Mental health and psychosocial response after the worst natural disaster in the history of the Maldives

ATHIFA IBRAHIM1 & ABDUL HAMEED2

1Ministry of Gender and Family, Male’, Maldives and 2Ministry of Health, Male’, Maldives

Abstract
The Maldives as a geographically diverse nation had to face tsunami with a number of key issues in hand. These included large geographical spread of islands, varied levels of communication across islands and internal displacement of people. One third of the total population was directly or indirectly affected. All except nine inhabited islands were partially or totally flooded. Although the total loss of life was limited the effect on the population was tremendous. The cost to the economy was 62% of the annual GDP. The government not only assigned high priority to mental health and psychosocial support activities after the tsunami but took charge of training and support measures. The community outreach programme provided psychosocial support to every affected person. This was provided by local Maldivians, who were appropriately trained, thus making it culturally and technically appropriate. Long-term plans for mental health and psychosocial aspects of disaster preparedness have been initiated. The experiences of the tsunami disaster has provided an opportunity to review the existing state of mental health services in the Maldives and to develop a plan to meet the mental health and psychosocial needs of the community. A rapid and appropriate response to a disaster depends on an existing policy structure and system, and an ability to mobilize these plans.

Introduction
The Maldives is an archipelago of about 1190 islands grouped into 26 natural coral atolls that straddles the equator and lies outside the Indian Ocean cyclone belt. The islands of this small nation are not more than 1.5 meters above sea level and range from 1 to 9 kilometers in length. The population of the Maldives is 298,842 (Ministry of Planning and National Development, 2006) scattered among approximately 200 islands dispersed over a large geographical area. The country consists of a homogenous group of people, sharing the same language, religion and culture.

Impact of the tsunami on the country
The tsunami that formed as a result of a massive earthquake that hit the Indonesian island of Sumatra struck the Maldives shortly after nine in the morning of 26 December 2004, bringing along death and unimaginable destruction in its path, and forever imprinting the horror and suffering in the hearts and souls of the Maldivians. Waves ranging from 1 to 4 meters in height slammed into the islands sweeping across entire islands, carrying with them lives, homes, vital infrastructure and entire livelihoods. One third of the Maldivian population was directly hit by the waves and although the loss of lives in the country was not high in number compared to some of the other affected countries, the relative impact both in terms of the economy and the population was much greater than in other affected countries.

All except nine inhabited islands were either partially or fully flooded. About 130 people lost their lives or were missing and most of these were women and children. Some islands had to be completely evacuated as entire communities had been deracinated and basic infrastructure, homes and vegetation had been completely destroyed. 12000 people or 7% of the population was displaced (World Bank, Asian Development Bank (ADB), UN system, 2005). Thus, thousands had to be provided alternative accommodation in temporary shelters or with host families while some fortunate ones were given refuge by other family members and friends living elsewhere. This was a difficult issue for the country to deal with as the nation has never had to face the issue of homeless people before.

The cost of destruction and damage to infrastructure and industries is estimated to be 62% of the annual GDP of the country. 15% of the islands have had their water supply disrupted and 25% of islands had major damage to essential infrastructure such as jetties and harbours (World Food Programme, 2005). Houses and personal assets, educational and health facilities, transport and communication and utilities'
infrastructure have been either completely destroyed or severely damaged in the affected communities.

The Maldives economy is based on two industries; tourism and fisheries. Agriculture also plays a significant role in the local small scale economies. The disaster had a terrible impact on all these economic activities. According to the Joint Needs Assessment (World Bank, 2005), tourism, fisheries and agriculture suffered approximately USD 266.2 million in losses directly and approximately USD 30 million in indirect losses.

In the case of the Maldives, the December 26th tsunami disaster was a nation-wide catastrophe. It has been the worst natural disaster in the history of the Maldives and has set back the country by twenty years of development.

*Psychosocial distress in tsunami-affected communities*

The psychosocial impact of the catastrophe has been exacerbated by the loss of livelihood and consequent uncertainty of the future. In addition to losing livelihoods and a lifetime of savings and assets, the damage to the fishing and tourism industries have meant job losses for many people, especially the younger segment of the population. Initially the issues confronted by the affected populations were emotional problems such as excessive crying, immense grief, survivor’s guilt, fear, hopelessness, nightmares, hyper vigilance, anger and some somatic problems such as headache, chest pain, loss of appetite, increased fatigue and insomnia.

Many social problems emerged, such as domestic violence, vandalism, violence, drug abuse and thefts. Also social tension is evident in communities with Internally Displaced Persons (IDPs) especially in communities where there are IDPs from other islands. Some of the other issues include low acceptance of the tragedy, high expectations from aid agencies, differences in values, favouritism in service delivery and employment.

