conduct of a supervisor or manager should initially approach the individual concerned. If this is not possible or the outcome is not satisfactory, psychosocial workers and community facilitators should inform the line-manager of the person concerned.

2.4 Psychosocial workers and community facilitators should acknowledge and express appreciation of the positive performance of their colleagues.

3. Upholding the Credibility of the Agency
3.1 Psychosocial workers and community facilitators should bring to the attention of their employer or another appropriate authority within the agency, the resource or operational difficulties or the limitations of the recommended approach and practice that constrain the quality of service provided.

3.2 It is the responsibility of psychosocial workers and community facilitators to ensure that their personal conduct is not a threat to the reputation of the agency or to the psychosocial sector. Where it is evident that psychosocial workers and community facilitators’ behaviour contravenes the given ethical codes of conduct, the agency/supervisors involved should examine the nature and possible detrimental effects of this behaviour and take appropriate action.

3.3 Psychosocial workers and community facilitators should not misrepresent the services provided by the agency, leading service users to believe that the agency offers more services than it really does.

3.4 It is not ethical for psychosocial workers and community facilitators to offer private services for fees to individuals who have sought services from their agency.

4. Upholding the Credibility of the Psychosocial Sector

4.1 Psychosocial workers and community facilitators should be aware of the impact of their behaviour outside of work and uphold the principles of psychosocial work outside working hours.

4.2 Psychosocial workers and community facilitators have the responsibility to lobby against any violations or inequalities when working with people in situations of inequality, conflict, injustice, or abuse and in crisis situations.

4.3 Psychosocial workers and community facilitators should seek opportunities for supervision to ensure quality of service.

4.4 Psychosocial workers and community facilitators should not participate in or condone fraud or any other misrepresentation.

4.5 Psychosocial workers and community facilitators should not misrepresent professional qualifications, education, experience, affiliations or services performed.

5. Responsibility to Service Users

5.1 Psychosocial workers and community facilitators have the responsibility to explain the following aspects of confidentiality to service users; namely, what is meant by confidentiality, the service users’ right of confidentiality with regard to information provided by them to the psychosocial worker and community facilitator in the course of service utilisation, and the limits of confidentiality.

5.2 Psychosocial workers and community facilitators should obtain informed consent from service users before taping, recording, photographing, videotaping, or permitting third party observation of their activities or discussions.
5.3 Psychosocial workers and community facilitators should obtain informed consent from the service user prior to sharing information on individual cases with any other person either within or outside of the agency. Such sharing of personal information on individual cases within or outside agencies should never be motivated by curiosity, either one’s own or of another.

5.4 Psychosocial workers and community facilitators also need to inform service users of the practice of supervision in psychosocial work, including who provides supervisory support to them. They can either obtain informed consent from the service user to share personal information of service users for supervisory purposes or can ensure that the identity of the service user is not disclosed to the supervisor.

5.5 Service users have the right to read or be told the contents of any records kept about them during the course of service provision. It is essential that the service user is informed at the beginning what is being recorded and for what purposes such information can be used such as supervisory discussions, case presentations, advocacy, programme evaluations, and research.

5.6 Psychosocial workers and community facilitators have the responsibility to extend the same service provision to people who have committed a crime as to other service users. Nonetheless the psychosocial worker and community facilitator has to inform the service user of the limits of confidentiality and their own legal responsibilities.

6. Responsibility to Psychosocial Workers and community facilitators

6.6 Agencies have the responsibility to discuss and agree upon the guiding principles of psychosocial work and community facilitation with relevant authorities in the governorates, including the right to confidentiality. This will help psychosocial workers and community facilitators to refuse any request to disclose information of service users in a safe and responsible manner.

6.7 Agencies should ensure that psychosocial workers and community facilitators are able to report to them in cases of undue influence in the form of unauthorised questioning or threats by any person inside or outside the agency, and act quickly to ensure the safety of their staff and to safeguard the right of the service user to confidentiality.

