



International Federation
of Red Cross and Red Crescent Societies



Real-time evaluation of the ERU psychosocial support component deployment to Haiti earthquake 2010



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Type of disaster	Natural disaster/earthquake
Location of disaster	Haiti, Port-au-Prince and surrounding areas
Number of people affected	Approximately 3 million people

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Abbreviations

CHM	Community Health Module
DMIS	Disaster Management Information System
ERU	Emergency Response Unit
FACT	Field Assessment Coordination Team
HRCS	Haiti Red Cross Society
IASC	Interagency Standing Committee
ICRC	International Committee of the Red Cross
IFRC	International Federation of the Red Cross and Red Crescent Societies
IOM	International Organisation for Migration
MHPSS	Mental Health and Psychosocial Support
PFA	Psychological First Aid
RAT	Recovery Assessment Team
RCRC	Red Cross Red Crescent
RTE	Real-time evaluation
TOR	Terms of Reference
UN	United Nations
UNICEF	United Nations International Children’s Emergency Fund

Executive Summary

On 12 January 2010 an earthquake of a magnitude of 7.0 on the Richter scale struck Haiti, the epicentre being just 22 km from the densely populated capital of Port-au-Prince. Haiti is the poorest country in the Western hemisphere, ranking 153 out of 177 countries in the UN Human Development Index. Following the earthquake the Red Cross Red Crescent augmented the relief efforts initiated by Haiti Red Cross Society and mobilized its biggest single-country emergency response operation ever. ERU deployments included two mobile hospitals which for the first time deployed psychosocial delegates who worked alongside medical staff, in order to provide an integrated health response.

The Norwegian RC, together with Canadian RC, deployed its rapid deployment emergency hospital to Port-au-Prince. It was initially set up at University Hospital in the centre of Port-au-Prince. After about one month the ERU Hospital moved to Petit Goâve, a town of about 200.000 inhabitants 75 km West of Port-au-Prince. The German and Finnish RC deployed a referral hospital which was set up in a sports stadium in the area of Carrefour in Port-au-Prince. The hospital served the camp that was set up next to the stadium and the area of Carrefour in general.

The present real-time evaluation (RTE) was conducted in order to document the effects of integrating psychosocial action in the emergency response. It took place from 19-28 February 2010 and was conducted by the IFRC Psychosocial Support Centre's technical adviser. The psychosocial delegates, medical and administrative staff of the two hospitals are the main sources of information presented in the report.

Deploying psychosocial delegates as part of the health ERUs teams from the very beginning of the operation seems highly relevant as the delegates and their volunteer teams have been able to address some of the normal and acute stress reactions that are experienced following intense emotional distress. The delegate's position – being in contact with both community members and the overall coordination forums and organizations – gives him/her a unique opportunity to link specific needs for action up to the wider coordination level and ensure standardization of practices on this level as well. All interviews conducted in connection with the RTE explored the issue of how psychosocial support is complimentary to traditional health ERU work. Respondents expressed in very positive terms the work of the ERU psychosocial teams. Clinical personnel were very grateful for having this extra capacity to draw upon when patients had to be supported. On a general level the teams were seen to raise the spirit among patients, in the rapid deployment hospital the psychosocial team was named 'the sunshine team' because of the positive atmosphere that they were able to create.

The delegates and their volunteer teams provided a range of services in the hospital, including PFA and emotional support for hospitalised children and adults; they took care of and established a protocol for ensuring protection and continuous care of unaccompanied minors/isolated children. Activities included sensitisation and awareness-raising sessions with adults on normal reactions to stress and coping mechanisms and establishment of child-friendly spaces. As the work moved from the emergency to the recovery phase, changes in disease patterns were observed, from earthquake related trauma to everyday ailments and accidents. The ERU psychosocial activities in this phase increasingly focused on the communities and camp outside the hospital. Providing psychosocial support to the volunteers was an important activity as they themselves were seriously affected by the earthquake.

The ERU psychosocial support component consists of kits with toys and play items for younger and older children, games that may also be played by adults, and sports items. The kits also contain a set of information, education and communication materials, i.e. brochures and hand-outs that explain about normal reactions to abnormal events, psychological first aid and the stress that humanitarian workers may be exposed to as part of their work. Finally the kits contain administrative items, e.g. pens, paper, notebooks and materials for conducting workshops. Before the Haiti deployment Norwegian RC had trained one group of psychosocial delegates, with participants from Norway, Spain, France, Canada, and Denmark. In order to increase the number of available ERU psychosocial delegates and have broader range of competencies (e.g. language, experience, specific psychosocial skills) to draw upon, ERU National Societies interested in deploying psychosocial delegates in future should plan and conduct more trainings.

It is important that both psychosocial delegates and the ERU management team have a clear understanding of the scope and mandate of ERU psychosocial action. This point should be underscored in delegate as well as team leaders' trainings and enforced in pre-departure briefings. In order to ensure full integration of ERU psychosocial support activities it is crucial that these are understood and accepted by hospital management, administrative and technical staff.

It is essential to ensure that psychosocial support does not happen in a vacuum and that activities are conducted in collaboration with and coordinated with the local National Society. In Haiti, the psychosocial delegates were able to establish contact to the local branches and selection of volunteers was done in collaboration with HRCS. Delegates and staff in both hospitals agree that the group of volunteers have made a remarkable difference. They have come to work relentlessly although their own living situation is as hopeless as that of the people they are assisting and in a sense they can be said to be a target group. As is known from other settings, the fact that volunteers become engaged in the response is a healing process in itself.

As the ERU work moves into the recovery phase, it becomes increasingly evident how psychosocial support action quickly becomes a long-term commitment. Due to the community-based nature of psychosocial work there is scope for linking the psychosocial teams up with the work of the community health module which is a part of the work of the rapid deployment hospital. At the time of the RTE this option was only tried on one occasion but it does seem that there would be opportunity for combining resources and linking up psychosocial support with the CHM work.

