Disaster Psychosocial and Mental Health Support in South & South-East Asian Countries: A Synthesis

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Abstract:

The South and South-East Asian countries, comprising of Afghanistan, Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Pakistan, Sri Lanka and Thailand share similar socio-economic profile, natural resources, common geological and climatic features, and disaster risks from many natural hazards. Multiple countries in Asia witness many devastating disasters across boundaries. The paper attempted to cover extensively the disaster profile and policy perspectives/legal framework for disaster psychosocial care and mental health services in highly disaster prone Asian Countries. Commonalities in approaches and practices in this field; nature of services -whether curative, preventive or promotive; quality and quantity of post-disasters service provisions; training manpower & capacity building; profile of service providers; institutional mechanisms for implementation of project/program; funding mechanisms for service and training activities; and major constraints were critically analyzed. The findings highlighted the prevalence of agency-run/project based ad-hoc approach in post-disaster service provisions and absence of proper institutional mechanism with mandatory guidelines to be followed during disasters, grossly inadequate trained manpower, absence of proper community based mental health care system, poor referral system, inadequate pre and post disaster psychological need assessment and ad-hoc funding sources. Nevertheless, a strong emerging trend of integrating this into larger disaster policy, planning, relief and rehabilitation services, seeking regional cooperation in developing a trained manpower, and building a community-based disaster psychological service delivery system was also found.

Key Words: Asian Countries, Disaster profile, Disaster Psychosocial Support & Mental Health Services, Emerging Trends

Introduction

The long-established trend of natural hazards and their manifestation as disasters have demonstrated time and again that many natural hazards cross national boundaries and affect multiple countries in South Asia. Drought, flood, cyclone, earthquake, tsunami, glacial lake outbursts etc have become shared risks for all countries in the region.

While a severe tropical cyclone in 1998 caused heavy damages in Sindh province of Pakistan and moved into Indian State of Gujarat, causing extensive damage in both countries, the drought in the year 2000 gripped parts of India, Pakistan and Afghanistan simultaneously. The monsoon flooding and subsequent river erosion in north-east India, Nepal and Bhutan triggered severe floods in the western districts of Bangladesh in the year 2000. In the same year a cyclone crossed the northern part of Sri Lanka and reached the southern tip of India damaging houses, fishing boats and crops. The impact of the Gujarat earthquake in India next year was felt throughout northwest India and parts of Pakistan. The tsunami of 2004 in Indian Ocean is the disaster crossed the boundaries and impacted eleven Asian countries. The massive earthquake in the Himalayan region in 2005 again damaged extensive life and living of the people in Kashmir of India and bordering parts of Pakistan. These are the most recent examples of large-scale disasters, which crossed state borders and triggered the need for regional cooperation for disaster risk reduction and management in South and South East Asia.

Psychosocial and mental health problems are particularly important for low-income countries, which face a high burden of illness due to infectious disease, greater socio-economic disparities, and have limited resources for mental health care. The psychosocial and mental health impacts of these disasters have been exacerbated by the multiple losses due disaster and subsequent stressful life events and consequent uncertainty of the future. The Inter Agency Standing Committee Guidelines on Mental Health & PsychoSocial Support in 2007 mentioned, “Emergencies create a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies erode normally protective supports, increase the risks of diverse problems and tend to amplify pre-existing problems of social injustice and inequality”. Hence, the disaster management policies of the countries need to consider their own vulnerability factors in socio-economic situations and look for best alternatives to rebuild the supports system at the earliest. Facilitating psychosocial support services is therefore needs to be a continuous process within the developmental projects of the country. The need of the centralized body and decentralized structure with regional capacities should be approached to reach to the people at the time of disaster.

Aim and Objectives

The paper comprises of two sections. One focuses primarily on providing a selective account of disaster psychosocial issues and mental health services. The other commences with an overview of policies and agency responsibilities and their relationship in psychosocial and mental health service provision during disasters. The paper aims to provide a qualitative analysis of broad range of issues in disaster psychosocial support and mental health services often experienced and reported in these eleven countries during last two decades. The paper is limited to the analysis of the following issues in disasters caused largely by natural hazards although the review would specially make references to manmade disasters also if there is a need. The key objectives of the paper are to:

i. Provide a review of the available literature on disaster psychosocial support and mental health service in SAARC and SEA regions.
ii. Analyse the policy, legal and institutional framework related to the overall disaster psychosocial and mental health service provisions in the selected countries.
iii. Discuss the commonality and differences in approaches and practices in this field (e.g., nature of services -whether curative, preventive or promotive; quality and quantity of post-disasters service provisions; training manpower & capacity building; profile of service providers; institutional mechanisms for implementation of project/program; funding mechanisms for service and training activities; and major constraints).
iv. Identify future areas of research to be explored in this field, which can contribute to the global and regional research in this field.