7. Maintaining the Best Interests of Children

7.1 Where the service user is a child, the same conditions of confidentiality apply as to an adult.

7.2 In the case of child abuse, the priority is the protection of the child. Psychosocial workers and community facilitators can help the child to identify safe and trustworthy people either within or outside the family with whom the child can work together to ensure protection and support. Psychosocial workers and community facilitators should consider all available resources such as siblings, neighbours, and other family members in order to increase protection or support for the child service user. If the issue does not involve abuse or harm to the child, the decision whether or not to involve others should be left to the child.
7.3 Where there is a risk of harm to a child or disclosure of ongoing abuse, the need to make an exception to confidentiality in order to provide protection should be explained to the child. The child should be encouraged to identify a person whom the child trusts (preferably in the family or the extended family) to whom the child could disclose the issue.

7.4 The child’s choices as to whom to disclose to should be respected since it is the child who knows the internal dynamics of the family. In case the risk or abuse is from a family member, the psychosocial worker must ensure that the disclosure or discussions should only involve the non-abusing parent or family member. The parent or family member would need to be informed of all available support and options to ensure protection to a child.

7.5 Psychosocial workers and community facilitators can play a very important role in ensuring that children are informed of all steps taken for their protection and wellbeing.

7.6 Psychosocial workers and community facilitators should remember that the legal custody remains with the (non-abusing) parents or caregivers. Therefore, they need to ensure that parents or caregivers become involved in the process and be given adequate information so that they can make informed decision and support the child.

7.7 Before deciding on the best course of action to support or protect a child, psychosocial workers and community facilitators should consider which course of option would optimise the wellbeing of the child. Particular consideration should be given to the issue of increased stress or risk to the child service user as a result of breaking confidentiality. In any case, this should be discussed with the child prior to disclosure.

8. The Limits of Confidentiality

8.1 Psychosocial workers and community facilitators should not consider breaching confidentiality except in extreme circumstances. These include situations where they need to act promptly in order to ensure the security and safety of service users or others involved. It also includes circumstances where the Sri Lankan judiciary system receives a court order to provide information related to specific criminal offences under investigation.

8.2 At the beginning of service provision psychosocial workers and community facilitators should inform service users of circumstances under which confidentiality may be breached.

8.3 If time and safety allows, any breach of confidentiality should be discussed with the service user, unless the safety of service users or psychosocial workers and community facilitators could be compromised.

9. Legal and Civic Duties of Psychosocial Workers and Community Facilitators

9.1 If psychosocial workers and community facilitators come to know or suspect an ongoing criminal or abusive act by service users, the psychosocial worker and community facilitator should encourage them to take all possible options to stop the act including reporting themselves to the relevant authorities.
9.2 Psychosocial workers and community facilitators are not legally obliged to report criminal acts to relevant authorities, although they have a civic duty to do so. However, law enforcement and legal authorities such as the police and courts have a duty to investigate crimes and can question psychosocial workers and community facilitators in the course of carrying out their duty with due procedure.

9.3 Psychosocial workers and community facilitators can confirm to law enforcement or legal authorities with the service user’s permission that service users disclosed an incident of abuse or other criminal act. However, they do not have to provide details regarding the act even where service users have reported the case to the police themselves unless the service user has given prior permission.

9.4 In most cases, it is unlikely that psychosocial workers and community facilitators have information of value to the police or legal authority, as they only know what the service user tells them. Psychosocial workers and community facilitators are not qualified to determine the truth of whether or not a criminal or abusive act has occurred. Hence, the limited benefits of psychosocial workers and community facilitators’ breach of confidentiality should be shared with the relevant law enforcement or legal authorities.

10. Transparency in Work

10.1 Prior to undertaking service provision, psychosocial workers and community facilitators should provide service users with all relevant information regarding the service, including the different steps and processes involved in the service, the nature of their relationship, the practice of confidentiality and its limitations, their level of competence and the purpose of the services. They can subsequently obtain informed consent from the service user.

10.2 Psychosocial workers and community facilitators are encouraged to discuss the rights and responsibilities of psychosocial workers and community facilitators and service users.

