Well-being and resilience after the tsunami

Evaluation of Terre des hommes
Psychosocial Programme in Sri Lanka
2005 – 2007

Final Report

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Summary

The following evaluation of the Terre des hommes Foundation (Lausanne) two year post-tsunami psycho-social project in Sri Lanka was done by the Centre for Humanitarian Psychology, between 2005 and 2006.

In 2002 already, Terre des hommes had come to realize that there were very few in-depth evidence-based psychosocial projects that were implemented in complex emergencies. Sri Lanka was definitely such a context, with a natural disaster of unknown magnitude crashing on a population that suffered twenty years of terrible civil war.

So far, most researches has focused on the traumas of the studied victimized populations. A psychosocial orientation – contrary to a purely mental health approach – focuses not on pathology but on the resources of the survivors. A psychosocial project based on play activities helps children draw on their resources to cope with the aftermath of a disaster – from the very first weeks.

The following quantitative study shows the positive impact of recreational activities on thousands of children registered during that period. It took place in 18 of the 25 recreation centres run by Terre des hommes, in the areas of Batticaloa and the coastal region of Kalmunai by Terre des hommes. The concepts of well-being and resilience were taken as measuring yards to analyse the results of two field-based surveys. It highlights the complex effects of risk and protective factors on the improvement of the children's condition and their environment.

We chose to examine several direct and indirect risk and protective factors which influenced the development of the children's well-being in the post-tsunami context, such as the degree of dysfunctional behaviour and their vulnerability. We analysed the impact of the trauma of the caregivers on their children and showed how the children developed enough resilience to distance themselves from this negative influence. The recreation centres were quite instrumental in so doing. We also analysed how their social network and belief system, their worries and hopes for the future, helped them cope with their difficult everyday life. Finally, we looked at how self-esteem, as a protective factor, helped develop their well-being and resilience.

The study also looks at the question of beaten children, both at home and in schools, to show that it is one of the major worries of the children, mostly because they are totally dependant on the abuser. It is very difficult for them to develop resilience in this area, not to speak of stalling development. This is why the Child Protection Programme, which Terre des hommes has developed alongside the psychosocial one, is of invaluable importance. Responsible adults are the only way out for children when abused and beaten.
A number of indicators have been determined through this study, which might be used in the future to better monitor Terre des hommes' recreation centres. First, it is important to build recreation centres and work with the children in the perspective of their well-being and resilience. The lowering of trauma level and dysfunctional behaviour could be taken as indicators. However, this way of seeing things increases the risk of "pathologising" the situation. Moreover, this study, as well as others, has shown that the use of play and recreational activities, right after a disaster as well as in the following years, are instrumental in helping children resume development towards more well-being and resilience.
Social networks also serve as a precious indicator of the capacity of children to face and overcome the destruction of their community after a disaster. Certainly recreation centres are the best places to help children acquire social skills and thus grow richer social networks.
Another indicator should be used in monitoring recreational activities: self-esteem can be a measuring stick and help choose the right types of play and games which may improve the children's confidence.

This evidence-based study showed how Terre des hommes' recreation centres helped the children in a very positive way, mainly through applying the best practices recognized by the international community as basis for any psychosocial programme: community empowerment, capacity building and respect of the local culture.

Introduction

There has been a plethora of psychosocial interventions in the tsunami region – some have spoken of a psychosocial industry! Either with programmes which are specifically psychosocial or with psychosocial aspects to more traditional aid programmes. In general, they include 'counselling', game-play therapy, art therapy, logopedics, relaxation and meditation programmes, focus groups, playgrounds for sports and physical exercise, all kinds of support networks – not to mention entire communities submitted to clinical investigations on their traumatic experiences by NGOs or university consultants, who often disappeared without trace…

Terre des hommes wanted to go further. Along with the Centre for Humanitarian Psychology (CHP), it had begun a scientific investigation into the pertinence of their recreation centres, first in Bam(Iran) in 2004, with the aim of verifying whether they had any beneficial effects on the distress of children. This effort has been carried out then in Sri Lanka in the post-tsunami context, where Terre des hommes has asked the Centre for Humanitarian Psychology to run an identical evaluation of their two year psychosocial programme.

This mandate has been conducted over several stages. The first, begun in September 2005, produced an evaluative survey of the psychosocial state of children attending 18 of a total of the planned 25 recreation centres, in the regions of Batticaloa and Ampara, on the East coast of Sri Lanka. A mid-term report presented the initial analysis at the end of 2005. A second survey, using the same tools, was carried out in August 2006. The present Report completes this final stage. It compares the two series of data produced by the research, allowing for the verification of hopefully positive effects of recreational activities on the children who attended the Tdh centres.

Objectives of this survey

The general objective of this work is to know whether the recreational activities taking place in the Tdh centres had a positive effect on the psychosocial health of the children between the time of their set-up three months after the tsunami and the end of 2006, when the programme was on its way to betransferred to local NGOs. More specific objectives were also identified in the course of the study:

■ to better understand the impact of adult trauma on the children they are responsible for ;

■ to determine the risk and protective factors which the recreational centres should take into account for their better effectiveness;

■ to take the results of this research as a basis to determine the means for a future monitoring tool;

■ to continue reflecting on the best practices to put in place in this kind of psychosocial programmes.

The acronym of Tdh will further replace Terre des hommes Foundation (Lausanne), as well as CHP will replace Centre for Humanitarian Psychology.

I

Definition of the mandate 1

1. The context of the mandate

After an early evaluation made by Tdh just days after the tsunami, the needs of children and the local communities were identified. The general objectives of the programme could thus be defined:

- to develop the protection of children against abuse (violence, criminal activity, alcohol, child trafficking…)
- to assist their psychosocial rehabilitation by the creation of recreation centres.

Where child protection is concerned, the programme benefited throughout its term from remarkable developments in best practices and had an effect on children and the community from the very first year. We will further return to this subject.

With regards to psychosocial rehabilitation, the concrete objective was to bring – over a term of two years with 4,500 children and 1,800 families – psychosocial support for all ages and both genders in the areas around Batticaloa and Ampara, along the coastal region. The centres created for this programme were able to take advantage of projects conducted prior to the tsunami by three local NGOs which had had long-term support from Tdh.

We should add that, after some months, the Protection Programme became the primary objective of the Sri Lanka project, and the general framework of the enterprise. The psychosocial part, with the recreation centres, came as a complementary, concrete support to protection, as they were a perfect place for working against abuse, as well as offering a safe space for rehabilitation[1].

The programme was based on a number of concepts which have been used for several years within psychosocial humanitarian projects and which are recognised by the international community.

This meant:
- for all activities to be rooted within the life of communities, thus giving them back control over the environment they had lost with the tsunami (empowerment);
- this led to more community participation in the recreation centre programmes, re-inforcing capacity building;
- it was based on the concept of sustainable development;
- it was to be established within a partnership framework with local NGOs[2].

The intention was to implement the general objectives through:

- recreation centres;
- hygiene, education and nutrition programmes;
- recreational activities, with an emphasis on sports;
- school support within all the recreation centres;
- counselling services provided by a psychologist;
- social assistance for families in difficulty;
- material support through school and hygiene kits;
- awareness raising for local councils, especially on Child Protection issues;
- an evaluation of the programme by the CHP.

All these activities had been established and fully developed by our last visit in August 2006, except for the appointment of a local counsellor.

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[1] The mandate for CHP covered only the psychosocial support aspect of the recreational centres and not the Child Protection part.
[2] Tdh Concept paper submitted to the CDB – January 2005

2. The CHP's Mandate

The guidelines in the ToR defined the task to be accomplished over eighteen months (June 2005 to January 2007) in the following manner:

"The overall objective of the mandate is the evaluation of the effects of recreational activities on the affected children who visit the Recreation Centres and participate in project activities. It should allow in the near future a better understanding of how and why the project has helped the children through supporting their healing process and how it has promoted healthy emotional, cognitive, behavioural and social development. The CHP will evaluate the effects of the Terre des hommes project on the psychosocial well-being of the children through a qualitative and a quantitative survey of the children, the families and the community".

This research was to take place over four phases:

■ first survey in the field, in August-September 2005;
■ intermediary report on the evolution of the children's well-being in the recreational centres;
in the eight months since the tsunami;
■ a second survey in August 2006, which would include the collection of a second series of data to allow comparison with the figures from the previous year;
■ a final report.

3. A monitoring tool

Tdh's mandate to the CHP provided also for the creation of a tool to monitor the progress of the psychosocial condition of children. It was to be based on the indicators identified during the research, which could be used over the longer term to assess and monitor the variations of dysfunctional behaviour and well-being of the children.

Due to the circumstances of the research in the field – an emergency evacuation following security threats – this monitoring tool could not be created as initially planned. Nevertheless, continuing exchange with field personnel has allowed this project to begin and, we hope, it will be continued in other post-emergency Tdh missions.

The context

2

1. The tsunami – a historical collective experience

The tsunami, which happened on 26th December 2004, was a disaster on a scale without reference in recent human memory. For this very reason, it has had an enormous psychological impact on the region's population: 230,000 deaths in 13 countries around the Indian Ocean – with millions of direct and indirect victims. Despite the scale of this phenomenon, we should not think that its psychological and social consequences are essentially different in nature to those of other seismic events. The order of psychological destruction is the same as that of the earthquake in Bam (Iran) in December 2003, for example, and certainly so on the traumatic level: material and family losses which extend grief over years; destruction of socio-economic networks; drastic changes in value systems; unemployment; acute poverty; violence and increases in all kinds of abuses; human and children's rights violations; etc. are all identical in horror. This similarity implies that principles usually applied in psychosocial programmes will be the same in the wake of different disasters magnitude.

The new field of Disaster Psychology is currently developing on the ruins of the exponentially increasing number of natural disasters. A wide range of field studies are in progress, describing in exhaustive detail the psychological and socio-economic repercussions of such traumatic experiences, and proposing solutions and treatments – both at micro and macro-level. Anthropology and sociology are also adding their specific expertise to the study of thesocial and cultural consequences of the increasing number and violence of today's catastrophes.

It is interesting to note that the magnitude of the tsunami is such that its victims cannot make reference to any other catastrophes in their collective memory. The implication of this 'gap' complicates the healing process for destroyed communities. After a traumatic shock, in effect, the victim will actively attempt to make sense of the event by comparing and replacing it in their history and in that of preceeding generations. In the case of the tsunami, this is impossible. The recreational centres can help by offering a place where families come together in communal and cultural activities, such as story telling, which can be handed down to the next generation. This instills meaning in the collective memory.

We should add that prior to this catastrophe, twenty years of civil war had weakened the population's resistance. This makes for a complex psychological and socio-economic context in which to construct humanitarian programmes. A study made by Vivo[3], an NGO working in the north-east of Sri Lanka, on post-tsunami trauma among school children (n=264 distributed across three communities), has described in the introduction, the traumatic after-effects of the civil war: in 2002, 24% of the child population showed symptoms of PTSD – in 2004 the percentage had dropped to only 20. These figures should thus be added to the traumatic consequences of the tsunami. They also show a slow decrease of the after-effects of a disastrous experience and paint a dark picture for the future of this population.

To add to this depressing picture comes the reprise of the civil war after four years of ceasefire, with its accompanying violence to children, especially with the recruitment of child soldiers. This affected the progress of the second survey, in August 2006, in that the interviewer had to be evacuated in the middle of collecting the data, which was taken on by the staff later on.

Despite these events, by the end of 2006, the international community and Sri Lankan government's reconstruction programmes had largely begun. However, the inevitable delays – commonplace in any disaster - did not encourage the population's resilience, even more so since many of the transit camps were still occupied.

[3]Personal communication – Biannual Conference of the European Stress & Trauma Studies Society (ESTSS 2005)

2. The stages to rehabilitation after a natural catastrophe

Humanitarian intervention in the context of a natural disaster must take into account the different phases which the population goes through. Disaster Psychology generally describe eight phases in recovery from a disaster: phases of threat, warning, impact, inventory, heroic, honeymoon, disillusion and finally reconstruction. The following diagram may help visualise those stages:

Honeymoon phase

Heroic phase

Predisaster phase

Threat & Warning

Impact

Grieving process

Anniversary reactions

Predisaster phase   Inventory phase   Disillusionment phase   Reconstruction phase

One day to one or two weeks   One or three years ....
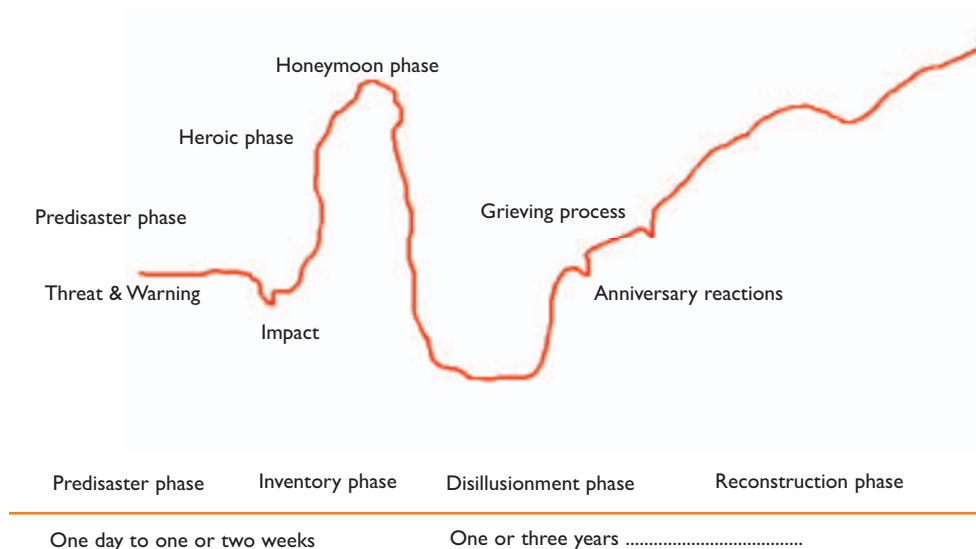
Figure 1 – Psychosocial phases of post-disaster recovery

Sectioning the recovery phases in this way is useful for planning psychosocial operations and their further management. Of the eight phases we retained for the purpose of our study – the heroic, inventory, disillusion (or so-called depressive), and reconstruction phases – it was certainly the disillusion and depression phases which the population was going through during our first survey, eight months after the tsunami – as they were facing delays and seamingly insurmountable obstacles to the reconstruction, namely the first retreat of a majority of NGOs from the scene, and the threat of civil war resuming. During the 2006 survey, eighteen months after the tsunami, the population was going through a mix of depression and hope – as reconstruction was beginning to have a few results (most camps closing down, house and fishing fleet rebuilding, road network rehabilitation, etc.), contradicting the critics of many western visitors, especially about the allocation of the initial funding.

During the first phase (from 0 to 4-5 months), the emergency required professional and proactive interventions, as NGOs were faced with a population in shock, feeling frequently powerless at every level. Action was oriented towards assessing what seemed often insurmountable problems. As a result, during the depression phase, the population found itself confronted with the necessity to transform itself from a 'victim' to a 'survivor' status, where it had to learn, little by little, to confront those problems, and do so through their own psychosocial resources. This phase tends to be a solution oriented stage. It focuses mainly on the slow reconstruction of a vision for the future, which in itself reinforces the mechanisms of collective and individual resilience.

This had obviously a direct impact on the way Tdh's psychosocial programme of recreational centres had to be conceived and implemented. Generally speaking, these centres can become the driving force in psychosocial recovery, especially by centering on children as the main source of energy in the community, through the healing powers of play and sport activities. Through the knowledge acquired in previous programmes (in Algeria and Bam), Tdh experienced that such children friendly spaces had an effect beyond the

children – on parents, local staff, community – because its life was communicative. The underlying concept is one of resilience, which will come to provide us with the necessary indicators for efficient monitoring. We will return to this subject later in this report.

3. Traumatic experience after a natural disaster

It should be underligned that a psychosocial perspective, must not obviate the reality of what has been called the "invisible injury", i.e. the traumatic shock. We have noted that expatriate staff has often difficulty knowing how to handle this kind of suffering, sometimes to the point of denial. They argue that they do not feel adequately trained to confront these kinds of "mental health" issues. Aside from the fact that it is a simple matter of being and remaining human, a psychosocial programme should not only begin with the raw reality of psychological and collective suffering; it should also provide a wide range of tools to enable staff itself to cope. It is a matter of recognizing this fact as a fact and learning how to work "with" and not against it.

The danger of such a denial is that the recreation centres may become nothing but pure and simple transpositions of Western style summer camps, with staff who pay little heed to the raw reality of despair. It is true that the countries hit by the tsunami have seen an invasion of well-intentionned Western psychologists right after the disaster and that the clinical approach has often revealed itself as insufficient and even harmful (re. the phenomenon of retraumatisation). This cannot justify however focusing only on the 'social' part of a psychosocial programme. It impels us instead to keep a balance between community intervention – the social part – and the psychological rehabilitation of the children.

It is a fact: the child population of the recreation centres, along with their caregivers, are a traumatised population. Even if they develop positively in the coming years, which is to be hoped, we cannot deny that they present an array of symptoms which are painful and difficult for themselves and their families to manage over the longer term. Eight months after the tsunami, the local staff we trained for the survey, described these ongoing symptoms:

- emotional withdrawal
- night-time terrors - fears
- bed-wetting with the youngest
- constant anxiety
- lack of concentration
- confusion in verbal expression
- irritability - increase in aggressive behaviour
- insomnia and sleep-walking
- tearfulness, despondency, depression
- weight loss
- risky behaviours

As we know, these are the symptoms of Post-traumatic Stress Syndrome (PTSS)[4] in children. They were at the core of their vulnerability in the post-tsunami context. In spite of discussions on the pertinence of this diagnosis in a humanitarian context, it is certainly worth using it as an indicator of children's level of dysfunctional behaviour, as we used in this research.

However, it should be underlined that parents also presented numerous signs of traumatic stress and grief, as well as the centres' staff – particularly those who worked directly with the children, and who, ten months after the tsunami, were suffering more than the children and caregivers, as we shall see in the second part of this report. It was thus an entire community which was, eight months after the catastrophe, in a post-traumatic state.

[4]Cf Diagnostic Manual DSM-IV (1994)

This is nevertheless considered as a set of natural reactions in view of the circumstances and, paradoxically, does not constitute – for the population as a whole – a pathological state. But these reactions still make daily life painful, even unbearable. It was with this initial situation that the Tdh's programme had to grapple, as well as live and work on a daily basis, devoting itself to the well-being of the children and their entourage.

The psychosocial health of the expatriates is also to be included in this recovery process – people in constant contact with such collective suffering and who risk, sooner or later, a 'burnout' if their own difficulties are not carefully managed by the organization. Over the last decade, numerous studies have called this form of suffering "secondary trauma" or "compassion fatigue", which has been described as a state close to the Post-traumatic Stress Syndrome. The expatriates identify sometimes too much with the victims whom they care for daily. These studies have shown that this is one of the causes of the high turnover rate among humanitarian personnel[5].

4. Grief in natural disasters

In the normal course of events after the death of a close relative, grief follows a path which, to date, has been relatively well studied. Natural reactions are often close to signs of depression and may include a distinct preoccupation with the deceased, a period of psychological adaptation, and feelings of loneliness, sadness and vulnerability in regards to the outside world. The experience of the death of a loved one – reminding us of our own unavoidable mortality – is usually accompanied by fears and worries, in getting used to the idea of our disappearance. Sometimes, there are also feelings of anger, but also of guilt to be alive while the other has had the 'misfortune' to die. All these reactions follow a number of different phases, just as the collective post-disaster set of reactions follow the four stages we have already described – with, in the course of time, a slow return to life.

On the other hand, in the context of the post-tsunami victims, the losses have been so massive and dramatic that grief has been termed traumatic. The shock has made the grief process a personal experience that is both intense and longer-lasting. The populations involved do not always have the capacity to adapt and recover over the long term.

Additionally, "ambiguous grief"[6] should be mentioned here – that is, a form of grief which occurs with the loss of the physical bodies of the deceased. It is very difficult for the grieving process to come to a close when one asks oneself constantly if the person really has died or might reappear one day. The physical disappearance of the body thus complicates the grief process – which may never be completed.

 All these reactions have been well documented over the years. But there are other factors which can also complicate and increase the vulnerability of the griefstricken population. Socio-economic factors have often been noted: the region of Sri Lanka touched by the tsunami has always been poor and essentially rural (fishing and farming). Added to this, is the massive death-rate of the child population in the tsunami, along with a large percentage of women – with many mothers among them. If we also take into account the previous traumas linked to the civil war, the grieving process becomes almost impossible.

A psychosocial programme such as that of Tdh is thus indispensable to help the population move beyond not just the initial horror, but also to recover – little by little – some sense of life. The option of sustainable development in such a context is also obligatory and Tdh plans the transfer of the programme to local NGOs, after training them over two years.

[5]Charles Figley (2002)
[6] Pauline Boss, Phd (1999)

5. Choosing resilience

In a psychosocial programme, two major principles preside in the recovery of populations in distress: what we term "empowerment", which is aimed at their capacity to return to a certain level of control of their own resources and environment, and "capacity building", which allows them to improve their life skills in all areas.

The premise here is that the distressed people are not victims, but survivors. This interpretation re-inforces their resilience in the face of tragedy by appealing to their own resources: political, socio-economic, cultural and spiritual. It allows them to rebuild their lives by looking at the living and not at death and misery. This message is constantly conveyed through the humanitarian work of the international community, and in particular by Tdh in its choice of favoring a psychosocial approach over one of mental health – with its emphasis on pathology and psychiatry.

Child Protection & Humanitarian psychosocial intervention

Historically, the recent evolution of humanitarian emergency actions towards what is termed psychosocial intervention has evolved out from the mental health approach to traumatic events, usually translated into entirely or partially medicalised programmes. There is widespread discussion within the humanitarian community on how to define so-called psychosocial action, the concepts on which it should be based, and the activities which can be labelled psychosocial, when addressing psychological issues in communities after disasters or conflicts. The definitions so far – caught between the 'psycho' and the 'social' – are frequently confused and incoherent.

As a way out of the dichotomy in our study, we propose a distinction between clinical "psychology" used as a diagnostic tool for psychological states (mental health) of a sampled population, and the "social" as a field of implementation aimed at the concrete improvement of the well-being of children and caregivers, through community resources.

1. Principles common to both perspectives

An initial question should be asked. How do we know whether the programme of recreation centres in the post-disaster context of the tsunami is effectively a psychosocial intervention? And, second question, what are the principles which guide this intervention ?

The following list has been produced from two excellent documents on mental health and humanitarian psychosocial principles. The first, 'Mental and social health during and after acute emergencies: emerging consensus,' by Mark van Ommeren, Shekhar Saxena and Benedetto Saraceno (2005), from the World Health Organization (WHO), is the result of an expert consultation on questions of mental health in humanitarian context. It concentrates on the current consensus on best practices and strategies to be implemented in the domain of mental health in the field.

The second document, "Psychosocial Care and Protection of Tsunami Affected Children – Guiding Principles", was produced right after the tsunami in January 2005, by a platform of several large NGOs. It suggests guidelines that are resolutely "psychosocial", especially for child populations in distress.

We provide here a synthesis of the principles and strategies proposed in the two articles as a general basis for all psychosocial programmes, such as those of Tdh.

General Principles of a Psychosocial Implementation including Mental Health

Basic principles:
- recognition of collective trauma as a reality & building programmes on this basis;
- local culture and values based interventions;
- reinforcement of recovery mechanisms by utilising community resources.

Before the disaster, contingency planning which includes:
- development of coordination with other agencies;
- detailed planning to ensure pro-active and efficient intervention;
- training of expatriate personnel in the psychosocial domain.

At the start of operations:
- initial and immediate evaluation of victims' needs;
- security needs of all vulnerable categories ensured at the outset;
- rapid set-up of services for all, as in "psychological first aid" programmes, including psychosocial and evaluation for the most vulnerable, working with remaining public health organisations and NGOs specialised in the area of mental health;
- emphasis on a quick return to school.

Within communities:
- negotiation of the psychosocial programme with the communities concerned;
- choice of a supportive attitude towards the communities, and not a leadership role;
- empowerment of people to help them regain power and control over own lives.

With children and families:
- building of a child centred programme;
- rapid normalisation of daily life by the establishment of safe and structured activities;
- set-up of a team allowing children to express themselves and share their painful experiences, their concerns and their hopes, especially in peer groups;
- appropriate activities which offer development opportunities;
- psycho-educational activities for caregivers and animators;
- policies for family cohesion reinforcement and preservation.

Staff training, both national and expatriate, on psychosocial themes and with regular psycho-education and supervision.

Monitoring and evaluation of programmes.

Table 1 General principles for humanitarian pyschosocial implementation

These principles were by and large observed in the establishment of the Tdh programme in Sri Lanka, over 2005-2006. We will return to this subject later.

2. Levels of psychosocial interventions

These guidelines can been applied within psychosocial interventions at different levels, aiming at different sectors of the population according to different objectives. The diagram below reflects these levels of intervention in general use[7], with the corresponding levels of psychosocial activities in the Tdh programme.

a. At community level, the Tdh programme can offer educational activities which allow physical and emotional health to be taken into account, such as hygiene improvement programmes.

b. At family level of children cared for by the centres, psychopedagogical activities or support groups can be offered which apply to aspects of their daily lives.

c. At child level, all the recreational and sports activities provided by the centres contribute to the recovery of psychopedagogical development. A mental health referral system for the most vulnerable is planned within the programme.
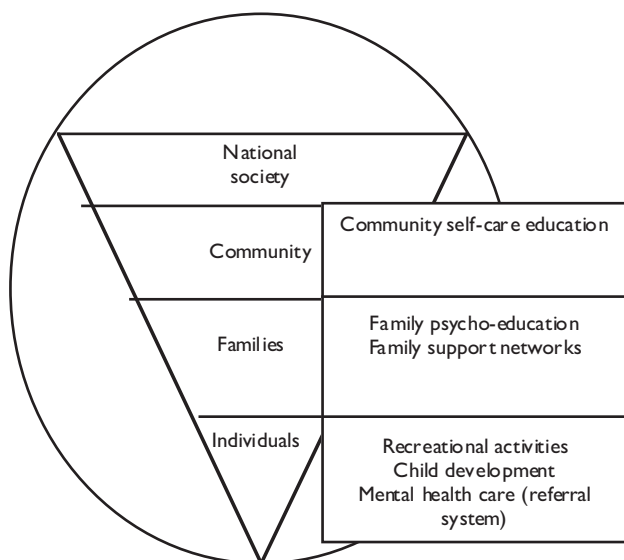
Figure 2   Levels of intervention and the function of the recreational centres

These different levels of intervention within the Tdh programme address the needs of all three groups which animate the recreation centers – that is, not just the children, but also families and communities, where the local staff is recruited. In the annexes to this report, one may find a detailed approach to the implementation of activities at the children's level.

[7]Cf. Division for Social Policy and Development, ECOSOC

3. Child Protection and psychosocial intervention

A. Protection and Human Rights

In the Tdh Child Protection Manual[8], the protection of the child is defined as a set of actions with a view to guaranteeing the survival and an acceptable level of development of the child, with respect to his/her human rights. It includes the responsibility of governements. However such work in the field is based upon internationally defined humanitarian principles. Its implementation is integrated within community life and its empowerment centered on the children.

