

**MENTAL HEALTH AND PSYHOCOCIAL SUPPORT ACTIVITIES
IN RESPONSE TO THE TSUNAMI DISASTER
IN MALDIVES**

**DETAILED EVALUATION
IMPACT ASSESSMENT AND
RECOMMENDATIONS FOR DISASTER PREPAREDNESS**

BY

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1. Magnitude of the tsunami disaster

Maldives is a low-lying country encompassing an archipelago of 198 widely dispersed islands which are at a maximum of 1.5 metres above sea level. Even in normal times, 88 of those islands record perennial beach erosion. The tsunami affected many islands, some being destroyed altogether. The death toll reached 82, the highest in the history of the Maldives in a single disaster, with another 26 people missing and 2,214 people confirmed injured. Over 11,000 were left homeless of which nearly 5,000 had to be evacuated to other islands. The entire population of 13 islands had to be evacuated. The existing health infrastructure suffered severely, with one regional hospital, two atoll hospitals and 20 health centres totally destroyed.

2. Mental health scenario in Maldives prior to the tsunami

2.1 Mental health services

Health services are organized in Maldives in a four-tier system. At the tertiary Care level there are two large general hospitals both in Male'. There are 6 regional hospitals (of which, one has been badly damaged in the present disaster). There are 10 atoll hospitals (two have been destroyed in the present disaster) and 63 health centres (20 health centres totally destroyed) and 127 health posts. A large percentage of doctors in the islands are expatriates, with a high turnover.

There are two psychiatrists who provide services at the Indira Gandhi Memorial Hospital and the private hospital in Male'. There is no separate inpatient service for psychiatric patients at either of the two hospitals, though a few patients are admitted to the medical wards as needed. No specialized mental health services are available in any of the regional or atoll hospitals. There is only one trained clinical psychologist but no trained psychiatric nurse or trained psychiatric social worker in the country. There are several trained counselors in Maldives. Many of them work in the field of drug de-addiction while others work in diverse agencies including NGOs. Nurses and community health workers are taught the basics of mental health during their training by the Faculty of Health Sciences.

There is one Home for People with Special Needs at Guraidhoo, housing approximately 120 patients. These patients include long standing mentally ill, aged persons and mentally challenged persons. One psychiatrist visits the facility 1-2 times a month. Patients requiring psychiatric consultation in other parts of the country either have to come to Male' or get some telephonic consultation through discussion between the psychiatrist in Male'' and the medical officers in the islands. There is no established system for follow up of those receiving psychiatric treatment in the islands.

The Drug Rehabilitation Centre at Himafushi is very modern with a well motivated staff. A full range of therapeutic activities throughout the day are outlined and the key programmes are

run by clients of the programme. Families are also involved. The average length of stay is 9 months and an increasing number of clients are voluntary.

In 1998, the Ministry of Health (MoH) of Maldives declared that mental health and rehabilitation services need to be further enhanced. This came into sharper focus following the celebration of World Health Day on the theme of mental health in 2001. In 2003 MoH further declared that the progress of mental health interventions was not satisfactory. Lack of qualified human resource in mental health was reported to be the main hindrance in implementation of mental health services.

Patients with major neuropsychiatric disorders can obtain free medications from the Ministry of Gender, Family Development and Social Security. In order to avail of this benefit they must first be seen by a physician and be registered with the Ministry.

As of now there is no formal policy for mental health and specific mental health legislation has not yet been drafted. Current laws relating to mental health are in the health act.

2.2 Mental Health Surveys

A survey was conducted in 1989 in 5 northern atolls. The reported prevalence of mental disorders was 0.29% and epilepsy 0.27%. Details of survey methodology and definition were not available at this time.

A national registry that covers mental disorders is maintained at the Ministry of Gender, Family Development and Social Security. This ministry also published a “Report of Survey on people with disability” in 2003. As per this report which is based on data for 2002, the prevalence of paralysis in the nationwide sample was 0.22%, mental disorder 0.94%, epilepsy 0.21%, and learning disorder 0.79%. Details of the definition of each condition is not provided in the report.

The Rapid Situation Assessment of drug abuse in the Maldives has shown that nearly 20% of drug users reported their primary reason for drug abuse as psychological problems.

A survey carried out in 2004 by the MoH estimates prevalence of psychoses at 1%, neuroses as 22.3% and epilepsy as 6.1%. This survey used the Self Reporting Questionnaire (SRQ) developed by WHO.

The report of this survey made the following recommendations:

- Mental health problems in the country need serious and careful attention to be addressed by the health sector.
- Mental health services should be made accessible to every individual affected in the country across all atolls and islands. Hence, existing mental health facilities need to be expanded.
- Further in-depth research is required to be carried out in order to understand factors associated with mental disorders in the country.

- There is an urgent need to develop a national mental health policy and a national multisectoral action plan.

2.3 SEARO Mental Health Unit support to Maldives

Based on the findings of the national survey conducted in 2004, the government of Maldives decided to enhance the capacity of community-based health care providers in the identification and management of common neuropsychiatric conditions in the community. SEARO was requested to provide technical support. Training for community health workers and nurses in the identification and management of generalized tonic clonic seizures has already been conducted at the Kulhudufushi Regional Hospital in the northern region and Hithadhoo Regional Hospital in the southern region.

2.4 Activities of other agencies

National Narcotics Control Bureau (NNCB)

NNCB's primary responsibility is on the issue of substance abuse in Maldives. They have an active programme using the life skills approach addressed towards children in school and out of school. It is their opinion that not enough efforts are being made in the area of drug rehabilitation and supply reduction. NNCB has also been concerned about the increase in IV drug abuse and its link to HIV/AIDS.

Care Society

Care Society conducts courses in special education. Their programmes are specially targeted at schools, youth, ward offices, island committees, NGOs and community-based organizations (CBOs). They conduct awareness programmes for parents with mentally and physically disabled children. They also have programmes to raise awareness about disability issues in the community.

Society for Health Education (SHE)

SHE is working in partnership with the Ministry of Education in the pilot project on teaching life skills to students supported by UNFPA. This programme is mainly for prevention of AIDS among IV drug users.

MANFAA Center of Ageing

There is increasing concern about the ageing population in Maldives including their mental well-being. The MANFAA Center which was recently established conducts programmes for the well-being of the elderly but mainly in Male'.

Ministry of Gender, Family Development and Social Security

One of the concerns of this Ministry is gender-based violence in Maldives which has been identified a priority area.

Ministry of Education

The main activity of this Ministry in mental health is the life-skills programme which is conducted in Male' and the islands.