11. Time Keeping

11.1 Psychosocial workers and community facilitators should ensure that they are punctual for meetings with service users.

11.2 In cases where there are changes in dates or times of meetings with service users, psychosocial workers and community facilitators should ensure that adequate notice is given to service users.

11.3 Times and dates for meetings with service users must be set in a participatory manner, taking into consideration the convenience of the service users. Psychosocial workers and community facilitators should avoid changes to set times and dates as much as possible as this could have potentially distressing consequences to the service users.

11.4 Psychosocial workers and community facilitators should ensure that sufficient time is available at meetings with service users so that the discussion on the needs of service users is not rushed and issues overlooked. At the same time, they should ensure that the duration of meetings is not so lengthy as to be inconvenient to service users.
12. **Record Keeping**

12.1 It is the responsibility of psychosocial workers and community facilitators to ensure that some form of record keeping about service users and service provision is maintained. At a minimal level, the contact details of the person/s, details of meetings (such as dates and times), main issues discussed, follow-up steps identified and observations made, with the permission of the service user.

12.2 Where psychosocial workers and community facilitators deem the existing political context to be too risky to maintain detailed records (i.e. that the service users’ security and safety may be threatened), the level of record keeping must be at the discretion of the psychosocial worker and community facilitator.

12.3 It is the right of service users to gain access to their own records if they so desire. Psychosocial workers and community facilitators should take care that the records do not cause further distress to the service user.

12.4 Even after the end of psychosocial service provision to service users, psychosocial workers and community facilitators are bound to maintain the confidentiality of service users.

12.5 Psychosocial workers and community facilitators should ensure that records are processed and stored in such a way that the identity of service users is protected, for example, through the use of codes instead of names.

13. **Handing Over Services**

13.1 In cases where service provision by particular psychosocial workers are interrupted, they have an obligation to obtain informed consent from service users whether they are willing to consider to continue with a new or replacement psychosocial worker.

13.2 Where service users are unwilling to do so, choice must be given to them to destroy or take back any recorded information on them. Where service users are willing to continue, consent must be obtained regarding which information to be shared with the new or replacement psychosocial worker.

13.3 Psychosocial workers and community facilitators should undertake the following steps, where possible, to ensure smooth transition for service users from one psychosocial worker to the other; namely, introduction of the new or replacement psychosocial worker to service users, meetings with service users together with the new or replacement psychosocial worker, and the provision of private opportunities for service users to provide feedback and share concerns and queries regarding the new or replacement psychosocial worker.

13.4 Based on the feedback from service users and their concerns, psychosocial workers and community facilitators should prepare new or replacement psychosocial workers so that they can provide the best possible services to service users.

13.5 Psychosocial workers and community facilitators should provide information of the handing over process well in advance of the initiation of such a process to the service users. If such a process is envisaged or incorporated into project or service design and planning, this must be shared with service users at the beginning of service provision. Information thus provided
must include envisaged timeframe, the process of handing over and who will be responsible for coordinating the process.

14. **Self-Awareness**

14.1 Psychosocial workers and community facilitators should maintain self-awareness of their general state of wellbeing. This must be done so as to ensure high quality service provision and to avoid the creation of tension as a result of poor physical and emotional state of the psychosocial worker. Towards this end, psychosocial workers must understand and take steps to prevent burnout.

14.2 Psychosocial workers and community facilitators should maintain awareness of their specific emotional state during service provision so that they can monitor their own reactions and reflections in response to the service user and the service user’s experience.

14.3 Psychosocial workers and community facilitators should be sensitive to their own needs and work towards their personal development and personal fulfilment apart from their role as psychosocial worker and community facilitators. This is important for the workers’ personal development and to protect the service user from undue influence from the psychosocial worker.

14.4 Psychosocial workers and community facilitators should maintain awareness of their own cultural values and their own social-economic-political status, which may affect the ability of the psychosocial worker to maintain a non-judgemental position during service provision, and must take steps to remain as non-judgemental as possible.