The Ministry of Planning has previously conducted two Vulnerability and Poverty Assessment (VPA) surveys in the Maldives. One in 1998 and the second concluded in October 2004. These surveys are very well designed and include a nationally representative sample. After the tsunami a third partial VPA has been conducted from July-August 2005. This has been called the Tsunami Impact Survey. This survey questionnaire consists of some of the relevant household questions, new household questionnaire to assess tsunami damage and two new modules—one on psychosocial issues and one on reproductive health. The survey has been conducted only in the 14 officially designated most-affected islands. Fifty per cent of the original sample of the VPA (approximately 15–30 households in each of the 14 affected islands, totalling 240 households) in these islands have been re-surveyed. The households have been selected randomly. Each person over 15 years in the household has been interviewed. The psychosocial module was developed by the United Nations Population Fund (UNFPA), Ministry of Health (MoH) and the technical group for psychosocial issues. Some of the questions from the needs assessment survey form given by WHO were also included. Data analysis has been completed. The results will be released shortly.

The Ministry of Gender, Family Development and Social Security in collaboration with UNICEF conducted a survey to determine the effects of the disaster on the population with particular focus on children, parents and caregivers; to determine the needs of the affected communities and to recommend actions for the future. A qualitative assessment in the form of educational workshops was conducted. A total of 1031 persons living in 4 islands, some affected and some hosting the affected people were interviewed. The findings clearly point to the tremendous psychosocial morbidity in children, adolescents and adults. Based on this survey they recommended urgent measures to provide psychosocial support to the affected communities.

Care society, an NGO based in Male’, is conducting a quantitative assessment of psychosocial distress and mental health needs in 5 islands in Raa, Baa, Laamu and Gaafu Alifu Atoll. They will be using the GHQ-12 as an assessment tool. This instrument was validated with WHO South East Asia Regional Office (SEARO) assistance in February 2005.

*Mental health and psychosocial activities in the maldives after the tsunami*

The immediate response to the disaster at the island level was led by local community leaders of the islands and involved the entire community. The magnitude of injuries and extent of damage was quickly assessed. Information from neighbouring islands was obtained by VHS radio which continued to function. By the afternoon of the same day most of the severely affected islands were evacuated by boat and moved to neighbouring less affected islands. At the less affected islands the displaced persons were warmly received by the local community and provided with food and shelter in private homes. The support at the island level was also provided by the atoll chiefs.

*Emergency psychosocial support response team*

The National Disaster Management Centre (NDMC) was established within days of the
Psychosocial response to the tsunami in the Maldives

Psychosocial first aid

The PSS Unit comprised only of volunteers and was responsible for the psychosocial support services provided by the NDMC during the emergency phase (first 3 months). The volunteers included counsellors, social workers, teachers, students, and people with other relevant skills. An overall coordinator was appointed. From its inception, the Unit established various services to lessen the psychological impact on the people. The activities of the unit included psychosocial interventions in the islands, training programmes for volunteers in psychological first aid, media awareness, outreach programmes to the islands and a helpline for information and crisis management.

Immediately after the disaster, this unit mobilized volunteers consisting of some previously trained counsellors working with different agencies and other volunteers interested in providing psychosocial support to the disaster-affected community. (75 islands in 16 atolls for interventions/assessments) All members of the team were local Maldivians who spoke the local language and were familiar with the local culture. The American Red Cross conducted a qualitative rapid assessment of the affected islands in terms of overall emotional status. Based on this assessment the American Red Cross conducted two programmes – psychological first aid programme in which 70 counsellors were trained in a two day workshop. This programme was in collaboration with UNFPA. The second programme was entitled ‘Tsunami Operation Teachers Training Programme’ in which one teacher from each inhabited island was trained to provide psychological support to students. 321 teachers in 20 atolls were trained. This programme was in collaboration with UNICEF.

The volunteer teams immediately went to the islands and formed Emotional Support Brigades in each affected island consisting of youth, teachers, and health care providers. Through this out-reach programme, all affected islands were reached, and each and every affected person was provided at least some emotional and psychological support.

Staff at the Indira Gandhi Memorial Hospital, the tertiary hospital in the Maldives, were also trained to support traumatized patients from other islands coming to the hospital. A helpline was established with four lines on a central number. This programme received support from UNFPA and UNICEF who also provided toys and relevant educational material for schools.

All the activities undertaken in the psychosocial and mental health area have followed the basic approach recommended by the Sphere guidelines (these were developed with assistance from WHO, Geneva, and are entirely consistent with the WHO approach). Formal counselling has been recognized to be unnecessary for the vast majority of affected individuals and offers of counsellors from other countries were declined or deferred by the government. Care has also been taken to avoid labelling of affected individuals as psychologically abnormal or damaged.

Since the unit was well organized and had a substantial pool of volunteers, it was able to effectively utilize the timely donor assistance, especially in the areas of programme assistance, training and logistics.

