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In response to pressing needs, a mechanism for coordinating psychosocial activities evolved organically in the Jaffna peninsula of Sri Lanka following the Asian tsunami of 2004. The Mental Health Task Force attempted to coordinate both governmental and nongovernmental organizations, local and international, which were involved in psychosocial work. In time, the District Psychosocial Forum took over the role of coordination under the direction of the Regional Director of Health Services and District Psychiatrist. With the resurgence of the civil war, the forum has had to respond to the urgent psychosocial needs arising from the conflict situation. The Inter-Agency Standing Committee (IASC) delineates guidelines for coordinating psychosocial responses of agencies to emergencies due to natural disasters and war that was remarkably similar to the development functioning of the Mental Health Task Force and Psychosocial Forum and their experiences and the lessons learnt.

Keywords: Inter-Agency Standing Committee (IASC), guidelines, Jaffna, Sri Lanka, coordination, psychosocial, mental health

The urgent need to coordinate psychosocial activity became clearly evident after the massive Asian tsunami of December 2004. The tsunami caused around 3000 deaths in the Jaffna district, with a population of around 500 000. It left 80 000 displaced in temporary shelters and camps. There was an immediate outpouring of local and international aid and humanitarian workers (Galappatti, 2005; Frerks & Klem, 2005) that flooded the district. For the first time, the need for psychosocial work was recognized at the national level, and was referred to as *'tsunami wisdom'*. However, no coordination mechanism existed and at that time there were no Inter-Agency Steering Committee (IASC) guidelines for emergency settings.

This brief description of the coordination mechanism that evolved spontaneously at the local level in the Jaffna District in response to the immediate psychosocial needs of a natural disaster. It includes how this evolution continued during the man-made disaster called war that soon followed, and will look at the lessons learned in light of the guidelines. Significantly, many of the recommendations in the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* were foreshadowed in the steps taken after the tsunami.

Within three days after tsunami, local and international agencies involved in psychosocial work, 18 in total, came together to form the *Mental Health Task Force* (MHTF) to coordinate the response (Danvers et al., 2006; Van der Veen & Somasundaram, 2006; Somasundaram, 2008). Initially the MHTF met daily. Organizations discussed the needs of the affected people and ways to help the survivors psychosocially. There were training programmes on needs assessment,

psychological first aid, debriefing and handling acute grief. Pamphlets and booklets on simple *do's* and *don'ts* were published by the forum. Media briefings and public awareness programmes were carried out regularly. The organizations attended the meeting in a regular manner and shared their experiences and lessons learnt in their fieldwork.

At that critical period there was no competition or rivalry, indeed there was an overwhelming spirit of urgency, comradeship and cooperation. Particularly affected geographical areas and tasks were allocated to different organizations that reported back on their achievements. Resources were shared. The Task Force was quickly recognised by the local inter sectoral coordinating bodies of the affected areas and the district level committees chaired by the government administrators. Representatives from the MHTF participated at the local and district level inter sectoral meetings and efforts.

At the local level, the preexisting and experienced primary health care and militant structures proved most effective in organizing services during the acute emergency. However, links to the national level post tsunami activities did not develop and the responses in the north (and east) were in isolation from the well resourced and funded programmes at the national level. This led to glaring disparities and inequities in the relief, rehabilitation and reconstruction efforts (Asian Development Bank Institute (ADBI), 2007; Grewal, 2006) that became part of the resurgence of the ethnic conflict. Unlike in Aceh (Jaffna district), the post tsunami work in Sri Lanka did not become the means to long term reconciliation and peace.

In view of the plethora of programmes claiming to do psychosocial work, MHTF was requested to process all the psychosocial programmes. A subcommittee was selected to go through the proposals and provided necessary advice and guidelines for their implementation. It soon became clear that some programmes, probably in their ill conceived enthusiasm to help, did not meet minimum standards of training or psychosocial work. They were also often culturally inappropriate and did not provide for continuing follow up or support. In the language of the IASC, *'they were doing more harm than good'*. However, there was no real control over these programmes, or the authority vested in the MHTF, to take administrative action as its' role was merely advisory.

Once the immediate emergency and relief phase were over, some ten months post tsunami, the MHTF lost steam. There were no mechanisms to sustain the Task Force. Following this, in the latter part of 2005, the government of Sri Lanka wanted to streamline the tsunami activities and the district level government authority (Government Agent) were given powers to work out the mechanisms. The Government Agent (GA) of Jaffna requested the Regional Director of Health Services (RDHS) to organise a coordinating mechanism for the psychosocial activities. It was in this context that the District Level Psychosocial Forum was established as a continuation of the MHTF. to enhance the coordination between various governmental, nongovernmental, and international organizations involved in psychosocial activities in the Jaffna District. It is officially chaired by the RDHS, Jaffna, technically supported by the District Psychiatrist and has over 20 organizational members.

The experiences of the previous Task Force proved useful in organizing the Psychosocial Forum. Many organizations once again took active roles in the psychosocial forum: exchange information of the activities carried out by various organizations, areas of implementation, lessons learnt and best practices. The forums' objectives included:

understanding and discussion of the psychosocial needs in the communities; to coordinate, monitor and evaluate psychosocial activities and progress in implementation; ensure and improve the quality of services; get guidance from consultants; avoid the duplication of service and improve cooperation; to plan for the future; and to identify the lapses and gaps of services.