UNFPA

UNFPA is active in psychosocial support programmes. A list of their pre-tsunami activities in psychosocial support is pending

3. WHO missions for mental health and psychosocial (MHPS) support activities after the tsunami:

3.1 Mission from HQ

In response to the tsunami disaster WHO mobilized a team from headquarters to visit Maldives and develop a plan of action for MHPS support to the community. Drs. Shekhar Saxena and John Mahoney visited Maldives from 24th to 27th January 2005. The consultants concluded that the initial psychosocial support to the disaster-affected victims was appropriate and should be continued. Their recommendation was to focus on developing community mental health systems. The detailed report of this mission is available on file.

3.2 Mission from SEARO

WHO SEARO sent a team from the mental health unit consisting of Drs. Vijay Chandra and Rajesh Pandav. They visited Maldives from February 24, 2005 to March 11, 2005.

This team took note of the government of Maldives interest in developing their community mental health system which is suitable to its culture and its unique geographical layout. The detailed report of this mission is available on file.

4. Mental health and psychosocial activities in Maldives after the tsunami

4.1 Initial response

4.1.1 Activities by the island community

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 food and shelter in private homes. The support at the island level was also provided by the atoll chiefs.

Lessons learnt:

- *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.*

4.1.2 Psychosocial First Aid

The National Disaster Management Centre was established within days of the disaster to provide a coordinated response from all Governmental and non governmental agencies. A Psychosocial Unit was formed in the National Disaster Management Centre. An overall coordinator was appointed. The activities of the unit included psychosocial interventions in the islands, training programmes for volunteers in psychosocial first aid, media awareness, outreach programmes to the islands and a helpline for information and crisis management. Their activities were facilitated by UNFPA and UNICEF in terms of budget for travel and by American Red Cross for training. WHO also provided the technical material for training.

Immediately after the disaster, this unit mobilized volunteer groups consisting of some previously trained counselors working with different agencies and other volunteers interested in providing psychosocial support to the disaster-affected community. 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 has conducted two programmes – psychological first aid programme in which 70 counselors have been 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 have been 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 have been reached, and each and every affected person has been provided at least some emotional and psychological support.

Staff at the IGMH were also trained to support traumatized patients from other islands coming to the hospital. A helpline was established with 4 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 counseling has been recognized to be unnecessary for the vast majority of affected individuals and offers of counselors from other countries were declined or deferred by the government. Care has also been taken to avoid labeling of affected individuals as psychologically abnormal or damaged.

Lessons learnt:

- *The government of 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.*

4.1.3 Work of agencies other than MoH

Agencies other than MoH who participated in providing psychosocial first aid to the tsunami-affected communities include the following agencies:

- Department of Public Health
- Society for Health Education (SHE)
- Care Society
- Indira Gandhi Memorial Hospital (IGMH)
- Educational Development Centre
- Youth Counseling Services
- UNFPA – Psychosocial support programme
- American Red Cross
- UNICEF

A summary of their activities is provided in the proceedings of the national workshop.

4.1.4 Coordination of activities of multiple agencies

After the tsunami there was an outpouring of sympathy, and offers for material and personnel in support of the victims from around the world. In addition many UN agencies also mobilized their resources and personnel to provide support to the government and affected community. The government of Maldives mobilized its own resources very rapidly. They were quick to seek assistance from select UN agencies to support their efforts including providing technical material, personnel and funds.

Some external agencies particularly INGOs, were not permitted to work in the community on the basis that they were not familiar with the local culture and language.

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.

Lessons learnt:

- *The government of 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.*

4.1.5 Assessment of psychosocial distress in tsunami-affected communities

The Ministry of Planning is the nodal agency which conducts all population-based surveys in Maldives. Generally any survey to be conducted should be approved by this Ministry. These guidelines prevent duplication of efforts since one Ministry is aware of all surveys.

The Ministry of Planning has previously conducted two Vulnerability and Poverty Assessment (VPA) surveys in Maldives. One in 1998 and the second concluded in October 2004. These surveys are very well designed and include a nationally representative sample. Questionnaire design, data collection, entry and analysis are exceptionally good.

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, totaling 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. Data entry is in progress. The psychosocial module was developed by the UNFPA, 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 for this questionnaire is complicated and special expertise will be needed. WHO has offered to help.

Immediately after the tsunami disaster multiple assessments were carried out by different agencies (UNICEF, Care Society, IFRC, Save the Children, Ministry of Planning, Ministry of Gender, Family Development and Social Services). Essentially each agency was trying to assess the field situation in terms of its own mandate. The surveys used different methods in sample selection and study design (quantitative and qualitative measures). People working with the relief efforts point out that these surveys often duplicated information. Also, the lack of normative data made interpretation of the findings difficult. However, some officials of the government feel that being the first experience with such a disaster, multiple assessments helped corroborate findings of other surveys leading to evidence-based responses.

The Ministry of Gender, Family Development and Social Services 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 the 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 Gaa atolls. They will be using the GHQ-12 as an assessment tool. This instrument was validated with SEARO assistance in February 2005.

Lessons learnt:

- *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.*

4.1.6 Communication and transportation between islands immediately after the tsunami disaster

The geographical nature of the country and distances between islands makes communication and transportation between islands a critical issue. Immediately after the tsunami disaster communication equipment was damaged and power plants were switched off to prevent electrocution. Thus communication between islands and with Male' were interrupted. Only the VHF instruments continued to function.

Regular public information reports were given to the media and senior government officials themselves spoke on radio providing information and suggestions.

Fortunately the fishing boats were out at sea when the tsunami struck and were not damaged. They saw household items floating in the ocean and realised that something was wrong. The boats returned to the islands and then discovered the magnitude of the disaster. These boats were used to evacuate people from affected islands.

Lessons learnt:

- *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.*

4.2 Ongoing activities in mental health and psychosocial support

4.2.1 WHO consultant to assist the MoH in development of mental health services

One of the recommendations of the SEARO mission to Maldives was on developing a community mental health system in which GPs and paramedical health workers will be trained in providing basic mental health care. To implement this recommendation the government of Maldives requested that a consultant in mental health be recruited for three months.

The consultant completed the following tasks:

- Assisted the WHO Representative (WR) office and MoH in implementation of recommendations made by previous consultants on tsunami-related activities.
- 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 Home for People with Special Needs at Guraidhoo in rehabilitation and clinical services.

Training workshops

The WHO consultant prepared an outline of a mental health module to be used in the workshops. The training included lectures, group discussions, brain storming, case vignettes, discussion and role plays. The trainees included nurses, community health workers and family health workers. An additional session was held for the doctors working in local hospitals at the venue.