Training of community-based health care providers

The MoH recruited a consultant in mental health for three months. The consultant completed the following tasks:

- Developed training programmes for identification and management of common mental disorders in the community.
- Conducted several training workshops for physicians, nurses and community health workers on identification and management of common mental disorders in regional and atoll hospitals.
- Worked with the Faculty of Health Sciences to assist them in the development of a curriculum for psychiatric nurses, community mental health workers and psychiatric social workers and conducted the first training programme.
- Trained the staff of the Home for People with Special Needs at Guraidhoo in rehabilitation and clinical services.

Forum for partners in mental health

The MoH brought together all stakeholders working in the field of mental health from 6 to 9 June 2005 with the aim of exchanging information on work of
individuals/organizations/institutions with emphasis on issues related to mental health. This groups was entitled the “Forum for Partners in Mental Health”. It is a major initiative of the Government of the Maldives. The forum paid particular attention to existing policies, regulations and research.

Technical advisory committee for mental health

After the Forum meeting, the MoH proposed the formation of a technical group to serve as an advisory body to the MoH on development of the mental health system in the country. An informal group has already been set up. Currently the committee includes one elected representative (MP), people in decision-making capacities in various ministries, counsellors, community leaders, etc. The formal terms of reference (TOR) for this technical body is likely to be developed shortly. The TOR will be sent to all ministries for comments before finalization.

American red cross

The American Red Cross has several programmes on psychosocial support to the community.

Community resilience project. The community resilience project in coordination with the Ministry of Gender, Family Development and Social Security of the Government of the Maldives will develop the skills of community facilitators (1 community facilitator per 50 population) to

(a) conduct risk assessment;
(b) promotion of resilience through community recreational activities;
(c) facilitate participatory planning for action that enhances the entire community’s well being;
(d) work with different groups in the community.

The community resilience project will contribute to the development of a community which will

(a) have community maps with detailed analyses of risks and resources in the community;
(b) have a strong sense of community characterized by open relationships between people and good communication;
(c) have a plan focused on community development for the benefit of all groups, supported by local systems such as schools, health posts, women’s self help groups, religious groups and local organizations;
(d) acknowledge its problems of poverty and conflict as shared rather than individual problems and committed to developing collective responses.

Safe schools programme. In this programme one teacher from each inhabited island was trained to provide psychological support to students. 321 teachers in 20 atolls have been trained. This programme was in collaboration with UNICEF.

IDP/host family psychosocial project. Initially it appeared that people would be relocated to their islands within months. However the IDP/host family situation is far from resolved and psychosocial support has emerged as a need. The American Red Cross programme is addressing these needs.

Ministry of education: Educational development centre (EDC)

Pursuant to the tsunami, the Ministry of Education has assigned the School Health Unit of EDC to carry out and coordinate psychosocial support programmes in the schools of the country. In this regard the School Health Unit is collaborating with the American Red Cross to carry out a comprehensive psychosocial support programme which will include preparedness and resilience enhancement activities as well as a safe schools programme.

Ministry of youth and sports: Youth counselling services

Following the tsunami, visits were made to some of the affected islands in the northern and southern parts of the Maldives (Meemu, Thaa, Shaviyani and Kaafu Atolls). The objective being to carry out psychosocial needs assessment and psychosocial interventions. The activities conducted were clay therapy, art therapy, story writing, group sharing, individual sessions and home visits. They also counselled clients referred from IGMH, and their counsellors were deputed to NDMC for technical support.

Ministry of gender, family development and social security and UNICEF

This Ministry in collaboration with UNICEF conducted a survey to determine the effects of the disaster on the population with particular focus on children, parents and caregivers to determine the needs of the affected communities and to recommend actions for the future. Their programme and findings have been described in a previous section.
Care society

Care society is an organization formed to advocate for the rights of the disabled. Before the tsunami, Care Society ran a series of activities related to mental health to create awareness about disabilities, train special educators and management staff to establish community-based rehabilitation (CBR) centres, promote independent living skills and socialization skills through vocational training programmes and assisting disabled people to find work, and advocating for the rights of disabled. After the tsunami, the objectives of Care Society were revised to include advocating for the rights of children and women, strengthening of community-based organizations, and responding to the national disaster. In January 2005, Care Society implemented a cash for work programme in 8 islands in Laamu and Gaafu Alif, funded by OXFAM. The project lasted two months. In April 2005, a project on tsunami recovery efforts began. The project included four components, namely agriculture, preschool development, preschool building and psychosocial support. The project was implemented in 15 islands in Raa, Baa, Laamu and Gaa atolls. The psychosocial support programme was implemented by training two community level workers (CLW) in each island, who were attached to a community based organization or a women’s development committee. The capacity of these CLWs was built through a series of short-term trainings. A long-term training is also being considered. A quantitative assessment using GHQ-12 as a tool is being presently implemented. Care Society is also in the process of integrating disaster preparedness into all the components of the project, including a psychosocial support programme.