Methodology

Selection of countries was done due to following reasons:

(a) The geographic border and physical proximity among the countries
(b) The natural disaster vulnerability profile of these eleven countries
(c) History of these countries in terms of frequency of cross border disasters affecting more than 2 countries at a time.
(d) Similarity in the approach to disaster management in this region

Although the major emphasis of this article would be on natural disasters, if necessary references would also made to the profile of human made disaster which reveal a lot of civil unrest, political issues which are compounded with incidents of blast, terrorist attacks and subsequent mental health problems in these countries.

Data collection methods

The paper is based on primary as well as secondary source of data.

Primary data was collected through experiences of field visits undertaken in few countries (India, Sri Lanka, Indonesia, Thailand and Maldives) in the post-tsunami period in 2005 and 2006. The duration of filed visit was for a period of a week to a country and visits were made to the areas where some services were provided. A structured observation schedule focusing on important aspects such as commonalities in approach and practice, magnitude and pattern of the psychological problems, approach to provide psychosocial and mental health services, major service providers, legal provision and institutional mechanism to address the issue, post disaster service in past disasters and funding of service provision and capacity building in the sector. The data were recorded on the observation sheet on daily basis as visits were made to different location/places in the affected areas and analysis was done at the end of the visit by noting the finding on each aspect where there was 90% or above matching among the reporting days. Later on focused discussion with official handling such service provisions and other activities in this filed was also held to corroborate the observational findings.

Secondary data was collected through desk research on available literature on the subject. The research search was done through internet with the search words like, disaster psychosocial care, tsunami-mental health-SEA countries, disaster induced PTSD in SEA countries and country specific disaster psychosocial care. In addition to that various journals in the area of disaster, disaster management, response and mitigation as well as mental health, psychology and psychiatry available either in the form of abstract or full text on the Internet were also included. Various reports on the issue were collected from the respective organizations. Studies on war and other complex emergencies are excluded largely so as to focus on the natural disasters.

Analyses of Published Studies

Need and Significance of the Study

There has been a great mismatch in the areas of mental health research, practice, policy and services in this region as compared to the developed countries. Few studies that have investigated major mental health problems prevailing in these countries but missed out significant health problems. Studies have tended to be more donor driven and conducted in tertiary centres. The low priority accorded to mental health by the policy

makers, scarcity of human resources, lack of culture-specific study instruments, lack of support from scientific journals have been some of the impediments to mental health research in these countries. In addition, lack of community participation and absence of sound mental health policies have deprived the vast majority of the benefit of modern psychiatric treatments. Recently, with increase in collaboration in research, availability of treatment including low-priced psychotropic, and a growing emphasis on the need for mental health policy in some low-income countries, the bleak scenario is expected to change (Isaac et. al. 2007).

A particular country's response to a disaster was based on a multitude of factors. Some of these factors operated at the national level such as having a disaster management Act/Policy/Plan or Mental Health Act/Policy/Plan and some factors operated at the affected community level in terms of service provision done by the government along with reputed international organizations. The studies included in this paper varied greatly in terms of approach, objectives, methodology, and variables studied. However, the need to consolidate the existing mechanisms and initiatives in this filed is very important to understand the regional perspective on the application of disaster psychosocial support and mental health services in all these countries, so that regional cooperation in this area is clearly outlined.

With a high natural disaster vulnerability profile, **Afghanistan** has a long history of series of complex emergencies including refugee problems. The research on psychological and mental health impact and service provision, therefore, perhaps emphasize on the impact of these complex emergencies on human beings. The mental health problems pattern before and after the continuous violence and war has been reported to be significantly different. Few studies done in refugee camps (Mufti 1986; Dadfar 1994) reported higher incidence of anxiety and depressive symptoms among the refugees. Lot of studies (Rasekh et.al 1998; De Jong, 1999; Grima 1993) reported that major depression and high suicidal incidences among the women survivors in the Taliban controlled area as compared to the non-Taliban controlled area. A nation wide survey (Lopes Cardozo et. al. 2004) and an in-depth province wide survey in Nangarhar Province (Scholte et. al. 2004) found high figures of depression and anxiety among the women. These surveys also reported that survivors with physical disabilities had a higher chance of developing psychopathology. Inadequate number of mental health professionals in the country and their unavailability of data-base of their place of residence also realized as a major hindrance in providing mental health service provisions (WHO Mental Health Policy Atlas, 2001). Recognizing the importance of mental health problems in the affected area, The Afghanistan Ministry of Public Health