Based on interviews, consultations and observations made during the mission to Haiti, the main conclusion of the RTE is that including psychosocial support action in the ERU hospitals deployed to the Haiti earthquake response has had a tangible effect in terms of supporting the emotional and social well-being of patients to speed up their recovery process. Adding psychosocial support to ERU hospital work supplements what is already being done and enables a holistic approach to the healing process of patients and their relatives. Although a truism, it may be said that with psychosocial support, care is being taken of the wounded and not just the wound. The overall recommendation of this RTE is that including psychosocial support in the International Federation's ERU hospitals deployed to Haiti has been a positive experience which has the potential to be repeated and expanded in future emergencies.

Introduction

On 12 January 2010 an earthquake of a magnitude of 7.0 on the Richter scale struck Haiti, the epicentre being just 22 km from the densely populated capital of Port-au-Prince. The earthquake and subsequent aftershocks caused extensive loss of life and damage to infrastructure in Port-au-Prince and surrounding areas – affecting over 3 million people.

Haiti is the poorest country in the Western hemisphere, ranking 153 out of 177 countries in the UN Human Development Index. Combined with a precarious socio-economic and political history and reality, Haiti has suffered from past disasters including hurricanes, flooding, landslides, soil erosion, deforestation, drought, fires, internally displaced persons, civil strife, political violence and environmental pollution. Prior to the earthquake Haiti was beset with chronic levels of poverty and vulnerability. Law and order issues and weak government institutions have proved to be surmountable challenges to post-hurricane recovery operations in recent years. Initial assessments conducted in the weeks following the earthquake indicate that the crisis has significantly exacerbated already acute vulnerabilities and problems facing many Haitians.

Following the earthquake the Red Cross Red Crescent (RCRC) augmented the relief efforts initiated by Haiti Red Cross Society (HRCS) and has mobilized its biggest single-country emergency response operation ever. A total of 21 emergency response units (ERUs) and 230 delegates were deployed for the initial response. These include two mobile hospitals: a rapid deployment emergency hospital deployed by the Norwegian and Canadian Red Cross on 14 January and a referral hospital deployed by German and Finnish Red Cross on 21 January. Both hospitals deployed psychosocial delegates who worked alongside medical staff, in order to provide an integrated health response. The work of the delegates is structured around the ERU psychosocial support component that was developed in 2008 by the International Federation's Psychosocial Support Centre, in collaboration with Norwegian RC, and deployed for the first time in Haiti.¹

The present real-time evaluation (RTE) was conducted in order to document the effects of integrating psychosocial action in the emergency response following the earthquake and to provide recommendations for the finalisation and further development of the ERU Psychosocial support component. The overall aim of the RTE is to contribute to the ongoing development of effective disaster response tools of the International Federation, for the consideration of ERU technical working groups, the Federation Secretariat, National Societies and other RCRC stakeholders.

Planning and conducting the real-time evaluation

The RTE took place from 19-28 February 2010 and was conducted by the IFRC Psychosocial Support Centre's technical adviser. Terms of reference (TOR) for the mission had been drafted in advance of the mission and was finalised with the input from Norwegian and Danish Red Cross who had deployed the psychosocial support component, kits and delegates to the field (see Annex 1). As much information as possible was obtained in advance of the mission, including field reports from the

¹ All materials in relation to the ERU psychosocial support component are available on DMIS: https://www-secure.ifrc.org/DMISII/Pages/03_Response/0306_eru/030605_eru_bhc/030605_eru_bhc.aspx

psychosocial delegates, situation and activity reports from the Federation's Disaster Management Information System (DMIS) and other relevant background information (see Annex 2).

The purpose real-time evaluations or RTEs is to inform operational practice and decision-making through a process-oriented interactive evaluation or review that emphasises lessons-learning and on-going adjustments over impact evaluation or accountability.² With this in mind, and based on the TOR for the mission, interview guides were developed to structure discussions and data collection. Some delegates and staff who had returned from mission prior to the RTE were interviewed via skype or phone. A questionnaire was sent by email to others who could not be interviewed during the course of the RTE mission.

Upon arrival in Haiti the technical adviser immediately started interacting with relevant RCRC and other psychosocial support stakeholders. Discussions and conversations around the ERU psychosocial support component took place continuously during the course of the mission (see Annex 3 and 4). Close consultations were held with the Field Assessment and Coordination Team (FACT) Health Delegate and the Recovery Assessment Team (RAT) psychosocial profile. While this report focuses on psychosocial work in the emergency phase of the operation, the RAT mission report outlines the longer-term ideas and perspective for RCRC psychosocial work in Haiti.

Overview of the deployment situation

Norwegian/Canadian RC Rapid Deployment Emergency Hospital

The Norwegian RC, together with Canadian RC, deployed its rapid deployment emergency hospital to Port-au-Prince. The site selected for the ERU hospital was the University Hospital in the centre of Port-au-Prince which was partly collapsed and some of the remaining buildings deemed too unstable for occupation. Upon arrival two psychosocial delegates immediately started working alongside their medical colleagues. Together with a team of 20 volunteers who were trained in psychological first aid (PFA) and other basic psychosocial skills, the delegates provided PFA and emotional support for hospitalised children and adults, took care of and established a protocol for ensuring protection and continuous care of unaccompanied minors/isolated children. Providing psychosocial support to the volunteers themselves was an important activity as they themselves were seriously affected by the earthquake.

After some time a child-friendly space was set up, with structured playing and activities that allowed the children a break from the chaotic situation of the post-earthquake. A space was created for adults to come and talk, play games or simply be with others, this was used by mobile patients, visitors and relatives as well as hospital staff. In the third week of deployment there was a need to move the ERU psychosocial work outside the hospital. Together with the ERU community health team, the psychosocial team visited the nearby camp of La Piste. A link was established to the University hospital and Médecins du Monde who would train around 70 persons (psychologists, social and community workers) to continue activities here and expand psychosocial support activities in the camps set up around the hospital.

² Humanitarian Practice Network (2005); Cosgrove et al. (2009).

After about one month it was decided that the ERU Hospital would move to Petit Goâve, a town of about 200.000 inhabitants 75 km West of Port-au-Prince. Here the ERU moved into the existing and undamaged hospital which was abandoned one year prior to the earthquake. This move coincided with the shift from the emergency to recovery phase, with earthquake related trauma decreasing steadily, while everyday emergencies and chronic diseases were on the rise.