Evaluation of workshops

All trainees completed examinations prior to and upon completion of the training. These examinations were conducted to allow quantitative assessment of change in trainees' knowledge as a result of the training. Improvement was found in trainees' total examination scores from pre-training to post-training for all training modules. Scores improved from 6 to 10, where the maximum possible score was 12. Although the trainees showed significant improvement in knowledge, only training and knowledge does not necessarily result in reducing the morbidity in the community. Assessment of impact of training one year later as measured by reduction in treatment gap is needed.

Training of facilitators for future workshops

To facilitate the remaining workshops and develop local expertise for future training one faculty nurse from Faculty of Health Sciences and one senior nursing staff from IGMH were given two days briefing about the methods, contents and delivery of basic mental health and psychosocial care modules. This group will serve as resource persons for future training of health workers in mental health as well as trainers for proposed training courses in psychiatry at the Faculty of Health Sciences.

Summary of recommendations made by the consultant for strengthening mental health services

1. To develop a general hospital psychiatric unit at IGMH.
2. To develop two community out reach facilities one in north and one in south.
3. Expansion of mental health facilities in regional and atoll hospitals by training a community psychiatric nurse, backed up by periodic visits by the consultant psychiatrist.
4. To streamline the referral system.
5. Provision of care for wandering mentally ill in the community.
6. Ensuring the availability of psychotropic medications.

7. Proper record keeping and follow-up.
8. Mental health promotion activities in schools.
9. Continued education of health staff in mental health and psychosocial well-being (including doctors and nurses)
10. Training of clinical psychologists, psychiatric social workers and occupational therapist possibly at NIMHANS, Bangalore, India.
11. Study of post-tsunami psychiatric morbidity among internally displaced populations
12. Development of mental health policy and plan for Maldives.
13. Follow up workshops to assess the impact of training of community and family health workers.

4.2.2 Forum for Partners in Mental Health

The MoH brought together all stakeholders working in the field of mental health from 6 June 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 Maldives. The forum paid particular attention to existing policies, regulations and research.

The participants were:

Government Organizations (Ministry of Health, Ministry of Gender, Family Development and Social Security, Ministry of Education, National Narcotic Control Bureau, Department of Public Health, Indira Gandhi Memorial Hospital, Maldives Police Services, Psychosocial Unit of National Disaster Management Centre)

Non Governmental Organizations and UN agencies (SHE, Care Society, MANFAA, UNFPA, UNICEF, WHO)

Recommendations and suggestions made by the Forum for Partners in Mental Health:

1. To identify a national level key agency to coordinate the wide ranging mental health activities in the country.
2. To develop a national policy on social issues and mechanism to deal with them.
3. Standardize the life skill training programme and develop a manual applicable across different organizations except differing in content based on objective of the programme.
4. To develop a mechanism for registering and licensing counselors.
5. To ensure the easy accessibility of counselors, they should be placed in hospitals, island office or ward offices.
6. To work towards reducing the stigma of mental and psychosocial problems in the community by educating and changing attitudes.
7. To strengthen judicial and legal systems to advocate appropriate social security and support for those with mental and other psychosocial problems.

The forum pledged to continue its deliberations till a national coordination mechanism is established and starts functioning.

4.2.3 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 development of the mental health system in the country. An informal group has already been set up to advise the MoH on mental health issues. Currently the committee includes one elected representative (MP), people in decision making capacity in various ministries, counselors, community leaders, etc. The formal terms of reference (ToR) for this technical body is likely to be developed in the next two months. The ToR will be sent to all ministries for comments before finalization

5. Recommendations of the SEARO mental health team

5.1 Activities recommended in the next four months

The mental health and psychosocial relief efforts in response to the tsunami are progressing very well in Maldives. To further support the effort, the following activities are recommended to be undertaken in the next four months.

5.1.1 Training of nurses in psychiatric nursing skills

Twelve nurses (2 from each regional hospital and 2 from IGMH), and 1 faculty member from FHS should be sent to the Institute of Human Behaviour and Allied Sciences, New Delhi, India for three months training in psychiatric nursing. Since all nurses are local Maldivians who are unlikely to leave their duty stations, this training will play a major role in providing community-based mental health care in a sustainable manner. Dr. R. A. Singh (WHO consultant to Maldives) is a faculty member of this institute and can thus facilitate the training with his prior knowledge of the situation in Maldives.

5.1.2 Conversion of training programme for general physicians developed by the WHO consultant into a video based training

Most of the general physicians serving in the islands are expatriate physicians who come for short durations. This high turnover makes it uneconomical to train the physicians each time a new person is recruited. The video-based programme will enable fresh expatriate physicians to take mental health training on arrival. WHO can provide assistance for development of this video.

5.1.3 Implementation of the common learning and behavioural problems programme for parents and teachers

Maldives has identified that learning and behavioral disorders among children as a consequence of tsunami is a serious problem. SEARO has been requested to provide technical support to address this issue. In response to this request SEARO has identified two consultants (one psychiatrist and one psychologist) and developed technical material for training parents and teachers to deal with this issue. Suggested participants are 2 head masters from each atoll, 6 head masters from Male' and 50 parents from Male'. A date for this training is being finalized.

5.1.4. Maldives delegates to proposed SEARO conference in Thailand on mental health aspects of disasters preparedness.

Five delegates from Maldives can participate in this conference which will assist the country in sharing experiences and developing a plan for MHPS issues in disasters. The dates for the workshop are being finalized.

5.1.5 Local capacity development for delivery of community-based mental health care (epilepsy)

The government of Maldives had previously requested SEARO to provide technical support to train paramedical staff and GPs in the identification and management of the most common neuropsychiatric conditions in the community. A SEARO consultant has completed the training for epilepsy in two regional hospitals. Training at the remaining four Regions can be completed in two weeks.

5.2 Recommendations for long-term plans for development of mental health systems

There is active interest in developing all aspects of MHPS services in the long-term including legislation, policy, programmes and services. The government should be complimented on development of clear plans for the long-term. For a small country like Maldives to consider modern mental health legislation reflects the farsightedness of the government.

5.2.1 Development of mental health legislation

There is no specific mental health legislation at this time in Maldives. Mental health laws are included under the general health law and generally describe the criteria for declaring a mentally ill patient "dangerous". It does not address specific needs of patients such as optimum quality of care or ensuring availability of psychotropic medication.

A WHO consultant has reviewed the health act and has strongly recommended that the mental health section be revised and separate mental health legislation be created. This recommendation has been accepted in principal by the Attorney General's Office.