The psychosocial programmes and the child protection programmes established by Tdh are privileged tools with which to introduce the principles of the Rights of the Child within complex emergency situations. They can change mentalities in a 'gentle' and coherent manner over the long term. Nevertheless, these more democratic vectors – which include most especially the respect of the child – often create conflicts with traditional cultural values in the field and with the way in which the child's education is understood. It is most often viewed more as 'breaking in' of a young colt than as a harmonious development of the child's emotional and cognitive skills.

This is even more so the case when a child-protection framework is introduced after a disaster, when it opposes any violence against children, in a particularly traumatic context. The Tdh programmes are thus the place where these forces confront each other in daily life, but also a place of education in human rights. As such, the recreation centres are privileged tools

B. The Tdh model

In Sri Lanka, Tdh has established an extremely interesting model of Child Protection, designed by Dr. Patrick O'Leary, from the School of Social Work and Social Policy, at the University of South Australia, and implemented by all the staff on site, expatriate and local. At the core of this model is a Case Management System which provides for detection of children at risk in the recreation centres, with the mobilisation of key personnel, namely the Tdh team, as well as among local and government authorities. It then offers appropriate support for the suffering children, on a case by case basis.

Personnel, as well as local authorities, were trained in targeting and evaluating protection problems . As a consequence, we saw much improved skills, in 2006, among the Sri Lankan local staff following the introduction of this system. It has also been a real added-value for the psychosocial aspect of the programme, and thus for the improvement of the children's well-being – and for the animators at the recreation centres.
The principles established in this protection programme are the same as those in the psychosocial programme of the recreation centers, that is:

■ Tdh's recognition of the specific sufferings of children and thus centering the programmes around their needs for security and development;
■ empowerment of communities by integrating them into the activities and approach to protection and the purpose of the recreational centres, especially by giving responsibility to local authorities;
■ capacity building activities for the local staff involved in the programmes, with particular emphasis on the training and mentoring necessary for effective work at all levels of the programmes.

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[8] Terre des hommes internal document, Lausanne, 2006

C. Different definitions of risks

In a society made chaotic by natural disasters or conflicts, the detection of children at risk is not conducted in the same way as in less perturbed situations. In the Case Management System established by Tdh in Sri Lanka, the evaluation of such risks was the object of a categorisation from the greatest of risk to its total absence:

A = Exploitation and abuse
B = Health risks
C = Psychological risks
D = Chronic abuse
E = Social exploitation

The definition of risks within the framework of this programme is contextual and social (family dysfunction, with possible incest at stake, political context of war for child soldiers, human traffic, etc.). Action taken is thus concrete: removal of the child from the pathogenic environment, judiciary intervention by local or government authorities, community education on protection, negotiation with militias, etc.

With a psychosocial approach, on the other hand, the risk to the child in terms of psychological suffering (trauma level, developmental arrest, diminuition of well-being, etc.) is tackled first, and the solution oriented towards healing and resilience and thus the improvement of well-being. The recreation centres are consequently a privileged space for this type of action. Nevertheless, both approaches are highly complementary and in our final recommendations, we will make some suggestions as to how the two programmes could be better integrated.

The conceptual framework 4

1. General

The model we propose here presents our hypotheses and gives a conceptual framework to our survey.

For some years in the field of humanitarian psychosocial intervention, efforts have been made to find a theoretical basis for practice in the field. Yet it should be noted that up to now, organisations have designed guidelines with a view to the implementation of programmes, without providing a real conceptual framework. The first efforts in this area were made by the Psychosocial Working Group in the UK, which formulated a model which establishes a bridge between theory and field practice. The latest effort was carried out by the WHO and the Inter-Agency Standing Committee[9] to define best practices in the area of intervention. These agencies have purposely avoided entering into theoretical debates.

The psychosocial approach is inspired by two human sciences: Clinical Psychology and Social Psychology. Added to those branches, we have Environmental Psychology and Disaster Psychology. In our previous study of Tdh programme in Bam (Iran), the questionnaires used (CBCL) – and globally validated – belonged essentially to Clinical Psychology. We have been justifiably criticised for not having given then a social dimension to our study. We describe below how we have attempted to create links between the two.

2. The proposed psychosocial model

Our present model starts from the dysfunctional behaviour of children, and the traumatic state of their families and the staff of the recreation centres. We know that, in a disaster context, the needs of children differ according to age, gender, post-disaster phase, and such other factors. These are not necessarily purely psychological needs, but also social needs linked to family, school, religion, culture, and community in general. We hope to show here that psychosocial intervention – which encompasses all the aspects of a child's life – is the best response, and certainly the broadest.

The Tdh model for recreation centres proposes to answer to these needs and to transform the suffering of children through leisure and sports activities. It is thus a space for healing in the widest sense (and not only in a medical one): as such, it is central in the child's life during the rehabilitation phase. Other studies carried out on previous disasters have shown that the larger part of distressed populations recover through their own means. This also includes children, whose capacity for resilience is often greater than that of adults.

Psychosocial programmes thus target this larger part of the population, who tend to recover through their own external and internal resources. This approach does not necessarily imply creating mental health infrastructures, even if they are indispensable sometimes for groups most at risk.

Nevertheless, this does not allow for an amateur approach in this domain, and presumes a good understanding of the impact of play on the development of the child, of its psycho-pedagogical aspects, which means adequate training of the staff. It is not enough to just throw a ball to a group of young people, or to give them some crayons, to address their needs and ensure quality support despite a chaotic context. We will return to this point.

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[9]IASC Task Force on Mental Health and Psychosocial Support in Emergencies (2006)

3. The concepts

We have chosen a certain number of concepts, taken from clinical and social psychology, to posit our working hypotheses and create our model for the survey.

A. The well-being of children

This concept was invoked by the World Health Organisation in 1946 in its Constitution, to define health as being "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[10]. To follow WHO, we can say that the Tdh centres are focused less on pathology, and more on well-being. For decades, the notion of well-being has been broadly studied and used in human sciences research. Sociology and Political Economy have used it as an equivalent to that of the notion of quality of life. But well-being is used above all in the field of Psychology, and especially in Clinical Psychology and Social Psychology. It is within this framework that we employ the concept here.

In humanitarian literature, well-being is constantly invoked as a laudable objective for interventions – especially in regard to child populations – yet without defining it when it is employed to evaluate the pertinence of a psychosocial action.

The notion of well-being makes reference to a subjective experience, whether of the person themselves ("I feel well, happy…"), or defined through the observation of those around them, often mediated by cultural values ("He looks pretty depressed to me today…"). This understanding translates how people evaluate their lives, which includes such aspects as overall satisfaction or an evaluation of their social status or professional activities.

Personal well-being can be evaluated on an emotional as well as a cognitive basis. In other words, a person feels a sense of well-being if he/she judges that he/she has reached a level of general satisfaction in key points of his/her existence and if he/she most frequently feels positive emotions – such as joy or affection – and few negative emotions – such as anxiety or anger. Numerous factors thus contribute to well-being, such as a sense of accomplishment, using one's abilities, being recognised by peers and work colleagues, having the possibility of fulfilling dreams and thus being able to conceive a positive future, etc.

Where well-being is described starting from the perception of self, it is called Subjective Well Being (SWB). Material factors certainly enter into the equation, but numerous studies have shown that they do not in themselves create a feeling of well-being; they only contribute towards it. Emotional, relational and intellectual factors are far more important – and in all cultures.

We can argue against the idea that children's well-being is a concept created by affluent societies to reflect its wealth and that, after a collective tragedy, it is essential to first bring the minimum necessary. We would respond that a framework and a global perspective should be in place from the beginning of any project, based on the idea of sustainable development. Which leads us to note that humanitarian operations which focus essentially on material support – which is the majority of cases – are missing an essential element in the rehabilitation of victims. Psychosocial programmes should be centred more effectively on well-being, which is a less tangible measure.

In this survey, the concept of Subjective Well Being (SWB) of children and those close to them, is measured starting from a hypothesised traumatic state to a more positive development, so putting emphasis on psychological and social reconstruction. The test for the measurement of SWB used in this survey was integrated to our Resiliency Scale Questionnaire, which we will discuss in the next chapter.

[10]Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948

The degree of life satisfaction of those questioned – children and adults - in the post-disaster phase they were going through, is thus the main criterion of evaluation and will be retained here as the most important indicator in the evolution of the children. Furthermore, the notion of well-being is seen here as undergoing a dynamic change over the longer term. The analysis of its development is a fundamental indicator of the effort given to rehabilitation, within the perspective of sustainable development. While the evaluation of the traumatic level of victims is useful in the medium term (from 0 to 18 months), especially at the time of a programme's establishment, it is as much useful to use a notion such as well-being over the medium and long term.

That said, numerous studies have shown that subjective well-being is not necessarily synonymous with good mental health. It can exist among happy fools! Nevertheless, in our enquiry we have chosen to place SWB alongside the traumatic experience, which we have just seen to be the first issue in all humanitarian psychosocial programmes. Our study thus follows the following axis:

Trauma level   →   Subjective well-being (SWB))

Time factor t1-t2
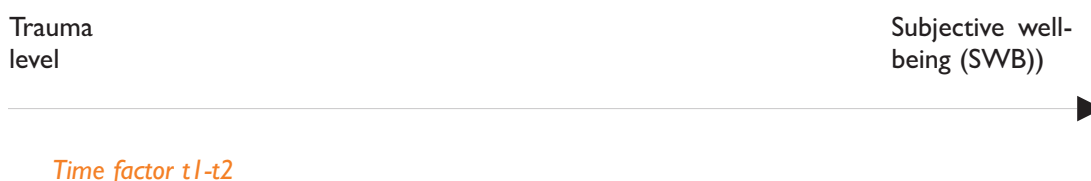
B. Resilience

The time axis represented above measures how the child has been able to develop in his/her capacity to confront the dramatic consequences of the tsunami. This process of improvement which directs the child and his/her entourage towards well-being is called resilience.

Resilience is in general defined as the aptitude of individuals and systems (families, groups, collectivities) to overcome adversity or a situation of risk. This aptitude develops with time; it is reinforced by protective factors within the individual or in the system and environment. It contributes to the maintenance of well-being and of health (or its improvement). In a collective sense, we may think of the group resilience of the recreational centres, which works on both these levels, over the long term.

Such a concept such as that of well-being, is at present a fashionable one – in humanitarian literature as well. But it should be noted that both these concepts are not the object of sustained reflection or are infrequently subject to concrete extension in psychosocial work in the field. We have not found any longitudinal research, for example, on resilience in the humanitarian field, neither following a disaster nor in the context of conflict.

It is often asked in a psychosocial humanitarian intervention why one group of victims recovers better than another; why some children reveal unsuspected internal resources and get back on their feet, while others remain in despair for a long time. The reinforcement of the capacity for resilience thus becomes a major concern for any psychosocial humanitarian programme.

Some studies have been able to determine the characteristics of a resilient person. In general this entails someone – sometimes a child – who has a developed intelligence, a certain ease in his/her relationship with his/her environment, with a good sense of his/her own value and good social skills. He/she is able to anticipate and plan, and has a sense of humour and optimism. Some of these characteristics are more easily measured than others, and we selected some of them for our questionnaire.

Resilience is often invoked as a desirable state. However, here we have chosen to take the dynamic aspect of resilience, as a process shown through the child's development, between time t1 and t2 – between August 2005 and August 2006.

C. Factors of risk and protection

The resiliency process, which we have hypothesised going from trauma to an enhanced state of well-being, takes place within a complex mix of risk and protective factors. If situations of risk prevail over situations favoring development, the child's capacity to develop resilience will be diminished. If the recreation centres offer a healthy environment in the midst of chaos, resilience can develop. In addition, this dynamic process is also at the base of protection programmes against abuse and violence.

In a recent study on the consequences and risks linked to the tsunami, the National Centre for PTSD[11] considered that risk factors, within the area of mental health, were numerous and severe in the long term for the population in the region.

Predictable factors of risk in poor psychosocial development

Before the tsunami	During the tsunami	After the tsunami
Gender (especially women)	Gender	Gender
Age and experience (40-60)	Age and experience	Age and experience
Culture and ethnicity		Culture and ethnicity
Poor socioeconomic status		Socioeconomic status
Difficult family factors	Family factors	Family factors
Personality problems		Personality problems
Addiction	Severity of exposure to the tsunami	Addiction
Psychiatric history	Grief	Grief
	Panic and horror	High degree of stress
	Separation from family	Conjugal stress
	Magnitude of material loss	Financial stress
	Displacement and relocation	Environmental stress
		Sickness
		Physical handicap
		Loss of economic resources

Table 2 Risk factors in the tsunami context

As an alternative, we propose the following list of protection factors – as much for the children as for their parents and the general community. Three poles of protection are often cited for children: individual, family and community.

[11]"A more extensive Psychosocial Consequences of Natural Disasters in Developing Countries: What Does Past Research Tell Us About the Potential Effects of the 2004 Tsunami?" - Source: www.ncptsd.va.gov/topics/tsunami.html

Protection factors

Individuals	Family	Community
Easy-going nature	'Ordinary' parents	Social support network
Gender (according to context)	Affectionate parents	School success
Age	Good parent/child relationships	Support of other adults
Good cognitive level	Parental harmony	Religious affiliation
Self-esteem	Parental support	Socioeconomic advantages
Social skills		Good school system
Empathy		Community resources
Self-control		
Humour and optimism		
Charm and charisma		
Productivity		
Culturally valued talents		
Finding a purpose in life		

Table 3   Protection factors after the tsunami

In the framework of a child protection programme, the accent is usually placed on the risks and their management. In contrast, a psychosocial approach, working within the area of protection, shifts the axis of intervention on to resilience and protection factors – which better favour the child's rehabilitation.

Let us return to our diagram on the development of the child's well-being, and add these remarks to it:

Trauma level   Subjective well-being (SWB))

RESILIENCY PROCESS

t l ————————————————————▶

Risk factors   Protection factors

The improvement or worsening of a child's condition oscillates between these negative and positive factors in their daily life. The question is then to know how they will develop their resilience, and consequently their well-being, through recreational activities.

We mentioned above the creation of our "Resiliency Scale Questionnaire" (RSQ) for the needs of our study. Questions on the factors of risk and protection asked to the children, their caregivers and the animators in the recreation centres, make up the main part of the questionnaire. The results can be found in the second part of this report. We provide here the different factors as a function of the environmental and internal resources of the child, as they were formulated in the RSQ.

D. External factors in the development of resilience

a. Schooling

The restoration of schools has been relatively rapid in Sri Lanka, compared to other countries which have been through natural disasters. This has certainly been a determining protection factor in the psychological improvement of children and their caregivers, in the sense that a normalisation of daily life allows children to control their environment again by going back to their usual frame of reference. But over the long term, failure at school, other more material factors, or a bad standard of teaching, can act as a risk factor, slowing their rehabilitation.

As we were unable to establish a relationship with the schools in the region for different reasons and thus quantify the children's educational development (through grades, teacher questionnaires, etc.), we chose to ask questions connected to the subjective feelings of children and their caregivers in regard to school attendance, as well as the material obstacles to regular school attendance. We give here the questions we asked the children[12]:

a. How are you doing at school ?
- ❑ Well
- ❑ Medium
- ❑ Baddly

b. What are the difficulties you have at school ?
- ❑ It's hard to listen
- ❑ It's hard to be interested
- ❑ It's often difficult to understand
- ❑ It's difficult to follow the rules
- ❑ I don't like the other children
- ❑ I don't like the teacher
- ❑ Other (give detail) ……………………………………………………………

c. Are you happy with your work at school ?
Not at all   1   2   3   4   5   6   Completely

d. Are your parents happy with your work ?
Not at all   1   2   3   4   5   6   Completely

e. Is your teacher happy with your work ?
Not at all   1   2   3   4   5   6   Completely

f. Is your teacher happy with your behaviour in class ?
Not at all   1   2   3   4   5   6   Completely

[12] The other RSQ questionnaires to caregivers and youth animators are very similar

b. Religious life and belief systems

As creator and guardian of human values, religion can be seen as a factor of risk and/or protection. It can be understood as a system of belief and cultural practices which are part of a tradition, through which people develop their personal values and their way of giving meaning to their existence. Religion is intimately mixed into the social fabric and, in a country as profoundly religious as Sri Lanka, it constitutes a driving force of community and personal recovery, encouraging the development of resilience in traumatised individuals. Much current research looks at what we call "spiritual well-being." Authors such as Donahue (1985) have made an inventory of the numerous studies on the impact of spirituality on traumatic states. He shows how it can be used as an indicator of resilience and well-being, mostly within the frame of religious practices.

Reference to the religious is clear: a traumatising event, such as the tsunami, turns the universal order established in the collective consciousness upside down, as well as value systems and individual and community beliefs. The event makes people question the meaning of destruction and death, of the relationship between God and humanity. Several people in the local team reported how, during the first months after the tsunami, and among the three religions on the Tamil coast, believers felt and expressed anger at their divinity, and tended to desert their temples and churches. From our figures, these phenomena have since faded. Several studies have shown how individuals who have been through a highly traumatising event often stop practising, which reduces their social network – another indicator of resilience.

In the Resiliency Scale Questionnaire (RSQ), we chose the following questions:

a. Do you believe in God ?							
Not at all	1	2	3	4	5	6	Strongly
b. Do you often speak about God with your family ?							
❑ Rarely							
❑ Sometimes							
❑ Often							
c. Do you think religion is important in your life ?							
Not at all	1	2	3	4	5	6	Enormously
d. Has your religion helped you to cope with the tsunami ?							
Not at all	1	2	3	4	5	6	Enormously

We intentionally avoided asking about membership of this or that religious community, for evident reasons. However, thanks to the Child Individual File, administered between our two surveys, we obtained the percentage of local religions and note that Hinduism is the most important and seems best placed to help recovery[13].

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[13] See page 71

c. Hygiene

This external protective factor can be placed alongside another one: the socialisation of the child and the way he/she wishes to be considered by others. In this sense, hygiene can improve confidence and self-esteem. Hygiene also inscribes the child within a cultural – and thus social – system, and thus increases his/her feeling of membership within a group.

The questions asked around hygiene were the following:

a. Do you think you are clean ?
   Not at all   1   2   3   4   5   6   Definitely

b. You wash…
   Not enough   1   2   3   4   5   6   Sufficiently

c. If you don't wash, why not?
   ❑ I can't where I live
   ❑ I don't like it, I don't want to
   ❑ My parents don't make me
   ❑ I don't think of it

d. Socio-economic status

We know that material poverty, worry about tomorrow and the future, are extremely important risk factors in the improvement of the situation of children and those around them. Where the material situation of the population improves, we can imagine that the well-being of children will likewise be improved.

This question was examined largely through the Child Individual File, in March 2006 – a little more than a year after the disaster, when reconstruction was well on its way. The socio-economic status of the parents of the children questioned was as follows:

Professions	%
Unqualified manual labour	26,8
Working abroad	3,3
Fishermen	21,8
Carpenter	3,3
Driver	5,0
Farmer	2,9
Gardener	0,8
Goldsmith/jeweller	5,0
Trader, salesman	4,2
Builder	5,0
Schoolmaster	0,8
Hospital worker	0,8
Other	3,3
No answer (unemployed, deceased)	15,9

Table 4 Caregiver's professional status

We can see that fishing and manual labour are the majority. Furthermore, 91.6% of mothers are deceased or "without profession" (housewife, unemployed). The other 8.4% seem to be those working in the Arab Emirates.

e. Density of social networks and emotional security

We will see in the results of the survey that the social network of the child in 2005 is centred on the extended family, to the detriment of a broader network of friends. In 2006, this network had broadened and opened towards external people.

In the Resiliency Scale Questionnaire (RSQ), the density of the social network was estimated by calculating the number of people the children estimated having in their social network, both close relatives (parents, siblings) and less close (teachers, neighbours, etc.), on four concentric circles going from the centre where the child drew him/herself, towards the periphery where he/she named people increasingly less close. (See the annexes)

f. Habitat

Habitat and attachment to place of residence have been the object of particular study in Environmental Psychology. Work has shown how the uprooting caused by any form of disaster is an important risk factor. Reconstruction is thus vitally important for the psychosocial balance of children, their family, and their community.

E. Internal factors in the development of resilience:

a. Self-esteem

After living through traumatising events, feelings of depression, guilt, anger, even rage, or a loss of human emotions such as confidence in others or the desire to help, are common. In everyday life, these feelings eventually erode self-esteem. This sad picture is a well-known consequence of the post-traumatic state.
As we have already said, one of the elements the recreational centres can work on is the improvement of a child's self-esteem. However, this means also contributing to the improvement of the self-esteem of the adults around the child – caregivers and animators – since the recreational centres are a whole. In the Resiliency Scale Questionnaire, we decided to include Rosenberg's questionnaire (1969), as it has been largely validated and open to the public.

Please answer the following questions:

a. I am generally rather content:
Not at all   1   2   3   4   5   6   Definitely

b. Sometimes, I believe I am worth nothing:
Not at all   1   2   3   4   5   6   Definitely

c. I think I have quite a few qualities:
Not at all   1   2   3   4   5   6   Definitely

d. I believe I can do as well as my friends:
Not at all   1   2   3   4   5   6   Definitely

e. Sometimes, I really feel useless:
Not at all   1   2   3   4   5   6   Definitely

f. I believe I am as good as my friends:
Not at all   1   2   3   4   5   6   Definitely

g. I don't like myself:
Not at all   1   2   3   4   5   6   Definitely

b. Social skills

After a traumatic shock, the ability to communicate and control emotions in the context of social relations, to create new relationships, to approach others, etc. is often diminished. The Tdh centres are particularly well placed to allow these skills to develop.

In the Resilience Scale Questionnaire (RSQ), we asked some questions on the perception children had of the recreation centre they attended:

a. Are you happy to go to the Recreational Centre?
Not at all   1   2   3   4   5   6   Definitely

b. Do you like the animators?
Not at all   1   2   3   4   5   6   Definitely

c. Do you like the other children at the Recreation Centre?
Not at all   1   2   3   4   5   6   Definitely

We shall see in the results that these three questions revealed a willingness to please the organisation and thus do not really give a clear view of the real interest children had for the Tdh.

c. Health

Psychosomatic symptoms are part of the clinical picture of psycho-trauma and are necessarily included among the risk factors, alongside physical health and/or physical handicap.

Obviously, good health protects to the child in his/her process towards more resilience. In the RSQ, given below to the animators, we asked the simple question:

Does the child seem to you to be in good health?
Not at all   1   2   3   4   5   6   Definitely

4. Coping strategies

It is now necessary to ask how the recreation centres reinforce protection factors and the ability of children and those around them to cope with the tsunami's consequences in their daily lives, today and in future years. This also includes the support of survival skills in the individual as well as in the community.

Several studies have shown that 'coping' is a combination of abilities to find solutions to various problems while adapting internally to the test (such as serious illness, physical handicap, or the loss of someone close). A person can feel so overcome by events that he/she adopts a negative coping strategy, such as alcohol or drug dependency, suicide, isolation, violence, etc. Thus we come back to the problem of risk factors.

The recreation centres are excellent places to learn positive coping strategies and play is an ideal way to experience them before transferring them into the adult world. This is why the Tdh centres cannot replace schooling and have a unique role to play in this dramatic context.

After the tsunami, the acquisition of such strategies will vary according to the phase. The Tdh programme has now covered two years (2005-2006) and the coping strategies have gone beyond those aimed at survival, after the initial shock phase, to others closer to tools used in any difficult period of life. An emergency programme should thus be established over the short and medium term to cover the two first post-trauma phases, helping children to develop necessary coping mechanisms – i.e. life, social, and personal skills.

Research methodology

5

For this study, we conducted two field surveys within an interval of thirteen months, using the same sets of questionnaires. However, for both ethical and circumstantial reasons, we were not able to use control groups and have compensated this unfortunate situation by collecting the data during those two periods, which allowed at least for the possibility of comparison.

1. Collecting the data

As said previously, the objective of this study was to determine the impact of recreational activities on the children's well being attending the Tdh centres, over one and a half years, across two surveys.

August 2005: first survey

a. Pre-testing the Resiliency Scale Questionnaire:
The field mission to gather data lasted over a month. Once we had created this new questionnaire, pre-testing was indispensable in order to ensure its relevance. This allowed us to verify its minimal pertinence in relation to the targeted population, the geographic and socio-cultural context (whether there were any sensitive questions to be reworked or removed), its validity (measuring what is measurable), and its sensitivity to the culture. The results of this pilot test allowed us to adjust some of the questions and to remove others, mainly some concerning religion, schooling, or hygiene – socio-cultural areas par excellence.

b. A week of training was then provided for the 36 animators/supervisors and social supporters who would have to administer three series of three questionnaires, in the 18 selected centres. Three training sessions of two days each were given, two in Batticaloa and one in Ampara. The questionnaires were planned for small groups, with their respective supervisors. Obviously, two days of training were insufficient. But the time factor in emergency situations does not allow the freedom to choose a more in-depth option. Nevertheless, all the teams worked well, which gave us some security in the collection of data. Furthermore, those who were trained largely appreciated the opportunity and felt that their skills were recognised by Tdh.

c. Giving the questionnaires and coordinating the collection of data. The 2,388 questionnaires distributed among the children, caregivers and animators were returned within the given deadline of two weeks. The researchers were very motivated and interested, and did their work remarkably well, given that it was a major first for them and they had had very brief training.

d. Entering the questionnaire data on to the computer, with the aid of expatriates and local staff.

B. August 2006: second survey

The second time in Sri Lanka was unfortunately marked by the security situation, which had been worsening in recent months, and particularly just before the mission. Nevertheless, a two-day training session was conducted. It aimed above all at refreshing the knowledge of those who had had training in 2005, but also at initiating some new animators who had replaced the others who had left. We had some of the 'old' ones coach the 'new'. The good surprise was to note that memories of the previous year were still fresh. Other training had been given in the interim, especially in the area of protection and artistic activities, and the animators showed considerable progress in their psycho-pedagogical understanding of children and recreational activities since 2005.

That said, the collection of data in the field was delayed by the civil war. Displaced persons (IDPs) from the north of the island, after weeks of bombardments, flooded the recreation centres and Tdh, along with the local personnel, had to look after these new victims by distributing food and medicine. It was thus with several weeks' delay, and without the supervision of the head researcher, but with that of trained expatriate staff nevertheless, that the questionnaires were administered and entered on to the database.

The unexpected development of the situation in Sri Lanka shows how a study in the emergency humanitarian context cannot pretend to absolute scientific rigour! All the same, we noted that for the national staff to participate in these enquiries, corresponds to two of the most important principles of psychosocial intervention: community empowerment and capacity building.

2. Methodology

In 2005, the selected sample was of 417 children and their caregivers and 242 in 2006, divided over 18 centres targeted by the surveys, where two animators had been chosen per centre, accompanied by their supervisor and social supporter, to administer the questionnaires. During the 2006 survey, following modifications in the lists of children attending the centres (closing of camps, return to their community of origin...), we thus had only 242 children left from the 2005 list. But the sample remained sufficiently representative and this did not disturb the statistical analysis.

From the start of our study, Tdh had planned to create a questionnaire, the Child Individual File, to collect demographic data, with the objective of better understanding the socio-economic status of the children registered within the centres. The creation of this File unfortunately did not happen until March 2006, fifteen months after the tsunami. Consequently, little of the collected data could be of real use to us. We chose the data on the socioeconomic status of the caregivers, the development of habitat, and figures on losses of property and human lives.