This forum organizes monthly meetings at RDHS Office in Jaffna. With the escalation of the war, the main land route to the Jaffna peninsula was closed in August, 2006. Jaffna was isolated from rest of the country and curfew was reinforced in all parts of the Jaffna, not only at night but also during the day. As a result, time was restricted for free movement. There were frequent cordon and search operations with arrests and detention. The roads were being blocked for military purposes and the bus services were irregular. The centralised District level coordination mechanism faced many difficulties in this environment and quickly adapted some solutions.

Identification cards were issued to authorised psychosocial workers in the hope that the warring parties would respect them. Divisional level psychosocial forums were established at nine divisional secretariats under the chairmanship of the Divisional Secretaries to decentralize and improve the coordination mechanism. It helped to increase the liaison between the governmental and nongovernmental organizations at the ground level. Everyone became known to their counterparts, and all who were working in the respective fields learnt what other organisations were doing in the same area. Ground level coordinating bodies helped to prevent duplications and to fill in gaps in psychosocial services. Travelling became easier for the psychosocial workers and clients in need, and thus risks were reduced. These forums conduct monthly meetings and do coordination and referrals at the division level itself. The divisional coordinators raise important issues at district forum meetings. Also, the district forum provides technical support and makes policy decisions.

The forum conducts periodic training for various categories of staff at the district and divisional levels on community and primary health care approaches. This helps to encourage grass root level management of psychosocial issues, with appropriate referral and networking mechanisms for more difficult problems. The forum is linked to the District inter-sectoral level under the GA, through the RDHS and the national level psychosocial forum coordinated by the Consortium of Humanitarian Agencies (CHA) and the Ministry of Health through the RDHS and District Psychiatrist. The Departments of Education, Health, Social Services, local government and nongovernmental organizations (NGOs) are closely linked at the different levels, beginning at the district and grass root levels.

The forum has established the District Level Psychosocial Technical Evaluation Committee (DLPTEC) of persons with competence in aspects of psychosocial work. It serves as an advisory body to help enhance the quality of the project proposals, submitted by the various organizations and access technical capacity. The focus of this exercise is to ensure bench marks and minimum standards as set out for quality psychosocial service delivery as outlined in the *Guidelines for Good Practices in Psychosocial work in Sri Lanka* prepared by the Psychosocial Forum of the Consortium of Humanitarian Agencies (CHA) in Sri Lanka and the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*.

The Committee confines itself to the psychosocial component of the project, taking into

account ground realities and needs, appropriateness of the psychosocial interventions, availability of suitable human resources and a system in place for supervision and ongoing capacity building in relevant areas specific to the project and psychosocial advocacy. DLPTEC reviews any kind of socially acceptable, culturally sensitive psychological and/or (psychotherapeutic) social intervention/s, which mitigates any psychological dilemmas of a person, family, group or a community by providing appropriate psychological and/or social assistance.

The forum has tried to establish minimum standards for various categories of psychosocial workers such as counsellors, '*befrienders*', social workers, those using creative arts like drama, art, narration, music, dance and play; relaxation therapists, and occupational therapy assistants. The forum tried to specify selection procedures, the minimum period of training, supervision, reporting and monitoring. Although recognized at various levels, even the IASC does not address this issue.

The forum has been actively involved in planning and production of the Annual Health Plan by the RDHS. At present the district forum is involved in the process of the development of a psychosocial framework, in order to define various psychosocial activities, their objectives, possible outcomes and their indicators; to maintain minimum standards of the said activities; and to ensure the minimum qualification and capacity of the different psychosocial workers. It also organizes various training programmes and workshops for the psychosocial workers of the member organizations to create a cooperative environment and to raise their knowledge of Sphere Project Humanitarian charter, minimum standards and the guidelines for emergency settings.

Therefore, the Jaffna District Level Psychosocial Forum has evolved naturally to function along the lines envisioned in the guidelines recently published by the IASC. It functions as the recognized inter sectoral coordinating body for local governmental and nongovernmental organizations involved in mental health and psychosocial work to plan, share information, integrate activities, organize support and advocate for positive practices. The timely establishment of a coordinating body prevented fragmentation of mental health and psychosocial support (MHPSS) services, duplication and overlap, competition and rivalry as well as overwhelming and inappropriate interventions. Though this worked well in the post tsunami work, the war situation created problems of security, transport and recognition by combatants that could not be fully solved by the Forum. Although national level links are in place, they have not developed adequately, practically isolating the district and hampering access to resources and support. In addition, the Forum lacked power and the facilities to assess psychosocial needs, monitor activities and determine the capabilities or standards of MHPSS workers. It would be helpful for the guidelines to address minimum criteria for MHPSS work such as training and supervision.

Although the guidelines for emergency settings outline comprehensive responses for long term MHPSS programmes, a different perspective may be needed in chronic war situations that develop into a continuing emergency. The classical temporal division of disasters into emergency preparedness, impact of disaster, emergency, post disaster stabilization and reconstruction phases may not be appropriate in chronic emergencies, such as a continuing war situation that tends to be a series of emergencies overlapping one another.

While providing for immediate needs and responding to acute crisis situations, a more

long term effort to mobilize and rebuild family and community structures and processes may be needed. For example, psycho education, awareness programmes and training in simple MHPSS skills to empower local communities to take care of themselves would all be helpful. Psychosocial principles for best practice in these situations will have to be elaborated in more detail in the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*. In particular, general guidelines to address the destruction of social capital, and the collective trauma (Somasundaram, 2003, 2007) that ensues in long drawn out civil conflict and post conflict situations, have to be developed. Guidelines will help the coordinating body to plan and direct activities that also take the long term perspective into consideration, in addition to responding to immediate emergency situations.

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