The psychosocial work in this second phase focused on meeting the needs of people staying in the 15 camps found in and around Petit Goâve. Follow-up for patients with stress-related problems was still done in the hospital, and for the outlying areas a needs assessment was conducted to outline the main issues to be addressed and to get an overview of organisations working in the area. Through the local branch of HRCS, a group of 27 volunteers was identified and trained to start work in pairs in the camps. At the time of RTE the main activities were envisaged to be child-friendly spaces, support groups for mothers, peers groups, dissemination of information, follow-up on specific issues and referrals of cases to UNICEF and other specialised agencies.³ It was suggested to develop a long-term plan for the continuation of psychosocial support activities.

German/Finnish RC Referral Hospital

The German and Finnish RC deployed a referral hospital which was set up in a sports stadium in the area of Carrefour in Port-au-Prince. The hospital serves the camp that was set up next to the stadium and the area of Carrefour in general. Upon arrival the psychosocial delegate collaborated with HRCS to recruit and train a volunteer team, initially 28 volunteers were trained and seven of these immediately started working. Over the following weeks the number of volunteers engaged rose to 20. Basic training included PFA with particular focus on listening skills, stress and stress management, and child protection issues. As more volunteers became active, refreshers training was conducted and this included child development stages.

The delegate and volunteers provided a range of services in the hospital, including sensitisation and awareness-raising sessions with adults in the waiting area of the hospital, on normal reactions to stress and coping mechanisms. Mobile teams of volunteers moved through the wards and provided PFA and supportive listening to patients and played with bed-ridden children. There was support to people who had lost a relative and a tent was set up where bodies were kept for a maximum of ten hours. This allowed people to say goodbye to the deceased. A transportation service was organised to facilitate the transportation of the deceased whenever necessary.

Also in Carrefour was a strong focus on children. In the hospital compound two tents were set up for child-related activities with structured playing and games mainly for younger children. Those attending were either patients themselves, children of patients or came from the nearby camp. For older children and adolescents, outdoor activities (including ball games, races, dancing and singing) were organised in the basketball courts next to the stadium. Care and support for unaccompanied minors/isolated children was ensured and contacts established to HRCS and ICRC to ensure proper registration and continued care in appropriate homes or institutions. Contact was established to local mental health

³ At the time of RTE mission, International Medical Corps (IMC) was planning to set up a community-based specialised mental health programme in Petit Goâve.

professionals for referral of people in need of therapy or specialised services. Throughout the period psychosocial support was also provided to volunteers through structured group discussions.

As the work moved from the emergency to the recovery phase, changes in disease patterns were observed, from earthquake related trauma to everyday ailments and accidents. The psychosocial activities increasingly focused on the communities and camp outside the hospital. Contact was established to UNICEF who provided schools kits and tents to allow for around 250 children from the community to attend school for the first time since the earthquake. All government schools in Haiti closed after the earthquake and according to UNICEF this was one of the first, if not the first, school to re-open after the earthquake.⁴ A number of teachers from the community expressed interest in the taking part in the activities, since they were out of work due to the closed schools. These were trained alongside other volunteers and engaged in training activities. It is not envisaged that the hospital will remain in Carrefour and an exit strategy is to be developed, including longer-term psychosocial support activities. The activities will gradually move out of the hospital and become anchored in the local community.

Findings

A. Scope and purpose

Following the earthquake Haiti is experiencing typical impact of large crises where many lives are lost, families and communities are separated, basic services destroyed, disrupted or overwhelmed and informal protection mechanisms weakened. Deploying psychosocial delegates as part of the health ERUs teams from the very beginning of the operation seems highly relevant as the delegates and their volunteer teams have been able to address some of the normal and acute stress reactions that are experienced following intense emotional distress. These include grief, sadness, hopelessness and sense of being overwhelmed. Dealing with protection issues was another core area of work for the psychosocial delegates, where ensuring care and protection of separated children featured prominently.

As described in the overview section the ERU psychosocial delegates have been able to complement traditional health ERU activities through providing immediate emotional assistance to patients and relatives in the hospitals. On a practical level the psychosocial support teams filled a gap by being able to look into the social situation of hospital patients. In some cases it was difficult to discharge patients from the hospital because their living situation outside was rather hopeless and in the hospital they received a certain level of care.

Within the geographical locations where they operated, the ERU psychosocial teams paid particular attention to children; these are a specifically vulnerable group whose needs must be looked after. They comprise a large segment of the population, as 50% of Haiti's 9 million inhabitants are below the age of 20. For unaccompanied minors a process protocol was established in collaboration with UNICEF, HRCS and ICRC to ensure continued care in homes or orphanages that are approved by the government. For other children present in the hospital, child-friendly spaces were created, where the children would play, interact and be occupied for while. Volunteers would monitor the behaviour of children and talk to the children themselves or their parents when needed.

⁴ See article on school in Carrefour here: http://www.unicef.org/infobycountry/haiti_53025.html

B. Assessment and planning

When the ERU teams arrived in Haiti, all team members immediately started working to meet the enormous needs of the earthquake affected population. Thus initially no formal assessment, using the formats that had been prepared as part of the delegate manual, was undertaken. As the teams started working the delegates would collect and act on information provided by HRCS, community members, IFRC FACT team members and organizations that they interacted with. The delegate's position – being in contact with both community members and the overall coordination forums and organizations – gives him/her a unique opportunity to link specific needs for action up to the wider coordination level and ensure standardization of practices on this level as well. This point is explored in further detail below.

As ERU psychosocial work moves into the recovery phase, there is greater scope for undertaking assessments, because the acute needs are fewer and due to the shift towards outreach work in communities that was seen in both ERU hospitals. Thus the ERU psychosocial team moving to Petit Goâve undertook an assessment as one of their first activities and the plan for further action was developed on the basis of this. Forms for data collection on psychosocial issues have been developed and are included in the Delegate manual which all trained ERU psychosocial delegates have access to, and which explains the standard operating procedure for ERU psychosocial work. Delegates report that these forms for data collection do fulfil the requirements for undertaking a rapid assessment in the ERU context.