We mentioned above that we used three series of questionnaires. Two were chosen to evaluate from the very beginning the trauma level of parents and animators and the degree of dysfunctional behaviour among the children. This included:

n The Impact of Event Scale (IES)[14], often used to measure the traumatic impact of disasters, throughout the world (and by some mental health NGOs in the tsunami region), with fifteen questions. It was given only to parents and animators, in order not to overburden enquiries among the children – especially the youngest, since it was expected that data on the post-traumatic state of the children would be collected in the Child Individual File. Unfortunately, as said, we were unable to use this late data and had to rely on the SDQ questionnaire.

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[14]www.swin.edu.au/victims/resources/assessment/ptsd/ies-r.html

■ The Strength and Difficulties Questionnaire (SDQ)[15] with 25 questions, aims at the evaluation of behaviour and affectivity of the children. It has also been validated in over forty countries. We administered it to children over the age of 11, and to all the parents and animators of the 417 selected children.

These are thus two clinical tools, and they allowed us to evaluate the mental health of the adults responsible for the children attending the recreational centres.

■ As we have already seen, the third questionnaire, the Resiliency Scale Questionnaire (RSQ), was expressly created for the Sri Lanka mandate (accompanied by drawings to facilitate its administration among the youngest children), and in accordance with our working hypothesis and the psychosocial model described in the previous chapter. As already noted, it entailed the evaluation of how certain risk and protection factors influenced the development of resilience and well-being among children. The RSQ was given to children of four age groups, to their caregivers, and to the selected animators who were responsible for them. We were thus able to have the opinion of each of the three groups on the psychosocial state of each child in the sample, in each of the 18 centres, in 2005 and 2006.

As we shall see in the following chapter, which gives the statistical results and analysis of the two enquiries, the three questionnaires (the IES, SDQ and RSQ) were cross-checked and their variables correlated, to the point where the level of pertinence of the research is very high, particularly in regard to the interaction of risk and protective factors.
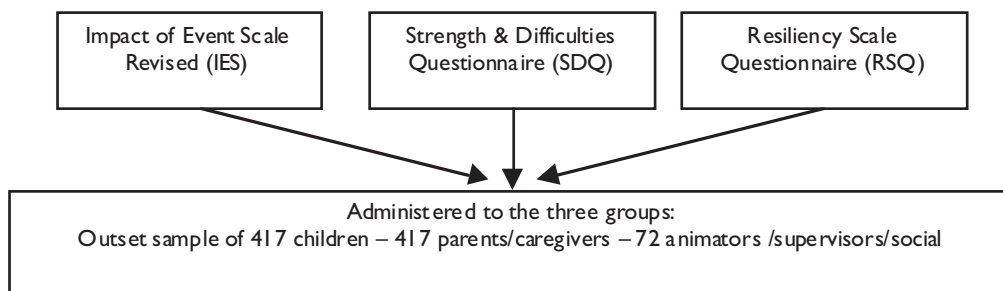

Figure 3   The Questionnaire Organisation chart

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[15]www.sdqinfo.com

II

Well-being and factors of well-being

6

Developments in 2005-2006

In the previous chapters, we explored our working hypothesis. In our 2005 intermediary report, we made an appraisal of the situation ten months after the tsunami, seeking to evaluate the level of traumatic shock among the children attending a particular number of recreational centres, as well as the responsible adults, caregivers[16] and animators. This allowed better comprehension of the risk factors after the tsunami.

A second survey in 2006 gathered a new series of data, which were then compared to that of 2005, in order to examine if the targeted population had improved their well-being, identify the protective factors which the recreation centres were able to establish, as well as measure possible increase in resilience.

I. Impact and consequences of the tsunami on the well-being of children

In our model explained in chapter 4. of this study, we start by examining the type of psychosocial trauma children experience after the tsunami, in order to then try to understand how it had developed – and why.

In so doing, we chose to examine several direct and indirect factors which influence the development of this well-being. The ones chosen for this survey - perceived vulnerability, subjective well-being, and dysfunctional behaviour - were measured in their interactions.

By direct factors, we mean those risks which come directly from the tsunami and its consequences. Indirect risk factors are the rebound effect of the tsunami on the society and the upheaval it creates.

[16]We shall use indifferently the words parents or caregivers

1. Direct effects of risk factors

As direct risk factors, we chose perceived vulnerability and dysfunctional behaviour of the children.

a. Effects of children's perceived vulnerability[17] on their subjective well-being.
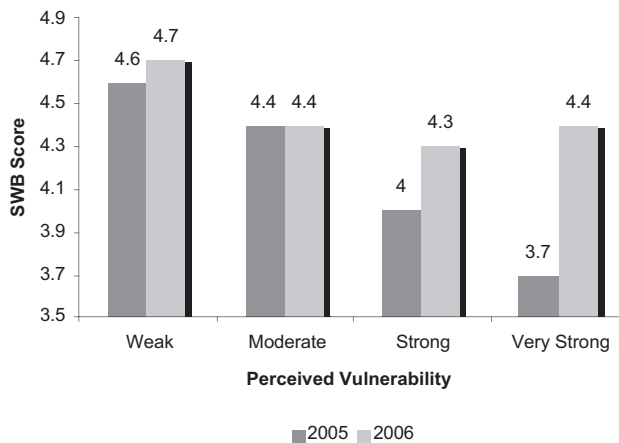

Figure 4 Effects of perceived vulnerability on SWB (N = 242)

In 2005, when children felt strongly to very strongly vulnerable, their well-being score was very low. It thus appears that the fear of another tsunami affects the subjective well-being of children (p <.0001). On the other hand, in 2006 perceived vulnerability had strongly reduced – one year having passed without recurrence of the disaster (p <.0001 between the two years). This factor is thus shown to have less importance, and no longer affects the subjective well-being of children (non-significant difference).

The feeling of vulnerability in regard to a possible second tsunami had strongly diminished by 2006, and this corresponds to an all-round impression in the field among the animators and the Tdh team. The possible reasons are first the 'time factor', well known to clinicians specialised in trauma and grief. On the other hand, reasons for worry were probably focused on other factors, such as the civil war.

b. Effects of dysfunctional behaviour of children on their subjective well-being
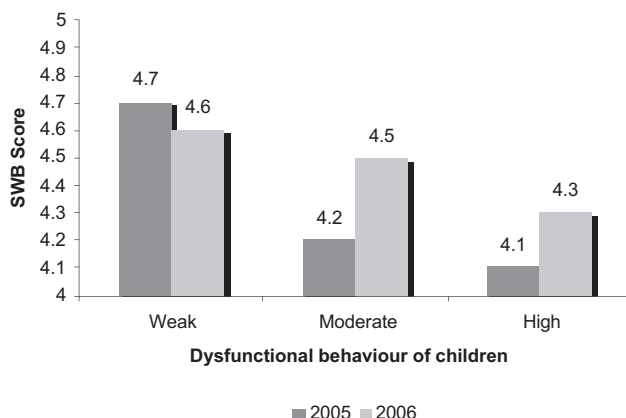

Figure 5   Effects of dysfunctional behaviour of children on SWB (N = 242)

[17]Perceived vulnerability is the subjective feeling of one's own fragility and corresponds to the fear felt by the child after surviving an undesired and terrifying threat. For this study, we chose to examine it in the light of the fear of a second tsunami rather than other subjects of worry

This graph shows that the dysfunctional behaviour of children affects their well-being score: where they present inadequate behaviour, their well-being diminishes correspondingly (p <.02 for 2006). These results also show that the effect was less important in 2006, however significant, and that the SDQ score is reduced.

c. Link between children's dysfunctional behaviour and their perceived vulnerability

In 2005, the higher the level of dysfunctional behaviour, the more we saw fear of another tsunami among the children (p<.08)[18.] On the other hand, we saw above that perceived vulnerability dropped strongly in 2006, as well as the dysfunctional behaviour of children. Overall, we note that there has been a general improvement in the well-being of the children.

2. Indirect effects of risk factors

These come principally from the relationships of children with their caregivers, who are indirectly one of the major risk in regard to the child's recovery.

a. Effects of the trauma level of caregivers on the subjective well-being of children
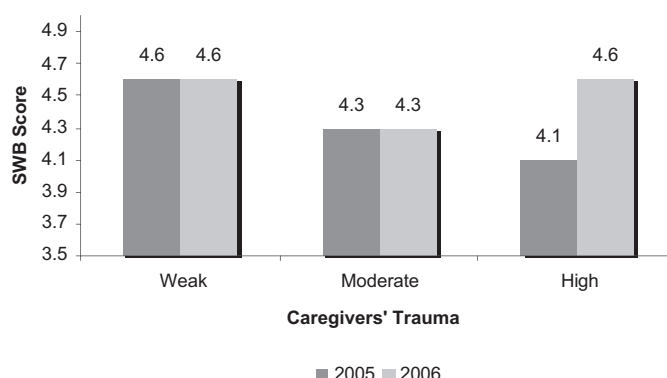

Figure 6   Effects of the caregivers' trauma on children's SWB (N = 242)

In 2005, the trauma level of caregivers affected the well-being of their children : when it was high, the well-being of children was weaker (p<.001). Thus, the well-being of children is not only affected by their own level of trauma, but also by those of their parents. On the other hand, in 2006 the subjective well-being score of the children was no longer influenced in the same way by the trauma level of their parents: the children whose parents had a high trauma score were well nevertheless. The beginnings of an improvement in the children's resilience can be seen here, as they became more emotionally independent of their caregiver.

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[18] This effect at p<.08 signifies that there is an 8% chance of error in saying that the higher the trauma level of children, the greater their perceived vulnerability. Given that this figure is based on a commonly given base of .05, this can be considered a tendential result.

b. Effects of caregivers' trauma level on children's perceived vulnerability
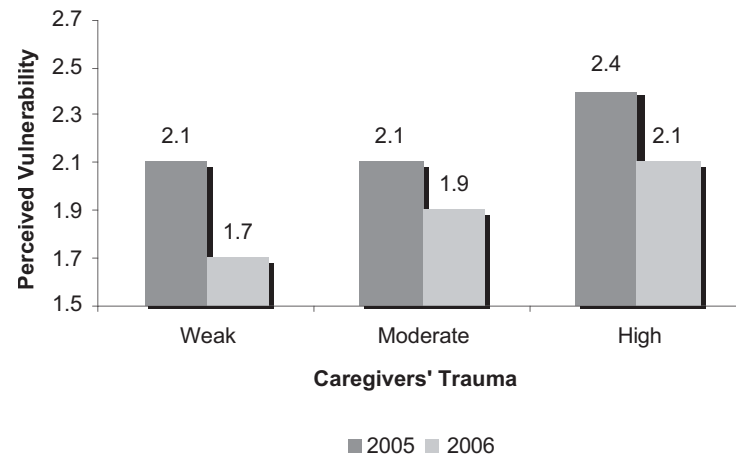

Figure 7 Effects of caregivers' trauma on perceived vulnerability, by year (N = 242)

The trauma level of caregivers affects the perceived vulnerability of children and remains constant over the two years. The higher the trauma score for parents, the more the children feared the recurrence of a tsunami (p <.02 in 2005 and p <.01 in 2006).

c. Effects of the trauma level of caregivers on the dysfunctional behaviour of children
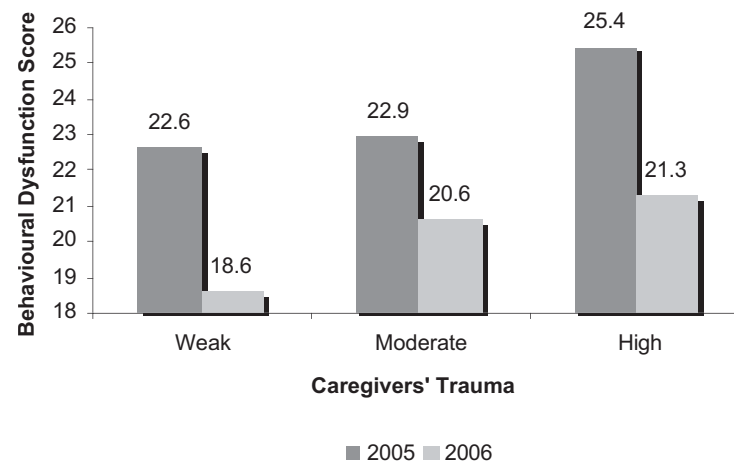

Figure 8 Effects of caregivers' trauma on the perceived vulnerability of children, by year (N = 242)

This graph shows first of all the decrease in dysfunctional behaviour among children in 2006, compared to 2005 (p <.0001). It also shows however that children's dysfunctional behaviour is closely linked to the trauma level of parents, as much in 2005 as in 2006: the higher the latter, the more dysfunctional behaviour among children (p <.0001 in 2005 and at p <.004 for 2006)[19]. The condition of the children thus does not change by itself: it depends in part on that of the parents. These results have also been cross-checked against age and sex, without revealing any influence of the latter. Nevertheless, between 2005 and 2006, we have seen that for the group of caregivers with a high trauma level, the dysfunctional difference of the children had fallen considerably (4.1), confirming again that the children were better in general in 2006, and that their resilience level had improved.

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[19]This effect is particularly important inasmuch as there is only one chance in 10,000 of error that the parents' trauma affects that of their children

3. External risk factors

Children's well-being is also affected by environmental factors after the tsunami, such as the destruction of their living environment (house, school, and hygiene facilities). On the other hand, we can already hypothesise that the reconstruction programmes established by the international community and the Sri Lankan Government will act as protection factors in the long run.

a. Effects of the tsunami's consequences on the SWB of children
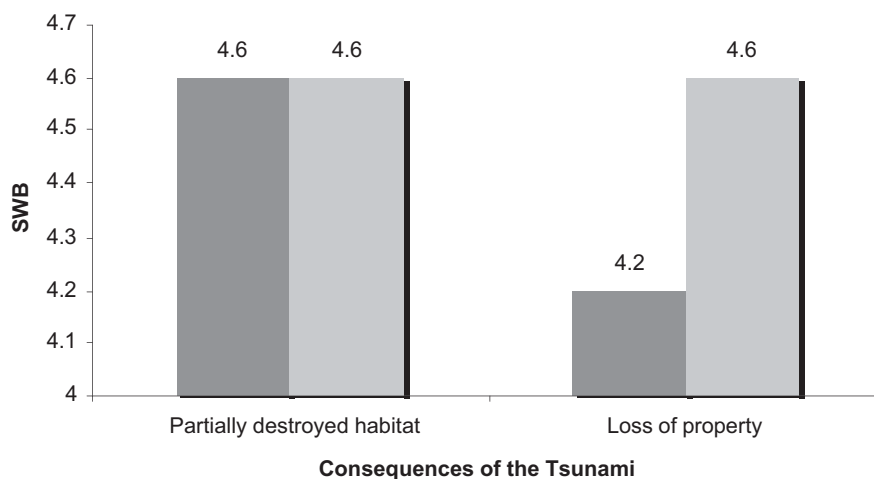
Figure 9 Effect of the tsunami's consequences on children's SWB (N = 242)

The tsunami's consequences (death, dwelling and material loss) affected the Subjective Well Being (SWB) of children only in 2005: where the consequences were critical, the children were less well (p<.02). On the other hand, these consequences no longer affected the children in 2006. Thus, the importance of the tsunami and its devastating effects on children are fading.

b. Effects of satisfaction at school on the subjective well-being of children

Figure 10   Effect of satisfaction at school on children's SWB (N = 242)

We can see here that satisfaction at school influences subjective well-being (p<.002 in 2005 and p<.0001 in 2006) and that eighteen months after the tsunami, school had become a very important protection factor. We will return to this point.

c. Effects of the state of health of children on their subjective well-being

In the context of humanitarian emergency, health problems are among the first targets of the international community's efforts. The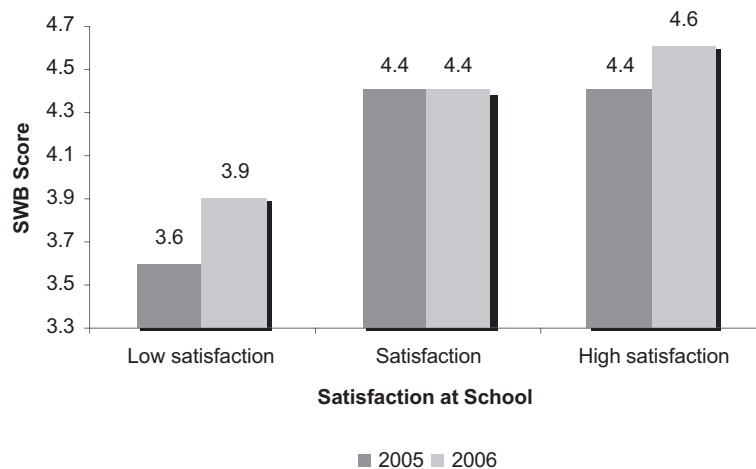 immediate impact of the tsunami was obviously the high number of victims of the disaster – deaths and injuries – as well as the destruction of housing and infrastructure, notably the provision of drinking water (wells, water mains, etc). Although epidemics could have been expected, thankfully they did not happen. The biggest sanitation problem came from the necessity of bringing populations together in camps, in precarious conditions: overcrowding, insufficient access to drinking water, primary care, and occasionally nutrition – which favour the spread of diseases such as respiratory infection and diarrhea, especially among children.

After the first impact phase (six months), and as living conditions slowly improved, health risks for the population came under control. The following graph shows the impact of the situation on the well-being of children.
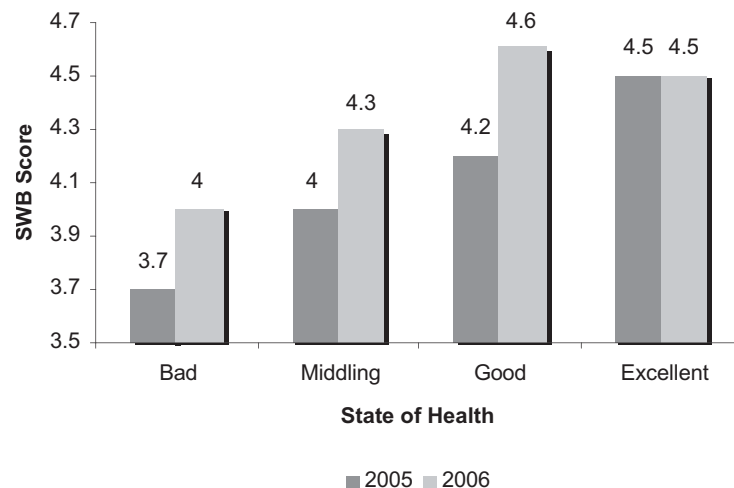
Figure 11 Effects of the state of children's health on SWB (N = 242)

In 2005, the well-being of children was strongly linked to their state of health: children in bad health had a low well-being score, while children in good health had a high well-being score (p <.01 in 2005). In 2006, the score shows nevertheless that health is an important risk and protection factor.

Discussion

We have thus noted in this first analysis:

■ a direct impact of children's feeling of vulnerability on their well-being;
■ a strong drop in perceived vulnerability in 2006 and thus the improvement of well-being and resilience;
■ a similar drop in dysfunctional behaviour in 2006;
■ and an important link between dysfunction and vulnerability, since both have diminished while the level of well-being has increased.

This shows that the children followed an upward curve between 2005 and 2006. We have also learnt about the important impact which the level of trauma of caregivers had on the psychological state of their children:

■ the more parents are fearful and anxious, the more their children are too, as much in 2005 as in 2006;
■ the impact of caregivers' trauma on the children was strong in 2005, but diminished considerably in 2006;
■ children's dysfunctional behaviour largely decreased in 2006, even if this improvement remains relatively dependent on the trauma level of caregivers.

This shows us that the children have recovered a level of resilience which leaves them more autonomous in regard to parental worries, demonstrating their capacity to resume their development while protecting themselves from adult concerns.

Finally, we can see from an examination of environmental risk factors – housing, satisfaction at school, health – that the children were not greatly affected by these in 2006. In a later chapter on the worries of children and their caregivers, we shall see that it is mainly the adults who take the full impact of environmental risk factors, and not the children.

We can thus already say that the children are better in 2006 and that their resilience had generally improved between the two surveys.

e. Evaluation of children's subjective well-being (SWB)

The above results are corroborated by the results obtained in the Resiliency Scale Questionnaire (section VI) on the Subjective Well Being of children (SWB).

In 2005, the average SWB is 4.3 out of 6. This score seems a priori good. All the same, it should be treated with caution, since we found a tendency in the Sri Lankan population to present themselves at their best, masking the problems they may have with their children.

In 2006, the average SWB is 4.4 out of 6. The improvement is too weak to be significant, but taking the development of SWB according to the three groups (caregivers, children and animators), we can at least note that the children said they felt better in 2006 than they did in 2005.
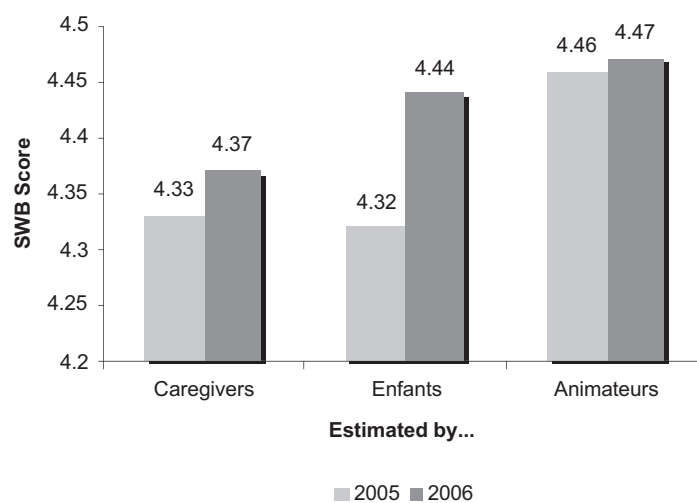

Figure 12 Estimate of children's SWB by year and group (N = 242)

II. Evolution of the recreation centres

The analysis of these results would not be complete without studying the variability between the recreation centres, between 2005 and 2006. In effect, the previous results are taken from a global sample, without taking such variability into account.

1. Life in the recreation centres

Each centre is part of a geographical area, with specific cultural and religious ties, and a local and personal history. Each in their own way, they can favour good health and a good quality of well-being, or they can increase feelings of distress or dysfunctional behaviour among children[20].

A. The context

This variability between centres comes from reasons that are not always individual, but which belong to the external environment and to discernable structure changes we have seen in the collection of data in 2006. The most important ones are:

■ the return to war, with the arrival in August 2006 of a mass of IDPs who flooded the centres, where Tdh had to face emergency actions such as food and water distributions. More recently, the civil war had been even more complicated by disputes between Muslims and Tamils.
■ an overly slow reconstruction, with the continuance of temporary shelters over the long term for numerous families who attend the Tdh centres.
■ the departure of international organisations at the end of their post-tsunami mandate. This has imperilled not just local structures, now handed over to social services – already deficient at the outset – but also whole communities, who feel particularly abandoned in zones which have only just begun to see rehabilitation.

B. The centres

Among those centres chosen in our sample, some have been shut down between our two surveys, due to the closing of the camps to which they were linked, and at others, children left because of the reconstruction of their housing in another district.

Elsewhere, some centres were opened by Tdh immediately after the tsunami, as part of the project. On the other hand, some of the centres were managed by local NGOs, partners with Tdh for many years before the disaster. In general these organisations did not offer the same level of services, nor managed their staff in the same manner. They were often more vulnerable to military factions, since their own managers were confronted with the same threats as those to the communities of which they formed an intimate part. Furthermore, the requirements defined by Tdh following their experience of building such programs over many years, in other places, could not be the same as those for local NGOs. This was the case, for example, for Dutch Bar and Swiss Colony, which was managed by Befrienders.

Finally, we note that some centres were situated on coastal zones more affected than others by the tsunami (such as Dutch Bar), and thus needing more time to rebuild.

C. Staff at the centres:

In 2005, the analysis of the IES scores of the animators showed that their trauma level was higher than those of the children and caregivers. We noted in our intermediary report that this posed a problem for the quality of the animators' interventions in the recreational centres.

In 2006, we note that this situation had changed, largely because of the support provided by Tdh and a relative stability of the local staff.

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[20]This includes the differences in well-being of children between the centres. In effect, all the centres are not equal: in some, the children are better (a 'healthy' centre) while in others, the children are less well ('distressed' centres)
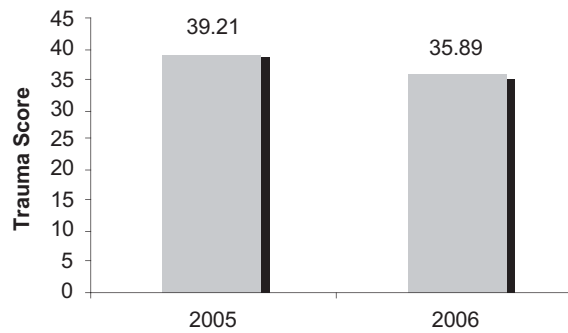
Figure 13   Trauma level among animators, by year

If the trauma level among animators remains still 'abnormal', it was still significantly reduced in 2006 (p <.045).

Indeed we noted in the field, in August 2006, that there had been a major improvement among the staff in general. First of all, their lower trauma level could be read in the relative stability of personnel in the recreation centres. Even where reconstruction obliged some animators to change site, they often remained attached to 'their' centre. Between 2005 and 2006, we noticed that their knowledge of the children and their skills in educational issues had greatly improved.