5.2.2 Development of mental health policy

A mental health policy can set the priorities and guidelines of the national government with appropriate financial commitment to ensure the development and maintenance of the community mental health programme. A policy can be revised as more amenities and resources become available. The Forum for Partners in Mental Health also recommended that a national policy on psychosocial issues be developed.

The MoH has also 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. This committee will advise the Ministry on the process and content of mental health policy for Maldives.

As of now there is no clear policy on availability of psychotropic medications at regional, atoll and island level health centre, but many psychotropic medications are available at private chemist shops. The government has a scheme through which patients once registered with Ministry of Gender, Family Development and Social Services are entitled to free psychotropic medications but very few patients are actually registered compared to the estimated need. The mental health policy which will be drafted will include a section on availability of psychotropic medications even at the island health centres.

5.2.3 Development of community mental health services

Several agencies and consultants have made recommendations to the government of Maldives on the development of community mental health services. Four of the major sets of recommendations include the mission report from WHO HQ, the mission report from WHO SEARO, the recommendations of the WHO consultant and the national workshop held in September 2005 in Male'. There are many common elements in all these recommendations. These were discussed during the national workshop and combined into an overall set of recommendations including the agency responsible to implement the recommendation. Details of such a system are provided in the proceedings of the national workshop.

5.3 Recommendations for MHPS aspects of disaster preparedness

1. A national disaster preparedness plan should be prepared. MHPS aspects of a disaster should be included in the plan.
2. One Ministry should be designated the lead Ministry for MHPS support in any future disaster. Suggested Ministry is the Ministry of Health.
3. Coordination mechanisms and responsibilities between Ministries at the ministerial level with a clear chain of command and responsibility for MHPS should be in place. A good example for interagency coordination for disaster preparedness could be coordination of ongoing activities on MHPS between various agencies such as MoH, WHO, UNFPA, Ministry of Planning, American Red Cross and NGOs.
4. All stakeholders interested in MHPS should be identified and a list prepared.

5. Now and in any future disaster every project related to MHPS should be implemented after clearance from the lead Ministry and be a part of the overall strategy.
6. The role of external international organizations, particularly INGOs should be carefully considered now and for the future.
7. Training workshops and periodic drills off all stakeholders should be carried out to implement the MHPS component of the disaster preparedness plan.
8. Technical material (such as training material for community level workers, survey instruments to be used, guidelines for NGOs, guidelines for the media etc.) should be validated for use in Maldives and be readily available.
9. Communication equipment should be installed/upgraded regularly.
10. A 'risk communication' strategy for disseminating essential information during emergencies should be prepared.
11. Efforts in empowering the community to launch the first response to a disaster and developing community resilience, coping skills and promoting community relationships and harmony should be encouraged
12. A well developed community mental health system is the best form of disaster preparedness. This can serve the needs of the community now and can be readily mobilized during a disaster. Details of such a system are provided in the proceedings of the national workshop (see Section II).

**Proceedings of the
National Workshop on
Current Status *and*
Future Preparedness
in
Mental Health and Psychosocial
Aspects in Disasters

Male', Maldives
14 – 15 September, 2005**

1. Introduction

The meeting was opened by the Deputy Minister of Health, Dr. Abdul Azeez Yoosuf, who welcomed the participants and provided some background information on the psychosocial and mental health programme in Maldives. WHO Representative to Maldives, Dr. Jorge Luna, addressed the meeting and complimented the government of Maldives for its foresightedness and vision in recognizing the importance of psychosocial support to the tsunami-affected communities. He mentioned that Maldives was the first country to hold such a national workshop.

Dr. Dinesh Bhugra, Professor of Mental Health and Cultural Diversity, Institute of Psychiatry, London was nominated to chair the meeting.

Dr. Vijay Chandra, Regional Advisor, Mental Health and Substance Abuse, WHO South East Asia Regional Office, New Delhi, India, gave a short presentation on the psychosocial and mental health aspects of the tsunami disaster. He mentioned that the tsunami disaster has imposed a huge burden on communities, not only physically but also in terms of the psychological trauma inflicted on them. It should be noted that each and every person in the population is psychologically affected to some extent. Thus, in terms of numbers, the magnitude of the problem of psychological trauma of the disaster affected population is as large as the size of the population. It is imperative that psychosocial interventions be made accessible to each person in the community, because psychological distress can hamper rehabilitation and resumption of normal life. The psychosocial relief efforts should be backed by appropriate community mental health services to treat not only preexisting cases with mental disorders but also the increased number of people needing mental health services after the disaster.

He emphasized that two issues were important at this stage after the tsunami disaster:

1. Carefully study the psychological and mental health impact of the disaster on the community, the response at every level and finally the impact of the rehabilitation efforts in progress.
2. Based on the experiences in the existing disaster within and between affected countries, develop a plan for disaster preparedness for any future disasters. Needless to say that the plan will vary from country to country and depend on type of disaster.

2. Core themes of the workshop

Observations from the current tsunami disaster suggest that there were several controversial issues in psychosocial and mental health relief efforts. Psychosocial relief was sometimes provided by a wide range of NGOs some of which did not speak the local language nor did they understand the local culture. There was virtually no coordination between these multiple agencies. Sometimes even the need for psychosocial support and the mode of its implementation

was a matter of disagreement. On the other hand, some affected countries launched an excellent well coordinated psychosocial support programme. This raises an important question for the future:

What is psychosocial relief and how should it be administered?

Similarly the limited back up community-based mental health support was very apparent in most affected communities. But much to everyone's amazement, even existing mental health services were not optimally utilized. This clearly points to a lack of linkage between community-based services and backup mental health services. This raises the second important question for the future: *What should be the framework of community mental health systems?*

3. Objectives of the workshop

1. Study the impact of past, ongoing and planned psychosocial and mental health rehabilitation efforts and if any midcourse correction is required.
2. Develop plans for psychosocial and mental health support for future disasters.

4. Presentations by participants

Each organization participating in the workshop made a brief presentation of their activities in mental health and psychosocial issues related to the tsunami. A summary of the presentation is as follows:

4.1 Ministry of Health

4.1.1 Survey of the prevalence of neuropsychiatric disorders in the community

A survey carried out in 2004 by the MoH estimates prevalence of psychoses at 1%, neuroses as 22.3% and epilepsy as 6.1%. This survey used the Self Reporting Questionnaire (SRQ) developed by WHO.

The report of this survey made the following recommendations:

- Mental health problems in the country need serious and careful attention to be addressed by the health sector.
- Mental health services should be made accessible to every individual affected in the country across all atolls and islands. Hence, existing mental health facilities need to be expanded.
- Further in-depth research is required to be carried out in order to understand factors associated with mental disorders in the country.
- There is an urgent need to develop a national mental health policy and a national multisectoral action plan.