14.5 Psychosocial workers and community facilitators have a duty to work to the best of their ability and should recognise own strengths and weaknesses to ensure that they work within their limits.

14.6 Psychosocial workers and community facilitators should be aware and address their own prejudices and stereotypes and make plans to deal with them when they interfere with effective service provision.

14.7 Psychosocial workers and community facilitators have the responsibility to seek regular support strategies so that they are able to deal effectively with personal stress, psychological, behavioural or emotional reactions that may affect effective service provision. It could be in the form of mutual support amongst psychosocial workers and community facilitators themselves, where they create exchange spaces and opportunities that feel safe to talk about the risks and concerns that they share.

15. **Responsibilities of Psychosocial Supervisors**

15.1 Supervisors should have sufficiently greater competence relative to the competence of the psychosocial workers and community facilitators who are being supervised. They should also have significantly more training and experience in the same or similar area of work to the psychosocial workers and community facilitators.
15.2 Supervisors should avoid intimate relationships with the psychosocial workers and community facilitators.

15.3 Supervisors should have respect for and trust in the psychosocial workers and community facilitators’ basic competence. Similarly, psychosocial workers and community facilitators should have respect for and trust in the supervisor’s competence to provide supervisory services.

15.4 Supervisors should maintain the same standards of ethical conduct as psychosocial workers and community facilitators and should provide models of good practice within the supervisory relationship.

16. Responsibilities of Peer Supervisors

16.1 Psychosocial workers and community facilitators are required to maintain confidentiality of service users within the peer group supervision sessions. Identifying characteristics (such as names, addresses, village, etc.) should not be disclosed in the discussion where there are psychosocial workers not involved in service provision to that particular individual or family.

16.2 The peer supervision colleagues are expected to provide the same services for one another.

17. Preparing for Supervision

17.1 It is important for supervisors to enquire about cases which psychosocial workers and community facilitators found difficult to handle as well as about cases which psychosocial workers found it easy to handle.

17.2 Psychosocial workers and community facilitators should be prepared to disclose to and discuss with supervisors the aspects of work that they did well and those that they did less well.

17.3 Supervisors and psychosocial workers should jointly negotiate a clear agenda that outlines the aims of the session, the structure and the process, with mutually clarified expectations, goals and ways of achieving them.

18. The Role of Supervision

18.1 Supervisors should help psychosocial workers and community facilitators to adhere to standards of good practice.

18.2 Supervisors should help psychosocial workers and community facilitators build their competence to carry out their work. At the same time, they must make psychosocial workers and community facilitators aware of the limitations of their abilities.
18.3 Supervisors should provide constructive feedback to psychosocial workers and community facilitators on their performance.

18.4 Supervisors should help psychosocial workers and community facilitators understand and deal with the personal issues relating to service users, but should not be directly involved in helping psychosocial workers and community facilitators deal with their own personal problems.

18.5 While supervisors may identify and discuss personal problems of psychosocial workers and community facilitators, it will be with the sole purpose of helping them to understand how their current and past experiences may influence the work they are doing with service users. Supervisors may suggest that the psychosocial worker may benefit from support strategies, if this is seen as necessary although they will not personally provide such services to the psychosocial worker.

18.6 Supervisors should help psychosocial workers and community facilitators to address and modify the anxieties and doubts they have experienced within the context of carrying out their work.

18.7 Supervisors should help psychosocial workers and community facilitators in the application and development of knowledge in relation to practice, with the result that the psychosocial workers and community facilitators’ range of skills and knowledge is extended.

18.8 Supervisors are required to provide feedback to the agency on the general performance and capacities of the psychosocial workers and community facilitators. Further areas for improvement can be identified for and requested from the agency.