One coordinator told us:

> *"The children feel better because the animators feel better. For example, we celebrated the end of the programme last week at one of the sites, and several animators put together a show for us which they had created from start to finish. For me, that means that the children are better cared for, and no longer just playing a good old cricket match every afternoon… The children themselves are more involved in the centres than before. They have, for example, brought the TAPORI project to Ampara and put together a theatre show themselves! The group feels better, but this is still fragile in respect to resuming hostilities."*
>
> *Audrey*

2. Variability between centres in the children's well being

Let us now analyse the variables according to our indicators:
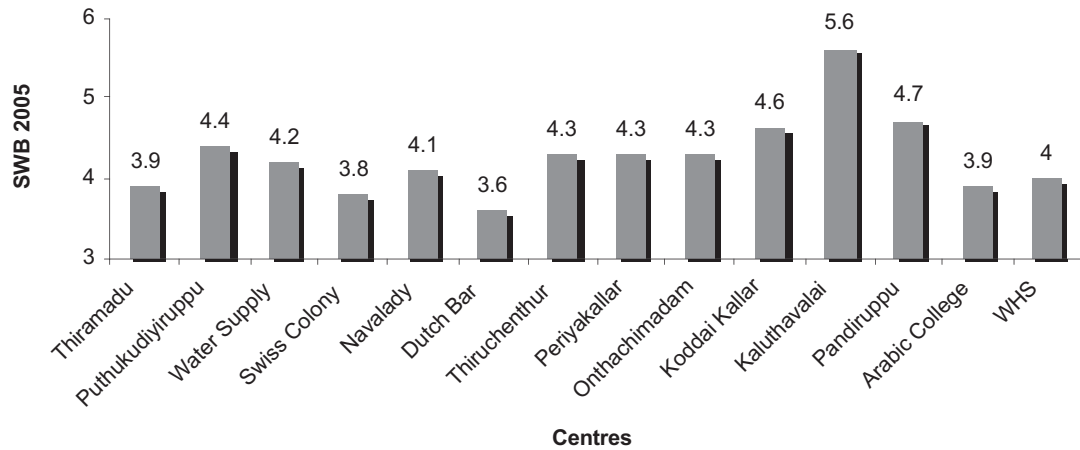
Figure 14 SWB results by centre for 2005 (N = 242)

In 2005, the children with a lesser level of SWB were located at Dutch Bar, Swiss Colony, Thiramadu, Arabic College and Wesley College. Inversely, those who felt better were at Kaluthavalai. We may see here that the difference between centres varies considerably – from 3.6 at Dutch Bar to 5.6 at Kaluthavalai. Around an average of 4.2 to 4.3, the lowest scores as well as the highest differ significantly.
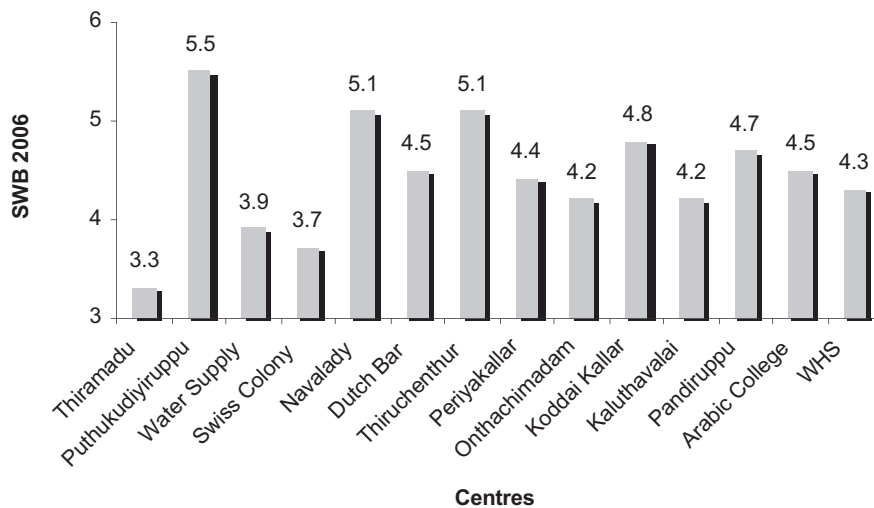
Figure 15 SWB results by centre for 2006 (N = 242)

In the same manner, in 2006 the average value oscillated between 4.3 and 4.4, while the lowest level, 3.3, came from Thiramadu, and the highest at Puthukudiyiruppu. The children were less well at Thiramadu and Swiss Colony. On the other hand, they were better at Puthukudiyiruppu, Navalady and Thiruchenthur. Centre by centre, we can also evaluate those which had a better well-being score between 2005 and 2006 (+ 1.2 for Puthukudiyiruppu, +1.0 for Navalady) and those which had a less favourable score (-1.4 for Kaluthavalai).

3. Variability between centres of children's dysfunctional behaviour

In the previous chapter, the analysis of dysfunctional behaviour was highly linked to the children's well-being, especially in 2005. In 2006 however, we also made an analysis of specific results for each of the centres sampled, regarding the state of the children (dysfunctional behaviour and well-being).
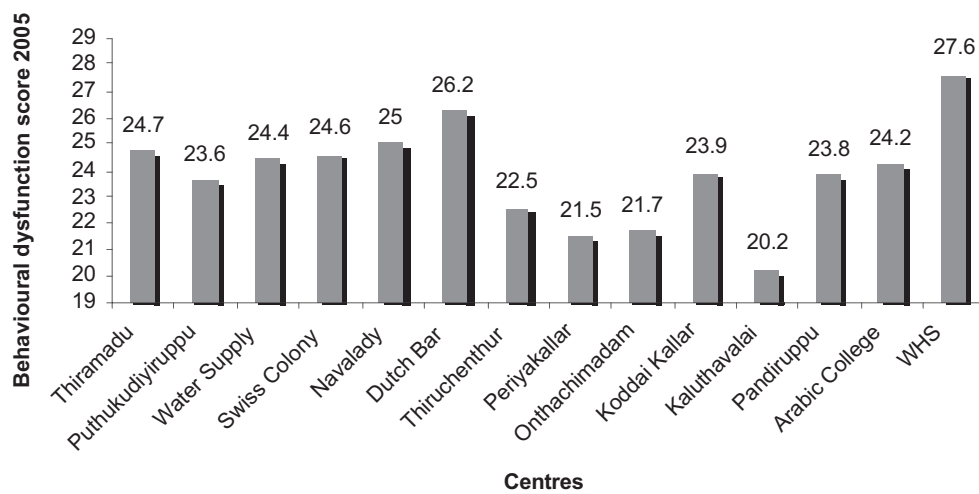
Figure 16   Results of dysfunctional behaviour of children by centre for 2005 (N = 242)

The above results are contrasting. In 2005, in some centres children seemed unwell: WHS and Dutch Bar in particular; in others, they definitely did better: Kaluthavalai, Periyakallar and Onthachimadam. Furthermore, the centres did not seem to start from the same base in terms of trauma level. Compare these results with those of 2006 below:

Figure 17 Results of dysfunctional behaviour of children by centre for 2006 (N = 242)

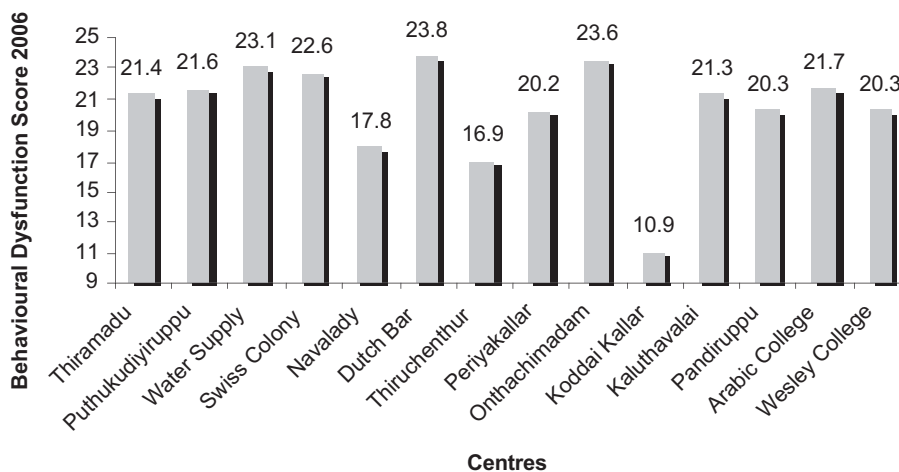We can see that the centres where children were better or worse in 2005 were not necessarily the same as those in 2006. The children were less well at Dutch Bar, as in the previous year, but also at Onthachimadam, where they were worse. At the same time, the results in these centres are close to the majority of the other centres. The children are feeling better at Koddai Kallar, Thiruchenthur and Navalady.

4. Four centres presenting poor results

Swiss Colony (7), Dutch Bar (9) and Wesley College (18): 3 centres with 42 subjects

Close analysis of the results indicate that the children at these centres showing the least improvement, also started from a 'lowest' level in 2005:

- the trauma level of parents was the highest (p <.0001);
- the dysfunctional behaviour of children was also higher (p <.002);
- the well-being of children was the weakest (p < .002).

If the children at centres presenting the best scores cannot be seen to be doing better because of their 'higher' base point, the children at centres presenting the worst scores have the weakest indicators: they are generally not well.

The whole set of risk and protection factors had combined to create this unfavourable situation (in 2005):

- the perceived vulnerability of children was the highest (p <.008);
- self-esteem was weakest (p <.0001);
- social networks were less dense (p <.003);
- health was worse (p <.03);
- and the recreational centres were less well perceived (p <.015).

The gaps in those centres worsened in 2006: the trauma level of parents remained higher than those of parents at other centres (p< 04), as did children's dysfunctional behaviour (p <.002).

If the children and parents at these centres were nevertheless better in 2006 than in 2005, (as seen in the results by the IES, SDQ and SWB questionnaires), they continue to be worse than others. On the other hand, the gaps of risk and protection factors decreased: only perceived vulnerability remains higher than that of other centres (p <.05), while belief in God diminished (p <.04).

Following, are a few comments on the context of the centres which were doing less well:

> Wesley College is a centre managed by a local NGO. Its staff, who have worked there for years, has had to adapt quickly to the arrival of emergency Tdh staff after the tsunami, which hasn't always been easy. Furthermore, before the second survey, there was an incident due to political and cultural problems: the centre is located in a Muslim zone where the local authorities have put pressure on female personnel of the international NGOs to stop working there (July 2006). Wesley College was forced to close for several weeks so that the situation could calm down. This also happened at Kalmunai, but there, Tdh had significant support from families.

5. Four centres presenting better results

Puthukudiyiruppu (3), Navalady (8), Thiruchenthur (10) et Koddai Kallar (14): 4 centres, at which 77 children were questioned.

In 2005, the indicators (trauma level of the caregivers, dysfunctional behaviour and well-being of the children) were not significantly different in the centres with the best scores than they were in other centres. In 2006 on the other hand, the children were significantly better in these centres ($p<.0001$ on the SDQ and SWB questionnaires), even if their parents were not feeling well.

This contradicts the idea that it is the children who start from a more favourable base (i.e. that they were feeling better than in other centres in 2005) who presented the best improvement. Exploration of the risk and protection factors on the other hand, shows the answer to this improvement. In fact, we can see a better starting base for the children in 2005:

■ their perceived vulnerability was weaker than that of children at other centres ($p<.04$);
■ their self-esteem was better ($p <.02$);
■ their social networks were denser ($p <.0001$);
■ their health was better ($p <.004$).

Even if the children present levels of dysfunctional behaviour and well-being similar to those of children at other centres, they benefited from a number of significantly better protection factors.

The intervals continue widening in 2006:

■ perceived vulnerability continued to be weaker in these centres ($p<.008$);
■ self-esteem was still better ($p <.0001$);
■ social networks remained denser ($p <.008$);
■ health was still better ($p <.002$).

At the same time, education is considered more important to the children – in their own words ($p<.008$).

Thus, there is a fairly wide interval between risk and protection factors which pre-existed before the establishment of the centres. Nevertheless, one may note a negative evolution similar to that of the other centres: social networks are significantly less dense in 2006 ($p <.0001$) and self-esteem is lower ($p <.001$).

It seems that some factors have favoured the better functioning of the centres:

> *"In the centres which function well, the social supporters have become excellent professionals, especially in the area of protection. We have thus kept them on board during the handover of the programme to the community and Tdh partners. As for Navalady and Thiruchenthur, on the other hand, the key element of their excellent level rests on the strong investment of the caregivers' group in the centre's activities and their support of the Tdh programme."*
>
> *Audrey*

Discussion

Independently of the external factors invoked, and on the basis of our analysis, we can say that the children at centres with the best results bring together favourable conditions: stronger self-esteem, denser social networks, weaker perceived vulnerability, and better health. These factors have been a good base with which to improve the well-being of the children. On the other hand, in the centres with worse results, not only the children were worse than others, but they were also affected by unfavourable factors: weaker self-esteem, less dense social networks, stronger perceived vulnerability, and worse health. Even if the children were doing better in the following year, they were still lagging behind in regard to the whole group.

Conclusion

Independently of the level of risk and protection factors – both external and internal – we note that all of the children are significantly better. The common factor for all these children are the recreation centres, which fostered the well-being of their little beneficiaries, whatever favourable or less favourable conditions they had to put up with.

Social networks and belief systems after the tsunami

One of the most important risk and protective factors for the improvement of a child's well-being is his/her social network. By this we mean the whole range of connections any individual tends to develop over time. The importance of the social network as a factor of risk and protection has been the subject of numerous studies and it is often cited as one of the most important factors in individual and collective recovery after a traumatic event.

We have just seen that after a traumatic shock, the psychosocial dynamics of child-family relationships are instantly activated after a natural disaster. Social networks follow the same process as that of a family: after the initial shock, where links are mobilised in a collective effort towards survival, they return to being a locus of social complexity, with their specific mechanisms of failure and resiliency. We were able to observe this development over 18 months, and the data confirms this passage from surviving to going back to life.

After the tragedy, social networks had been brutally destroyed – and for a long time. Many children lost someone close, whatever the conditions of that death (tsunami, civil war, sickness, accident, etc.). But thousands of children also died in the catastrophe.

Loss of close relatives or friends	%
Members of the family	31,2
Mother	2,9
Father	7,9

Table 5 Children who have lost a close relative or friend (N = 242)

The Child Individual File has shown that over 30% of the children had also lost someone from their close family (father, mother, brothers, sisters, grandparents, etc.). Those who had lost their father were more numerous than those who had lost their mother: 7.9% against 2.9%. One can easily imagine the psychosocial dislocation which tens of thousands of children have been through after such losses.

That said, the Italian NGO Vivo[21] had conducted a survey prior to the tsunami, which brought to light the massive destruction of the Sri Lankan children's social networks over the twenty years prior to the disaster. We cannot thus know whether the figure of 31% includes parents who had died previously. Nevertheless, whatever the cause of loss, the children in our study have lived through massive losses which they will have to cope with in future years.

Social networks are generally constituted by several circles: those of family members, ordered according to a cultural pattern, the circle of friends and acquaintances, authority figures such as teachers or priests, and others – more distant and thus less emotionally sensitive circle , such as neighbours, craftsmen, sports heroes, etc.

One of the major principles of humanitarian psychosocial intervention, as we have seen, is the empowerment of communities and families as participating in their own recovery process. Helping children rebuilding their social networks in the frame of recreation centres will thus also be of paramount importance. It will weigh on the development of children as much by its density as by the emotional importance it has for the child and the meaning it gives to his/her life. It should be noted that many studies have shown that social networks act as a factor both of risk and protection, and also that the level of resilience among young people generally improves as the social network improves.

We shall make a distinction below between the density of the social network and its content: in other words, how many people is part of it, and who is part of it (see the Resiliency Scale Questionnaire in the annexes).

1. The state of children's social networks after the tsunami

We do not know of any research done on the reconstruction of social networks after a natural disaster in developing countries. But we have been able to observe this process, though modestly, at the heart of the microcosm which is the recreation centre.

	Density of social network (Number of people)
2005	11
2006	7,8

Table 6 State of social networks by year (N = 242)

In the Resiliency Scale Questionnaire (Section VII), the density of the social network was estimated by calculating the number of people children thought they had in their life, both close (parents, brothers and sisters) and distant (teachers, neighbours, etc.), on four concentric circles going from the middle where the child drew him/herself, towards the periphery, where he/she placed those less close (see the RSQ in the annexes)[22].

The first thing which we can note is a reduction in the density of social networks between 2005 and 2006 (p <.0001). We may suggest that the context of civil war or changes in the area due to reconstruction might have contributed to this decrease. Nevertheless, there were also changes in the content of networks, as we shall see below, which seem to indicate that the children had begun to recover from the staggering shock. This had centred them firmly on their family, but they had now reorganised their connections differently. Furthermore, once the major traumatic effects had lifted, the interests of the children had definitely changed, putting new emphasis, for example, on study or professional training.

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[22]For the analysis, each person in each circle was associated to coefficients as a function of their importance to the child: a coefficient of 3 for circle 2, a coefficient of 2 for circle 3, a coefficient of 1 for circle 4

A. The effects of social networks on children

a. Effects of the density of children's social networks on their subjective well-being
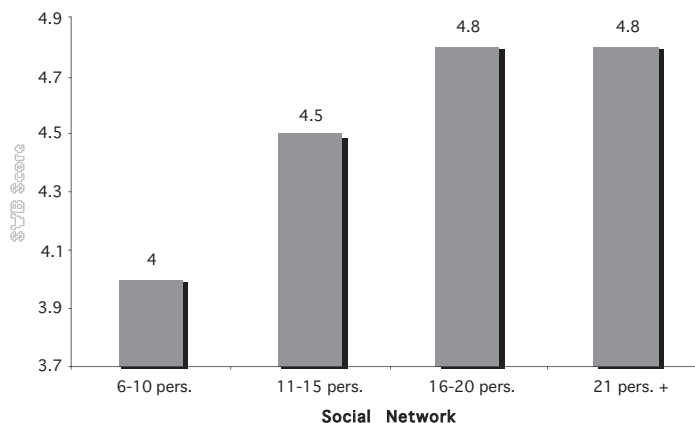
Figure 18 Effect of social network density on the children is SWB in 2005 (N = 242)

In 2005, the results show that well-being is strongly linked to the density of children's social networks: the more children had a dense social network, the better their well-being (p <.0001).

The results of 2006 (grouped in two blocks on account a lesser number of people in the social networks) act similarly:

Figure 19 Effects of the density of social networks on children's SWB in 2006 (N = 242)

Again, a less dense social network is accompanied by a weak level of well-being, while a strong density favours it (p <.02).

b. Effects of children's dysfunctional behaviour on the density of their social networks
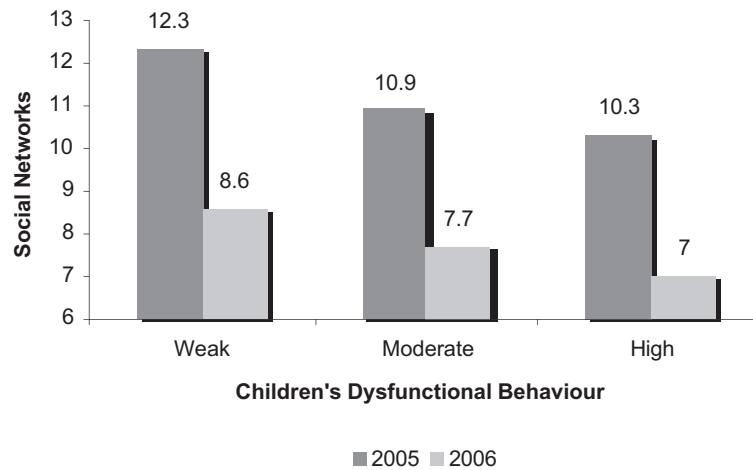
Figure 20   Effects of dysfunctional behaviour on social networks (N = 242)

Children's dysfunctional behaviour is connected to the density of their social network: children with inadequate behaviour happen to have a less dense social network. On the other hand, the changes between 2005 and 2006 within the different dysfunctional groups are important: for the weaker ones, the mobilisation of the social network by the child is less important. And for the other two groups, we can also note a lower density of social networks.

The figure above confirms the reduction of social networks between the two surveys.
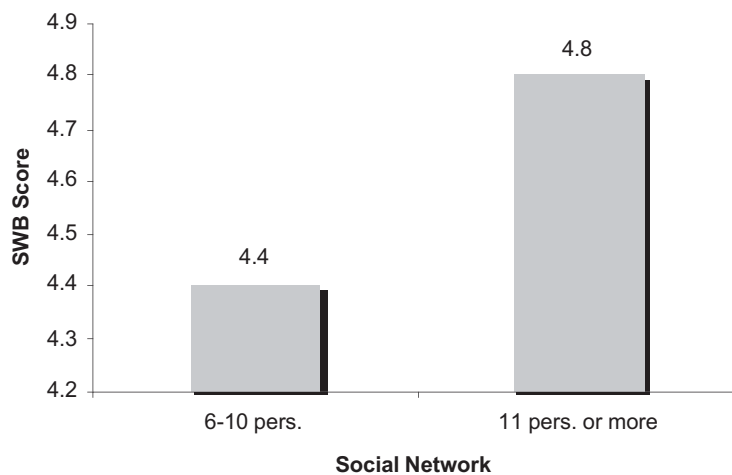
c. Effects of the density of social networks on the perceived vulnerability of children
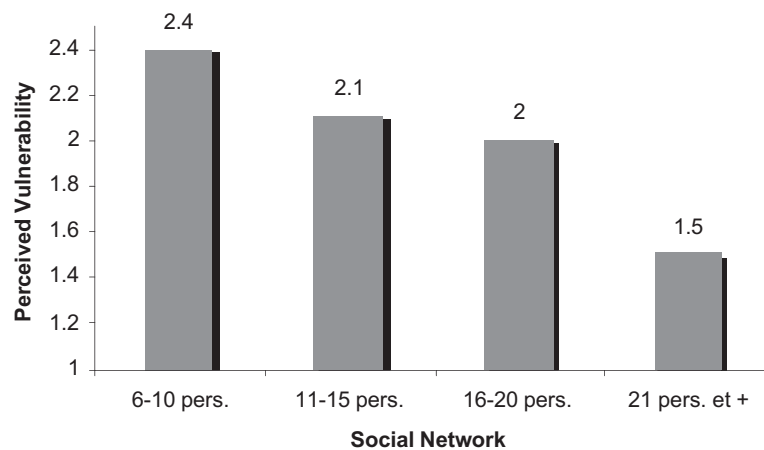
Figure 21   Effects of the density of social networks on perceived vulnerability in 2005 (N = 242)

In 2005, the denser the social network of children, the more reduced the perceived vulnerability (p <.002). Again, this result shows the importance of the child's entourage and his/her inclusion in the community. The more the child is surrounded, the less he/she feels vulnerable, and the better he/she feels.

In 2006 on the other hand, the social network has no effect on perceived vulnerability. This is probably linked to the vulnerability perceived as lower over the preceding year: this factor had lost the importance it had in 2005.

Discussion

We can see here how the density of social networks improves the well-being of children, in 2005 as well as in 2006, and that their perceived vulnerability diminished in 2005 during the immediate period after the tsunami. In the following phase, in 2006, the density of children's social networks did not influence their perceived vulnerability for the same reasons: the children seemed to have gained more autonomy and a better resilience. As for the link between dysfunctional behaviour and social networks, this can also be seen as favourable.

B. The content of children's social networks

The networks of people with whom the children have significant bonds changed between 2005 and 2006. In the 2005 sample, the children essentially cited the members of their close and extended family: father and mother of course, and cousins, uncles and aunts, paternal and maternal grandparents, in-laws. In 2006, although the children still named their close family (parents, brothers and sisters), they cited the rest of their family less. It is possible that the evocation of the whole family in 2005 reflected a way of 'sticking together' after the tragedy. A year later, there was less need to cite the whole of their family members. This is shown in the results below:

Family Members	2005	2006
Circle 2	95,3 %	76,6 %
Circle 3	84,8 %	78,5 %
Circle 4	65,8 %	51 %

Table 7 Place of the family in children's social networks, by year (N = 242)

In 2005, the people mentioned by children in the concentric circles in the RSQ are mostly members of their family, to the exclusion of other people such as friends of the same age or external adults. We can see that in 2006, while the family is still strongly present, it is nevertheless less cited than in 2005, which confirms our first hypothesis.

Several hypotheses can be proposed to explain why in 2005, children's social networks – whatever their age – are peopled essentially by members of their more or less distant family. A first hypothesis is the cultural norm: in Sri Lanka, the family is the pillar of society. A second hypothesis we can advance without too much risk is that after such a fracture as a tsunami, because of the vital necessity for families to gather their strengths to survive, the child too has no desire to make external connections. The child will instinctively bond with the family. A third hypothesis makes us ask whether the child may already have lost the desire and motivation to find friends of his/her own age, because of the number of displacements before the tsunami due to civil war.

In 2006, on the other hand, we see that family members tend to be cited together by the children, in all the circles, in a generic way: fathers and mothers become 'parents', while children no longer list their brothers and sisters who are younger or the same age as themselves. They are even sometimes grouped together, just as with grandparents. This lesser precision artificially reduces the number of persons cited as being in their social network. On the contrary, the children cite more people external to the family: friends, acquaintances, other children, teachers, animators. It thus seems that, despite everything, social networks are open to people outside the family. And beyond the lessening of the density of social networks, we may see the onset of a structural change.

This may be summed up in the following table (cf. table 3 for the placement of family in social circles):

People external to the family	2005	2006
Circle 2	4,3 %	7,3 %
Circle 3	13,7 %	22,3 %
Circle 4	31,1 %	41 %

Table 8 Place of people external to the family in children's social networks, by year (N = 242)

Discussion

We have just seen that sociability is a factor which plays a very important role in the improvement of children's well-being. The figures show, if there was any need, that it is vital to preserve children's social networks (no separation from the family, the community and friends, or placements in orphanages, etc.). Isolation damages the well-being of children, and should thus be avoided as much as possible. Here again, obviously, the recreation centres offer an important space for socialisation.

This question becomes even more acute in a protection programme. Where a child has been removed from his/her family following the team's detection of a risk situation, a strategy must be defined along two lines: who will the child trust the most after an abuse, and how to best preserve his/her friend and school network.

On the other hand, the lessening of social networks noted between 2005 and 2006 is probably due to the changes in the life of the children, and to their improved well-being. They have less need to call upon their entourage to rebuild their daily existence.

Finally, the content of social networks evoked by the children indicate the importance of the work of the recreation centres: animators and friends are part of children's social networks and thus can help them to feel better.

2. Belief systems and children's sociability

Religious debate does not belong in a study on the impact of a humanitarian psychosocial programme on its beneficiaries. Our approach will remain within the framework of concepts belonging to Social Psychology and the Sociology of religions. This allows us to present the three religions of the area: Hinduism, Islam, and Christianity, as belief systems within the social and cultural fabric of the studied population. The issues examined here have to do with beliefs and their influence on the development of children and their families after the tsunami and how these systems have been factors of risk or protection.

Before going into the subject however, let us underline that the authors of this study are not only of none of the above cited religions, but that they are agnostic or atheist and belonging to today's Western world. We shall also note that Tdh is non-denominational, and is resolutely non-interventionist in this matter. The organisation works for children and supports Human Rights. More concretely, religious discussions or practices do not form part of the life of the recreation centres. A tolerant attitude is encouraged though among children towards their companions of another religion, as well as keeping a moment of silence at the beginning of each activity session.

This voluntary or involuntary position, which some may call scientific, contrasts with the deeply religious attitude of the population. Daily life is infused with religious faith and practice. Every daily activity is placed within a dimension which increasingly escapes us in our part of the world, occupied as it is with the transformation of a two-dimensional everyday life into a comfortable and sophisticated environment.

Furthermore, the big question of how to give meaning to a disaster such as the tsunami is often evoked through everyday religious practice – explicitly or implicitly – by the survivors. It is a question for which the essentially Western international community has no answer. Can we speak here of a clash of civilisations, reinforced by international humanitarian aid and its inevitable repercussions on distressed populations? Whatever the cause, we wish to bring the reader's attention to the fact that this religious question, considered by our social sciences as just part of belief systems, cannot really be approached in its spiritual dimension and only in its dramatic reality.

Having made this cautious remark, we present the results of our research with due prudence. Let us now turn to the effects of belief systems on our indicators.

In the Resiliency Scale Questionnaire, we made the link between the system of beliefs and ritual practices at the heart of any religion, as factors of risk and/or protection. Beliefs nurture meaning in one's life – especially important in the case of a natural disaster – and ritualistic practices create a feeling of belonging to a community. Both elements are protective factors, central to the improvement of resiliency levels.

The population evaluated in our sample is divided between the three great religions: Hinduism, Christianity and Islam. Questions regarding the impact of the tsunami on those belief systems and the religious practices of the families were asked to all the sampled groups.

The religions people belong to in our samples were the following:

Religion	%
Islam	9,5
Hinduism	78
Christianity	12,5

Table 9   Division of religions in the sample (N = 242)

To start with, the children were asked to estimate their belief in God on a scale of 1 to 6 points (from 1 'not at all', to 6 'completely'). No child chose a response of 1, 2 or 3, and only the levels of 4, 5 and 6 were used.