4.1.2 Emergency Psychosocial Support Response Team

The Psychosocial Support Unit (PSS Unit), initially known as Social Support and Counselling Services, was established as a unit of the National Disaster Management Centre as a result of an initiative taken by a group of volunteer helpers immediately after the Tsunami of 26th December 2004.

The PSS Unit functioned as an autonomous body and comprised solely 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 skills. From its inception the Unit established various services to lessen the psychological impact on the people. The Unit's activities included counselling through house visits, walk-in counselling, a toll-free helpline, and posting counsellors at various relief centres in Male'. The Unit carried out a training programme on Psychological First Aid to train its care givers with the technical assistance of the American Red Cross. One major focus was outreach trips for need and situational assessment as well as for interventions. They included intervention trips to many affected islands to provide psychological first aid. Members of the Unit visited 75 islands in 16 atolls for interventions/assessments. 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 outreach programme, all affected islands have been reached, and each and every affected person has been provided at least some emotional and psychological support. 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. The main donor agencies included UNFPA, UNICEF, and the American Red Cross as part of IFRC.

4.1.3 Training of community health care providers

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

The consultant completed the following tasks:

- Assisted the WHO Representative (WR) office and MoH in implementation of recommendations made by previous consultants on tsunami-related activities.
- 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 Home for People with Special Needs at Guraidhoo in rehabilitation and clinical services.

4.1.4 Forum for Partners in Mental Health

The MoH brought together all stakeholders working in the field of mental health from 6 June 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 Maldives. The forum paid particular attention to existing policies, regulations and research.

4.1.5 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 capacity in various ministries, counselors, community leaders, etc. The formal TOR for this technical body is likely to be developed in the next two months. The TOR will be sent to all ministries for comments before finalization

4.2 American Red Cross

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

4.2.1 Development of national capacity in psychosocial support

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 has conducted a programme for psychological first aid in which 70 counselors have been trained in a two day workshop.

4.2.2 Community resilience project in Laamu, Meemu, Thaa, Dhaalu, Gaafu Alifu and Gaafu Dhaalu atolls

The community resilience project in coordination with the Ministry of Gender, Family Development and Social Security of the Government of 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.

4.2.3 Safe schools program in Laamu, Meemu, Thaa, Dhaalu, Gaafu Alifu and Gaafu Dhaalu atolls

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.

4.2.4 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.

4.3 Experience sharing by community representatives from affected areas

Participants from the affected communities did not make a formal presentation but the following description is based on detailed discussions held with community leaders and affected individuals in Dh Kudahuvadhuo and Th. Burunee islands.

The immediate response to the disaster at the island level was led by local community leaders 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 food and shelter in private homes. The support at the island level was also provided by the atoll chiefs. Many displaced persons have gone back to their routine activities, but others still have to be rehabilitated.

4.4 Indira Gandhi Memorial Hospital (IGMH)

IGMH is 232 bedded tertiary care hospital located in Male'. Currently there are two full time psychiatrists (one local and one expatriate) working at IGMH. They provide out-patient and in-patient care (to psychiatric patients) in a general hospital setting (includes referrals from other islands, and other agencies). In addition psychiatric services are provided to patients living in the Home for People with Special Needs which is situated in a separate island. They also offer phone consultations and advice to doctors working in regional hospitals, atoll hospitals and health centres regarding management of patients with psychiatric illnesses. Also consultation services are provided to substance abuse clients from National Narcotics Control Bureau.

In times of national disaster IGMH can provide mental health assistance for those referred to the centre from the islands or phone advise for those who call from the islands.. As IGMH has only two psychiatrists, it will be very difficult to send a psychiatrist out to the affected areas.

4.5 Department of Public Health

The mandate of the Department is to improve the health and well-being of the people through prevention and control of communicable and non-communicable diseases, provide essential care and promote health awareness. Special focus is given to areas such as healthy lifestyles, safe motherhood, child survival, and control of HIV AIDS, STI, FP and RH.

4.6 Ministry of Education: Educational Development Centre

The Educational Development Centre (EDC) is a professional branch of the Ministry of Education. It has many functions and responsibilities including developing and managing national school curriculum, conducting educational research, conducting and supporting school health programmes, etc. The School Health Unit of EDC is responsible for coordinating, implementing and monitoring school health programmes in the schools. It also formulates the policy on school health in collaboration with the MoH and the Ministry of Education. Pursuant to the tsunami disaster of December 2004, the Ministry of Education has assigned the School Health Unit of EDC to carryout 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 carryout a comprehensive psychosocial support programme which will include preparedness and resilience enhancement activities as well as a safe schools programme.

4.7 Ministry of Youth and Sports: Youth Counseling Services

The Youth Counseling Services established on January 2002 was aimed at providing youth with the opportunity to discuss their problems with professionals to assist them in dealing with and solving problems and also to help them to develop a positive attitude. Individual/group

counseling as well as thematic sessions have been conducted on dealing with fear, abuse, developing self-esteem, dealing with stress, parenting skills, relationship, family problems, skills of being able to say 'NO' to unacceptable habits (assertiveness skills).

Following the tsunami visits were made to some of the affected islands i.e, North and South of Maldives (Meemu, Thaa, Shaviyani and Kaafu Atolls). The objective being to carryout psychosocial needs assessment and psychosocial interventions. The activities conducted are clay therapy, art therapy, story writing, group sharing, individual sessions and home visits. They also counseled clients referred from IGMH, and their counselors were deputed to NDMC for technical support

4.8 Ministry of Gender, Family Development and Social Services 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. 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 the 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.

4.9 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 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, 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, a project on tsunami recovery efforts began. The project includes four components, namely agriculture, preschool development, preschool building and psychosocial support. The project is implemented in 15 islands in Raa, Baa, Laamu and Gaa atolls. The psychosocial support programme is implemented by training two community level workers in each island, who will be attached to a CBO or a women's development committee. The capacity of these CLWs are 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 done. Care Society is also in

the process of integrating disaster preparedness into all the components of the project, including psychosocial support programme.

4.10 Society for Health Education (SHE)

SHE was involved with tsunami relief activities in three main ways:

1. Psychosocial support
2. Relief Centre Management
3. Assistance in livelihood project

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

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

Future activities being considered include training community helpers in active listening skills (community resilience building)

4.11 UNFPA – *Psychosocial support programme*

Following the tsunami, UNFPA through field visits to the tsunami-affected islands, 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 Maldives”. The project is aimed at promoting the psychosocial well-being of the people affected by the tsunami in Raa, Meemu, Dhaalu, Thaa and Laamu atolls. The project comprises 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.