18.9 Supervisors should engage in mediating with the agency on behalf of the psychosocial worker and community facilitators, particularly to safeguard the wellbeing of psychosocial workers and service users as well as to uphold good psychosocial practices.
Annex 1

Fundamental Psychosocial competencies among children and adolescents

Fundamental psychosocial competencies essential to all children and youth are the following:

1. **Secure attachment with caregivers** - Child feels safe and cared for by supportive adult caregivers.
2. **Meaningful peer attachments and social competence** - Child has the capacity to create and maintain meaningful relationships with peers and adults. Feels he or she is able to effectively navigate his or her social world.
3. **Trust in others** – Child has a belief that he or she can rely on others in his/her community for nurturance, help and advice. Child feels that he or she will not be hurt by others in his/her community.
4. **Sense of Belonging** - Child is socially connected to a community and feels he or she is part of a larger social whole. Child adopts some key values, norms, and traditions of his or her community.
5. **Self-esteem** - Child has a self-concept of worthiness and instrumentality. Child has a sense of being valued. Shows a trust in the self.
6. **Empowerment** - Child has a sense of empowerment and has the capacity to participate in decisions affecting his or her life and to form independent opinions.
7. **Ability to access to opportunities** – Child has the ability to access and/or create opportunities for cognitive, emotional, and spiritual development and economic security.
8. **Hopefulness or optimism about the future** – Child feels confident that the world offers positive outcomes, that things are, or are likely to be, fine. Child has a realistic sense of the future and is able to plan for the future.
9. **Responsibility** – The child understands the implications of his or her actions, demonstrates a concern for the impact of his or her action on others, and assumes responsibility for his or her actions.
10. **Empathy** – The child demonstrates the ability to understand and empathize with the needs, rights and feelings of others.
11. **Creativity** – The child is able to be creative and to imagine different alternatives and options in a given situation.
12. **Adaptability** – The child is able to adjust to new situations. The child is able to acknowledge and evaluate new information, make appropriate and timely decisions and adjust his or her thinking and behaviour to new situations. The child is able to deal with uncertainty (adapted from Multi Agency Committee 2001).

The presence or absence of these psychosocial competencies deeply determines child’s dege of resilience and emotional performances in life, characterising the typology of adult that the child will grow into. For each of the presented psychosocial competencies, the Strategy proposes to develop relevant questions that can form the basis for a qualitative and quantitative pre and post intervention’s questionnaire.

Example could include:

<table>
<thead>
<tr>
<th>Area of Psychosocial Development</th>
<th>Questions</th>
<th>Never</th>
<th>Most of the time</th>
<th>Sometimes</th>
<th>Often</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure Attachment with others</td>
<td>Do you seek comfort to your parents when frightened?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel anxious if your parents leave you alone?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you disclose important secrets to your parents?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Meaningful peer attachments and social competence</strong></td>
<td>Do you have lasting friendship relationships?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you interested in your friends’ feelings and emotions?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Can you tell if your friends have some problems while looking at</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the way they behave?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you anxious when entering a group of people you don’t know</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>before?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Trust in others</strong></td>
<td>Do you have trusted friends upon whom you can rely on?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel secure in your family?</td>
<td>Do you feel secure in your community?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
ANNEX 2

Emotional and Social Assessment of the Child using Ages and Stages Questionnaire, Strengths and Difficulties Questionnaire, and indicators based on Erickson, Piaget, Freud and Bowlby’s theories

This Strategy suggests to adopt 2 main tools to assess the social and emotional improvement of children: the Ages and Stages Questionnaire (ASQ) for children aged between 3 months to 5 years; and the Goodman’s Strengths and Difficulties Questionnaire (SDQ) for children over the age of 5.

These tools have been chosen for use because they are:
- Age sensitive
- Have been thoroughly validated
- Are easy for most parents or coaches to complete
- Quick to score
- Low cost
- The scored domains will provide useful information to guide practitioners and youth in their approach

Seven behavioural areas are addressed in the ASQ:

<table>
<thead>
<tr>
<th>Behavioural area</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-regulation</td>
<td>The child’s ability or willingness to calm or settle down or adjust to physiological or environmental conditions or stimulation</td>
</tr>
<tr>
<td>Compliance</td>
<td>The child’s ability or willingness to conform to the direction of others and follow rules</td>
</tr>
<tr>
<td>Communication</td>
<td>The child’s ability or willingness to respond to or initiate verbal or non-verbal signals to indicate feelings, affective or internal states</td>
</tr>
<tr>
<td>Adaptive functioning</td>
<td>The child’s success or ability to cope with physiological needs (e.g. sleeping, eating, safety)</td>
</tr>
<tr>
<td>Autonomy</td>
<td>The child’s ability or willingness to self initiate or respond without guidance ie moving to independence</td>
</tr>
<tr>
<td>Affect</td>
<td>The child’s ability or willingness to demonstrate his or her own feelings and empathy for others</td>
</tr>
<tr>
<td>Interaction with people</td>
<td>The child’s ability or willingness to respond to or initiate social responses to parents, other adults and peers</td>
</tr>
</tbody>
</table>

In the SDQ, four development difficulties and one development strength are assessed:

- Peer Relationship
- Conduct
- Hyperactivity and inattention
- Emotional symptoms
- Pro-Social behaviours (Pro-Social behaviour can be defined as any act initiated and performed with the aim of benefiting another person. It is a predisposition to help, share and care).

Other specific indicators could be adapted starting from Erikson, Bowlby, Piaget and Freud’s developmental concepts by age summarized in the table below. Child development follows certain
principles that must be understood and respected in order to provide an optimal environment for growth. These are:

1. **All children are different from one another.** Even as little children, they already have different personalities and temperaments. Some babies are quick to warm up to people while others take a longer time to calm down. Children have different potentials, reactions to situations and rates of development.

2. **Children tend to follow the same sequence of development.** Even if the rates of development vary from one child to the next, the pattern is quite similar. For example, children learn to crawl first before they can walk. However, some children learn to walk earlier than others.

3. **There are basic requirements for the child to fully develop as a person.** One is a stable environment with routines and the other is available adults capable of providing the basic needs of growth.

<table>
<thead>
<tr>
<th>Theory</th>
<th>Age</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1 Erikson</strong>&lt;br&gt;psychosocial stages of development</td>
<td>1</td>
<td>Requires consistent and stable care to develop feelings of security. Begins to trust the environment but can also develop suspicion and insecurity. Deprivation can lead to emotional detachment throughout life and difficulties in forming relationships.</td>
</tr>
<tr>
<td></td>
<td>2-3</td>
<td>Begins to explore and seek independence from parents. A sense of autonomy develops but improved self esteem can combine with feelings of shame and self doubt. Failure to integrate may lead to difficulties in social integration.</td>
</tr>
<tr>
<td></td>
<td>4-5</td>
<td>Needs to explore the wider environment and plan new activities. Begins to initiate activities but fears punishment and guilt as a consequence. Successful integration results in a confident person but problems can produce deep insecurities.</td>
</tr>
<tr>
<td></td>
<td>6-11</td>
<td>Begins to acquire knowledge and skills to adapt to surroundings. Develops sense of achievement but marred by possible feelings of inferiority and failure if efforts are denigrated.</td>
</tr>
<tr>
<td></td>
<td>12-18</td>
<td>Enters the stage of personal and vocational identity formation. Self-perception is heightened, but there is a potential for conflict, confusion and strong emotions.</td>
</tr>
<tr>
<td><strong>2 Bowlby’s Attachmet theory</strong></td>
<td></td>
<td>Pre-attachment undiscriminating social responsiveness. The baby is interested in voices and faces and enjoys social interaction.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Begins to develop discriminating social responses and experiments with attachments to different people. Familiar people elicit more response than strangers.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Attachment to main parent is prominent with the child showing separation anxiety when the carer is absent. The child actively initiates responses from the carer.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The main carer’s absences become longer, but the child develops a reciprocal attachment relationship.</td>
</tr>
<tr>
<td><strong>3 Piaget’s stages of cognitive development</strong></td>
<td></td>
<td>Sensory motor stage – infants explore their physicality and modifying reflexes until they can experiment with objects and build a mental picture of things around them.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pre-operational stage, where the child acquires language, makes pictures and participates in imaginative play. Child tends to be self-centred and fixed in thinking believing that they are responsible for external events.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Concrete operations stage, when a child can understand and apply more abstract tasks such as sorting or measuring.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Less egocentric thinking and more relational thinking – differentiating between things. The complexity of the external world is beginning to be appreciated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Formal operations stage – characterised by the use of rules and problem solving skills. The child moves into adolescence with increasing capacity to think abstractly and reflect on tasks in a deductive, logical way.</td>
</tr>
<tr>
<td><strong>4 Freud psychosexual stages of development</strong></td>
<td></td>
<td>Oral stage – principle source of comfort is sucking breast milk from mother and the gratification from the nutrition.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Anal stage – anus and defecation are major sources of sensual pleasure. Child preoccupied with body control with parental/carer encouragement. Obsessional behaviour and over-control could</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phallic stage – the penis is the focus of attention. In boys the Oedipus complex and in girls the Electra complex are generated in desires to have a sexual relationship with the opposite sex parent. The root of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Latency stage - characterised by calm after the storm of the powerful emotions preceding it.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Genital stage – whereby the individual becomes interested in opposite sex partners as a substitute for the opposite sex parent, as a way of resolving the tensions inherent in the Oedipal and</td>
</tr>
<tr>
<td>indicate problematic development.</td>
<td>anxieties and neuroses can be found here if transition to the next stage is impeded.</td>
<td>Electra complexes.</td>
</tr>
</tbody>
</table>
Annex 3