C. Implementation

The RTE found that activities undertaken by ERU psychosocial teams are very much in line with the concept and general approach developed for the ERU psychosocial support component. Psychosocial support must always take the local social and cultural context into consideration, as well as the nature of the emergency that is being responded to; thus it is not possible to have one standardized approach. Nevertheless a global framework for mental health and psychosocial support has been developed and implemented over the past years;⁵ and this has been used to shape the general approach and direction of ERU psychosocial support work. The delegates and their volunteer teams managed to strike the balance between adhering to agreed standards and adapting these to the particular setting in which they operated.

The ERU psychosocial support component consists of kits with toys and play items for younger and older children, games that may also be played by adults, and sports items. The kits also contain a set of information, education and communication (IEC) materials, i.e. brochures and hand-outs that explain about normal reactions to abnormal events, psychological first aid and the stress that humanitarian workers may be exposed to as part of their work. Finally the kits contain administrative items, e.g. pens, paper, notebooks and materials for conducting workshops. The delegates report that the items in the kits were generally useful and sufficient to conduct activities and they have made concrete suggestions for things that must be added to the kits prior to future deployments (see Annex 5).

⁵ Inter-Agency Standing Committee (2007)

The brochures and hand-outs in the kits were available in English and French prior to the deployment to Haiti. All materials have been made in easily convertible word formats and with black and white drawings to allow for easy translation and reproduction. It soon became evident that translation of IEC materials into Creole was necessary, in order to facilitate effective communication with affected community members. It has been suggested that brochures are translated into a range of languages (e.g. Urdu, Tamil, Bahasa, Mandarin, Swahili etc.) as part of long-term psychosocial support programmes so that they are ready for reproduction in future deployments.

Already a few days after deployment, psychosocial delegates requested to have t-shirts available for the volunteers. As with all RCRC emergency work, having clear markings of staff and volunteers is essential. It gives the psychosocial volunteers an identity and sense of belonging to a group. The t-shirt also eased the way of moving past the security guards at the gates of the referral hospital which had been difficult for the volunteers when they did not have the t-shirts. The t-shirts produced were white, with the ERU and Federation logos on the front the print 'Psychosocial support team' in French or Creole on the back. It is suggested to develop a common design for psychosocial volunteer t-shirts that National Societies may print and include in the kits.

In terms of human resources, one ERU hospital deployed with two delegates, the other with one delegate. Being one delegate obviously increases the workload but it does not seem to have put a limit to the activities implemented. The two-person team has benefitted from being able to share and delegate tasks among themselves. While having one delegate on the team is a definite recommendation, deploying two psychosocial delegates on the first rotation may be considered whenever possible. Language was an obvious constraint, as French was needed in order to interact with volunteers and affected community members and only few of the ERU trained psychosocial delegates had this skill. After the first rotation it was not possible to deploy French speaking delegates. Before the Haiti deployment Norwegian RC had trained one group of psychosocial delegates, with participants from Norway, Spain, France, Canada, and Denmark. In order to increase the number of available ERU psychosocial delegates and have broader range of competencies (e.g. language, experience, specific psychosocial skills) to draw upon, ERU National Societies interested in deploying psychosocial delegates in future should plan and conduct more trainings.

In order to ensure full integration of ERU psychosocial support activities it is important that these are understood and accepted by hospital management, administrative and technical staff. There were some occasions of either misunderstanding or differing opinions in relation to this during the first deployment of the ERU psychosocial support component. At the same time, management in both hospitals was very appreciative and supportive of the ERU psychosocial work. This is explored further in the 'lessons learned' section below. In order to improve practice in future, it is important that both psychosocial delegates and the ERU management team have a clear understanding of the scope and mandate of ERU psychosocial action. This point should be underscored in delegate as well as team leaders' trainings and enforced in pre-departure briefings. It was suggested to develop a protocol that in a clear and brief manner describes ERU psychosocial support work and the responsibilities of the psychosocial delegates; this would be an extended version of the job description for ERU psychosocial delegates.

When the ERU teams arrive in the field it is important to set up communication lines and management procedures. This is best done if the psychosocial support area is considered a function in line with other ERU activities, e.g. surgery, clinic work, intensive care, mother and child health, community health. And that delegates report directly to the team leader, as was done in Haiti and also stipulated in the delegate job description.

Another suggestion that facilitates ERU psychosocial work is the inclusion of a budget for ERU psychosocial support activities. This ensures that volunteers are able to receive per diem to cover transport, lunches and other costs as per the regular standards used by the International Federation when engaging volunteers.

D. Monitoring and reporting

The delegates reported on activities in two ways: in narrative weekly reports and by contributing to the statistics being compiled for the ERU hospitals as whole. The narrative reports focused on activities conducted in the reporting period, explained about planned action and described specific issues that had required special attention (e.g. setting up a protocol for ensuring care of unaccompanied minors) and other things that needed follow-up. A fixed reporting format had not been prepared in advance as it had been agreed that initial deployment would provide the input for designing a reporting template.

The quantitative reporting done in the rapid deployment hospital was done in the common spreadsheet used for all hospital functions. Here the number of male and female patients under and over five years respectively is registered for all major disease categories. In terms of quantitative reporting, the delegates expressed a greater need to register children (not least those who were unaccompanied) and the elderly (i.e. particularly vulnerable groups) rather than whether they are new or old patients. Delegates were instrumental in developing monitoring tools that suited their information needs and were able to act on the information collected in order to adjust activities.

Due to the nature of ERU psychosocial work, the indicators to be monitored are mainly qualitative and best described in narrative reporting. They include normal and acute stress reactions, the ability to sleep and maintain normal daily routines, ability to express fear or concern and seek help from others, physical appearance etc. Another indicator that monitors the psychosocial work in the hospital is the communication and request by ERU clinical staff for psychosocial support assistance by the delegate and volunteer team. As the psychosocial work moves into the recovery phase some of the following indicators could also be used: Sense of belonging to a community, non-violent conflict resolution, pro-social behaviour, ability to assist others in need of help, engagement in reconstruction, problem-solving behaviour etc. For future deployments, it is suggested to agree on common indicators needed to effectively document the various phases of ERU psychosocial work and the practices for applying them.