4.12 WHO SEARO:

Presentation of the MHPS activities in other tsunami-affected countries

WHO SEARO made a presentation on the MHPS activities in the other tsunami-affected countries. Salient features of the response in each country are as follows:

- *Thailand:* excellent response based on mobilization of the village health volunteers in the community supported by a strong community mental health team, backed up by mental hospitals.
- *Sri Lanka:* Focus on community level work through recruitment of community support officers is currently in progress. A proposal to enhance the mental health services has been developed and is being considered for implementation. Mental health policy and legislation is being revised.
- *India:* Very strong administrative structure which regulated all activities in the disaster-affected areas. Psychosocial support provided by volunteers organized by the Ministry of Social Welfare, Tamilnadu, India. Linkage to mental health services being developed.
- *Indonesia:* Concentrating on developing community mental health system by training nurses and general physicians. Community level work is being done by NGOs. Efforts to coordinate NGOs by WHO consultant have not been very successful.

The presentation also pointed out the need for providing evidence-based services to the affected communities through a structured needs assessment instrument. In conclusion the need for having a plan for MHPS aspects of disaster preparedness was emphasized.

Presentation on disaster preparedness

Dr Schmid and Dr. Qudisia made presentations on strategies for disaster preparedness. Dr. Qudisia emphasized the need to have these plans prepared in advance and periodic practice drills to be conducted. Dr. Schmid mentioned about the ongoing work of the government of Maldives to prepare plans for future disasters. The essential component of such a plan include policy, contingency plan, standard operating procedure, simulation trainings, development of Awareness and research . Emergency Preparedness Plans are essential to - to minimize the mortality and morbidity, have an effective response and to minimize impacts of disasters.

5. Developing a plan for disaster preparedness in psychosocial and mental health aspects

A summary of the discussions and recommendations for the issues discussed is as follows:

The participants noted that the term “psychosocial support” has been used very loosely enabling multiple agencies to interpret the term and conduct activities without any clear understanding of the unmet MHPS needs of the disaster-affected persons. The WHO framework has clarified the issue as follows: “ The term social intervention is used for interventions that primarily lead to social effects, and the term mental health intervention is used for interventions that primarily lead to mental health effects. (It is acknowledged that social interventions have secondary mental

health effects and that mental health interventions have secondary social effects, as the term ‘psychosocial’ suggests). Mental health interventions cover both clinical interventions (medication, psychotherapy) as well as basic, non-clinical, psychological support interventions (e.g. psychological first aid). ”

5.1 Co-ordination of activities of agencies delivering MHPS support

Issues discussed

- Government of Maldives, UN agencies and NGOs mobilized their resources and personnel to provide support to the affected community. Coordination of these efforts was often difficult.
- The government of Maldives specifically sought the assistance from select UN agencies to support their efforts including providing technical material, personnel and funds.
- Most external agencies particularly INGOs, were not permitted to work in the community on the basis that they were not familiar with the local culture and language. This prevented serious problems of coordination between agencies, which has been observed in other countries.
- Although overall the 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.
- Overall, the coordination of relief efforts could have been improved by nominating one lead agency to serve as the coordinator of ministries, national and international agencies..

Recommendations

- One ministry should be designated the lead Ministry for MHPS support in any future disaster. Suggested ministry is the Ministry of Health.
- The lead Ministry should be responsible to develop a plan and determine coordination mechanisms and responsibilities in consultation with other relevant stakeholders at senior level with a clear chain of command and responsibility for MHPS emergency response.
- Coordination mechanisms and responsibilities between ministries at the ministerial level with a clear chain of command and responsibility for MHPS should be established.
- MHPS programmes should be integrated into disaster preparedness and contingency plan
- All stakeholders and resources for MHPS should be identified and listed.
- Every activity and project related to MHPS should be implemented after clearance from the lead Ministry and be a part of the overall strategy.
- The role of external international organizations, particularly INGOs should be carefully monitored.

- Training workshops and periodic drills to implement the disaster preparedness plan should be considered.

5.2 Assessment of psychosocial distress in the community

Issues discussed

- The Ministry of Planning is the designated nodal agency which conducts all population-based surveys in Maldives. Generally any survey to be conducted should be approved by this Ministry. These guidelines prevent duplication of efforts since one Ministry is aware of all surveys.
- Immediately after the tsunami disaster multiple assessments were carried out by different agencies (UNICEF, Care Society, IFRC, Save the Children, Ministry of Planning, Ministry of Gender, Family Development and Social Services). Essentially each agency was trying to assess the field situation in terms of its own mandate. The surveys used different methods in sample selection and study design (quantitative and qualitative measures). People working with the relief efforts point out that these surveys often duplicated information. Also, the lack of normative data made interpretation of the findings difficult.
- After the tsunami a third partial VPA has been conducted 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 technical contents of this survey has been discussed with all stakeholders.
- The Ministry of Gender, Family Development and Social Services 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.
- 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 Gaa atolls. They will be using the GHQ-12 as an assessment tool. This instrument was validated with SEARO assistance in February 2005.
- Not having quantitative community-based data on the magnitude of psychosocial distress and mental health needs limits assessment of the impact of psychosocial relief efforts.

Recommendations

- A clear plan should be in place to determine which instruments will be used, when and by whom in case of future disasters.
- Qualitative information on MHPS problems, resources and ways of coping should be collected on a regular basis and linked to quantitative assessments.

- Validated questionnaires (quantitative) for needs assessment and mental health status of the affected population should be readily available to all partners.
- Rapid assessments (if done) should be interpreted very carefully within the social and cultural context of the event.

5.3 Communication and transportation between islands immediately after the tsunami disaster

Issues discussed

- The geographical nature of the country and distances between islands makes communication and transportation between islands a critical issue. Immediately after the tsunami disaster communication equipment was damaged and power plants were switched off to prevent electrocution. Thus communication between islands and with Male' were interrupted. Only the VHF instruments continued to function.
- Regular public information reports were given to the media and senior government officials themselves spoke on radio providing information and suggestions.
- The fishing boats were out at sea when the tsunami struck and were not damaged. These were used to evacuate the residents of the most severely affected islands.

Recommendations

- 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.
- Reliable public information should be provided by senior officials which can help to reassure the public and avoid rumours.
- Prepare a 'risk communication' strategy for disseminating essential information during emergencies using damage resistant technologies.
- Some thought should be given to damage resistant water transportation (such as inflatable boats) which can be stored in island offices.