developed a basic package of health services (BPHS), which included mental health as a component (Govt. of Afghanistan 2003). A study done by Ventevogel et. al. (2002) mentioned that the creation of available, accessible, affordable and acceptable mental health facilities in Afghanistan can only be accomplished through a major primary health care service. Although there was some mental health programmes for children initiated by NGOs, there was no large-scale psychosocial programmes. Disasters other than war and complex emergencies where large scale or long term psychosocial rehabilitation was carried out is not evidenced. Even there is paucity of research in the area of psychosocial and mental health service provision, psychosocial intervention or impact. Community based psychosocial and mental health service provision after disasters caused by either natural or manmade disasters have to be evolved, hence a long way to go for larger implementation by the Govt.

Although the mental health professional in **Bangladesh** is significantly inadequate (Choudhury et.al. 2006), Govt. of Bangladesh's positive policy regarding the training of graduate doctor and civil surgeons, health assistants, nurses and religious leaders was a welcoming step towards wider acceptance of the magnitude of psychosocial problems after a disaster and provide support services to reduce mental stress and trauma. This change in the approach in fact after a study done by an NGO named as "Social Assistance and Rehabilitation for Physically Vulnerable" (SARPV 1996) reporting sixty-six percentage of the total tornado (13 May 1996) affected population were psychologically traumatized. It was also reported in the same report that women were more affected psychologically than men. The diagnosis of psychiatric illness was mainly mentioned as PTSD and Adjustment Disorder. Although lot of proactive measures for disaster mitigation and overall management have been taken up by the Govt. of Bangladesh, no special team or committee has been formed for the management of psychosocial trauma occurring in a disaster (Choudhury et.al. 2006). Psychiatric services are not yet incorporated in the existing health sector services. The referral is done in primary health care set up (with one medical officer trained in Psychiatry) and by the trained community level workers. Coming up with a series of policy level changes in this area along with Mental Health Act and implementation of Mental Health Policy are significant steps that could be extremely useful in the context of disasters.

Bhutan has taken the initiative in developing a comprehensive guideline on disaster risk preparedness and management in response to disasters caused by natural and manmade hazards during the last couple of years. It is now widely accepted that the psychological symptoms of trauma resulting from devastation to lives and livelihood of affected people remain much longer and sometimes throughout their entire life span

unless taken care of. Therefore, it is important to include psychosocial components of mental health protection and treatment of the affected persons in disaster risk preparedness and management to make it a comprehensive package. To respond to the medical and public health emergencies during disasters, the Ministry of Health of Govt. of Royal Bhutan instituted an Emergency Medical Response Team in 2003, which did not have a separate mental health and psychosocial care component (Dorji 2006). However, a four-tier system of mental health intervention and counselling has been proposed in line with the existing healthcare system and resources available in the country to make it sustainable. Training of community volunteers on psychosocial intervention, counselling and rehabilitation, is proposed to be backed up by three layers of trained health workers and mental health professionals. Evidence based research on the magnitude and severity, and prevalence profile of psychological and psychiatric illness in disasters in Bhutan is extremely inadequate. Some of the refugee studies (Thapa et.al. 2003) reported psychiatric disability among the tortured Bhutanese. However, any kind of focused study either on mental health impact or intervention during natural disasters is almost non-existent.

A review of **Indian** research on psychosocial and mental health aspects of disasters in terms of service delivery, training and research activities carried out during last more than two decades reveals a progressive shift in the nature and scope of services, the focus and objectives of training activities and in the issues pursued in the research activities. This shift is well reflected in the developments that have taken place during few major disasters viz. Bhopal Gas Tragedy (1984), Marathwada Earthquake (1993), Orissa Super-Cyclone (1999), Gujarat Earthquake (2001), Tsunami (2004) and J & Earthquake (2005). Although there is plethora of studies on the psychosocial and mental health impact (Srinivasamurthy 1990; Sethi et. al.. 1987; Narayanan et. al. 1987; Srinivasamurthy 2004; Agashe 2004; Parikh 2001:quoted in Vankar & Mehta2004; Bhadra 2004; Desai et. al., 2001; and service provision/intervention (Srinivasamurthy and Isaac 1987; Joseph, 2000; Prewitt-Diaz, et. al. 2004; Chachra 2004; Satapathy & Walia 2006; Satapathy & Walia, 2007; Math et. al. 2006) in the after math of disasters, literature is skewed towards the natural disasters as compared to the manmade disasters is still in its infancy. The Indian studies on mental health consequences of disasters have mainly covered the natural disasters. The interventions primarily were basic psychosocial services, psych-education, relaxation/meditation, child focused psychological problems and intervention (Vijaykumar et. al.2006a, 2006b), psycho-behavioural therapies and psychiatric treatment. The developments in the area of service, training and research have been occurring parallel to each other as well as following a combined approach. There has