**Ethnographic Indicators used to assess PSS programming’s Outcomes at the Child, Family and Community level**

PSS field-focused ethnographic techniques are based on recording community perceptions about their own well-being. Focused PSS ethnography specifically looks at the (1) general conditions of the community, (2) parents and their relationship to children and to each other, (3) children and adolescents and how they see their world. They also determine what services are available to the community members.

Example of indicators derived from PSS field-focused ethnographic techniques are:

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Stimulus Question</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Community</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Families are living together.</td>
</tr>
<tr>
<td></td>
<td>Privacy in the shelter for the family and family members is available.</td>
</tr>
<tr>
<td></td>
<td>Community conducts activities to help children with difficulties.</td>
</tr>
<tr>
<td></td>
<td>The community can identify three strategies to deal with psychological distress.</td>
</tr>
<tr>
<td></td>
<td>The community has identified resilience factors that have helped them survive.</td>
</tr>
<tr>
<td></td>
<td>The community has a strategy to recover from the situation of emergency and insecurity.</td>
</tr>
<tr>
<td></td>
<td>Social organization promotes social well-being through information, cultural and recreational activities.</td>
</tr>
<tr>
<td></td>
<td>Measures have been taken to improve the living conditions of children and their families.</td>
</tr>
<tr>
<td></td>
<td>There are persons in the community that provide regular activities for children (informal education, play and recreation).</td>
</tr>
<tr>
<td><strong>Parents</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parents are facing stress that is affecting their wellbeing and how they care for the children.</td>
</tr>
<tr>
<td></td>
<td>Parents want to participate in self-care activities.</td>
</tr>
<tr>
<td></td>
<td>Parents seek support for stressing difficulties.</td>
</tr>
<tr>
<td></td>
<td>Parents learn how to reduce the stress level in their children.</td>
</tr>
<tr>
<td></td>
<td>Parents and children participate in stress reducing creative and expressive activities.</td>
</tr>
<tr>
<td></td>
<td>Parents have changed practices regarding corporal punishment.</td>
</tr>
<tr>
<td></td>
<td>Parents have change practices regarding intra-household violence.</td>
</tr>
<tr>
<td><strong>Child</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children are provided with adequate nurture and care at home.</td>
</tr>
<tr>
<td></td>
<td>Children are provided with adequate nurture and care in school.</td>
</tr>
<tr>
<td></td>
<td>Culturally appropriate ways are used to promote expressive activities and play.</td>
</tr>
<tr>
<td></td>
<td>Culturally appropriate ways are used to promote creative activities.</td>
</tr>
<tr>
<td><strong>Services</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children who are alone are cared for in the community and school.</td>
</tr>
<tr>
<td></td>
<td>Children participate in development enhancing activities to re-establish a sense of place.</td>
</tr>
<tr>
<td></td>
<td>Children and adolescents are taught methods of self-care.</td>
</tr>
<tr>
<td></td>
<td>Training and support to provide psychosocial support is provided to</td>
</tr>
</tbody>
</table>
Children experiencing psychological distress are identified and supported in formal and informal schooling.