We noted that the belief in God was very strong: 5.7 out of 6 in 2005, and 5.6 out of 6 in 2006. Nevertheless, we cannot tell if this is just a statement of principle (following a social norm that says one should believe in God) or a reality: not one child said he/she believed in God only 'moderately'. This seems to show on the three last points of the scale, as if the children did not want to say they did not believe in God, but moderated their answers according the strongest values of their community.

In 2006 however, the children said they believed less in God (p <.02). Similarly to their remarks on school satisfaction, it is possible that the children had less need to hang on to their beliefs, almost two years after surviving the tsunami. In fact, the importance of religion receded, it seems. We shall return to this issue later.

a. Effects of belief in God on children's subjective well-being
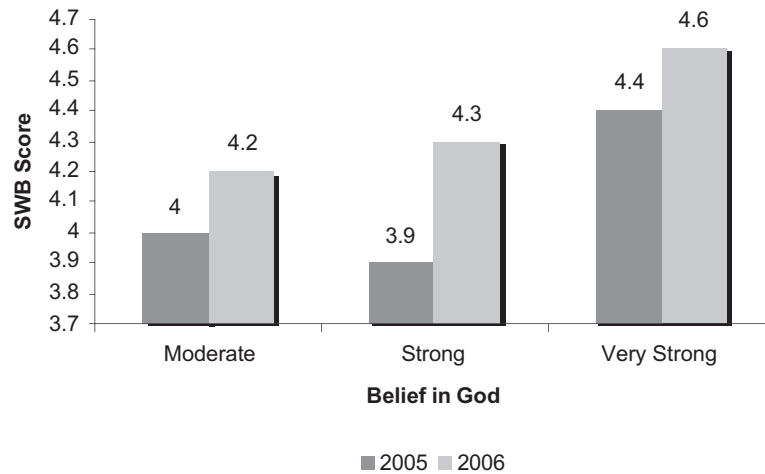
Figure 22 Effects of belief in God on chidren's SWB (N = 242)

A very strong belief in God is accompanied by a higher well-being among children (p <.03 in 2005 and p<.05 in 2006).

b. Effects of the belief in God on the density of children's social networks
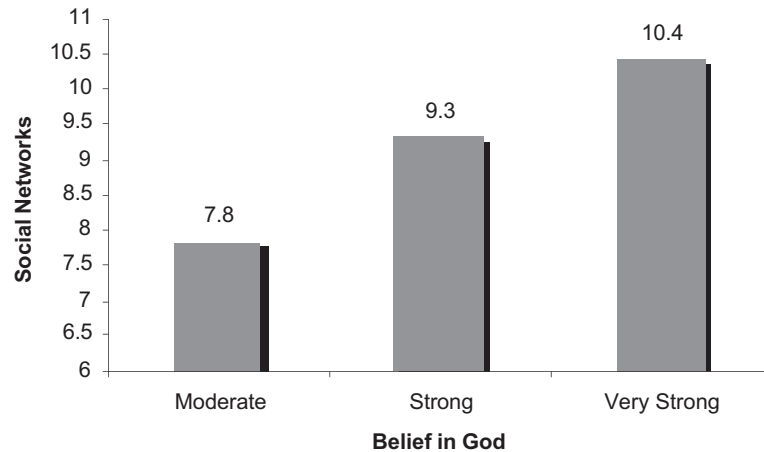
Fig.ure 23   Effects of the belief in God on the density of children's social networks (N = 414) in 2005

In 2005, belief in God affected the density of children's social networks: the stronger the belief, the denser the children's social networks (p <.006). Religion thus appears to be a factor of sociability which can contribute to the indirect improvement of children's well-being. However, in 2006 this effect is absent. As we have already noted, it seems that the importance of religion is less.

c. Effects of belief in God on children's satisfaction at school
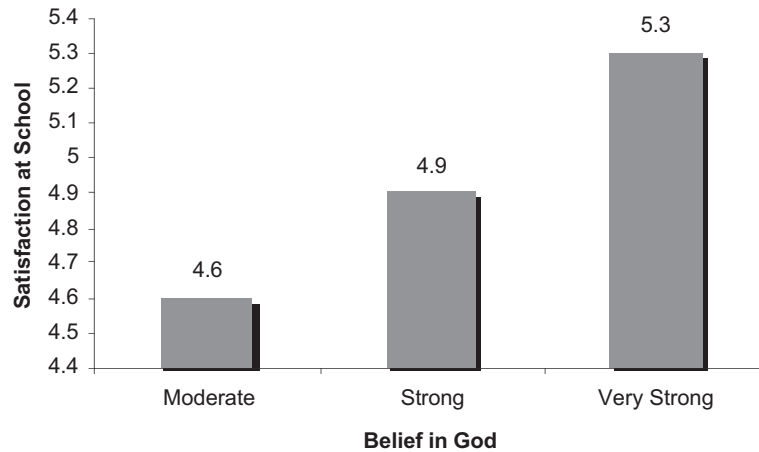
Fig.ure 24   Effects of belief in God on satisfaction at school in 2005 (N = 414)

This result shows the influence of the belief in God on education: the children who strongly believed in God presented a higher degree of satisfaction at school (statistically significant effect of $p<.001$). The connection is difficult to explain. We can posit that a child who feels happy at school also feels fundamentally to be a good Christian or good Muslim. Or that these are sociable children who feel at ease both in their school and religious environments.

We find the same result in 2006:
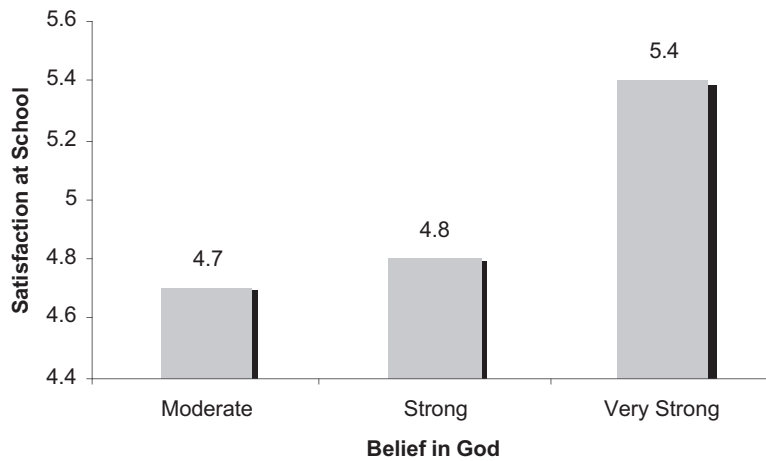
Fig.ure 25   Effects of the belief in God on satisfaction at school in 2006 (N = 242)

d. Effects on caregivers' belief in God on the practice of religion

Just like the children, parents declared their strong belief in God (5.6 out of 6 in 2005, and 5.4 out of 6 in 2006).

As regards religious practice (the question was to estimate how much they practised all of the rituals), everyone declared frequent practice (5.6/6 in 2005, and 5.4/6 in 2006). Practice was nevertheless as weak in 2006 as it was in 2005 (p <.04).
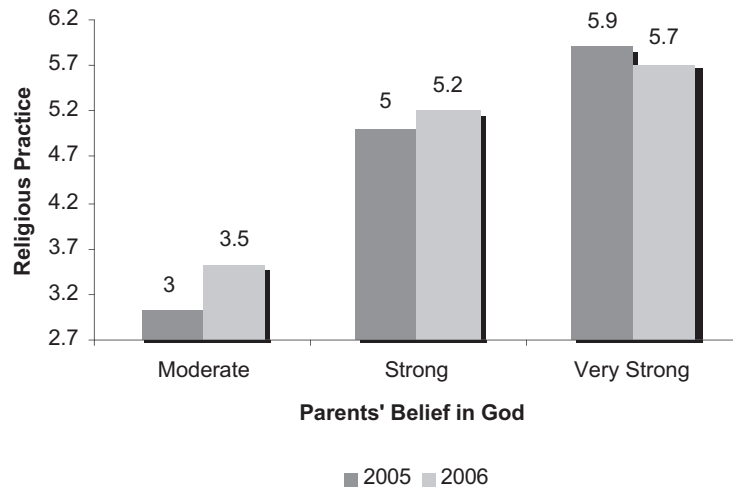
Fig.ure 26   Effects of caregivers' belief in God on religious practice (N = 242)

The more parents said they believed in God, the more they declared practicing (p <.0001, both in 2005 and in 2006). Faith and practice are at equal level.

e. Effects of caregivers' belief in God on the density of children's social networks
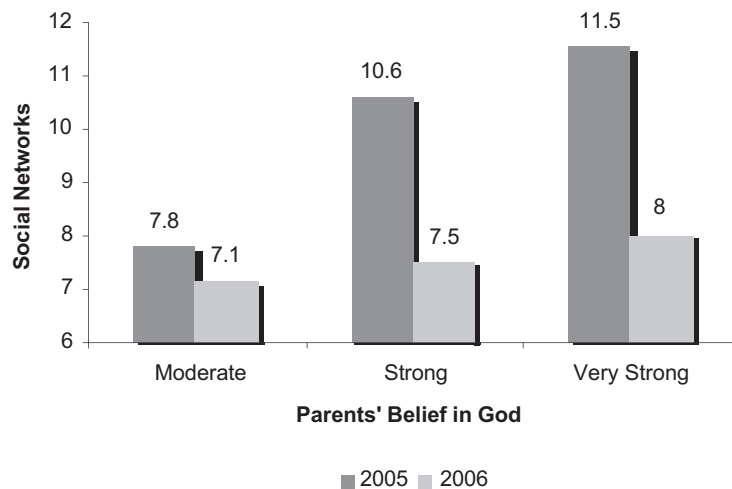
Fig.ure 27   Effects of caregivers' belief in God on children's social networks (N = 242)

In 2005, the more parents declared their belief in God, the denser their children's social networks ($p < .01$). On the other hand, caregivers' belief in God did not affect the social networks of children in 2006, confirming the lesser importance of religion, for children as much as for caregivers.

Discussion

Our survey showed that religion – faith as well as ritual practices – seems to be an important mediating variable. It works not only directly on the level of children's well-being, but also plays an important role in self-esteem and satisfaction at school, which are strong important protective factors.

Nevertheless, we note that in 2006 there was a weakening of the belief in God among children and of religious practice among caregivers. Belief in God has then only a slight influence on social networks.

It thus seems that religiosity, whether on the level of belief or of practice, had diminished eighteen months after the tsunami. There was perhaps less need for a spiritual explanation and a meaning for the experience of the tragedy: the basic needs of daily life had become uppermost in the victims' preoccupations.

3. Giving meaning to a disaster

Every distressed human being instinctively searches a meaning to his/her suffering, as a way to alleviate and find the strength and means to move beyond it and to keep the least ill out of life. This reaction is known to be part of the characteristics of a resilient person.

The children at the Tdh recreation centres also want to give meaning to their unhappiness, in their own way. The interpretations given to them by their caregiver offer an initial matrix within which to build survival strategies, closely followed by the belief system of their community and religion. To build and develop their resilience, children need this inter-connected support, which gives them greater inner security and control over their environment. With this as a basis, they can recover their growth with greater serenity.

A. Explanations given for the tsunami

To learn about the different meanings which children and parents were able to give to the tsunami, we used the concept of locus of control, as part of the risk and protection factors which influence the development of resilience.

Some people think that their capacity to cope depends solely on themselves – what we can call an internal locus of control – while others think that they depend on others or on chance: an external locus of control. This is generally the case for individuals who consider themselves helpless victims. In the Resiliency Scale Questionnaire (RSQ), a number of questions on the tsunami showed whether the child spontaneously attempted to protect him/herself using his/her own resources, or whether he/she was convinced that only an adult could save him/her. The impact of this perception of oneself on the beliefs about the tsunami and its consequences will be determinant for the future of the child and family.

We shall now examine the causes mentioned to explain the tsunami, as listed by families[23]:

Explanation	2005	2006
God's will	33 %	31,2 %
Submarine earthquake	31 %	38 %
Don't know	15 %	0,4 %
God's punishment for our sins	9 %	9,7 %
The evils of modern man	8 %	10,1 %
Natural disaster	2 %	0,8 %
Nuclear bomb trial	1 %	0,4 %
Poverty	1 %	0 %

Table 10 Causes invoked for the tsunami by caregivers, by year

Caregivers favour a religious explanation of the tsunami, God's will and punishment, over a more natural cause. The omnipresence of religion in Sri Lankan life can explain such a position.

Indeed, we can regroup explanations in three categories, as follows:

Explanations	2005	2006
Natural causes	39 %	43,2 %
Divine causes	50%	45,5 %
Human causes	11 %	11,3 %

Table 11   Categories of explanation for the tsunami by caregivers, by year

In 2005, divine origin were more frequent, cited by one caregiver out of two, while natural causes were only cited by 39%. On the other hand, in 2006, divine origin declined in favour of natural causes. As for the children, they explained the coming of the tsunami a little differently:

Explanations	2005	2006
God's will	20 %	23,1 %
Submarine earthquake	46 %	51,6 %
Don't know	19 %	5,4 %
God's punishment for our sins	10 %	11,1 %
The evils of modern man	5 %	7,4 %

Table 12 Causes invoked for the tsunami by children, by year

[23]The 2005 results in this section are taken from the 2005 sample of 414 children

Contrary to their caregivers, and even though religion was important for them, children favour more natural explanations – as much in 2005 as in 2006. It is possible that the children were better informed than their caregivers on geo-climatic phenomena because of television or school – or even Internet.

We can likewise regroup these explanations by category, as follows:

Explanations	2005	2006
Natural causes	56 %	55,3 %
Divine causes	37 %	36,7 %
Human causes	7 %	8 %

Table 13 Categories of explanation for the tsunami by children, by year

The fear of another tsunami, which we have noted previously, was greater among children, especially in 2005. This is perhaps linked to the fact that they considered, more than their caregivers did, that this phenomenon had a natural cause, i.e. it was a vagary of nature over which they had little control. To perceive the tsunami as a divine punishment gives some indirect measure of control: it's enough to be a better person for the phenomenon not to recur. On the other hand, if the causes were natural, there can be no control over the coming of another tsunami, creating greater fear.

B. The locus of control

a. Relation of children's locus of control on the causes invoked for the tsunami

As we have just said, the locus of control returns to the question of personal control and of control over events which affects the lives of everyone. As we have seen previously, people who have a strong locus of control consider that their lives depend on themselves, while others with a weak locus of control see themselves as a pawn of events and of destiny[24].

Children's locus of control was measured with the aid of several scenarios in the Resiliency Scale Questionnaire (section 4), which provided a score between 6 (weak locus of control) and 13 (strong locus of control)[25].
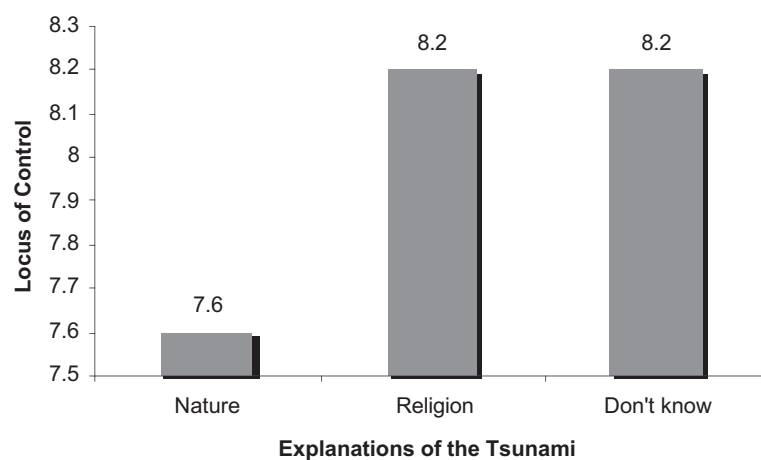

Figure 28   Relation of locus of control on explanations invoked for the tsunami in 2005

[24]The results presented in this section are taken from the 2005 sample of 414 children
[25]cf. Beauvois, 1994; Beauvois & Dubois, 1988 ; Dubois, 1987, 1994

Locus of control is higher where children do not evoke a natural explanation of the tsunami (statistically significant effect of p <.02). This seems to confirm the explanation advanced above: a natural explanation of the tsunami leads children to consider themselves as a pawn in events.

However, the role of the locus of control seems to have been reduced: it had no effect either on well-being or on perceived vulnerability among the children. Neither is it affected by children's dysfunctional behaviour, nor by the trauma level of parents.

b. Effects of children's locus of control on density of social networks

The idea that a strong locus of control is an important part of a person's identity is typical of Western culture, where individuals conceive of themselves as masters of their own destiny. It seems to be a less important factor in a country like Sri Lanka. In effect, in more community-centred cultures, an individual's control over his/her destiny and environment seems to be less important than in the West [26].

This is clear from the following results:
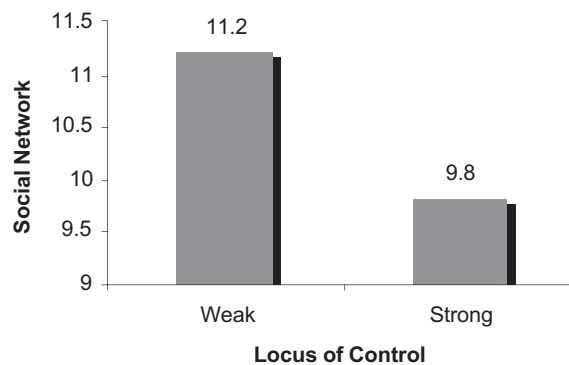
Fig.ure 29 Effects of the locus of control on social networks in 2005

Where children have a weaker locus of control, they have a denser social network than where they have a strong one (p <.03). This seems to confirm the inexistence of individual control over what happens: the community seems to take charge of control over events and the destiny of each member of the group. Inversely, where an individual shows a strong locus of control, and thus a certain independence in regard to the community, he/she has a less dense social network, and thus less need to mobilise social resources.

Discussion

The locus of control is a Western concept and is difficult to apply to a culture where community and family life is central to the child's development. We should thus be wary of exporting our theoretical models to countries they are little adapted to. Because of this lack of fit, the results for locus of control in 2006 have not been analysed.

[26]In regards to these results, refer to the work of Hofstede (1980) and of Triandis (1989) on the measures of individualism and communitarianism, as well as work by Hiesh, Shybut and Lotsof (1969); Lao (1977); Szalay, Strohl, Fu and Lao (1994), or Weber, Hsee and Sokolowska (1998) on external control and the perception of risk among Asian populations.

4. At the heart of the child's social network: school and recreation centres

A. Children and school

Apart from family, school is at the heart of children's social networks throughout the world. After a life-destroying disaster, school is the one place which offers the resources for recovery. If the schooling conditions are good, school is a factor of protection. But after a disaster, it may well be a risk factor. In this case, school would no longer be a way to develop well being and resilience.

The Sri Lankan school system is, it seems, one of the best in this area of the world, and the literacy rate in 2004 was over 90.5% (UNICEF). Despite the tsunami's destructions, the majority of schools were soon re-opened, and many children were back to school at the time of the first survey. That said, much of the teaching personnel were missing, and those who attempted to put together the pieces of a school programme did not manage to provide a level of teaching satisfactory for the caregivers or their children. It also seemed that they themselves were often in a high degree of trauma, and there was widespread absenteeism[27].

The section of the Resiliency Scale Questionnaire (RSQ) concerning the schooling as a factor of risk and/or protection, provides information on two levels: the personal difficulties which children may have, and the environmental obstacles to their studies. The table below gives the list of personal difficulties according to caregivers and children:

	Caregivers	
	2005	2006
No difficulty	51 %	40,9 %
Doesn't work hard enough	19,3 %	21,5 %
Doesn't understand	10,2 %	12 %
Doesn't respect the rules	6,6 %	9,9 %
Doesn't get on with other children	3,9 %	3,7 %
Other	8,0 %	9,5 %
No answer	12,3 %	2,5 %

Table 14 Personal difficulties encountered at school described by caregivers, by year (N = 414)

Overall, caregivers consider that their children do not have difficulties at school (51% in 2005, 40.9% in 2006). Incomplete work and difficulties of understanding come after.

[27]We note here that it was not possible for us to study the scholarly progress of the children of our sample, nor to question teachers

	Children	
	2005	2006
Don't work hard enough	11,7 %	11,2 %
Don't understand	16,2 %	19 %
Don't respect the rules	11,5 %	15,3 %
Don't get on with other children	11,2 %	10,3 %
Other	8,5 %	34,3 %
Other	40,9 %	9,9 %

Table 15 Personal difficulties encountered at school according to children, by year (N = 414)

Fewer children responded to this question in 2006 (9.9%) than in 2005 (40.9%) – perhaps because they had not yet returned to school. However, overall, the difficulties were similar. The greatest change was in regard to the choice of 'Other': over 34% of children felt there were other sources for their difficulties at school in 2006. We can hypothesize that difficult living conditions and civil war were some of the problems.

We also asked the caregivers and children to estimate what were the external obstacles to good schooling.

	Caregivers		Children	
	2005	2006	2005	2006
Poor teaching	15,9 %	13,6 %	22,2 %	13,6 %
School is too far away – transport difficulties	52,3 %	28,5 %	48,5 %	35,1 %
Changes/problems in the family	18,8 %	9,1 %	15,2 %	9,1 %
Little or no school support	8,3 %	4,5 %	7,7 %	5,4 %
Other	4,7 %	39,7 %	6,4 %	27,3 %
No answer	32,9 %	4,5 %	28 %	9,5 %

Table 16 External obstacles to schooling, by year (N = 414)

Other obstacles include: life in the camps, repeated absence of teachers, absence of caregivers, economic difficulties (low income, endemic poverty), lack of water, lack of teachers, etc.

We may first of all note that in 2006 the level of non-response was much lower, both among caregivers and children. The principal problem was the distance to get to school. Nevertheless, this problem is a little less salient in 2006, which leaves us to think that the reconstruction of schools and housing had continued over the previous year. Family changes and problems also lost their importance between the two years, which leads us to suppose some stabilisation at home. The lack of support for students' homework, a sensitive subject in 2005, had lost its acuity in 2006 as, in between Tdh had established such support in most of its centres.

B. Children and the recreation centres

The responses given to the section's questions on attendance at the centres were systematically positive, to the point where it is difficult to give any type of interpretation. We have already taken note how difficult it is for caregivers to make critical remarks and thus giving the impression that they did not appreciate Tdh's work. The criticisms came instead from the supervisors and animators in regard to the maintenance of the centres, the difficulty of holding some activities because of the sandy ground, and because there was too much to do in little time.

Yet, during our visits to the different centres, we often witnessed scenes which demonstrated the children's happiness in being there and the affection they had for the animators. And reciprocally so!

Beyond this more than favourable welcome, we can note one tendency: the general satisfaction in regard to the recreational centres had however slightly dropped between 2005 and 2006:

Questions	2005 Score	2006 Score	Statistical Effect
I'm happy to go to the Tdh centre	5,9	5,8	p < .002
The games at the centre do me good	5,8	5,6	p < .001
I like to play with others while I'm at the centre	5,8	5,7	p < .04

Table 17 Children's appreciation of the recreation centres (N = 242)

Reading this table, it should not be forgotten that appreciation of the centres is measured on a scale from 1 (bad estimation) to 6 (positive estimation). The averages in this table, oscillating between 5.6 and 5.9, are extremely high and show the more than positive appreciation of the children and their caregivers.

Even if the children remain very satisfied with the recreation centres, the drop is statistically significant for the three questions. This does not mean that the centres are less well perceived, given that the high scores continue, but may simply indicate the reduced need of children to be accompanied and monitored. The results are similar for the parents:

The results are similar for the parents:

Questions	2005 Score	2006 Score	Statistical Effect
The child is happy to go to the centre	5,9	5,6	p < .0001
Number of days per week at the centre	4,7	4,4	p < .001
The child feels better for going to the centre	5,8	5,5	p < .0001

Table 18 Caregivers appreciation of the recreation centres (N = 242)

Overall in 2006, both caregivers and children were better and – as a result – were less dependent on the recreation centres than in 2005.

After the disaster: hopes and concerns

<div align="right">8</div>

1. Worries and visions of the future

Trauma clinicians recognise that one of the important signs of traumatic stress, over the medium and long term, is the loss of hope of a better future. The brutal confrontation with death creates a crisis about the precariousness of life: I could die, right here, right now! Hope can become an important indicator that shows if children and caregivers' resiliency has returned in the years after a disaster. It can also indicate the emotional zones at risk where the child has difficulty in recovering, as well as the actions to take at the recreation centres to favour his/her protection.

We have thus placed at the heart of the Resiliency Scale Questionnaire (RSQ), a series of questions on the immediate concerns and worries of children and their caregivers, as well as questions on their dreams for the future.

A. Worries and concerns of children and caregivers

Clinically, the propensity to worry is part of anxiety disorders. Scales of worries and concerns are often used, in Public Health as well as in Social Psychology. In the frame of humanitarian research, one of these scales has been used, for example, in the Gaza Strip by Colin MacMullin (1999)[28], to evaluate the degree of anxiety of children in Palestinian camps, the type of worries they had, their number and whether they were different from those of their caregivers (which was the case). This exploration rests on the desire to favour the expression of the children by themselves. In effect, in emergency situations, it is always adults who are the subject of enquiries – if they are questioned at all.

When the caregiver comes to register his/her child at a recreation centre, it is his/her concerns and distress which will be listened to at the time. For animator's support to be effective, the concerns and worries of their small beneficiaries should be listened to. We have seen in the first part of this report that the recreation centres work through the interactions of three populations: not just the children, but the caregivers and the animators are also distressed and need to be listened to. In the final run, it is as important to listen to adults as to children.

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[28]Colin Mac Mullin and Maryanne Loughry (1999) A Method for Identifying and Understanding the Concerns of Refugee Children and Adolescents

A. Worries of children and caregivers in 2005[29]

WORRIES	PERCENTAGE
Fear of another tsunami	**19 %**
Death of someone close	6 %
Difficulties in studying	6 %
Destroyed housing	4%
Being beaten by family or teacher	4 %
Poverty	3 %
Mother's absence	3 %
Problems in getting to school	3 %
Uncomfortable living conditions	3 %
War	3 %

Table 19 Worries and concerns of children in 2005

Thus in 2005, almost 20% of children feared another tsunami. We can see that this fear is the most frequent, and the strongest. The second worry, the loss of a close relative, was evoked by only 6% of the children. This corroborates our conclusion on the perceived vulnerability of children, which was strong in 2005.

WORRIES	PERCENTAGE
Destruction of housing	**15 %**
Children's education and future	**14 %**
Poverty	**12 %**
Unemployment	7 %
Fear of another tsunami	7 %
War	6 %
Sickness of someone close	4 %
Death of someone close	4 %
Uncomfortable living conditions	3 %

Table 20 Worries and concerns of caregivers in 2005

Adults are themselves more worried about the material conditions of their existence: destroyed houses, poverty, their children's future and unemployment. Fear of another tsunami seems almost secondary in comparison to the problems of daily life, even if it is cited by 7%. Despite the often insurmountable obstacles to rebuilding their lives, adults potentially have greater means to act upon their environment and their lives, and thus have control over their worries, than their children do.