E. Coordination and hand-over

As with all RCRC emergency work, it is essential to ensure that psychosocial support does not happen in a vacuum and that activities are conducted in collaboration with and coordinated with the local National Society. In Haiti, the psychosocial delegates were able to establish contact to the local

branches and selection of volunteers was done in collaboration with HRCS. Other volunteers were recruited on the spot, interested to work and were found to have the right qualifications. Despite the very chaotic situation, the first psychosocial delegate to arrive with the rapid deployment hospital was able to conduct interviews with those interested in becoming ERU psychosocial volunteers. After this hospital had moved to Petit Goâve, the next round of volunteers was selected in collaboration with the local HRCS branch which also participated in the training and presented the RCRC perspective. As the psychosocial work has moved from the relief to the recovery phase, the discussions on how to anchor psychosocial support activities in the National Society, and ensuring a joint approach by the International Federation and the Participating National Societies, become increasingly important. These discussions were on-going at the time of RTE.

In terms of inter-agency coordination, the psychosocial delegates were able to link up and provide information to the overall coordination work that took place in the cluster mechanism, coordinated by the UN. The delegates, supported by the IFRC Psychosocial Support Centre, contributed to the mapping of psychosocial support activities (called 4W – who, where, what and when) which helped establish an overview.⁶ For mental health and psychosocial support (MHPSS) a cross-cluster group was set up for agencies working in protection and health, led by UNICEF and IOM. At the time of the RTE meetings were held twice a week. To the degree possible, the delegates attended these meetings and shared information about RCRC psychosocial activities. For the Haiti operation at the Federation level, MHPSS was covered by the FACT health delegate. For future deployments it is suggested that this person coordinates with IFRC Psychosocial Support Centre and arrange for information sharing procedures. If several psychosocial delegates are deployed, one may be appointed as focal person for engaging with IFRC FACT and external stakeholders and then communicate internally. The Centre represents the IFRC on the Inter-Agency Standing Committee MHPSS global level reference group and can feed information provided in meetings to delegates in the field.

F. Lessons learned

All interviews conducted in connection with the RTE explored the issue of how psychosocial support is complimentary to traditional health ERU work. Respondents expressed in very positive terms the work of the ERU psychosocial teams. Clinical personnel were very grateful for having this extra capacity to draw upon when patients had to be supported. One delegate working in the operation theatre told how having access to this service makes “a world of difference” for patients before or after operation. Another tells how psychosocial support was “a big extra to the care given by the medical team, by helping patients to share what they experienced to ease their healing process and improve their sense of well-being”. It was also described how psychosocial support “was essential to the healing process of our patients.” On a general level the teams were seen to raise the spirit among patients, in the rapid deployment hospital the psychosocial team was named ‘the sunshine team’ because of the positive atmosphere that they were able to create. Many RCRC staff who visited the hospital said how they had to stop and look at the children playing in the tents, because here was a bit of happiness, something which is not seen often in Haiti these days.

⁶ Available on <http://psychosocialnetwork.net>

At the operational level, the RTE found that the psychosocial teams were integrated in the ERU work and despite the interaction issues described earlier; there is a genuine interest in among all deploying National Societies to mainstream psychosocial work as part of the ERU capacity. As the ERU work moves into the recovery phase, it becomes increasingly evident how psychosocial support action quickly becomes a long-term commitment. The ERU psychosocial support component has been designed on the premise that patients and other recipients of services may benefit from the support given, even if it a single encounter between the ERU psychosocial team member and affected community members. Nevertheless the nature of psychosocial support is aimed at enhancing the well-being of individuals in their social setting and involving the communities around the ERU hospitals is a natural extension of the work carried out in the hospitals.

Another basic premise of ERU psychosocial work is that it is aimed at communal and group settings. The RTE found that this had been the overall approach applied; however there were some instances where support was given on an individual level. PFA and other emotional support is an obvious example. On some occasions the psychosocial teams accompanied families to go to the morgue. Because of the contextualised nature of the work, it is difficult to clearly demarcate what type of support is desired over another. However delegates must always make the judgment and, if needed, consult with ERU management of how time is best spent when the needs to be attended to exceed the capacity, as is often the case in this type of setting.

Due to the community-based nature of psychosocial work, it was mentioned on several occasions that there is scope for linking the psychosocial teams up with the work of the community health module (CHM) which is a part of the work of the rapid deployment hospital. At the time of the RTE this option was only tried on one occasion but it does seem that there would be opportunity for combining resources and linking up psychosocial support with the CHM work. The nature of the work for the two areas is separate however the mobilisation strategies and outreach-oriented work follow the same lines. The ERU team in Petit Goâve was exploring the possibility that the psychosocial volunteers would make use of the same transport as CHM volunteers and thus be present in the same communities, albeit interacting with separate groups and engaging in different ways.

Delegates agree that in both hospitals the group of volunteers have made a remarkable difference. They have assumed responsibility and, due to their knowledge of Haitian society and culture, have been able to provide support in a contextualised manner. They have come to work relentlessly although their own living situation is as hopeless as that of the people they are assisting and in a sense they can be said to be a target group. As is known from other settings, the fact that volunteers become engaged in the response is a healing process in itself. The delegates have been careful in selecting, training and continuously engaging with the volunteers, in order to ensure their well-being. There have been daily meetings (morning and evening) where the volunteers had a chance to express how they were doing and elaborate on issues that needed discussion in the group. It is found that this approach to engaging and supervising volunteers has had a positive effect on the standards of work conducted and also promoted the well-being of the volunteers themselves.

Analysis of findings

Based on interviews, consultations and observations made during the mission to Haiti, the overall conclusion is that including psychosocial support action in the ERU hospitals deployed to the Haiti earthquake response has had a tangible effect in terms of supporting the emotional and social well-being of patients to speed up their recovery process. The ERU hospital provides a practical base and starting point for providing psychosocial support in emergency settings. The ERU psychosocial support component targets the psychological needs of patients and others affected by the earthquake, and operates in the social space that is created in the presence of the hospital and surrounding areas.

In the initial stages the work focused inside the hospital, caring for patients suffering from normal or acute stress reactions and with a particular focus on children. Providing PFA to patients, relatives and others in need of here-and-now assistance, as well as attending to the needs of bed-ridden patients adds a dimension to traditional health ERU work. The delegates were able to recruit, train and supervise their volunteer teams who extended the outreach of the work and were able to support the affected community-members in ways that take into consideration the Haitian cultural and social setting.