been a marginal change in the recognition and acceptance of disaster psychosocial and mental health care at the policy, planning, and programme level. The paradigm shift from the "medical model to psychosocial model" with community based care and support at the core of it is remarkable. Apart from the significant changes in the disaster management initiatives, the few future plans focusing on psychosocial care and mental health in disasters are revision of Mental Health Act, National Guidelines on Psychosocial Support & Mental Health Services in Disasters, and inclusion of disaster psychosocial care in People with Disabilities Act. This has already been included in the recently released National Guidelines on Medical Preparedness and Mass Casualty Management by the National Disaster Management Authority, the apex authority in Disaster Management.

Indonesia is highly vulnerable to natural disasters because of its geographic location. While the scenario of unavailability of adequate number of trained mental health professionals in **Indonesia** is not very different from many other countries in that region, Indonesian Government had a policy to address the tsunami affected populations' psychosocial and mental health needs in an integrative way with community based approaches. Prior to tsunami, mental health has been neglected for many years across Indonesia and mainly hospital-based services were available. The national disaster preparedness plan does not include mental health & psychosocial aspects, hence not integrated to disaster preparedness and contingency plans (Setiawan & Viora 2006). In fact despite having a Disaster Mental Health Policy in 2003, service delivery models were difficult to implement, as mental health was not a priority therefore, was not a part of routine health care delivery system. After tsunami with the help of World Health Organization, mental health services are executed in three stages in tiers from community level to the highest referral level (such as services at the level of public heath centre and Specialist services). Primary Health Care System was the fundamental system of the new health care policy for the tsunami affected people. Although, community mental health providers (Maramis 2006) and community mental health nurse-CMHN (Saxena 2006) were the main service providers from the govt.'s side, the emphasis on the CMHN as the key service providers was very evident and was an innovative programme of its kind (Report on Inter Country Meeting, WHO, 2006). The basic (10 days), intermediate (30 days) and advance course on various aspects of mental health including diagnosis, intervention, management of common disorders, promotion and prevention for nurses were developed (Prasetiyawan et.al. 2006).

Tsunami, 2004, was the worst natural disaster **Maldives** had ever experienced in its history. In response to Tsunami, the Ministry of Health developed a draft health sector

Emergency Preparedness and Response (EPR) Plan (Ministry of Health, Republic of Maldives 2005), which contained components of mental health and psychosocial support following the World Health Organization's recommendations. Keeping the severe scarcity of trained mental health experts and Maldivian psychiatrist in view, a community based programme was initiated with the help of trained community level workers (Ibrahim & Hameed 2006b). The government assigned high priority to mental health and psychosocial support after tsunami. A Psychosocial Unit (PSS) was established to provide coordinated support to the disaster victims. The volunteer teams from the community formed Emotional Support Brigades in each affected island consisting of teachers, youths and health care providers. Some of other initiatives such as Ministry of Education's Education Development centre and Safe School programme, Technical Advisory Committee for Mental Health, and Youth counseling Services by Ministry of Youth & Sports are also remarkable. The profile of psychosocial distress found among the tsunami affected communities included emotional problems, such as, excessive crying, immense grief, survivors' guilt, fear, hopelessness, nightmares, hyper vigilance and anger; and somatic problems such as, headache, chest pain, loss of appetite, increased fatigue and insomnia (Ibrahim & Hameed 2006a). The joint study done by the Ministry of Gender, Family Development and Social Security- UNICEF also found tremendous psychosocial morbidity in children, adolescents and adults.

Myanmar has a well defined health care system under the Ministry of Health, which has three significant committees named, National Health committee, National Emergency Health Care Committee, National disaster Preparedness and Response Committee, inter-sectoral committee for Disaster Preparedness and Response, and others state and division level committees to look after emergency and disaster health care issues. However, it was found that not a single committee includes a mental health professional. After Tsunami, the Ministry of Health with support from World Health Organization held a series of training programmes and workshops and finally decided upon the proposed national plan for mental health and psychosocial aspects of disaster preparedness, which considered activities in pre, during and post disaster phases operating at three levels along with the organizational set up for providing care services (Htay 2006). Inter-sectoral partnership was also taken into considerations. It was also found that psychosocial impact assessment studies were almost not reported.