[29]Worries and concerns are taken from the 2005 sample

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A.2 Worries of children and caregivers in 2006

WORRIES	PERCENTAGE
War	**17 %**
Difficult living conditions	**13 %**
Studying	**12 %**
Fear of another tsunami	7 %
Death of someone close	7 %
Being beaten	7 %
Worries linked to the tsunami	6 %
Poverty	5 %
Illness/injury	4,5 %
No worries	4,5 %
Alcoholism in the family	3 %

Table 21 Worries and concerns of children in 2006

We can see here that priorities changed between 2005 and 2006. The main worry is now the civil war, which had resumed in the year between the two surveys – cited by 17% of the children.

WORRIES	PERCENTAGE
War	**33 %**
Living conditions (inc no housing)	**25 % (19 %)**
Poverty	**20 %**
Children's study	**16 %**
Unemployment	**13 %**
Worries about the child (and their future)	**12 %**
Illness/injury	6 %
Alcoholism in the family	4 %
Death of someone close	4 %
The future	4 %

Table 22 Worries and concerns of caregivers in 2006

As for the children, in 2006, caregivers were preoccupied by the war. This worry was widespread, given that it was cited by 33% of caregivers. At the same time, as in 2005, the major preoccupation among caregivers remained their means of subsistence and the future of their children.

Discussion

The worries of children and their parents can be regrouped in three general categories:
Environmental (fear of another tsunami, fear of civil war), emotional (death of someone close, separation, illness in the family, injuries, fears and worries for the future, being beaten, alcoholism in the family), and material (destroyed housing, difficult living conditions, poverty, loss of property, economic difficulties, unemployment, difficulties to study).

We shall go through the most interesting results according to these three categories:

a. Environmental

In 2005, the fear of another tsunami was a recurrent concern, both for children and for parents (it was often cited first), although more for the former (19% against 7%). In 2006, on the other hand, this worry had receded: it was invoked by only 7% of children. Nevertheless, two years after the tsunami this theme remained important for the children, and was linked to other concerns: the death of someone close or troubles in daily life due to the tsunami's consequences. For parents, on the other hand, this concern had completely disappeared and had been replaced by worries about the war. Although this had been present for both children and parents in 2005, its importance had increased: 33% of caregivers cited it, and 17% of children.

b. Emotional

In 2005 and 2006, children seemed to be particularly affected by the experience of death (family and relatives), showing that grief continued to be a weight in their lives. Contrasted with concerns about the war resuming (17%) and lasting fears of another tsunami (6%), the traumatic picture and risks weighing on the child's psychosocial development are not negligible. Add to this, in 2005, mother's absence (3%): in many cases, she had had to work for long months in the United Arab Emirates to ensure the rest of the family's survival. However, this item is no longer mentioned in 2006, which could be read as a certain independence from the family, as we have already noted.

Equally so, in 2006 there are new concerns of the child in regard to the family: 7% of children say they are worried about being beaten in 2006, against 4% in 2005, while the worry about a problem of alcoholism in the family appears for the first time (cited by 3% of children, and 4% of parents). This worry about being beaten – whether by teachers or within the family (father, mother, or older brothers and sisters), will be further examined.

Fear for the future, whether in general or for children specifically, was invoked mainly by the caregivers: they were concerned for the future of their children, specifically about their education and studies. Children were also concerned about the same issues, but their problems were above all material – as we shall see below. In 2006, concerns about the children had decreased a little among the caregivers' worries, and could be divided in two categories: (a) child's studies (failure at school) for 16% of caregivers, and (b) general worry about the child him/herself and their future (for 12% of caregivers). Thus, the child is the objective of particular attention, as for the preceding year.

c. Material

In 2005, parents were also very concerned about the lack of permanent housing (frequently cited first). This concern was less important for children, but they mentioned difficulties of studying in their living conditions (noise, lack of space, lack of equipment, problems in getting to school such as long distance, fear of being abducted, fear of crossing the jungle…).

In 2005, parents and children spoke more of life in the camps as a source of worry. This included difficult living conditions, whether in terms of access to water and latrines, close proximity to other families, heat created by corrugated iron roofs, etc. These problems were nevertheless a side-issue in regard to other more important ones, in the sense that they were not frequently cited, or not cited first.

On the other hand, this theme had more importance in 2006. Living conditions were cited by children (13%), always in essentially material terms (distance to school, isolation, etc.). In 2006 as well, for caregivers, living conditions came right after concern about the war, while 19% of them said that the absence of housing was a major worry, though in the previous year only 15% noted their destroyed housing. The reconstruction of homes thus seems a particularly important task to take care of for the larger part of the Sri Lankan population affected by the tsunami. Poverty was also a growing cause for concern: 20% of caregivers cited it, against 12% in 2005. The result is similar for unemployment (13% in 2006, against 7% in 2005).

Finally, a comforting result – we can see that in 2006, 4.5% of children declared they had no worries, which was evidently not the case in 2005. This is a real sign of resilience. On the other hand, caregivers seemed doubly worried by the context of war and by the perspective of a grim future, whether in terms of housing, work, or the future of their child, in the context of civil war.

B. Children and their vision of the future

One of the marked signs of post-traumatic stress syndrome (PTSS), as we have seen, is the absence of a vision for a future in traumatised individual. In the second phase of post-tsunami reconstruction, the depressive phase, the capacity of imagining a positive future can be a driving force for the community. It supports the individual's and group's motivations to recover from tragedy and can be considered a protective factor.

How do you see your future?	2005	2006
Become a teacher	31,3 %	28,9 %
Become a doctor	23,2 %	36,6 %
Have a job	6,5 %	3,8 %
Help my family	5,8 %	2,8 %
Help others	4,2 %	1,2 %
Become an engineer	3,5 %	5,6 %
Study	3,1 %	1,2 %
Have a job like a bureaucrat	2,3 %	2 %
Work in social services	0 %	6 %

Table 23   Children's vision of the future[30]

[30]Children's vision of the future in 2005 is taken from the 2005 sample (414 children)

In general, the responses given were positive: almost all the children had a goal in life, both in 2005 and in 2006. Although this result may seem surprising, it should not be forgotten that optimism is one of the protective factors most often cited and a characteristic of resilience. It may also be that it is a cultural characteristic in Sri Lanka.

There were differences between 2005 and 2006: children preferred to be a doctor than a teacher. The importance of helping others was less strong (helping family or others) in 2006, but the desire to work in social services appeared for the first time. Possibly the example of the animators and social supporters in the recreation centres had suggested certain ideas for a professional life.

2. The question of beaten children

A. The state of the question in Sri Lanka

The issue of corporal punishment, both at home as well as at school, is among the most important risk factor in the recovery of children's emotional health, especially after a disaster: when a grieving child establishes a particularly strong and anguished connection with the sole surviving member of the family, who then beats him/her, it is easy to imagine the terrible conflict he/she goes through.

This issue is contained within the framework of the United Nation Convention on the Rights of the Child (art.32), and is not simply a cultural issue. The Sri Lankan government signed and ratified the Convention in 2002 and thus has an obligation to legislate and monitor in the same way as all other signatories to the treaty.

In this respect, Sri Lankan lifestyle in 2006 seems to lag behind in this field. As yet, there is no legislative ban on beating children, whether at home or at school. This ban exists only in regard to its use as an instrument of punishment within the penal system.

B. Inventory of the question in Tdh recreation centres

In section 4 of our Resiliency Scale Questionnaire (RSQ) for the children, four short stories allowed the evaluation of their ability to control and move beyond their fears. This was part of the locus of control evaluation (see above). The themes were chosen on the basis of a previous mandate given by Tdh to Dr. Jo Boyden et al. in the same region, two years before the tsunami. The team noted in their report the four main worries children had: fear of snakes, fear of ghosts, fear of road accidents, and fear of being beaten[31]. Each short story in our questionnaire was illustrated by a comic strip, which we attached to the RSQ in order to help the youngest (5 years and over) to answer. However, even the teenagers thoroughly enjoyed it!

For the story which was specifically related to a beaten child, we did not give a direct question of whether he/she had really been beaten, and by whom, but rather in an indirect manner: "Do you have a close friend who is often beaten by their parents?" in order not to provoke the child's natural reaction to protect his/her possible abusive caregiver on such a sensitive subject.

Almost two child out of three said he had a friend who was frequently beaten by his/her parents (see table below). Furthermore, in our preceding investigation on the concerns and worries of children (see Table 21), that of being beaten (by a member of the family or a teacher) was 4%.

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[31] There was also a story about a kidnapping by a soldier, but we took it out of the questionnaire for obvious reasons.

Do you have a close friend who is often beaten by their parents?	2005	2006
Yes	63,5 %	54,5 %
No	34,5 %	45 %
No response	2 %	0,4 %

Table 24 Having a beaten friend, by year

It thus seems that being beaten is a widespread phenomenon and does worry Sri Lankan children. Protection officers wouldn't say anything to the contrary!

One may ask the question of a possible link between the concern of 'being beaten' and declaring 'a friend who is beaten by their parents'. A statistical technique (Kh2) provides the answer to this question:

	Worry about being beaten	No worry
Having a friend who is beaten	**.29**	-.02
No friend is beaten	**-.53**	.03

Table 25 Weighted deviation (Kh2) between "being beaten and a beaten friend"

Children who worried about being beaten (from Table 23 of worries) are over-represented among the children who say they have a friend who is beaten by their parents ($p < .05$). Conversely, these children are under-represented among the children who say they don't have a friend who is beaten by their parents. We can thus suppose that the children who say they have a beaten friend are worried and possibly even beaten themselves.

Given this link, the second question we may ask is that of the impact of the concern about being beaten on the dysfunctional behaviour of children.
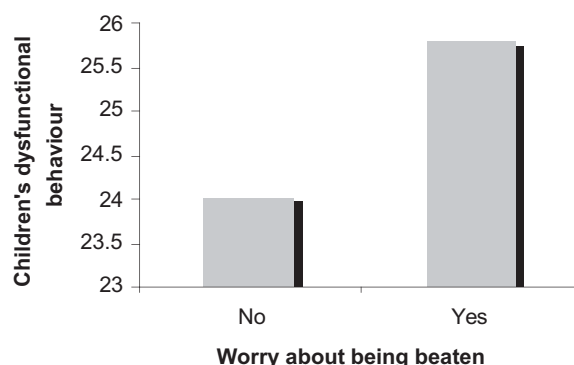

Figure 30 Effects of the worry about being beaten on children's dysfunctional behaviour (estimated by caregivers)

Children who said they were worried about being beaten had an SDQ score tangentially higher than those who were not worried (tangential statistical effect of p <.08). Nevertheless, these results should be treated with caution: they do not clearly mean that beaten children have a higher level of dysfunctional behaviour, since we do not know for sure whether they were beaten, but only that they worried about it.
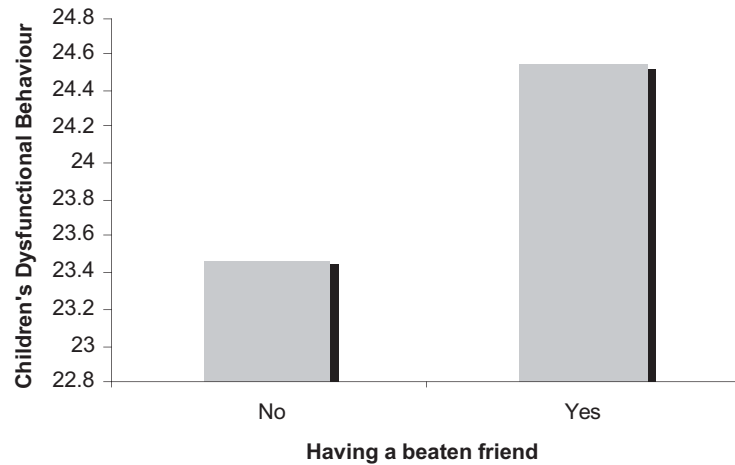

Figure 31   Effects of the declaration "have a friend who is beaten by their parents"
on children's dysfunctional behaviour (estimated by parents)

Here again, the children who said they had a friend who was beaten by their parents had a higher SDQ score than children who did not have a beaten friend (statistically significant effect of p <.03). These results should also be treated cautiously, but we can suppose that children who spoke of a beaten friend were concerned as well, and that the fact of being beaten affects the level of dysfunctional behaviour.

From our analysis, we found that worry about being beaten does not have a direct effect on children's well-being but it does work on their perceived vulnerability:
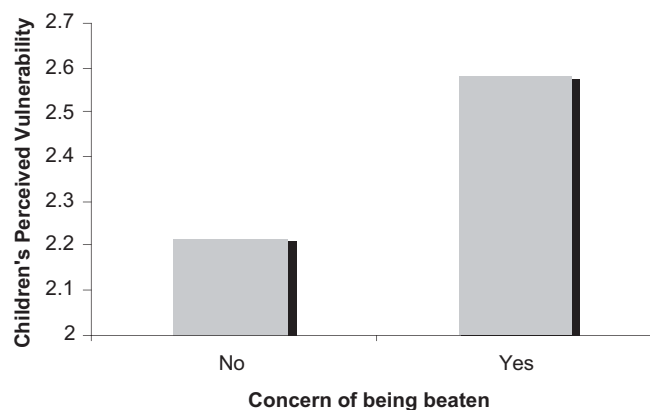

Figure 32   Effects of the concern of being beaten on children's perceived vulnerability

Children who said they were worried about being beaten felt more vulnerable than children who did not have such a worry.

Discussion
The results obtained are interesting when connected to Child Protection work in the context of Tdh's programme. It would be interesting to refine our tools, in order to improve the detection of risks at the recreation centres, and thus facilitate their transfer into the framework of the Case Management System.

Other protective factors

1. Hygiene as a protective factor

The issue of hygiene and one's outward appearance in one's social life is central to Sri Lankans – and even more strongly so after such a disaster. Dirt, absence of clean water and the necessity of a long walk to fetch it, absence of latrines, lack of privacy in the camps, risks of infection and illnesses, etc., are all reasons why hygiene is not just a health or disease prevention issue. In a psychosocial perspective, self-esteem, which is closely tied to the hygiene issue –is often lost after such massive trauma. In many respects, such a situation can become a synthesis of all the risks for physical and emotional health – for adults as well as for children. In a programme such as that of Tdh, it thus becomes key, in the first days after a disaster, to furnish not just the material items for the improvement of living conditions, but to establish educational projects to develop this protection factor[32].

It was for all these reasons that Tdh, from the start of its intervention in 2005, distributed 1,500 toilet kits in the camps, and established health education classes in most of the recreation centres (including an introduction to the SODIS method for water disinfection by solar radiation, basic nutrition rules, mosquito control, latrine hygiene and correct use of bins, etc.). Furthermore, courses were made available to parent committees in the areas of AIDS, family planning, family nutrition, the prevention of diseases such as cholera or chinkunguniya.

We can thus see that the Tdh programme does not target hygiene only as health protection. It helps to improve the self-esteem of children and their caregivers – and the whole psychosocial aspects of community life.

1.2 The results of our study about hygiene

In the second section of the Resilience Scale Questionnaire (RSQ), the questions are focused only on the child's washing and body cleanliness. We had the following results:

Caregivers	2005	2006
Material conditions don't allow it	75,2 %	32,2 %
The child refuses to wash	12,2 %	2,5 %
You don't think it's important	2,2 %	2,1 %
The child doesn't wash unless reminded	9,5 %	6,6 %
No response	46 %	56,6 %

Table 26 Difficulties in maintaining good hygiene, according to caregivers, by year

[32]The results presented for 2005 in this section are taken from the 2005 sample (414 children)

In the caregivers' view, material conditions were 75.2% responsible for their children's hygiene in 2005. This seems to have been greatly improved in 2006, since only 32% of caregivers felt it was the reason then. Children were also more willing to wash than in the previous year.

Nevertheless, there is a high rate of non-response in both years. We can suppose that this is due to the social sensitivity of the issue, and that caregivers do not wish to respond: recognising that one's child has hygiene problems does not help rebuild a positive social identity!

Children	2005	2006
It's too difficult to wash where I live	87,5 %	44,2 %
I don't like it, I don't want to	5,2 %	2,5 %
My parents never ask me	6,6 %	4,1 %
I never think of it	5,6 %	2,9 %
No response	27,9 %	46,3 %

Table 27 Difficulties in maintaining good hygiene according to children, by year

Children also cited living conditions as causes for hygiene problems – conditions which were more problematic in 2005 than in 2006. Contrary to their parents, the children never said they did not like to wash, but rather that their parents did not care about the matter. It is interesting to see that the children's points of view are not the same as the parents'.

Again, we can see a high rate of non-response, especially in 2006.

Animators	2005	2006
Material conditions don't allow it	65 %	39,3 %
The child refuses to wash	7,2 %	0,8 %
You don't think it's important	15 %	7,4 %
The child doesn't wash unless reminded	12,8 %	11,2 %
No response	22,7 %	41,7 %

Table 28 Difficulties in maintaining good hygiene according to animators, by year

Discussion

The question of meaning given to hygiene as a factor for better self-esteem, and thus of protection, is eclipsed by extremely difficult contextual conditions, even in 2006 at the time of the second survey.

2. Self-esteem as a factor of protection

Self-esteem, a part of everyone's need to have a positive image of him/herself, is based on the success one may have in what he/she does in life and is a major protection factor. In this sense, it needs to be the driving force behind an intelligent construction of any recreational activity programme.

First of all, we note here that self-esteem is generally good: 5 out of 6 in 2005, and 4.6 out of 6 in 2006. This is the identified effect on subjective well-being: children try to present themselves in the best light. We can remark however that self-esteem diminished between 2005 and 2006 (p <.0001). Are these long-term consequences of the tsunami? Or of civil war? We have already seen (especially in the chapter on the recreation centres) how a number of factors could serve as an explanation. Unfortunately, further exploration is beyond the limits of this study.

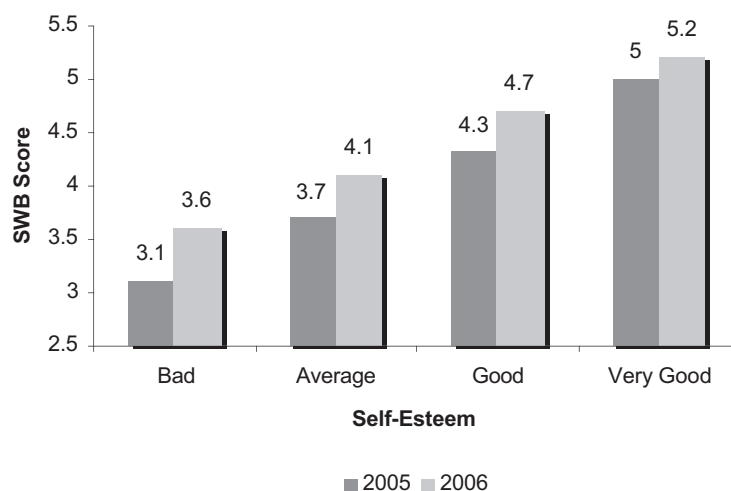## 2.1 Effects of children's self-esteem on their subjective well-being

Figure 33 Effects of Self-esteem on SWB

We can see here that children's self-esteem has a clear effect on their subjective well-being – as much in 2005 as in 2006: the higher the self-esteem, the stronger the well-being (p <.0001 in 2005 and in 2006).

This particularly salient result illustrates the importance of this protection factor in improving children's well-being.

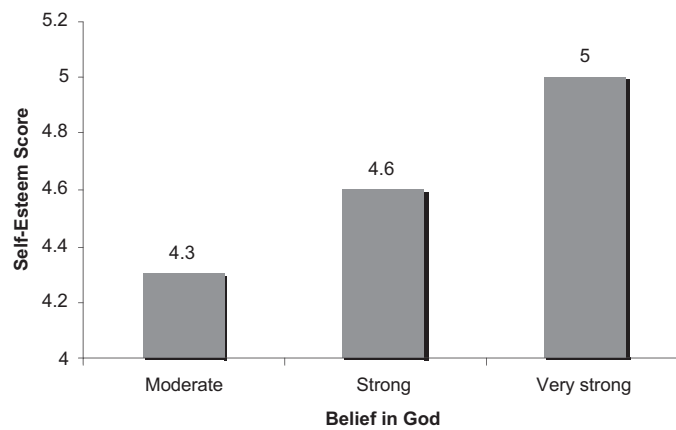## 2.2 Effects of the belief in God on children's self-esteem

Fig.ure 34 Effects of belief in God on self-esteem in 2005[33]

In 2005, we can see that belief in God plays an important role on children's self-esteem: the stronger the belief, the better the self-esteem (p <.0001).
This effect was again very significant in 2006 (p <.0001).
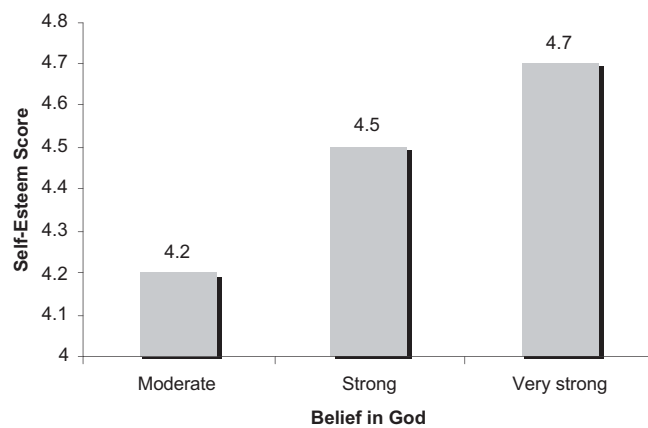

Figure 35   Effects of belief in God on self-esteem in 2006

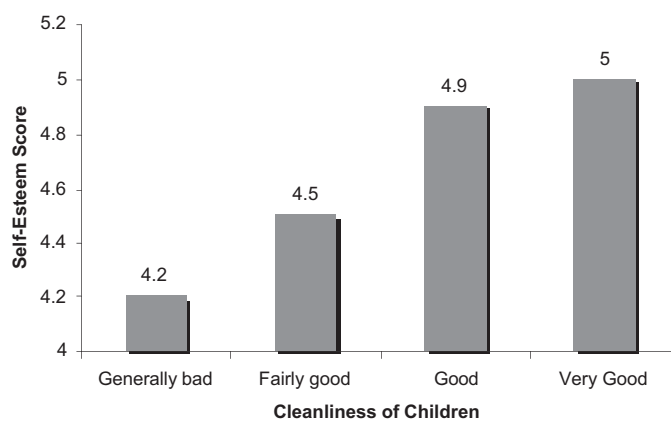## 2.3 Effects of hygiene on children's self-esteem

Figure 36 Effects of hygiene on self-esteem, 2005[34]

[33]Effects of belief in God on self-esteem is taken from the 2005 sample (414 children)
[34]The effect of hygiene on self-esteem is taken from the 2005 sample of 414 children

In 2005, not one animator said that the children's cleanliness was "bad" or "very bad". Nevertheless, an overall difference exists on the remaining levels of the scale: mediocre hygiene led to a weaker self-esteem (p <.0001). This is also a very interesting result and draws attention to the importance of cleanliness on self-image, and by extension well-being.

The 2006 results lead in the same direction, but for technical reasons had to be recoded in just three categories:
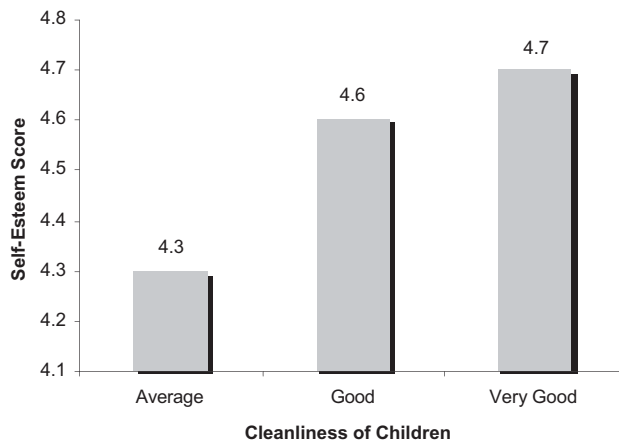

Figure 37   Effects of hygiene on self-esteem, 2006

In 2006, children's hygiene had the same effect on their self-esteem (p <.003).

2.4 Effects of satisfaction at school on the self-esteem of children
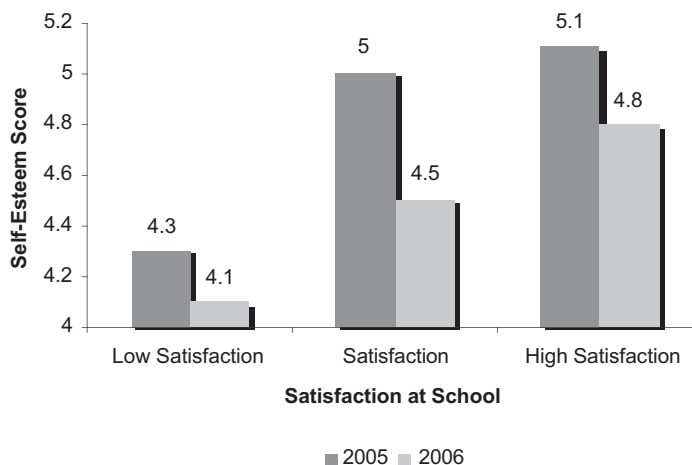

Figure 38   Effects of satisfaction at school on self-esteem

Satisfaction at school also plays an important role in children's self-esteem: the greater the satisfaction, the better the self-esteem (p <.002 in 2005 and p <.0001 in 2006).

Discussion

Self-esteem is thus an important protective factor, affecting the well-being of children and modified by several variables (such as children's hygiene, but also satisfaction at school, belief in God, and the importance given to religion). Recreational activities will have a major role to play here.

The major role of the recreation centres as a protection factor

We will now show how the role of the Tdh recreation centres has been particularly instrumental – in regard to other factors of protection – in the positive development of children's well-being.

Let us summarize the global results obtained from the analysis of indicators and factors of risk and protection in 2006. We had chosen the following two indicators:

■ the dysfunctional behaviour of children, which has noticeably reduced;
■ the subjective well-being of children, which has improved.

We have also chosen the following as factors of risk and protection:

■ perceived vulnerability, which has diminished;
■ parents' trauma, which is less high;
■ social networks, which are less dense;
■ self-esteem, which has lowered;
■ health, which has remained stable;
■ school, religion and recreation centres which have less importance

Taking into account uncontrollable variables, such as the context of civil war and other factors which have deteriorated, we can say that the recreation centres have definitely helped children to get better. To confirm the strength of such a result, it would have been necessary to compare the children cared for by Tdh with those who were not, such as in a control group. However, this was unfortunately impossible in such an emergency context, mainly for ethical and organisational reasons.

One particular statistical analysis, the multiple regression analysis, allows the measurement of the combined effect of all the risk and protection factors on the development of subjective well-being and dysfunctional behaviour of children[35]. By eliminating the effect of these factors, we can thus estimate the real effect of the Tdh programme on the improvement of children's condition.

We thus saw that three factors worked primarily on the development of children's well-being and the reduction of their dysfunctional behaviour between 2005 and 2006:

■ their self-esteem;
■ the belief in God;
■ the consequences of the tsunami.

This result does not mean that the other factors have less importance: they affected the levels of well-being and dysfunctional behaviour of children, but not necessarily their development over the two years.

[35]The exact procedure consists in keeping these factors constant.