Society for Health Education (SHE)

Starting from the first day after the disaster, SHE counsellors were posted in IGMH round the clock and provided support to the casualties and their relatives being brought in from the islands. SHE counsellors collaborated with other counsellors in setting up the Psychosocial Support Unit at NDMC.

Activities on psychosocial support at relief centres included individual counselling by SHE volunteers for those traumatized by the disaster, management of one relief centre along with other NGOs and assisting the community of Vilufushi with the livelihood project in collaboration with OXFAM.

UNFPA – Psychosocial support programme

Following the tsunami, UNFPA identified the importance of providing psychosocial support to the affected communities. A project was formulated entitled: “UNFPA response to the psychosocial impact of the tsunami disaster in the Maldives”. The project was aimed at promoting the psychosocial well-being of the people affected by the tsunami in Raa, Meemu, Dhaalu, Thaa and Laamu atolls. The project consists of 5 activities.

1. Develop and implement monitoring tools for assessing psychosocial well-being and to integrate these in the on-going data collection.
2. Strengthen the capacity of current and newly recruited national health social services staff.
3. Strategically place trained staff in the atolls to enhance the national and community level capacity in the psychosocial area.
4. Involve regional authorities and communities in defining and managing psychosocial interventions.
5. Liaise with relevant agencies to support a process for the development of appropriate and relevant policy and frame-work for the programme of psychosocial and mental health care.

Lessons learnt from dealing with the tsunami (WHO 2005)

The immediate response to the disaster at the island level was led by local community leaders of the islands and involved the entire community. The magnitude of injuries and extent of damage was quickly assessed. Information from neighbouring islands was obtained by VHF radio which continued to function. By the afternoon of the same day most of the severely affected islands were evacuated by boat and moved to neighbouring less affected islands. At the less affected islands the displaced persons were warmly received by the local community and provided with food and shelter in private homes. The support at the island level was also provided by the atoll chiefs.

The following points illustrate some of the lessons learnt from dealing with the experience and resilience shown by the community in responding to the disaster:

- The immediate island level response was excellent.
- The success of the island level response and the warm reception by the host community points to the need for developing community resilience, coping skills and promoting community relationships and harmony.
The government of the Maldives launched a well-organized community-based campaign to provide psychosocial support to the disaster-affected persons.

The immediate response of the government in establishing a psychosocial unit is highly commendable and indicates the government’s recognition of the issue as important for the community.

All members recruited and trained by the psychosocial unit were local Maldivians who spoke the local language and were familiar with the local culture.

Through the Emotional Support Brigades all affected islands have been reached, and every affected person has been provided at least some emotional and psychological support.

The technical content of the psychological first aid was appropriate and in keeping with WHO guidelines.

The government of the Maldives requested support from select agencies and denied access to numerous INGOs. This prevented problems of coordination between agencies, which has been observed in other countries.

Overall, the coordination of relief efforts was good, but perhaps one lead agency serving as the coordinator of Ministries would have been more beneficial.

Not having quantitative community-based data on the magnitude of psychosocial distress and mental health needs of the tsunami-affected victims limits assessment of the impact of psychosocial relief efforts.

A clear plan should be in place to determine which instruments will be used, when and by whom in case of future disasters.

Validated questionnaires (quantitative) for needs assessment and mental health status of the affected population should be readily available to all partners.

Modern communication equipment should be installed/upgraded regularly.

Use of modern technologies such as e-mail, web-cam, wireless and satellite communication at regional, atoll and island level should be made available.

Public information provided by senior officials of the MoH helped to reassure the public and avoid rumours.

A ‘risk communication’ strategy for disseminating essential information during emergencies using damage resistant technologies should be prepared.

Some thought should be given to damage resistant water transportation such as inflatable boats which can be stored in island offices.

Although the overall response to the tsunami of the government was excellent, local Maldivians who worked in the community mentioned the lack of information sharing between Ministries and agencies on who was doing what e.g. many assessments were done by different Ministries each for its own specific mandate. It has been mentioned that many of these could have been combined.

The experiences of the tsunami disaster has provided the opportunity to review the existing state of mental health services in the Maldives and to move forward by preparing a plan to address the MHPS needs of the community now and in future. A quick and appropriate response to a disaster depends on an existing policy structure and system. The best form of disaster preparedness in MHPS is to have a strong community mental health system in place to which additions in terms of personnel, skills and resources could be mobilized rapidly should the need arise.

References

3. World Health Organisation (WHO), 2005 Mental health and psychosocial relief efforts after the tsunami in South-East Asia.