Nepal has the Natural Calamity Relief Act, last amended in 1992 and has included disaster management in its Ninth Plan. As a part of overall health care planning, although Nepal has a National Mental Health Policy, Strategy and Plan of Action -1997, the filed level application in terms of clearly defined programmes and activities is not very

promising. Inadequate number of trained mental health professionals in the country and unavailability of mental health services at district and community level is a result of ambiguity in this policy. Mental health services are mainly available in the capital city (Upadhayaya 2000). Mental health is not considered as a priority in the public health programme (Acharya et.al. 2006). The country's vulnerability to natural as well as manmade disasters such as complex emergencies pose greater threat to mental health of the affected population for which preparedness measures are being taken. The guidelines on best public health practices in emergencies in 2003 has included psychosocial and mental health needs of the disaster affected population and it is envisaged to provide comprehensive community based psychological intervention (Acharya et. al. 2006). Extremely few published documents mention the psychosocial and mental health effects of past disasters happened in the country and the service provision thereafter.

The massive earthquake in **Pakistan** in 2005 was the worst disaster the country faced ever in last hundred years, as a result of which hundreds of survivors were reported to be diagnosed to suffer from mild, moderate and severe psychological distresses. And this emerged as the biggest challenge to muddle through for the psychiatrists and psychologists here. Stress related disorders, acute stress reactions, anxiety, adjustment and panic disorders were the most commonly mental sufferings developed in maximum number of diagnosed psychiatric victims. Around 20-40 percent was reported to have mild psychological distress, while 30-50 percent was entrapped in moderate or severe psychological distress. Those who are with mild and moderate mental disorder have been in the range of 10 to 20 percent (Husain 2006). A study on the psychological trauma effects on the relief workers was also documented highlighting the significant impact of the disaster on the mental health of the relief workers as care providers (Bilal et. al. 2007). The Institute of Psychiatry & WHO Collaborating Centre in collaboration with Rawalpindi Medical College established mental relief teams within a week after the earthquake for providing psychological first aid to survivors at the three teaching hospitals. Each of the team consists of a consultant psychiatrist, three post graduate trainee psychiatrists, a psychologist and volunteers trained for psychosocial first aid at the Institute. General doctors and volunteers were also trained on these aspects to meet the demand from the huge number of people suffered from psychological and psychiatric disorders. National Plan of Action for Mental Health & Psychological Relief was proposed, which emphasized on early detection, intervention, referral and follow-up of acute trauma related with psychosocial consequences and psychiatric disorders along with restoration and provision of psychiatric services are also considered as prime objectives of the national action plan.

The first major disaster in **Sri Lanka** where mental health was recognized and assessed was after cyclone that hit Easter Sri Lanka in 1977 (Patrick & Patrick 1981). Then the epidemiological survey of general population in war affected areas of the country (Somasundaram & Sivayokan 1994; Somasundaran 1998, 2001) showed widespread exposure to traumatic events. Later on lot of studies on war victims done by various organizations such as Vivo 2003;; Doney, 1998; Bracken et.al 1998; reported wide prevalence of post traumatic disorder and other psychosocial problems among the war population in war affected area. Adverse psychological and psychiatric impact of various disasters on the children (Arunakirinathan et.al 1993; Sivashanmungarajah et.al 1994; Vivo, 2005a; Vivo 2005b) and women (Sivachandran 1994) and family systems (Jeyanthy et.al. 1993; Kumerandran et. al. 1998) have been reported in last few years. Development of a comprehensive and efficient psychosocial intervention at community level after a disaster should recognize the importance of dead body management as an integral part of it (Sumathipala et.al. 2006). Management of post-disaster mental health problems are reported to be provided on the basis of a three-tier service model, where trained community level workers work at a community level, a multidisciplinary of team work at primary health care level, and psychiatry care is provided at the district level. Therapeutic interventions for disaster survivors included psycho-education, crisis intervention, psychotherapy, CBT, relaxation 9both traditional and Jacobson's), pharmacotherapy, group therapy, family therapy, and other emotive methods. However, the service provision is largely done by the NGOs, both national and international. However, the most sustainable form of basic community based disaster psychosocial care is the need of the hour, hence should be strengthened. Govt. disaster management protocol and institutional mechanisms are needed to include the same in their protocol of post-disaster regular service provisions. A strong psychiatric referral mechanism is yet to be put in place.

The prevalence of PTSD, anxiety and depression among the natural disaster and exposed to traumatic events survivors in **Thailand** has not been assessed previously (van Griensven et. al. 2006). The rapid mental health needs assessment after tsunami, 2004 (= 392 displaced and 323 non-displaced) was done by these researchers as a part of public health emergency response. The report revealed that while symptoms of PTSD were found among 12% of displaced and 7% of non-displaced persons, anxiety symptoms were found among 37% of displaced and 21% of non-displaced, and depression was reported by 30% of displaced and 21% of the non-displaced survivors. A study done (Chakrabhand et. al. 2006) with a sample of 7,130 tsunami affected revealed that 30% of the victims had mental health problems during the first two months of the tsunami.