In later stages the focus of psychosocial work shifted to the communities surrounding the hospital. Although some variation was seen in the two hospitals deployed in Haiti, the pattern of conducting activities and engaging volunteers was similar. It is important that National Societies engaging in ERU psychosocial action takes into consideration that fact that activities quickly become anchored in the communities surrounding the health ERU, and that proper exit or long-term strategies must be considered from the start of the operation.

Adding psychosocial support to ERU hospital work supplements what is already being done and enables a holistic approach to the healing process of patients and their relatives. Although a truism, it may be said that with psychosocial support, care is being taken of the wounded and not just the wound. Delegates and their volunteer teams are able to follow up on social issues and particular needs of patients and relatives which do not fall in the scope of medical work but are nevertheless crucial in the process of addressing public health needs and improving the general well-being of the Haitian population. Furthermore, through the identification of local and international mental health resources, follow-up for patients with specialized needs has been ensured.

Recommendations

The overall recommendation of this RTE is that including psychosocial support in the International Federation's ERU hospitals deployed to Haiti has been a positive experience which has the potential to be repeated and expanded in future emergencies. Psychosocial support in the emergency phase both complements and works in synergy with other relief sectors. The experience in Haiti has been in health; in future psychosocial support may be integrated in other ERUs e.g. shelter, relief or watsan.

Additional recommendations are extracted from the findings and listed below:

Federation wide level

- Continued awareness raising on the positive effects of including psychosocial support in emergency response action among relevant stakeholders at all organisational levels

- Include a psychosocial team member in FACT – this helps assess the needs in the initial aftermath of an emergency and provide guidance on how best to proceed. For this to happen more psychosocial profiles need to be FACT trained (at the moment less than 5).
- Ensure visibility of ERU psychosocial support work by continuously updating the materials available on DMIS – and moving these ‘up’ to the general ERU level (materials are currently found under ERU Basic health care unit: https://www-secure.ifrc.org/DMISII/Pages/03_Response/0306_eru/030605_eru_bhc/030605_eru_bhc.aspx)
- Emphasize the point that National Societies that engage in psychosocial work in the ERU phase must consider the long-term perspective and possible exit strategies from the very beginning.

National Society and Psychosocial Support Centre level

- Conduct more ERU psychosocial delegate trainings to increase number of people on available rosters. ERU deploying National Societies may consider doing joint trainings.
- Include session on psychosocial support in ERU team leaders training and ERU delegate refreshers trainings and ensure pre-departure briefings of team leaders and delegates so that all know the responsibilities and procedures.
- Develop a brief protocol for hospital administrators and management on how to support and facilitate the ERU psychosocial work.
- Whenever possible, consider deploying two psychosocial delegates for the first rotation.
- Include a budget for psychosocial support activities in the ERU hospital, to cover per diem and lunches for volunteers, procurement of additional items needed and other ad hoc costs
- Finalise delegate manual based on the suggestions provided by delegates
- Update kits as per delegate recommendations (see Annex 5), revise packing lists and complete items overview
- Agree on key psychosocial indicators to be monitored and finalise the monitoring formats for use in future ERU deployments
- Develop a common design for psychosocial volunteer t-shirts that National Societies may print and include in the kits.
- Each delegate to have their own laptop to ensure the ability to communicate
- Translate IEC materials into a range of languages (e.g. Urdu, Tamil, Bahasa, Mandarin, Swahili etc.) as part of long-term psychosocial support programmes to ensure availability in future disasters.

Operational/field level

- Team leader to establish responsibility of tasks communication procedures within ERU teams
- Psychosocial delegate to participate in relevant ERU team meetings to receive and give information about the progress of work
- In future, establish procedures for participation in coordination work and cluster meetings between the IFRC Psychosocial Support Centre, FACT member for Health and delegates in the ERU hospitals

Annex 1 – Terms of reference

Terms of reference for real time review of the ERU psychosocial support component

Deployment to Haiti earthquake, 20-28 February 2010

1. Background

Among humanitarian actors it is recognized that armed conflicts and natural disasters cause significant psychological and social suffering to affected populations. Emergencies erode protective supports that are normally available, increase the risks of diverse problems and tend to amplify pre-existing problems. Previous ERU deployments have shown high numbers of patients presenting multiple somatic complaints; this group of patients places a heavy burden on the available health care delivery system.⁷

To enhance emergency response in this area, the International Federation has established an optional and additional component to the health ERU. This was developed in 2008 by the International Federation's Reference Centre for Psychosocial Support with the support of Norwegian Red Cross. All materials available in the ERU psychosocial support component aim to facilitate support that meet the psychosocial needs of disaster-affected populations, and raise awareness among staff and volunteers about the benefits of providing such assistance as part of emergency response.

During the first deployment of the ERU psychosocial support component, a real time review (RTR) will be conducted with the aim of assessing the appropriateness, effectiveness and efficiency of the ERU psychosocial support component and to make recommendations for future deployments. The RTR will focus on the component as a whole, and will not include performance appraisal of individual team members.

The International Federation and the Norwegian and Danish Red Cross are committed to collecting lessons learned through post-disaster review and see this as a unique opportunity to undertake real time lesson learning, strengthen the response, and facilitate and strengthen the ERU system.

2. Goal

To contribute towards the ongoing development of effective disaster response tools of the Federation.

3. Purpose

To understand, document and provide recommendations for the finalisation the ERU Psychosocial support component to be considered by the Health ERU Technical Working group and other ERU technical working groups as applicable.

⁷ Inter-Agency Guidelines for Mental Health and Psychosocial Support in Emergency Settings (IASC MHPSS). Geneva 2007; A. Sumathipula et al: Management of Patients with Medically Unexplained Symptoms – a Practical Guide (2006); van Ommeren et al: Mental Health and Psychosocial Health during and after acute emergencies: emerging consensus?