A. *Effects of self-esteem on the development of subjective well-being and dysfunctional behaviour between 2005 and 2006*

Where self-esteem measured in 2005 went up by one point, the subjective well-being score went up by 0.47 points (p <.002). In other words, having good self-esteem in 2005 favoured a positive development of well-being between the two years. In the same way, where self-esteem in 2005 went up by one point, the dysfunctional behaviour score went down by 1.61 points (p <.04).
Thus, children's self-esteem in 2005 is an important protection factor, in the sense that it improves the development of children's well-being and reduces their dysfunctional behaviour over one year.

B. *Effects of children's belief in God on the development of well-being and dysfunctional behaviour between 2005 and 2006*

Where belief in God measured in 2005 went up by one point, the SWB score increased by 0.54 points (p <.01). Additionally, where belief in God measured in 2006 went up by one point, the dysfunctional behaviour of children went down by 2.75 points (p <.003).
Belief in God is thus an influencing factor, in the sense that it improves children's SWB and reduces their dysfunctional behaviour between 2005 and 2006.

C. *Effects of the tsunami's consequences on children's housing and the development of well-being and dysfunctional behaviour between 2005 and 2006*

The tsunami's consequences are the last factor influencing children's development. The SWB score of children diminished by 0.59 points (p <.01) where the consequences of the disaster were major, while the dysfunctional behaviour score went up by 2.5 points (p <.03). Thus, the destruction of housing and the loss of property was a very important risk factor on the children's well-being and dysfunctional behaviour.

D. *Estimating the real effect of the recreation centres on the development of SWB and dysfunctional behaviour between 2005 and 2006*

Thus, only three factors had a major impact on the development of well-being and dysfunctional behaviour between 2005 and 2006. This suggests that the rest of the positive developments noted between the two years are notably due to the Tdh activities and the recreation centres' programmes.
Part of the variance explained here in this analysis gives us some clue on how to explain the tested factors. The analysis presented above shows an average of 40% variance. In other words, around 40% of the development of children's well-being is explained by the factors presented here.
The remaining 60% includes the Tdh action, as well as the risk and protection factors not taken into account in this analysis. Nevertheless, as over a dozen factors – some very important – have been taken into account, we can consider that the major part of the remaining 60% of the improvement in children's subjective well-being and dysfunctional behaviour is attributable to Tdh's work and their recreational centres. This estimate should be further tested, but without a control group from outside of Tdh's programme, we must be content with it.

Furthermore, it should not be forgotten that other risk factors have worked to reduce the well-being of children, especially civil war and its disastrous consequences on the population. However, its effect was impossible to measure within the terms of the present survey. The results obtained by Tdh are only the stronger and more commendable for it.

Discussion

It is difficult, in this analysis, to be categorical for lack of the ideal testing conditions in the recreation centres. However, one may observe the tremendously positive effect of Tdh's work on the children. They definitely are better, especially on the level of dysfunctional behaviour observed in the centres. and over half of the good results seem to be attributed to the Tdh programme.

III

Synthesis, lessons learnt & recommendations

11

This study – a relatively new one in the field of humanitarian psychosocial research – is not intended to be exhaustive, but explores a model of evaluation which, we hope, will be broadened and deepened. Indeed, we have been able to note that the tight network of factors at work on children's well-being and the diversity of situations in the field are infinitely more complex than any theoretical model can incorporate. Even if this model is necessarily reductive, it is still interesting in that it allows us to better understand what is happening and how things are developing.

To summarize again, we have chosen from the start to orient our study on the development of well-being of Sri Lankan children after the tsunami, according to a psychosocial approach. Here again is the model we used:

Trauma level   **RESILIENCY PROCESS**   Subjective well-being (SWB)

t ⟶

Risk factors   *Protection factors*

Well-being was taken not as a static state, such as a set of personality traits, but as an important element at the core of a process which the Tdh programme supports, a process we termed resilience. It is the result of a constant interaction between risk factors and protection factors: children's feelings of vulnerability, human and material losses, parents' levels of trauma, socio-economic status, social network, their health and level of hygiene, school, beliefs and finally self-esteem.

The notion of well-being has also been taken not as a set of indicators of greater satisfaction about self and existence, but as evidence of children's recovery, of their resumed growth and degree of rehabilitation. This is why we position well-being as inseparable from the improvement of resilience.

We shall not repeat the results of this survey in the following pages, but rather take the most salient points in order to see what lessons we may draw and what Tdh could make of it in the future, in its future recreational activity programmes, in other countries.

I. Synthesis of the study

## 1. Subjective well-being and resilience

Our first step was to isolate three indicators: subjective well being, children's feelings of vulnerability after the tsunami, and their dysfunctional behaviour, as signs of a more or less high trauma level and a means to understand the impact of the tsunami on their emotional life.

a. All the survey shows that the children are generally better in 2006. The Subjective Well-Being questionnaire in our Resiliency Scale Questionnaire (RSQ)[37], showed a real improvement over the 18 months of study and, by default, the dysfunctional behaviours of children had notably diminished in 2006, as well as their feelings of vulnerability in regards to another tsunami. Finally, the analysis of factors of risk and protection showed equally that in 2006, children's resiliency level had developed positively.

As already said, to obtain greater precision on the level of subjective well-being, we should have been able to create control groups not attending the recreation centres. But we saw that this was not possible both for logistical as well as ethical reasons.

b. Furthermore, we have been able to identify a major risk factor for the children: the trauma level of the caregivers. This remained very high in 2006, due notably to their worries about the resumption of civil war and its disastrous effects on everyday life and the future of their children. We have been able to show that parental trauma had a direct impact on the child in 2005 as well as in 2006, but that in the latter year the children's well-being was much less affected by their caregivers'. The children had managed to distance themselves a little, and reorient their interests away from the family. We also noted that they were slightly more perturbed by their caregivers' worries than by the difficult environmental factors. This shows that it is crucial in their development to give them emotional stability and positive intimacy with their family, which helps to cope much better with the economic vagaries of the post-tsunami context.

We can also define the chain of following risk factors:

Difficult living conditions	→	Parental level of trauma	→	Children's dysfunction and vulnerability
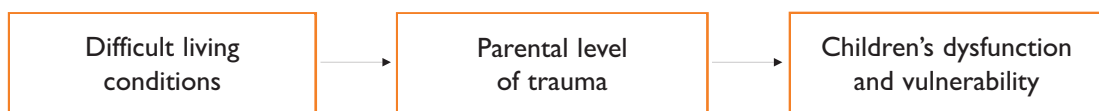
To respond to the material needs of a population in distress is one thing: it is the main function of most complex humanitarian emergency aid programmes (food, health, etc.). But we know that material aid is not enough. It needs to be accompanied by psychosocial programmes which will impact as directly as possible the social and psychological suffering of the child. We can see here that it is also important to include a supportive element to the caregivers in the activities in the recreational centres, to diminish their negative impact on children's dysfunction, as they are the main way-station and buffer between the child and the outside world.

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[36]Inspired from the Andrews & Robinson questionnaire (1991)

2. Impact of social networks on children's well-being

We have seen that the social network can also be a factor of risk and protection – both in its density and in the emotional value the child gives to the people who form part of it.

The primary evidence of this study is that the more people around the child, the better he/she will be. This is particularly true in the immediate post-tsunami period, when he/she will seek any kind of security, especially by sticking to the family. This is confirmed by the fact that the people cited by children in the 2005 survey are essentially members of the family.

In August 2006, which were the second and third post-disaster phases, we saw that the density of the children's social networks had diminished, leaving us to suppose that they had modified their interests towards things which created more autonomy, such as their studies and professional future. The content of the networks confirms this hypothesis, since the family was less present and other people, external to the family network, had entered into the daily life of the child. We can see here that the child is more discriminate about his/her needs, which confirms more resilience. We have included school in our analysis - obviously a privileged place for this kind of development - but also the interplay between recreational activities and social networking, which the Tdh centres can offer in an atmosphere of emotional security.

This part of the questionnaire could later be refined to create a monitoring tool. We were only able to detect, in our survey, the difficulties children had in attending school and a slight drop in interest in the recreation centres. These results are not corroborated by the opinion of the animators and caregivers when talking freely with them in the field; they reflected more the diversification of children's interests and a greater creativity in activities.

What does this mean for Tdh's future psychosocial programmes? First of all, particular attention to the types of activities offered, relevant to the post-disaster phases. In the first phase, the family is central to allow the child to pick up the pieces of his/her development and move on from simple survival. Privileged times to share grief, frustrations and newly found skills, for instance through focus groups, could be offered, as much for the caregivers as for the children, or any other way to give expression to suffering, or information on natural disasters, etc.

After eight months, there is a long-term benefit in proposing group games and activities which help the centres to work better, as well as cultural community days or sports days – which has been done mostly in 2006. The games[38] proposed in the centres were above all group games, board games or role-playing, which allowed children to develop their social skills – indeed, all types of activity which allow children to acquire new social skills and improve their self-esteem.

[37]See in annexes

3. Belief systems and their impact on children's well-being

In the chaos of an emergency intervention, it is difficult to measure the culture shock between Human Rights values brought by the international community and the local culture. A psychosocial programme, introduced by a Western organisation, should know and understand the culture of the country before doing anything. But expatriate staff should also understand their own cultural values – what they hold important, and why. Spiritual choices, in particular, should be as clear as possible. To intervene in countries where religious life is the pillar of collective life cannot be without ambiguity and some conflict.

In this study, we have chosen to analyse belief systems at the heart of the psychosocial dynamic of the centres, by putting particular emphasis on religion, as a sociological entity. We hoped to better understand its impact on children's well-being and sociability. The filters of belief systems act as much as a risk factor as of protection, according to place and circumstances.

Again, according to the post-disaster phase the population is in, we observed different reactions: in 2005, religion was to be included in the picture of the collective shock. Its mediating value in the interpretation of the experience was very strong: religion had a direct and important impact on children's well-being. On the other hand, in the following phase, when life had regained some normality and pressure from an impersonal and powerful force such as a tsunami, had decreased, religious life seemed slightly to wane – even if remaining a major pillar in daily life. Religious practice seemed less infused with terror and was thus more peaceful. In parallel, the children had less fear of a second tsunami, which they also largely attributed to natural causes, unlike their caregivers. Indeed this contributed to the improvement of their well-being.

In creating a psychosocial programme, it is obviously important to respect local belief systems, as they are an essential bearer of recovery for distressed populations. In the recreation centres, traditional games were chosen, as they are part of the Sri Lankan culture. This offered, during moments of terrible fracture, symbolic representation of beliefs, which helped give meaning to what the child saw in and around him/herself, contributing to the restoration of resilience. This first step, planned and coordinated from the start in the Tdh programme, supported the interpretative 'work' around the tsnunami – for example, through reciting legends or tales showing how to escape from dramatic situations. Equally so, the representation of these tales in theatre or traditional dance helped the child to symbolise his/her suffering and move beyond it more easily. Finally, the hygiene programmes, taught in the centres, allowed the creation of a link between society's requirements and the image a child had of him/herself and had an extremely positive outcome.

4. Self-esteem as a factor of protection

Improvement of self-esteem seems to be a natural consequence of the set of protection factors evoked and measured. The child who picks up the pieces, who resumes his/her development, who obtains the affection and encouragement from those around him/her, who acquires new social skills, will naturally have more confidence in him/herself and see his/her self-esteem improve.

We can also see self-esteem as a protection factor that snowballs – bringing in turn more opportunities for development.

Our study has shown the direct and positive effect of self-esteem on children's well-being[39]. It has also shown the close link with religion, school and better hygiene. Self-esteem could thus be utilised as an indicator in programme evaluations to assess the evolution of children's well-being.

5. Development of resilience

We can thus see that children had a natural tendency to pick up their life and a normal course for their development, fairly quickly after the tsunami. Resilience is in effect a normal capacity of any living system to cope with shocks and trauma. It is an identical system which heals a physical injury. But each child, each caregiver, each animator, had their own threshold of tolerance. This means victims should not be let pass this threshold to a point from which they may not be able to return.

This is the objective of the Tdh psychosocial programme and recreation centres. The issue is thus to know whether they can help beyond the natural tendency for resilience. In the previous chapter, close analysis of the data seemed to show that the recreation centres helped in 60% of the improvement of children's conditions.

6. Summary

Returning to our above model, we can now look at the synthesis of elements which essentially played as risk factors. They were: the trauma level of parents – both in 2005 and in 2006; living conditions, such as material losses and family deaths, socio-economic status, feelings of vulnerability – which can be taken as indicators of the child's development towards well-being, as much as a risk factor (on the contrary, we could cite security and the feeling of control over the environment as a factor of protection).

As protective factors we have selected satisfaction at school, social networks, positive interpretation of the belief system – especially in the meaning given to the disaster - security and support offered by religion, good integration in the recreation centres, the child's state of health and good hygiene.

We thus had some tools to help follow the development of children's resilience over eighteen months – that is, their capacity to 'rebound' after the tragedy of the tsunami. In other words, we have criteria to measure the 'emotional elasticity' of the child and his/her degree of rehabilitation.

We also have an important indicator of this elasticity. This is the capacity of children to envisage their future in a more or less positive light. We have seen previously that after a traumatic experience, people do not see themselves beyond a few days or weeks. Whether in 2005 or in 2006 however, the children projected their hopes to a massive degree onto their future – by seeing themselves as doctors, teachers or engineers. What changed from one year to the next, on the other hand, was that in 2005 children wanted to work to help their family – perhaps a natural consequence of the traumatic shock – while in 2006 they sought to escape from family ties: their vision described a professional future oriented more towards their own needs for better opportunities and social status. Healthy autonomy from the family – so characteristic of resilience - shows up again.

[38]See chapter 9

All this means that psychosocial programmes need to put emphasise as soon as possible on protective factors which may facilitate the child's development towards improved well-being. And not putting efforts only on the lowering of risk factors, which are more geared towards issues of mental health. In effect, a programme based on the idea of resilience has a better chance to be more effective, immediately after a disaster as well as in the long term, and at a lower cost.

This is so for several reasons. This approach is:

■ focused on the natural ability of physical and social healing ;
■ automatically including the ideas of psychosocial health and the child's well-being;
■ community oriented, focusing on their psychosocial resources;
■ cost effective;
■ makes the transfer of the programme to the local community easier;
■ respects traditional culture and its 'expertise' in the face of grief and trauma, rather than depending on Western skills in mental health (with their weighty pharmaceutical treatments).

In other words, the concepts of children's resilience and well-being form the psychosocial approach. We do not 'treat' victims or the mentally ill, but support everyone who puts their own resources to work to move on.

II. Recommendations

1. Better monitoring of children's well-being

This study has helped to suggest some indicators of children's resilience and well-being, such as health and the child's sociability and self-esteem, with which we can help create a monitoring tool. Nevertheless, we do not wish to encourage a purely Western perspective: we have proposed to develop such a tool using the community's own resources and see which indicators the centre staff could themselves propose. After all, how could we put into place a system based on foreign concepts, from experiences in foreign countries, perhaps incompatible with local culture, with untrained staff from the start, needing more time to incorporate the NGO's tools, in a post-disaster context, and leaving the children with monthly questionnaires, when they have already been through a few with this study – not to speak of the academic trials of other humanitarian organisations right after the tsunami!

2. Proposal for a monitoring tool

Our research for a monitoring tool began during our last survey in August 2006 and ended up with an evacuation – because of the civil war. This underscores the logistical problems of any survey in zones at risk and thus the difficulties in obtaining data with some scientific accuracy. Nevertheless, we wish to share here our working hypothesis and the beginning of our research, which it would be worth following up with a pilot study and validation missions in other fields.

The basic idea is that this tool should be created entirely by the staff themselves. We thus want to remain faithful to the psychosocial principles of community empowerment and capacity building.

A. During our second mission in August 2006, we asked the staff (animators, social supporters and supervisors) to determine for themselves what they thought were the indicators of child well-being, on the basis of their own experience over the 15 months, by telling us what were, in their opinion, 'the signs which showed the children were doing better'. The answers obtained were fairly similar to those which western animators would have probably produced, but expressed in their own language.

We thus worked towards a definition of well-being and resilience such that the personnel could integrate it in their activities. The table below classifies the responses in four categories of indicators:

SIGNS OF IMPROVEMENT OF CHILDREN'S WELL-BEING

1. Level of interpersonal skills:
a. at group level: better participation in the centre's activities – contributing to group cohesion – flexibility in position within the group (winner/loser/leader/follower) – participation in family and centre's life – better integration in the group – good communication with peers;

b. at family level: obeying adults, helping parents;

c. at social skills level: better kindness and helpfulness – less of foul language.

2. Level of intra-personal or psychological skills:
Creativity and imagination – drawings showing themes other than the tsunami, and the child no longer speaking about it – love of school and learning again – more interest in the benefits of education in regard to the future – a sense of future and resulting goals – playing more and well – reaching out towards others – more frequent spontaneous expressions of joy, laughter – more courageous and enterprising in the face of daily life difficulties.

3. Level of of the child's community life:
More integration in community life – better religious attendance.

4. At the level of physical health
Eating and sleeping better – taking better care of hygiene.

Table 29 Signs of improvement in children's well-being, seen by animators

We can see here that those who work directly with the children have their own tools or intuitions for evaluation and their own indicators. We can also see that the criteria of improvement of the child well-being incorporate much of what our study has covered. This shows that such a monitoring tool must depart from their expertise, their own perception and definition of well-being and resilience.

However, the knowledge of children expressed here is perhaps coming from having worked for 15 months with the children, as well as having undergone some training during that time. But is shows nevertheless, that the local staff taking care of the children can learn and become autonomous from the organization, if given enough time to do so.

B. We then asked the animators to name the games which, according to them, helped develop each of the psychological and social skills they mentioned. We obtained a list of essentially traditional games[40].

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[39]To be found in the appendices, under the heading "Recreational centres: play and well-being"

We classified these games in the following manner:

Types of game used	%
Group games	16
Sports activities	15
Creative and craft activities (theatre, dance, drawing, etc.)	8
Community activities	6
Skill games	5
Board games	50

Table 30   Classification of recreational activities in the Tdh centres in 2006

We can thus see that the majority are games where children are playing together. These are by definition games which develop social skills, physical agility and coordination (very important after a trauma), a decisive spirit, tolerance, leadership, etc.

C. From these indicators, determined by those who work daily with the children, it becomes possible to quantify and shape them in a relatively simple questionnaire, so that they can be administered regularly throughout the programme. If we had been able to follow up on our field research, we would then have asked the animators to select two or three of the games which, in their opinion, were the best stimulants for the recovery of the children's development, in order to create the scale. Furthermore, results are not derived from just another questionnaire, but through play and games.

The advantage of such an evaluation system is that it is constructed from local and traditional knowledge, and thus integrated into the fabric of community life and above all within their belief system. It is centred on the child, his/her development and capacity for resilience. It favours the development of the local staff's skills (capacity building) by being integrated in their training, stimulates the empowerment of adults in regard to the children, and finally, as we shall see, can be effectively used in the framework of a Child Protection programme. In other words, monitoring is part of psychosocial development for everybody.

3. Psychosocial intervention at the service of a protection programme: some thoughts

Previously in this report, we touched upon the issue of beaten children – both as a concern and as a fact. For this, we created two tools which could be developed in other programmes and perhaps become part of the Case Management System. One tool used a short story where a friend of the child being questioned was beaten, so that the child could react spontaneously, while acting as a buffer to the people around him/her. The other tool was in the form of a question on the various concerns and worries of the child at the time. In this, the question of corporal punishment was strongly present, as we have seen. This question is thus of direct interest for the Child Protection Programme.

During our last field mission in 2006, we saw an obvious complementarity at several levels between the Child Protection programme and the psychosocial work at the recreational centres. The detection of abuse, which is at the heart of the Case Management System, is conducted at three levels: in the centres by the animators, during family monitoring work by the social supporters, as well as under the responsibility of the supervisors. The case is then referred to specialists in the Protection programme. In this sense, the recreation centres play a specific and remarkable role. They are at this stage a privileged tool for the protection programme and act as a surveillance system.

Even if the two programmes are complementary, however, it seemed to us that the Case Management System was missing some thinking on the child's reintegration in the psychosocial programme after his/her return to normal life. We believe that here, the recreation centres offer important rehabilitation opportunity:

■ a healthy value system which the child can refer to, where he/she can find recourse after a painful experience of abuse or violence;
■ return to his/her psychological and social development;
■ a bridge, mediated by the staff, to rebuild family ties, especially in the case of abuse by one member of the family;
■ a discreet space for surveillance of the application of judicial decisions, when there are any;
■ a space for the re-socialisation process.

Indeed, protection is often geared more towards the judicial and socio-political fields, while the recreation centres are better focused on the emotional life of the child and his/her physical healing. The centres offer security and concrete protection, as well as rehabilitation after the child was subjected to violence.

It is in this sense that we suggest the creation of a working group on how to better coordinate the two programmes, which could improve the Case Management System by taking more into account the psychological aspect of protection against violence and abuse, for example, creating a system for re-integration after abuse.

3. Staff training

During our second survey, we were able to note considerable improvement in the skills of the staff at the recreational centres. Between 2005 and 2006, the staff had been able to train with 'activity specialists' in artistic and creative techniques, to have training in the Sport & Movement programme, and finally, to get started in the area of Child Protection – along with the social supporters and supervisors of the Case Management System.

Thus, in different ways and at different levels, those who work at the centres had the opportunity to add important psychological and educative skills to their daily practice with the children.

Nevertheless, we would like to share a couple of thoughts. The first is that the various trainings were given in a fairly haphazard manner, without great coherence. The first year was so occupied with the construction of the centres and the establishment of the programme, that there was little time left for training the staff in the field, not to speak of setting up a pre-deployment psychosocial programme in Switzerland for the expatriate staff.

It seems to us that it would be better in the future to plan in advance a psychosocial training programme, based on Tdh's model and with different modules. The advantage of creating such a programme before a disaster is to be able to react quickly and effectively, right from the first phase of local staff recruitment.

The second thought leads us to remark that the various trainings given the animators in everything to do with the psychological support to survivors, caregivers and children, around the traumatic aspects of the situation, remained curiously absent in the programme. Without going into an overly clinical dimension, it remains that local personnel, at the least, have need for a space to express itself in order to share their grief and emotional upheaval, to learn about the classic symptoms of trauma and what to do about them. This means also to the staff that their suffering is recognised by Tdh.

The development of psychosocial programmes in emergency situations has been going on for several years now, with a strong degree of professionalism on the part of Tdh, while it attempts to align itself with the best practices agreed upon by the international community. These programmes have developed well over the last few years, as we have witnessed during our two surveys in Sri Lanka, and in Bam (Iran) in 2004. It is thus time to deepen psychosocial training and give national staff coherent tools with which to better manage the recreational centres and contribute to more effective help of children.

CONCLUSION

This study aimed to confirm whether the recreational activities of the Tdh psychosocial programme had really improved the well-being of the children who attended them. At the end of this study, the evidence is positive. Moreover, we have sought to go further by analysing the resiliency process which the children were able to grow after the tsunami.

We are convinced that this concept of resilience should be at the basis of any psychosocial approach. Resilience is based both on individual and collective resources after any traumatic event. Resilience is a dynamic concept and infuses positive strength to working in the field. Resilience is part of a fundamental living mechanism and allows faster healing, provided it is well integrated in the practice of a programme. And resilience is also a philosophy of life…

We hope that future humanitarian interventions are able to apply these ideas in an increasingly professional way to the better benefit of children.

Appendices

Bibliography

General

Marie Anaut (2003) La résilience, surmonter les traumatismes, Nathan Université.

Donahue, M.J. (1985) Intrinsic religiousness: review and meta-analyses, Journal of Personality and Social Psychology, 48, 400-419.

Nicole Dubois (1987). La psychologie du contrôle. Les croyances internes et externes, Grenoble : Presses Universitaires de Grenoble.

Charles Figley (2002) Treating Compassion Fatigue, Psychosocial Stress Series - Ed. Charles Figley – Florida University.

Definitions of subjective well-being (SWB)

This term refers to subjective life experience mediated by cultural values, etc.

Diener, E. (1984). Subjective Well-Being, Psychological Bulletin, 95, 542-575.

Diener E., Suh, E.M., Lucas, R.-E., Smith, H.L. (1999), Subjective well-being: three decades of progress, Psychological bulletin. 125 (2), 276-302.

Resilience

See a very interesting project on the subject:

The International Resilience Project (IRP) is a multi-year international research. The purpose of the IRP is to develop a better, more culturally sensitive understanding of how youth around the world effectively cope with the adversities that they face in life.

www.resilienceproject.org/cmp_text/?&strCompname=home

The questionnaires

A. Evaluation of subjective well-being (SWB)

The evaluation of subjective well-being in this study is inspired by Andrews and Robinson's summary of the different measures:

Andrews, F.-M. and Robinson, J.-P. (1991), Measures of subjective well-being, In Robinson, J.-P., Shaver, P. et Wrightsman, L. (Eds) (1999). Measures of Social Psychological Attitudes, San Diego, CA: Academic Press.

B. Self-esteem

Model inspired by that of Rosenberg (1969) (10 items):

www.rehab-infoweb.net/SocProAccueil/Document%5CRehabilitation%5Cee_rosen.pdf

C. Strength and difficulty Questionnaire (SDQ)

www.sdqinfo.com

D. Impact of Event Scale Revised (IES)

www.swin.edu.au/victims/resources/assessment/ptsd/ies-r.html

Various issues

Beaten Children

The global initiative to End All Corporal Punishment of Children (2001-2006)

www.endcorporalpunishment.org/pages/pdfs/GlobalReport.pdf

Children's Worries and Concerns

Colin Mac Mullin and Maryanne Loughry (1999) A Method for Identifying and Understanding the Concerns of Refugee Children and Adolescents.

www.forcedmigration.org/psychosocial/inventory/pwg006

Locus of control

Beauvois. J.-L. and Dubois, N. (1988). The Norm of Internality in the Explanation of Psychological Events. European Journal of Social Psychology, 18, 299-316.

Dubois, N. (1994). La norme d'internalité et le libéralisme. Grenoble : Presses Universitaires de Grenoble.

Dubois, N. (1987). La psychologie du contrôle. Les croyances internes et externes. Grenoble : Presses Universitaires de Grenoble.

Hsieh, T., Shybut, J., and Lotsof, E. (1969). Internal versus external control and ethnic group membership: a cross cultural comparison. Journal of Consulting and Clinical Psychology,33, 122-4.

Lao, R.-C. (1977). Levinson's IPC (internal-external control) scale: A comparison of Chinese and American students, Journal of Cross-Cultural Psychology. 9, 113-124.

Szalay, L.-B., Strohl, J.-B., Fu, L. & Lao, R.-C. (1994). American and Chinese Perceptions and Belief Systems: A People's Republic of China-Taiwanese Comparison. New-York: Plenum Publishing.

Recreation centres, play and well-being

Tentative modelling of recreation centres in an emergency context

The following document represents a tentative improvement of a modelling of recreation centres in an emergency context, following Tdh now numerous psychosocial programmes in the world.

I. The recreation centres

There are many psychosocial projects where the principle activity is the establishment of recreational activities for children in the context of conflict or disaster. UNICEF was a pioneer in this field and an important advocate of this type of program in the international community. Yet for many years numerous NGOs have been specialised in this form of intervention – such as Save the Children, Enfants Réfugiés du Monde in France, or the Canadian organisation The Right to Play. Now, more and more humanitarian programmes include recreation centres within their emergency operations, as a complement to their projects.