While the prevalence rate of PTSD was found to be 13% among the children living in the camps, 11% among the children from affected villages; depression was found among 11% of children living in the camps and 5% of children from the affected villages (Thienkrua et. al. 2006). Thailand government's initiative of sending mobile mental health teams (consisting of one psychiatrist, 1-2 psychiatric nurses, pharmacist, nurse aid and driver) to the affected area within 72 hours was very remarkable (Dept. of Mental Health, 2005b). In addition to that, outreach programmes assisted survivors in ventilating stress reactions, which facilitate positive mental health (Cohen 2002). Assessment, referral, treatment, psycho-education and group activities were also provided as out reach services up to three months. Facilitating community resilience, addressing quality of life among the vulnerable groups, advance mental health support to people suffering from various mental health problems, mental health surveillance system, and establishing "mental health recovery centre" in communities and "mental health operations centre" at the Department of Mental Health were very appropriate initiatives that were taken up by the Thailand Government in the recovery and rehabilitation phase (Chakrabhand et. al. 2006). The Department of Mental Health also developed National Guideline for Mental Health Intervention in Natural Disasters along with other appropriate mental healthcare measures. The approach was to provide community based disaster psychosocial care support to the tsunami survivors in a continuous manner, even focused services for people with disabilities, children, and elderly. A study on the impact adaptive capacities of the tsunami affected Thai communities (Paton et. al. 2007) also highlighted the importance of collective efficacy in better coping of the affected communities. A clear set of strategies and line of command for management of psychosocial care and mental health programmes in the disaster situations are urgently needed (Panyayong & Pengjuntr 2006).

Increasing research on disasters is being done, to gain a better understanding accumulated from many different sources, to serve as a basis to anticipate the effects on the people, family and social systems in recovering from them or to avoid to some of the possible long term repercussions (Rehman et. al. 2007). However, this research is in an early stage with a history of 5-10 years in most of the countries in this region of the world.

Discussion

With the growing concern about the disaster management, the psychosocial component is becoming an urgent issue for the early recovery of the survivors and to build the resiliency of the community. The effort of building resiliency would also ensure higher disaster risk reduction as people develop the understanding and skills to deal with different vulnerability issues at their individual, household or community level.

Commonalities and Differences in Approaches and Practices:

Commonalities which emerged from the above review are as follows:

- Most of the countries have developed multilayer systems of disaster management and division of responsibilities with disaster management act, policy and preparedness plans. However, reference to mental health and psychosocial care for disaster survivors is extremely limited in its mention in various policies and plans either in disaster preparedness or health management area.
- The disaster management framework is mainly to deal with the housing, food emergency supplies and have less reference on the long term needs including mental health needs of the survivors.
- Inadequacy and unavailability of trained mental health professional is a common issue in most of the countries.
- In almost all countries the Ministry of Health is primarily responsible for disaster mental health and psychosocial care. Although inter-sectoral cooperation has been emerging strongly for a sustainable community based disaster psychosocial and mental health service in many countries capacity building in this area.
- The ministry of health is mostly given the responsibility to manage with health services and have very less reference on the mental health services in the immediate or in long term.
- A lot of reference to the mental health service provision, institutional mechanism for doing so and to research in this area has been reported in the context natural disasters and the sudden events of disaster, but the repeated nature of disasters and the disasters of slow onset (draught, monsoon flood) and manmade (fire, stampede, bomb blasts) are largely ignored.

Magnitude of the problems:

- While the effects of few large scale cross boundary natural disasters have been well researched and evidenced extensively in countries such as India, Sri Lanka, Pakistan,

Afghanistan, Thailand and Maldives, but not in other countries. However, the actual research on the magnitude and pattern of psychosocial and mental health problems in countries like Thailand, Maldives, and Pakistan has started in this decade only, mainly in response to the tsunami (2004) in the former two countries and to earthquake (2005) in Pakistan. This is also evident that research in other countries really peaked up after the tsunami and more coordinated response was planned for better recovery.

- On the basis of the literature, it is evident that the magnitude and pattern of psychosocial and mental health problems in all these countries are very similar, mainly highlighting the existence of largely stress related disorders and common psychosocial problems, as well as incidences of anxiety-depressive disorders, PTSD and associated psychosomatic problems.
- The impact assessment on the magnitude and pattern of psychosocial and mental health indicators largely covered adult survivors. Very few studies have been reported on children and extremely few studies have been reported on other vulnerable groups.
- It is also noticed that no country has a provision for time bound needs assessment of survivors' psychosocial and mental health needs. However, periodic needs assessment is very essential for quality service provision.