4. Focus Areas

a) Scope and Purpose

- Assess the relevance of the component in relation to the scale and severity of the emergency needs.
- Assess how the psychosocial activities were complementary to the traditional Health ERU activities and how this helped to provide a more integrated response to public health threats in the affected area.

b) Assessment and planning

- Assess the timeliness, content and relevance of the psychosocial aspects of the rapid assessment undertaken.
- Does the ERU psychosocial team have all the tools and resources required to undertake a timely and relevant rapid assessment to form a basis for targeting and for planning interventions?
- Does the ERU psychosocial team have the necessary tools and resources to produce a viable plan for the immediate and follow-on phase?
- If not, what are the key omissions/constraints?
- How has the psychosocial delegate and the ERU team adequately gathered and shared information with Red Cross and non Red Cross actors in the field (e.g. stakeholders in health including mental health, local and international NGOs, UN agencies and coordination bodies) and co-ordinated data management within the team?
- Has the psychosocial delegate and the ERU team adequately considered and acted upon information from Red Cross and non Red Cross actors in the field?

c) Implementation

- Is the intervention(s) undertaken within the projected scope and scale of the ERU Psychosocial support component?
- What have been the main activity areas enacted by the ERU psychosocial team?
- Have internal coordination and collaboration procedures with ERU team members been established and clearly communicated?
- If not, what are the key omissions/constraints?
- Do the needs exceed the scope of the ERU Psychosocial support component?
- Does the ERU team have the resources required (human, material, financial) to undertake a timely and effective psychosocial support response?
- Are the psychosocial kits appropriate and useful to the specific social and cultural context?
- Are the items in kits sufficient to serve the community members seeking services from the ERU Psychosocial support component?
- If not, what are the key omissions/constraints?
- If additional resources are required, are mechanisms in place for requesting those and are they provided? (Local procurement options, support from Federation Logistics function, Relief function and others i.e. finance and admin.)

d) Monitoring and Reporting

- Is there a monitoring plan in situ and is it being followed?
- What is being monitored and how is progress being reported?
- Does the team have the tools required to sustain the monitoring of key indicators over time?
- If not, what are the key omissions/constraints?
- How is monitoring information being used in real time (focus of activities, adjustments and influencing)?
- How is monitoring information being shared with other actors?

e) Co-ordination and Hand-over preparations

- Assess how much the ERU Psychosocial support component is co-ordinated within the ERU system and the Federation Operation, as well as outside e.g. within the inter-agency Health/Child protection/Psychosocial cluster if present.
- What is the preparation and planning around hand over? Is this feasible?

f) Lessons Learned

- To what extent is the ERU Psychosocial support component equipped to respond effectively to this emergency situation?
- What are the strengths and weaknesses of the performance of the component to the specific context?
- To what extent are these strengths and weaknesses attributable specifically to the component?
- What are the main lessons learned and how can these be addressed for future deployments?

5. RTR mission

The review will be conducted the International Federation's Reference Centre for Psychosocial Support (named: RTR person) that have been in charge of developing the ERU Psychosocial support component.

6. Roles and Responsibilities

IFRC Reference Centre for Psychosocial Support

- RTR person: To conduct the review and produce a report within 7 days of the end of the mission.
- To ensure necessary follow up on the recommendations.
- To lead on presenting key findings at the Health ERU technical working group and/or any related lessons learned forum as applicable.
- Presentation to Management team of deploying National Society (if appropriate).

Norwegian and Danish Red Cross

- To take responsibility for travel arrangements for RTR team member(s) to the affected country.

Host National Society

- While assistance from the Host NS should be kept to a minimum, there may be some areas of assistance that the NS will have to provide. It is acknowledged that they are likely to be one of key sources of information and also the key contact points for communities and also that the Review team may require support in the field of translation, transport etc.

Federation Geneva Secretariat

- To ensure that all relevant persons within the Secretariat, regional delegations and possible National Societies are aware of the proposed RTR.
- To contribute to providing feedback on the report and ensuring necessary follow up on the recommendations.
- To share the review report with Health ERU Working Group.

Federation Regional Delegation

- To make necessary arrangements in country for the team where these can not be arranged elsewhere.

7. Methods and Process

- Key documentation⁸ in relation to the ERU Psychosocial support component will provide the basis for conducting the review.
- Geneva will be responsible for collecting the documentation generated at field level (situation reports, assessment reports etc) to be shared with the RTR person as they are generated.
- The RTR person should expect to have opportunities to observe assessment and response work and coordination meetings and also should expect to conduct semi-structured interviews with the following stakeholders (list to be determined finally once location selected):
 - Relevant NS staff and volunteers both in the capital and at location
 - Members of the assessment team and/or FACT/RDRT
 - ERU psychosocial delegate and ERU team members directly involved in the emergency response.
 - Representatives of other PNSs involved in the response.
 - Representatives of any local co-ordination mechanism, particularly lead agencies within the Health/Child protection/Psychosocial cluster.
 - Members of the affected communities.
- The RTR person should debrief prior to departure (both at the location of the field work and in the capital if appropriate) and if feasible also in Geneva upon return.

Note: The RTR person should be as self sufficient as possible for their arrangements during their mission for, as with all RTRs, the priority of the NS and Federation must be the response.

⁸ ERU Psychosocial support component Delegate Manual and supporting documents including job descriptions, kits packing lists, summary of training curricula, tools and templates.

8. Timing

- The specific TOR should be agreed by the Federation and Norwegian and Danish Red Cross prior to the RTR mission.
 - RTR should last approximately 10 days to including travel time to and from the region, travel to affected area and contact with Module team and local NS partners.
 - The RTR will be planned to take place as close to deployment and start-up of activities as possible. Depending on the timing of the initial mission, a follow-up visit may be considered during later stages of deployment.

9. Outputs

Key outputs of the RTR will be:

- a) An analysis of the ERU Psychosocial support component deployment, with recommended further actions in the key focus areas selected.
- b) A review of whether the ERU Psychosocial support component has improved Federation capacity to respond to psychosocial issues in emergencies.
- c) A mission report (no longer than 10 pages) will be produced which will outline key findings and recommendations to help inform future action by the Federation and support to NSs, in the area of emergency psychosocial support. The report will cover the following areas:
 - A two page Executive Summary.
 - Sections on each of the focus areas, including sub-sections covering findings, comments and analysis, and recommendations.