5.4 Organization of relief at the island level

Issues discussed

- Immediate response to the disaster at the island level was excellent and was led by local community leaders involving the entire community. This was followed by appropriate atoll level response.

Recommendations

- 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.

5.5 Role of counselors in providing psychosocial support to the community

Issues discussed

- Role of counselors in the emergency response was exemplary. Initially it was a voluntary initiative and later it was integrated and received recognition from National Disaster Management Centre.
- Initially there were some instances in which individuals with no or minimal previous experience in counseling were calling themselves counselors and offering their services without any quality assurance or assessment of any outcome measures.
- Although leave from parent organizations was immediately granted during the emergency phase, leave for extended period has been difficult for some voluntary workers.
- Not enough attention has been paid to stress management among relief workers. This has been a matter of concern

Recommendations

- Serious consideration should be given to setting up a body which determines professional standards for counselors and monitors their performance.
- In view of the emergency situation, persons trained with short courses may be permitted to offer psychosocial first aid but in the long-term they should not be permitted to call themselves counselors.

5.6 Role of Community Level Workers (CLWs) in providing psychosocial support

Issues discussed

- Immediately after the disaster there were many CLWs sponsored by different agencies. (eg. Volunteers of Care Society, UNFPA Community Educators, Emotional Support Brigade formed by the Psychosocial Support Unit, island based community health care providers). These workers often worked in the same community at the same time.
- Role and responsibilities of these workers were substantially overlapping in generic psychosocial support functions with perhaps a specific component according to the mandate of each agency.
- In the emergency phase most of the CLWs trained were volunteers from within the community. Usually they received a short training. Because of the lack of monitoring and continued support their work in the community has gradually tapered off. However some volunteer workers continue to perform their duties, are monitored by their parent agencies and sometimes retrained. In addition, health care providers working for the government have been trained to provide psychosocial support to the community. This has led to an enhanced workload in an already overstretched group of workers.
- Multiple manuals and guidelines for training of CLWs are available and new ones were developed. An enormous amount of time and resources are spent on developing such

manuals and training programmes. The technical content of most of the manuals is substantially similar.

- Concerns were raised about regular monitoring and supervision of work of CLWs.
- Organizational policies for prevention and management of stress in relief workers have not been developed.

Recommendations

- The roles and responsibilities of CLWs in times of disasters should be clearly defined.
- Manuals and guidelines for their training should be translated and adapted to the local culture. As far as possible, one set of manuals dealing with overall psychosocial support activities should be prepared. To this each agency can add a section of specific interest to them such as children's programmes, women's programmes etc.
- The lead Ministry should be responsible for coordinating activities such as framing of standard curriculum for their training, deployment, supervision and monitoring.
- Support by mental health professionals for persons identified by CLWs needing specialized Care should be readily available.
- Organizational policies should be developed for the prevention and management of stress in all relief workers including CLWs.

5.7 Groups with special needs – children, women and the elderly

Issues discussed

- Children have been identified as a particularly vulnerable group in whom psychological distress persists even 9 months after the disaster.
- Widows and the elderly may experience disproportionate stress due to loss of support systems.

Recommendations

- Special programmes for children must be made available
- Multiple agencies working with children (UNICEF, Care Society, SHE, WHO) and concerned ministries should collaborate closely for a unified response.
- Gender issues should be addressed sensitively.

5.8 National guidelines for disaster preparedness related to mental health/psychosocial support

Issues discussed

- Many groups of workers ranging from volunteers to paramedical staff to GPs need to be mobilized for MHPS support to disaster-affected communities. Most of these personnel have never been faced with a disaster situation and thus need training to provide appropriate services.

- Lack of existing guidelines on disaster preparedness and management for different types of personnel was a matter of concern.

Recommendations

- Availability and dissemination of the following guidelines or manuals on clinical/psychological interventions should be ensured:
 - for mental health professionals
 - for general health staff (doctors, nurses, community level health workers, etc)
 - for human resources outside the formal health sector (eg. teachers, religious leaders, volunteers)
- Information documents for the media and general public on mental health/ psychosocial problems, coping, sources for social support, and available care should be widely available.
- Plans on specific problems like organization of family tracing and reunification, preventing child abuse, gender-based violence during and after disaster should be available.
- Availability of ethics guideline for post disaster research should be ensured.

5.9 Building Community Mental Health Systems

Issues discussed

- The experiences of the tsunami disaster has provided the opportunity to review the existing state of mental health services in Maldives and moving 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 a 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.

Recommendations

There is active interest in developing all aspects of MHPS services in the long-term including legislation, policy, programmes and services.

- **Development of mental health legislation**

There is no specific mental health legislation at this time in Maldives. Mental health laws are included under the general health law and generally describe the criteria for declaring a mentally ill patient “dangerous”. It does not address specific needs of patients such as optimum quality of Care or ensuring availability of psychotropic medication.

It is recommended that the mental health section be revised and separate mental health legislation be created.

- **Development of mental health policy**

A mental health policy can set the priorities and guidelines of the national government with appropriate financial commitment to ensure the development and maintenance of the community mental health programme. A policy can be revised as more amenities and resources become available. The Forum for Partners in Mental Health also recommended that a national policy on psychosocial issues be developed.

The MoH has also 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. This committee will advise the Ministry on the process and content of mental health policy for Maldives.

As of now there is no clear policy on availability of psychotropic medications at regional, atoll and island level health centre, but many psychotropic medications are available at private chemist shops. The government does have a scheme through which patients once registered with Ministry of Gender, Family Development and Social Security are entitled to free psychotropic medications, but very few patients are registered compared to the anticipated persons in need of these medications. The mental health policy which will be drafted should include a section on availability of psychotropic medications even at the island health centres.

- **Development of community mental health services**

Several agencies and consultants have made recommendations to the government of Maldives on the development of community mental health services. Four of the major sets of recommendations include the mission report from WHO HQ, the mission report from WHO SEARO, the recommendations of the WHO consultant and the national workshop held in September 2005 in Male'. There are many common elements in all these recommendations. These were discussed during the national workshop and combined into an overall set of recommendations including the agency responsible to implement the recommendation. Details of such a system are as follows:

- **Proposed administrative structure for mental health in Maldives**

- a. Deputy Director in the Ministry of Health
- b. Mental Health Programme Coordinator at the Regional level

- **Development of community mental health services**

- a. Development of community mental health teams*

These teams can provide mental health services through mobile/outreach facilities or through primary health care system. These teams can be led by a medical doctor with mental health skills. Suggested activities include:

- i. Training of general practitioners (suggested responsible agencies: MoH, WHO)

- ii. Training of nurses in psychiatric nursing skills (suggested responsible agencies: MoH, WHO)
- iii. Availability of common psychiatric and anti-epileptic medications (suggested responsible agencies: MoH, Ministry of Gender, Family Development and Social Security)
- iv. Video/telephone consultation between Regional Hospital, Atoll Hospital, Health Centres and IGMH (suggested responsible agency - MOH)

b. Mental health care through primary health care – Primary health care workers (community health workers, supervisors, nurses and medical officers) should be trained and supervised by the community mental health team.