Major Service Providers

Mental health services and psychosocial support services are mainly the portfolio of the Government, which is supported by various national and International organizations during disaster, crisis or emergency situations. The UN organizations, specifically WHO is extremely active in popularizing the concept and integrating this component into the main disaster preparedness and response plan of various governments. UNICEF has supported the psychosocial care support program for the children in schools following various disasters. Other organizations like, Save the children, Plan international, various Red Cross Societies with support from international Red Cross Partners, MSF, Action Aid, CARE and many other organizations have supported the psychosocial support program for the survivors of disasters in different countries.

Beyond the psychological support services in the wake of a particular disaster, some of the organizations have emphasized on the long-term development of skills in the government structure and administration. The purpose is creating skills and awareness among the government higher officials to initiate psychosocial support services immediately after the disaster or to initiate resilience building activities among the

communities. In many countries, it was found that some national level institutes in mental health or disaster management have developed a major footage towards this direction, which can be considered an important example in the region to develop similar initiatives.

Agency-run/Project based Approach vs. Institutionalization

It was found that although governments of most of the affected countries were very proactive and cooperative in the smooth running of programmes and projects on disaster psychosocial care and mental health services, the non-government organizations mainly were into the research as well as service provision at the community level. Starting with the training, awareness generation, developing resource materials and service provisions in this area, these organizations work with the respective governments, as one of their main mandate/priority is mental health. More importantly, the financing of these capacity building or service provision or research projects or programmes in disaster mental health and psychosocial support were largely done by the non-government organizations.

Duration of Service Provision

Duration of service provision for disaster mental health and psychosocial support is largely immediate and short term. The literature on the long-term mental health needs of the affected population is largely silent and under reported perhaps. In some situations it has also been noticed and reported that the services also have been extended by different organizations for two to three years or more after a disaster in the rehabilitation phase, specifically in tsunami affected countries. But mostly, the organizational and Government efforts are time bound and end up within the rehabilitation phase.

Multi-sectoral Approach in Service Provision

Community capacity building and training of people from different sectors including, health, education, social welfare, youth development, women & child development are essential part of the service provision. This multi-sectoral and community based approach is often very easily acceptable by the survivors. In the absence of available trained mental health professional in all most all countries, this approach to delivery psychological care and mental health services to a large number of survivors with non-medical personnel is the most viable option with the governments. Moreover, the acceptance of mental health and psychological needs as an integral part of other relief

and rehabilitation services and these are complementary and supplementary to each other for community resilience is now widely internalized by all the countries.

Issues Affecting the Response to Disasters

The culture of most communities in this region is deeply embedded in religion, traditions and faith. This affects the expression of psychological distress of disaster survivors. As contrast to prevalence of the disaster PTSD symptomatology in western countries, the presentation of psychological distress is more somatization in form with disassociative and conversion symptoms (Report of an Inter-Country Meeting, WHO, 2006). Sleep problems, vague body ache, headache, irritability, alcohol and substance abuse, suicidal tendencies, strange behaviour, aggression, etc. are very commonly seen amongst the disaster survivors. Another typical characteristics which is (associated with the deep rooted stigma about mental illness in this region) often found among these survivors is their reluctance in seeking help in this situation.

It is not very clear that whether periodic needs assessment on disaster psychosocial and mental health needs is done before carrying out the service provisions. The standardization of needs assessment format used in these countries also a big issue to look into, which can affect the outcome of the service provided to the survivors.

Nature of DMH-PSC Services: Curative, Preventive or Promotive

It was found that mental health is not a priority area in the overall health system of many countries irrespective of whether they faced frequent disasters or not. As per the report of an inter-country meeting on the mental health and psychosocial aspects of disaster preparedness held be WHO in 2006 at Thailand, disaster preparedness plans of its member states are extremely limited in terms of meeting the mental health and psychosocial needs of the affected population. Although, most of the service provision in different countries started with a motive to provide curative services in the post-disaster phase, gradually, government's survivors' friendly policies and initiatives found to be moved more towards community capacity building and sustainable mental health promotion in most of the countries, except a few, such as Nepal, where many positive steps are yet to be taken up. The tsunami affected countries although showed a greater sensitiveness towards the mental health and psychosocial needs of the survivors, actions were entirely reactive and response oriented. Ensuring sustainability through community mental health nursing in Indonesia, integration into the primary health care system in Sri Lanka, mental health surveillance system in Thailand, and community based services in India are some of the good examples of preventive and promotive

measures taken up by different countries. This is also observed that regional cooperation was highly prominent in developing manual and preparedness plan for training of community level workers.