Note: The draft report will be circulated to the Secretariat, the ERU Psychosocial support component team members, the NS and Norwegian and Danish Red Cross for comments. The team leader will incorporate these as appropriate. Once the report is finalised the Federation will write a formal response on follow up to the recommendations.

Annex 2 – Background information and literature

Cosgrove et al. (2009): Real-time evaluations of humanitarian action - An ALNAP Guide. Overseas Development Institute (ODI). Available online: <http://www.alnap.org/pool/files/RTEguide.pdf>

de Ville de Goyet, C (2004) “Epidemics caused by dead bodies: a disaster myth that does not want to die,” Pan American Journal of Public Health 15(5), 297-299.

Guerda, Nicolas et al: Weathering the Storms like Bamboo. The Strengths of Haitians in Coping with Natural Disasters. Available online: <http://education.miami.edu/News/pdfs/Haiti.pdf>

Humanitarian Practice Network (HPN) (2005): Real-Time Evaluation: Where Does Its value Lie? Issue Paper 32 available online: <http://www.odihpn.org/report.asp?ID=2772>

IFRC (15 January 2010): Haiti: Emergency Appeal no. MDRHT008

IFRC: Haiti Earthquake Operation. Regular WatSan and Emergency Health updates

IFRC DMIS: https://www-secure.ifrc.org/DMISII/Pages/03_Response/0306_eru/030605_eru_bhc/030605_eru_bhc.aspx - all materials and supporting documents in relation to ERU psychosocial support component

Inter-Agency Standing Committee (IASC) (2010): Guidance Note for Mental and Psychosocial Support – Haiti earthquake emergency response January 2010.

Kirmayer, Laurence D (2010): Mental Health in Haiti: A Literature Review. Paper commissioned by WHO after the Haitian earthquake 2010.

Reports received from delegates during assignment and at the end of mission

Annex 3 – Mission schedule

Date	Activity	Location	Name of person met
20 Feb	Arrival, initial contact to FACT health and RAT psychosocial team members.	Red Cross Base camp, PaP	Marianne Moclair Sirry Thormar
21 Feb	German RC Hospital	Carrefour	Jerome Grimaud Susanne Otto
22 Feb	Meetings with UNICEF and IOM MHPSS staff	UN	Guglielmo Schinina Gina Fleurantin Mazen Abou al-Horm
	Meeting with German RC	RC Basecamp	Katharina Ehrmann
	German RC Hospital	Carrefour	Annie Beaudette Joan Brooks Chantal Gagnon Ben van Jaerenbergh Karen Thomas 22 psychosocial volunteers
23 Feb	Norwegian/Canadian Hospital	Petit Goâve	Torild Araldsen Denyse Bourgault
24 Feb	Norwegian/Canadian Hospital	Petit Goâve	Jacques Pelletier
	Meeting with FACT Health and RAT PSP	Red Cross Base camp	Marianne Monclair Sirry Thormar
25 Feb	German RC Hospital	Carrefour	Susanne Otto, Katharina Ehrmann Mickel Ange LeBlanc
	RC Health Group meeting/debriefing	Red Cross Base camp	Marianne Monclair Sirry Thormar Health ERU teamleaders and members
26 Feb	Departure for Santo Domingo	Red Cross Base camp	
27 Feb	Departure for Geneva		

Annex 4 – List of people met

Name	Designation
Marianne Monclair	IFRC FACT Health delegate
Sirry Thormar	IFRC RAT Psychosocial team member
Ea Akasha	Psychosocial delegate, Norwegian/Candian RC hospital (Danish RC)
Karine Giroux	Psychosocial delegate, Norwegian/Candian RC hospital (Canadian RC) – interviewed via skype
Jerome Grimaud	Psychosocial delegate, German RC hospital (Danish RC)
Susanne Otto	Manager German/Finnish ERU hospital
Guglielmo Schinina	IOM Coordinator for Mental Health, Psychosocial Response and Cultural/Medical Integration
Gina Fleurantin	IASC MHPSS assistant
Katharina Ehrmann	Disaster Preparedness Delegate, German RC
Mazen Abou al-Horm	IASC MHPSS co-ordinator
Annie Beaudette	Nurse ICU unit, German RC hospital (Canadian RC)
Joan Brooks	Nurse ICU unit, German RC hospital (Canadian RC)
Chantal Gagnon	Paediatric nurse, German RC hospital (Canadian RC)
Ben van Jaerenbergh	ER Nurse, German RC hospital (Belgian RC)
Karen Thomas	Midwife, German RC hospital (American RC)
22 psychosocial volunteers	Haiti RC
Torild Araldsen	Psychosocial delegate, NorCan hospital (Norwegian RC)
Denyse Bourgault	Psychosocial delegate, NorCan hospital (Canadian RC)
Jaques Pelletier	ERU Team Leader NorCan hospital (Canadian RC)
Mickel Ange LeBlanc	PSP volunteer coordinator, Carrefour hospital
15 IFRC ERU health staff	IFRC and ERU teams

Annex 5 – Suggestions for items to be added to the ERU psychosocial kits

Item	Quantity and comments
Bags to transport material for going out to play areas, hospital wards or surrounding community	10
ID cards for volunteers and plastic shields for ID cards	30
T-shirts for volunteers	50, assorted sizes
Folders to keep drawings, questionnaires and other forms	Pack of 50?
Ruled and graph paper	2 packs of each
Additional boxes of pencils	10
Roll of string	4
Scotch tape – to be easily removed	1 pack of x pieces
Carton	2 packs of x pieces
A pair of proper/'adult' scissors	1
Mirrors to do the 'take care game' in a box	4, 20 x 20 cm
Additional packs of playing cards	3
Hand and finger puppets	5-8; these are found in the Mass Sanitation Module
Small teddy bears or dolls that are given to children and which they keep	50
Ready made sets of sewing material for girls	20
Boards for drawings to use for immobilized children	15 Made of stiff carton or light plywood
Clown's noses and glasses	2
Games for adults (e.g. snakes and ladders)	1
Dice	5 sets
Chess	2 games
PSP training kit and Psychosocial interventions	1 in each of the main languages
Rebuilding hope in different languages	3 CDs