Source: Adapted from Prewitt-Diaz (2006).
ANNEX 4

Evaluation of increased Resilience and Social Capital at the Individual, Family, and Community Level using the I AM, I HAVE, I CAN framework

The Strategy suggests to adopt 8 subscales to assess different areas of functioning and support:
1. Qualities of the individual;
2. Feelings;
3. Use of humor;
4. Spiritual belief;
5. Social support system;
6. Involvement with the community;
7. Capacity to work, and
8. Pattern of working

For each sub-scale, the Strategy suggests to develop questions that cover the individual’s dynamics of interaction at self, family, social system, and occupational environment levels.

Possible questions are:

<table>
<thead>
<tr>
<th>I am</th>
<th>I am considerate of the view points of others in difficult situations.</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am</td>
<td>I am proud of myself, my family, and my community.</td>
</tr>
<tr>
<td>I am</td>
<td>I am good at my work.</td>
</tr>
<tr>
<td>I am</td>
<td>I am valued by my friends, and neighbors.</td>
</tr>
<tr>
<td>I am</td>
<td>I am listened and respected in my community.</td>
</tr>
<tr>
<td>I am</td>
<td>I am part of at least two community groups.</td>
</tr>
<tr>
<td>I have</td>
<td>I have several who listen to me.</td>
</tr>
<tr>
<td>I have</td>
<td>I have people in my community who love me.</td>
</tr>
<tr>
<td>I have</td>
<td>I have been successful all of my life.</td>
</tr>
<tr>
<td>I have</td>
<td>I have someone to help me when I am in trouble.</td>
</tr>
<tr>
<td>I have</td>
<td>I have a network of people that believe that I can succeed.</td>
</tr>
<tr>
<td>I have</td>
<td>I have the capacity to achieve my goals.</td>
</tr>
<tr>
<td>I have</td>
<td>I have clear expectations about what my community can achieve.</td>
</tr>
<tr>
<td>I have</td>
<td>I have people in the community who listen to my worries.</td>
</tr>
<tr>
<td>I can</td>
<td>I can use humor as a way to cope.</td>
</tr>
<tr>
<td>I can</td>
<td>I can take the necessary steps to achieve my objectives.</td>
</tr>
<tr>
<td>I can</td>
<td>I can excel in creative activities.</td>
</tr>
<tr>
<td>I can</td>
<td>I can find something to laugh about.</td>
</tr>
<tr>
<td>I can</td>
<td>I can take things one day at a time.</td>
</tr>
<tr>
<td>I can</td>
<td>I can look at a situation in more than one way.</td>
</tr>
<tr>
<td>I can</td>
<td>I can succeed because I have experienced difficulties before.</td>
</tr>
<tr>
<td>I can</td>
<td>I can do many things at a time.</td>
</tr>
<tr>
<td>I can</td>
<td>When I make plans, I can follow through with them.</td>
</tr>
<tr>
<td>I can</td>
<td>I can see several sides of a situation.</td>
</tr>
<tr>
<td>I can</td>
<td>I can take care of myself, and my family.</td>
</tr>
</tbody>
</table>
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.) Minefields in their hearts; The mental health of children in war and communal violence (149-164), New Haven: Yale University Press;
Guiding Principles
Play Therapy International (2007). The Play Therapy TOOLKIT for play and creative Art Therapies. [http://www.playtherapy.org.uk/AboutPlayTherapy/PlayTherapyToolKit.htm](http://www.playtherapy.org.uk/AboutPlayTherapy/PlayTherapyToolKit.htm)


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