Existence of a Proper Referral System

It was observed and found that most of the countries did not have a proper psychiatric referral system at place while faced with recurrent disasters in past few years/decades. Referral was done in terms of ad-hoc arrangements either made by many international and UN organizations or by the respective governments. No single study is done on the long-term mental illness following a disaster in any country perhaps because of lack of data in absence of record keeping and existence of psychiatric referral system at place. While for strengthening a proper psychiatric and mental health referral system all countries need to integrate this component into their existing public health system available at the community level, developing and practicing mental surveillance protocol would be an asset.

Research and Development

The followings are few important areas of research which could be explored by future researchers could also take interest:

- The process and method of standardization of psychosocial and mental health need assessment questionnaire in few or all countries.
- Specific psychosocial and mental health intervention for more vulnerable groups and focusing on the pre and post intervention qualitative as well as quantitative studies.
- The correlates of sustainable community based mental health and psychosocial interventions such as mental health nurses in primary health care system and mental health surveillance system.
- It was also found from the review that research and development on disaster related psychosocial support and mental health services is yet to focus on the role of cultural differences in service provisions and natural coping strategies/resources; indigenous practices to manage physical, social and psychological recovery from a disaster; and comparative picture of culture-specific psychopathology in these countries and variation during disasters.

Emerging Needs

- It is found that except Bhutan, Nepal and Afghanistan, all other eight countries have included disaster psychosocial care and mental health services provision either at the

policy, Act, and national level disaster management planning or at least incorporated a component on this in disaster related activities. Even in these three countries, the issue is being discussed at higher level to be incorporated in the overall disaster management activities.

- However, there is no clearly defined institutional mechanism for disaster psychosocial and mental health preparedness (i.e. mainly all types of capacity building for creating adequate trained and sensitized manpower), response, and evidence based hardcore research and documentation, which could be a major constraint in providing quality and need based care for the disaster survivors. Disaster management framework for psychosocial and mental health services should loot at the specific budgetary allocation for all these aspects of care provisions. Therefore, all these countries should revise the existing system of health care provisions, and appropriately integrate this essential component into the public health preparedness for a better-coordinated response.
- On the other hand a clearly defined institutional mechanism would also ensure equal importance to the service provision to large as well as small-scale natural and manmade disasters.
- This would also ensure accountability on the part of the government mechanisms for culture sensitive quality services.
- Regional cooperation is highly needed in developing resource materials for training at all levels, developing system and institutional mechanisms, and working towards more disaster risk reduction measures.
- In most of the South and South –East Asian countries the community-based structures at the grass-root level are quite strong through initiation of the women groups, youth group or through development of micro finance structure and income generation activities. Facilitating psychosocial care support at this level would ensure the building resiliency and preparedness for dealing with stress and disaster related events at individual, family and community levels. Empowering the existing community based organizational structure would ensure a continuous flow of services, which is essential to develop the resiliency among the people. In most of the cases the Government structures in these countries are over burdened with the work and daily responsibilities, which become bottleneck to develop services above meeting the ongoing needs of the communities. Hence, ensuring adequate resources in developing structure may be an important matter to reduce the vulnerabilities.
- Further building professional skill is one of the areas, which is lacking for ensuring adequate services at the grass root level. Ensuring adequate knowledge and skill base

initiatives at the graduation level of education will certainly benefit the community at large. Specifically, mental health and psychosocial support education for the persons living in difficult situations may be included in the humanitarian streams like, psychology, social work or sociology. Similarly, facilitating the psychosocial care knowledge and basic health care requirements for the disaster survivors could be included in the teaching of college of nursing and medical courses.

Conclusion

Disasters caused by different natural hazards have taken significant toll on the lives and livelihoods of the people in South Asia and South East Asian countries in last few decades. However, one of the positive responses to these major disasters has been the development of disaster management initiatives by respective governments and other national and international agencies. The inclination for the inclusion of disaster psychosocial support and mental health services in the overall disaster management framework of all the countries is on rise, hence, shows wider recognition and acceptance of the fact that disaster affected people have certain specific psychosocial and mental health needs, which are required to be addressed during various relief and rehabilitation programmes, developmental activities and projects.

The best form of disaster preparedness in psychosocial and mental health area is to have a strong preventive and promotive community mental health system (including mental health surveillance system) in place and to be strengthened timely and appropriately so that trained manpower and resources could be mobilized rapidly should the need arise in the wake of any disaster.

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