I.1. Their role and place in psychosocial intervention

It should be remembered that there are different levels of intervention involved in the psychosocial concept at the basis of recreation centres. The difficulty in defining their psychosocial role and function in emergencies comes from their position between education and mental health. On the one hand, play has been recognised for over a century by the social sciences as a pedagogical tool: it occupies a privileged place in education. On the other hand, after a natural disaster, play takes place within a traumatic context which – as we have seen – is most often ascribed to mental health.

In general, recreational activities are usually seen by organizations as hybrid, however necessary, at least in the first phases after a disaster. Later on, matters become more complex, when national or local authorities take back responsibility on education and health infrastructures. It then is more difficult to maintain such programmes, in a sustainable development framework inside the community, unless serious training of the local personnel has taken place before any handover of the programme to this community, no to speak of a sustainable financial plan for the future.

There is significant investment in education and schooling in the lives of children and parents in Sri Lanka. In comparison, the recreational centres[41] are generally viewed as a nice distraction, but not very serious. During the first enquiry in 2005, the families demanded of Tdh that the time given to recreational activities be devoted to school support and trainings in subjects such as computing. There was little understanding of spaces for play as a driving force for the child's emotional rehabilitation inside its community. The centres seemed better to the adults as a place to keep their child where he/she would be secure and supervised rather than left to him/herself. Nevertheless, Tdh managed to provide cognitive activities for the children, not so much in study supervision, but with separate intellectual activities, such as English.

Obviously, it is not desirable that the centres should replace schools under reconstruction or as a compensation for the absence of teachers. Education is not really the main objective and function of the recreation centres. Nevertheless, they can and should stimulate children's learning and cognitive aptitudes, since these are necessary psychological functions in the process of rehabilitation. In this sense, 'psycho-educational' activities can contribute to helping the child without necessarily coming into competition with the school system.

I.2 Best practice in the management of recreation centres

In 2004, during the mandate Tdh gave us in Bam (Iran), a model for recreational activities began to unfold, which continued over in our survey in Sri Lanka. Such a programme needs a conceptual framework for a strong and sustainable set-up. It is thus necessary to outline some simple but durable lines along which to base the practice.

A. First principle: child centred:

First of all, the programme should be centred on the needs of the child in distress, more than on the construction and management of the structure, with all the problems characteristic of an emergency operation. A recreational centre is but a service tool for the mission, which is the improvement of children's well-being. The choice of activities, the recruitment of animators, actions linked to the community, as well as search for funding, negotiation of a site with local councils, local politics and their difficulties, relationships with other local and international NGOs, to take just a few examples, all serve towards the central objective: the children and their needs. What must be included, therefore, aside from an evaluation of such needs, is the establishment of recreational activities which respond to those needs in the most effective and concrete way. In other words, some recreational activities can respond to some needs and not others, as we shall see further.

When we speak of needs – emotional, cognitive and social – of children in distress after the tsunami, what does this mean? It will depend on several factors, of which the following two are the most important: age and developmental level of the child at the time of the disaster and the post-tsunami rehabilitation phase. A few examples will bring our point.

Exemple 1

A girl of four years of age in the first three months after the disaster depends heavily on her parents and may regress into infantile behaviour. Her main need is to get a feeling of emotional security and some stability from her environment. Her life should thus be made as normal as possible.

Exemple 2

A boy of twelve, in the third phase after the tsunami – i.e. the stage of disillusion and depression, keeps his suffering from his parents and/or other members of the family, has difficulties at school, and feels isolated and depressed. He will gain considerable benefit from sports activities, school support, and the opportunity to begin to recreate his social network.

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[40]Often called child friendly spaces.

Exemple 3

A teenage girl of sixteen continues to suffer from post-traumatic stress eighteen months after the tsunami – such as insomnia and nightmares, emotional withdrawal rendering her mute, a tendency to persecution, and confused self-expression. She will thus have need for a mental health evaluation, which can be conducted by the head of the recreation centre, to see whether she should be referred to local medical facilities Les besoins des enfants en situation de catastrophes ont été bien étudiés. Nous avons fait ici un petit tableau qui en résume quelques uns:

Age	Needs
From 1 to 5 years	- Strong dependency on adults for food, shelter, protection and security. - Need to understand what has happened from information provided by adults. - Strong need to 'play out' this information.
From 6 to 12 years	- Need to become autonomous and to act for his/herself. - Need to use imagination to represent what has happened to his/herself, to get his/her bearings and to look again towards the future. - Need for attention according to level of vulnerability.
From 13 to 18 years	- Going through enormous transformation. Separation from parents in numerous cultures. - Need for special support in this phase of life – integrated in a psychosocial program.

Tableau 31 Emotional needs of children after a disaster by age group

B. Second principle: including all adult survivors:

The programme should not be only addressing the children, but also caregivers and families, as well as the animators.

These three groups – children, caregivers and staff who work with children in the recreational centres, create a relational dynamic which, after a few months, becomes the soul and strength of the recreation centre. Since all three groups have lived through the same tragedy, it is likely that they will have suffered a similar trauma level and should all be included equally in the life of the centres. Improving the well-being of one group improves that of the others.
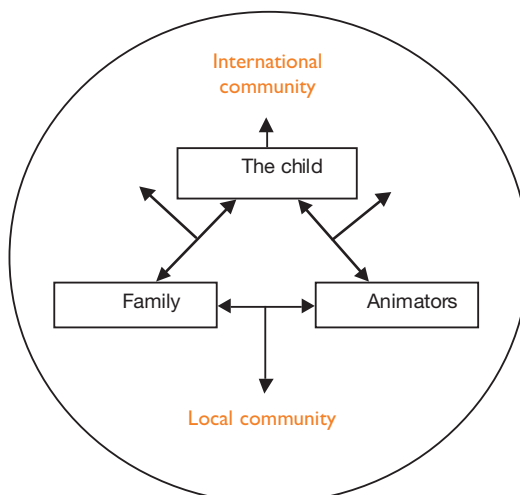
Figure 39 Core dynamic of a recreational centre

The adults grouped around the child in a centre – parents, family and animators – also have specific needs after the tsunami. Their needs generally appear to be material and social – at least that is the most frequent content of their requests. Nevertheless, they also suffer from serious psychological trauma and will go through years of grief. Meanwhile, they have to take care of the family and children who have survived, find work, rebuild a home, etc. It is clear from our study that the Sri Lankan families are above all worried about the education of their children. But in general they don't give time to themselves to confront their own anguish and sorrow, and are taken up by the task of survival. It may be that their religious beliefs, which have an important place in their lives, play a role of moral and social support. But Tdh can also give a form of support, as a place to speak and share, thus helping them to better manage their relationships with their children and develop their everyday psychosocial skills. In this way, the recruitment of 'social supporters' is an excellent system, especially through their home visits.

Furthermore, the local staff (animators, social supporters and supervisors, and – later – activity specialists) are, following the results of the 2005 survey, in a particularly traumatic state. But work has been done to help them improve their level of resilience, particularly through training, supervision and psychological support.
The "healing networks" between the children and the adults who cared for them and extended into the community, have been a real and positive force. In the face of despair and anguish, they encourage resilience, thanks to the psychological resources of children. They are often more proactive than their elders in this difficult phase, and their joie de vivre is contagious!

I.3. Structure and functioning of the recreation centres

The following principles are indispensable for the good functioning of the recreation centres:

a. An open and protected space inside the community
Tdh has created a protocol to facilitate some kind of uniformity in the construction of the recreation centres through best practice and based on recognised psychosocial principles. It is important to note that the organisation encourages the application of these principles to the point of constructing shelters in playgrounds[42].
Many of the centres we visited in September 2005 were not yet finished. But all had a fence, that defined a protected space for children.

b. Structured timeframe within a planned activity programme: the need to structure time after chaos brought by the disaster is self-evident. The children came after school around 2pm and could stay two or three hours before returning home. The activity programme was planned weekly.

c. Run by young animators with whom the children could identify, to whom the children could become attached, and could serve as an intermediary with the family, with the help of the social supporters. The task of the social supporter was to make frequent visits to the families of the children attending the centres. Furthermore, this person had a role within the framework of the Protection Programme which allowed him/her to diagnose cases of abuse during home visits.

d. All these staff were headed by supervisors who each coordinated three or four centres.

e. For each centre, a ratio of one youth worker to 20-25 children was planned at the onset of the programme. However, there was a heavy registration of children, sometimes up to 500 children in some of the centres, with 6-8 animators attending each centre, which made a ratio of 50-60 children to one animator. This left little time to the youth workers to get to know their clientele!
A code of internal rules governed relations and proscriptions. Rules are indispensable to help provide stability and security for the children: one of the most important post-trauma symptoms is agitation and aggressivity, and difficulty accepting any structure of any kind.

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[41]See the protocol summary further in this appendix.

II. Play and well-being of children

II.1. The importance of play according to the Convention on the Rights of the Child

Article 31 of the Convention on the Rights of the Child recognises play as being one of the most important rights of the child: "State Parties recognize the right of the child to rest and leisure, to engage in play and recreational activities appropriate to the age of the child and to participate freely in cultural life and the arts." and adds "State Parties shall respect and promote the right of the child to participate fully in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity."
Why is play so important? Why is it recognised by the international community as a human right? And why is play so particularly important when a natural disaster kills?

II.2 The role of play in the rehabilitation of children

It is important to note that, compared to the mental health model, the role of play is unique in a psychosocial approach to disaster or conflicts, inasmuch as it brings simple healing tools to distressed children, which local staff can be relatively easily trained to monitor. It can equally be a bridge between mental health and psychosocial intervention, where play brings several community groups together. In fact, play is holistic, complete – and is easily allied to the resources of entire communities and at all levels.
By definition, play is part of and ensures the well-being of the child, particularly after the tsunami. Such is the case for sports activities, for example, which assure the integration of the child and the reinforcement of the family network.

II. 3 The different types of recreational activities

For several years, Tdh has adopted three categories of recreational activities: artistic and creative, which act in the emotional and imaginative sphere; physical and sports, which allow the rehabilitation of the body; and psycho-educational, which stimulates cognitive activity in preparation for, or alongside, schooling.

In a situation of vulnerability due to trauma, it is important to emphasise the first two categories of recreational activities, above all in the depression phase of post-tsunami. The first, which acts in the emotional and imaginative sphere, allows children to recover their capacity for symbolisation – allowing them to represent painful memories rather than be drowned in them. Mental representation, as well as the words for self-expression, are the primary ways to distance the self from suffering. Physical activities, on the other hand, bring the body back into movement, and in relationship to others, thus also allowing emotional withdrawal and inhibition to disappear.

That said, during our visits we noted that the accent had been placed on physical activities and group games, and little on artistic activities – as the ground was sandy it wasn't possible to draw or paint, for example. This demonstrates that the psychosocial programmes need to be able to adapt to the local culture and geography of each country touched by disaster. Tdh constructs its recreation centres in conformity with these criteria, as it has done in Iran or Pakistan.

II.4 Recreational activities used in the centres

In Sri Lanka, where the recreational activities are decided directly by the animators and their supervisors, the majority were often taken from traditional Sri Lankan games – sometimes using our Western ones. A short questionnaire, distributed in a dozen of the centres, showed that most of the games were based around the social integration of the children: group games, sports activities, activities to help the community, drama representation games, board games, etc. Creative and craft games (painting, dancing, singing) and games of skill were less present.

It thus seems that this distribution of activities is marked by a majority of group games. We regretted that there was less opportunity for an intimate space where children would be able to focus on more internal, imaginative work, such as free painting, which is known to have a very positive effect in healing psychological trauma. We noted that, in effect, the only painting offered was according to predefined themes, such as Child Rights – leaving little freedom for self expression.

III. The referral system

When families come to register their children, it is possible to locate the most vulnerable. A small percentage of the population remains traumatised, unable to rise above the tide, and will very probably remain mentally deficient. In a country which has not suffered from a disaster, such children – psychologically ill, epileptic, depressed, drug addicted, or suicidal – would be taken care of by health institutions. In developing countries, which in general suffer endemically from lack of mental health structures, and to top it all, from repeated natural disasters as well as conflicts, the possibility of care for such children is often almost inexistant. This is a reality with which all emergency operations are confronted in the short and medium term: where to refer a child who presents symptoms of mental illness, plus a post-traumatic stress syndrom?

In a country like Sri Lanka, which prior to the tsunami had only one psychiatrist on the east coast for millions of inhabitants (which seems to still be the case), the possibility to refer children in psychological difficulty, without risking the aggravation of their mental situation, is slim. For now, the hospital in Batticaloa, the only psychiatric service available (with 27 beds), is for adults. Under certain conditions, children can be admitted, but with all the hazards which can be easily imagined, and a possible aggravation of their condition. A multidisciplinary outpatient clinic for children exists on a weekly basis. The only psychiatric consultant is trying to improve this precarious situation by creating a team of mental health professionals who can support and relieve him over the long term.

Generally, it seems that there is a majority of diagnoses of hyperactivity, as well as of epilepsy. There are only a few diagnoses of post-traumatic stress, which gives pause for thought. Medical treatments exist and most prescriptions are for sedatives.

We want here to raise the following issue: it seems an excellent idea to combine a psychosocial programme with a mental health referral system in order to be sure of having covered all the victims, and especially the most vulnerable. Practice shows that putting it in place is not so simple. By definition, as we have already seen, a psychosocial programme is not a mental health programme in the strict sense. Nevertheless, in a post-conflict or post-disaster context, abasic concern with which the programme deals is trauma, on both an individual and a community level. While setting up such programmes, focus should be given to problems of mental health with psychosocial tools such as recreation centres. Which is why it is important for Tdh to be clear in regard to the difficult question posed above: what is the function of the recreation centres, bridging mental health and education?

The initial Tdh Proposal for Sri Lanka (2005), states expressly that the staff of recreation centres should not act as "counsellors" – i.e. as mental health professionals. On the other hand, it provides for the recruitment of a local psychologist, and that he/she should support the staff in their pedagogical work and counsel them at all stages in the creation of recreation activities.

In August 2006, during the second survey, this professional had not yet been recruited, because difficult to find in the region. Evaluation of suffering children was done by the psychosocial coordinator responsible for the centres in Batticaloa, on the basis of short training provided to the social supporters, and then referred in an 'intuitive' way to a mental health service for children – which was non-existent!

This local deficiency in provision for mental health is commonplace in many countries subject to conflict or disaster. And broader questions need to be asked when creating such a service.
In the case of Tdh for example, is it really its vocation and its policy in emergency relief to apply itself to insufficiencies in the local mental health services? How can Tdh ensure that the most mentally and emotionally vulnerable children are best identified and cared for? If it is do so, within what limits and within which strict framework of intervention can the programme be developed? Do we choose to conduct mental health case work? And with which tools of pyschological evaluation and care?

The detection tool established by Tdh within the framework of its Protection Programme can partially act as a measure to understand the psychosocial causes of distress among abused children. But what do we do with abused children who have developed a serious pathology due to abuse? Or were ill before the tsunami?

If we remain within the framework of mental health intervention in the strict sense, as well as within one of emergency relief and of development, several mental health evaluation tools and especially questionnaires on post-traumatic stress already exist. They are often criticised within the field of pyschosocial intervention, but they could be adapted to the framework of a humanitarian psychosocial programme. Nevertheless, this choice must be subject to careful research in order to prevent further stress on programmes which are already complex and sensitive.

Resiliency scale questionnaire

This questionnaire was created for the needs of the two surveys in 2005 and 2006, in order to study the development of risk and protection factors influencing the well-being of children.

We provide below the RSQ which was administered to the children. The one for caregivers and animators have very much the same questions, thus we did not include them here.

The resiliency scale questionnaire for children

I. Education

1. How are you doing at school?
   - ❑ Well
   - ❑ Average
   - ❑ Badly

2. What are the difficulties you have at school?
   - ❑ I find it hard to listen
   - ❑ I find it hard to be interested
   - ❑ I often find it hard to understand
   - ❑ It's difficult to obey the rules
   - ❑ I don't get on with the other children
   - ❑ I don't get on with the teacher
   - ❑ Other (detail) : ……………………………………………………………….

3. Are you happy with your work at school?

| Not at all | 1 | 2 | 3 | 4 | 5 | 6 | Definitely |

4. Are your parents happy with your work?

| Not at all | 1 | 2 | 3 | 4 | 5 | 6 | Definitely |

5. Is your teacher happy with your work?

| Not at all | 1 | 2 | 3 | 4 | 5 | 6 | Definitely |

6. Is your teacher happy with your behaviour in class?

| Not at all | 1 | 2 | 3 | 4 | 5 | 6 | Definitely |

II. Health & hygiene

7. Do you think you are clean?

| Not at all | 1 | 2 | 3 | 4 | 5 | 6 | Definitely |

8. You wash…

| Not enough | 1 | 2 | 3 | 4 | 5 | 6 | Enough |

9. If you don't wash, why not?
- ❑ I can't wash where I live
- ❑ I don't like it, I don't want to
- ❑ My parents don't make me
- ❑ I don't think of it

III. Religion

10. What is your religion?
……………………………………………………………………………………………………

11. Do you believe in God?
Not at all   1   2   3   4   5   6   Strongly

12. Do you often speak about religion with your family?
- ❑ Rarely
- ❑ Sometimes
- ❑ Often

13. Do you think religion is important in your life?
Not at all   1   2   3   4   5   6   Definitely

14. Has your religion helped you cope with the tsunami?
Not at all   1   2   3   4   5   6   Definitely

IV. Vulnerability and control of the environment

15. Are you scared of another tsunami?
- ❑ Not at all
- ❑ A little
- ❑ Quite a bit
- ❑ A lot

16. How do you explain the tsunami?
……
……
……

17. Short stories

The snake

a. Have you, or a member of your family or your best friend, ever been bitten by a snake?
❑ Yes
❑ No

b. Imagine that a snake is trying to bite you…
❑ You defend yourself, you pick up a stick, you make it go away.
❑ You get away as quickly as possible.
❑ You call for help.
❑ You stay where you are, too scared to know what to do.
❑ You pray for God to save you.

c. A snake has just bitten you…
❑ You didn't take enough care.
❑ You were in the wrong place at the wrong time.
❑ The snake was too quick.
❑ You never pay any attention, your mother always says so.

d. The snake went away…
❑ Someone came along at that moment, you were lucky.
❑ You looked pretty convincing with your stick.
❑ You always manage to get out of tricky situations, you're brave.
❑ The snake was a little slow, you had the time to react.
❑ You think that God helped and protected you.

Ghosts and spirits

e. Have you ever thought you'd seen or heard a ghost?
❑ Yes
❑ No

f. One night, when you are in bed, you have the feeling you heard a ghost…
❑ You run to your parents for protection.
❑ You hide under the bedclothes.
❑ You take care of it and you look to see how you can scare the ghost.
❑ You know it's only in your head and you really aren't scared.
❑ You pray to God to protect you.

g. In your opinion, why did you think you heard a ghost?
❑ You've been naughty, the ghost came to punish you.
❑ You were unlucky, the ghost was passing by you.
❑ You and your house aren't protected enough against ghosts.
❑ You think of God because you think He will protect you.

Being beaten by parents

h. Do you know anyone close to you who is beaten by their parents?
❑ Yes
❑ No

i. One of your friends is regularly beaten by his/her parents. In his/her place…
❑ You would regret not having kinder parents.
❑ You would try to talk with friends or adults so that they could help you.
❑ You would try to stay out of the way at home.
❑ You would bear it without flinching.

j. If you were in your friend's place, you would think you were being beaten because…
❑ You were naughty, not good enough at school, etc.
❑ Your parents drink too much alcohol.
❑ You're a good-for-nothing.
❑ You're unlucky.

A road accident

k. Have you and/or your family ever been in a road accident?
❑ Yes
❑ No

l. One of your friends has just been in a road accident with his/her parents. He/she wasn't hurt.
In his/her place…
❑ You would remain calm and wouldn't panic.
❑ You would be very scared (panicked) and you would start to cry.
❑ You would get out of the car quickly so you could go to help anyone in your family who was injured.
❑ You would wait till someone came to get you out.

m. You are on your bike and you are run over by a car. You aren't injured, but you have lots of bruises…
❑ You get back up quickly and take your bike off the road.
❑ You wait for the driver of the car that ran you over to come back and help you.
❑ You cry.
❑ You look for a doctor or a hospital.

n. Why were you run over?
❑ You weren't lucky.
❑ The driver was driving badly and didn't see you.
❑ The driver was drunk.
❑ You never take enough care when you're on your bike.
❑ There was lots of traffic and you didn't see the car.

V. Self-esteem

18. Answer the following questions:
a. I'm generally happy.
Not at all   1   2   3   4   5   6   Definitely

b. Sometimes, I don't think I'm worth anything.
Not at all   1   2   3   4   5   6   Definitely

c. I think I have lots of good qualities.
Not at all   1   2   3   4   5   6   Definitely

d. I think I can do things as well as my friends can.
Not at all   1   2   3   4   5   6   Definitely

e. Sometimes, I feel really useless.
Not at all   1   2   3   4   5   6   Definitely

f. I think I'm as good as my friends.
Not at all   1   2   3   4   5   6   Definitely

g. I don't like myself.
Not at all   1   2   3   4   5   6   Definitely

VI. Subjective well-being

19. How have you been feeling lately?
❑ Really well
❑ Fairly well
❑ Not very well
❑ Not well at all

20. Why do you think you feel this way (physical, social, psychological reasons, etc.)?
....
....
....

21. And how do you feel right now?
a. Depressed/sad

| Not at all | 1 | 2 | 3 | 4 | 5 | 6 | Definitely |

b. In a bad mood

| Not at all | 1 | 2 | 3 | 4 | 5 | 6 | Definitely |

c. Calm/serene/relaxed

| Not at all | 1 | 2 | 3 | 4 | 5 | 6 | Definitely |

d. Irritable/aggressive

| Not at all | 1 | 2 | 3 | 4 | 5 | 6 | Definitely |

e. Nervouse/tense/stressed

| Not at all | 1 | 2 | 3 | 4 | 5 | 6 | Definitely |

f. Optimistic

| Not at all | 1 | 2 | 3 | 4 | 5 | 6 | Definitely |

g. Full of force and energy

| Not at all | 1 | 2 | 3 | 4 | 5 | 6 | Definitely |

VII. Social network and Interpersonal relationships

22. How much time do you spend with your friends each day?
❑ Very little time
❑ Quite a bit of time
❑ Lots of time

23. Do you like to stay at home with your family?
❑ Yes
❑ No

24. Do you feel comfortable in groups?

| Not at all | 1 | 2 | 3 | 4 | 5 | 6 | Completely |

25. Or do you prefer to stay alone with your best friend rather than be in a group?
Not at all   1   2   3   4   5   6   Completely

26. When you're worried…
❑ You ask your parents for help
❑ You ask another member of your family for help
❑ You ask another adult for help
❑ You speak to a friend of your own age
❑ You don't talk about it
❑ You don't talk about it and you stay alone

27. Are you happy to be back at school since the tsunami?
Not at all   1   2   3   4   5   6   Completely

28a. Does your child help you around the house (housework, fixing, etc.)?
Never   1   2   3   4   5   6   Frequently

28b. In what area? ……………………………………………………………………………………

29. Support network exercise: ask the child to draw him/herself at the middle of the circles. Then ask him/her who are the people who are closest to him, starting with circle 2.

For each circle, write the relationship of the person the child mentions in their life: mum, youth worker, my dog, etc.
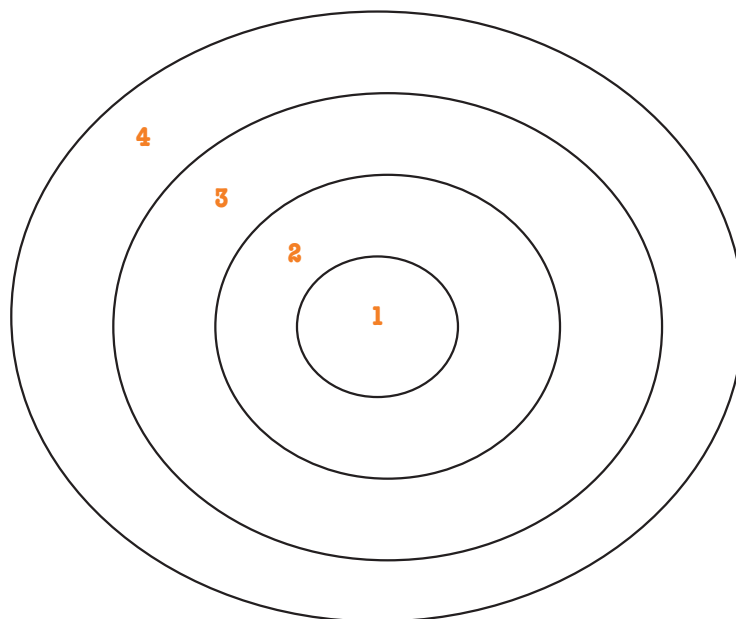
29a. Circle 1	
29b. Circle 2	
29c. Circle 3	
29d. Circle 4	

VIII. The child and the Recreational Centre

30. Are you happy to go to the Recreational Centre?
Not at all   1   2   3   4   5   6   Completely

31. Do you really like the youth workers?
Not at all   1   2   3   4   5   6   Completely

32. Do you really like the other children at the Recreation Centre??
Not at all   1   2   3   4   5   6   Completely

IX. Worries and opinions about the future

33. What are your biggest concerns right now?
a. ………………………………………………………………
b. ………………………………………………………………
c. ………………………………………………………………
d. ………………………………………………………………
e. ………………………………………………………………
f. ………………………………………………………………

34. What do you think they will be later on?
………
………
………
………

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Remarks: the short stories in Section IV and the questionnaires on self-esteem and subjective well-being were accompanied by drawings made at the Humanitarian Psychological Centre by Annapoorni Sitaraman.

For more information, please contact us at: ccolliar@worldcom.ch, mentioning Sri Lanka Report.

Good practices in the construction of playgrounds

In Sri Lanka, the recreation centres' playgrounds were set-up according to a number of principles which had already been tried and tested in other Tdh projects, including Bam (Iran). It is interesting to emphasise the fact that these principles run directly with those stated above, and which guide the building of psychosocial projects, such principles as community empowerment, respect of local cultural values, centring the programme on the child, staff capacity building, etc.

Below are some of the points which confirm the validity of the programme, at all levels, and which guide the construction of the recreation centres:

Inclusion of the community values

- socially and culturally acceptable construction for the community
- a choice of materials which reflects local culture
- construction, maintenance and repairs should be by local people
- equipement should be bought locally
- choice of site should be made with local communities and authorities. This facilitates handover at the end of the programme.

Choice of site

- centres must be built as soon as possible after the disaster
- sites must be close to where children live
- equipment should ensure minimum hygiene (water, latrines, sewage…)
- sites should be close to a road, but separate from it by a fence

Security

- should be according to context
- easy to access
- surrounded by a fence
- cleaned from rubbles after the disaster, and emptied of any dangerous objects, such as mines and rusted metal.

Construction itself should take into account

- the climate, for example solid enough to withstand the monsoon; sufficiently ventilated to maintain fresh air
- possible future growth in the number of children
- sufficient space available for children to move about freely
- different spaces for various activities – physical, artistic, group games, cognitive activities, etc.
- simple and solid structures

List of figures and tables

Section III

Appendices

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