- i. Training of health workers in identification and management of common neuropsychiatric disorders – eg. epilepsy and psychosis (suggested responsible agencies: MoH, WHO)
- ii. Community-based rehabilitation of intellectually impaired (suggested responsible agency: Care Society),

c. Care and support activities outside the formal health sector

- i. Building community resilience/coping skills (suggested responsible agencies: American Red Cross, Care Society, Ministry of Youth through NGOs, UNFPA, SHE, Counseling from Islamic perspective)
- ii. Promotion of adolescent mental health
 - Safe school programme (suggested responsible agency - American Red Cross)
 - Promotion of adolescent well-being (coping with stress using life skills and other programmes. (suggested responsible agencies: Ministries of Education, Youth and Sports, Department of Public Health, UNICEF, SHE, NNCB)
 - Managing common learning and behavioural problems among children and adolescents : programme for teachers and parents (suggested responsible agencies - WHO, MoH)
- iii. Women’s programmes on MHPS (suggested responsible agencies: UNFPA, Ministry of Gender)
- iv. Establishing a help line for information and crisis intervention (suggested responsible agencies - Counselors from various organizations – NNCB, SHE, Youth Counseling Service, URC, Police, FASHAN)

d. Management of substance abuse (suggested responsible agency: National Narcotic Control Bureau - NNCB)

e. Implementation research for development of appropriate mental health services

- i. Continuing regular data collection on common neuropsychiatric disorders
- ii. Impact evaluation of ongoing programmes in terms of reduction of treatment gap (suggested responsible agency: MoH, WHO)

Closing Remarks

Deputy Minister of Health, Dr. Abdul Azeez Yoosuf, attended the closing ceremony in which the recommendations of the workshop were presented. In conclusion he remarked that Maldives had never faced a disaster of the magnitude of the tsunami. Although the government response may not have been perfect considering the limited local expertise available, substantial amount of physical and psychosocial support was provided to the community, many lessons were learnt and a disaster preparedness plan for mental health and psychosocial support is in preparation. The proceedings of the workshop will contribute to the development of this plan.

**National Workshops on Current status and future preparedness in psychosocial and mental health aspects in disasters
Male', Maldives 14-15 September 2005**

List of Participants

- 1 Ministry of Health: Emergency Psychosocial Support Response Team
- 2 American Red Cross
- 3 Community representatives
- 4 Indira Gandhi Memorial Hospital (IGMH)
- 5 Department of Public Health
- 6 Ministry of Education: Educational Development Centre
- 7 Ministry of Youth and Sports: Youth Counseling Services
- 8 Ministry of Gender, Family Development and Social Services
9. Ministry of Health
10. UNICEF
- 11 Care Society
- 12 Society for Health Education (SHE)
- 13 UNFPA

14. WHO Maldives
 Dr. Lieselotte Schmid
 STP- Emergency Preparedness and Response
15. World Health Organization, South East Asia Regional Office, New Delhi, India
 Dr Vijay Chandra
 Regional Advisor, Mental Health and Substance Abuse
 Dr. Rajesh Pandav
 STP- Mental Health and Substance Abuse
 Dr. Qudsia Huda
 STP, Tsunami Operations, Emergency and Humanitarian Action

16. WHO Consultant
 Dr. Dinesh Bhugra
 Professor of Mental Health and Cultural Diversity
 Institute of Psychiatry, London, UK

**National Workshops on Current status and future preparedness in psychosocial and mental health aspects in disasters
Male', Maldives 14-15 September 2005**

Final Programme

Wednesday, 14 September 2005	
0800-0815 hrs	Registration
0815-0830 hrs	Inauguration By Dr. Abdul Azeez Yoosuf, The Deputy Ministe Remarks by Dr. Jorge Luna, WHO Representative in Maldivesr
0830-0900 hrs	Introduction to workshop (RA-MHS)
0930-1030 hrs	Presentation by Tsunami emergency psychosocial team
1030-1100 hrs	Presentation by American Red cross
1100-1130 hrs	Experience sharing by Community representatives from affected areas
1130-1200 hrs	Presentation by UNFPA (MIDP unit/Psychosocial unit)
1330-1400 hrs	Presentation by Care Society
1400-1430 hrs	Presentation by the WHO country office/Ministry of Health
1430-1500 hrs	Presentation by UNICEF/Ministry of Education
1500-1530 hrs	Presentation by Ministry of Youth and sports
1530-1600 hrs	Presentation by Ministry of Gender/URC
1600-1630 hrs	Discussion
Thursday, 15 September 2005	
0830-0900 hrs	International perspective: Drs. Chandra and Bhugra followed by discussions
0900-1000 hrs	Presentation on disaster preparedness – Dr. Qudisa Huda and Dr Lieselotte Schmid
1000-1030 hrs	Tea
1030-1200 hrs	Developing a plan for disaster preparedness in psychosocial and mental health aspects – Dr Rajesh Pandav
1300-1500 hrs	Developing a plan for disaster preparedness in psychosocial and mental health aspects (contd..)
1500-1600 hrs	Presentation of an outline for disaster preparedness for psychosocial and mental health relief efforts
1600-1700 hrs	Discussion
1700-1730	Closing

**IMPACT ASSESSMENT OF
MENTAL HEALTH AND PSYCHOSOCIAL RELIEF EFFORTS
AFTER THE TSUNAMI DISASTER
IN MALDIVES**

PREPARED BY:

WORLD HEALTH ORGANIZATION
SOUTH EAST ASIA REGIONAL OFFICE,
MENTAL HEALTH AND SUBSTANCE ABUSE UNIT

DR. VIJAY CHANDRA

Regional Advisor

DR. RAJESH PANDAV

Short-term professional

EXTERNAL CONSULTANT

DR. DINESH BHUGRA

Professor of Mental Health and Cultural Diversity
Institute of Psychiatry, London

SECTION 1: ASSESSMENT BASED ON INFORMATION TO BE OBTAINED FROM GOVERNMENT DEPARTMENTS

Impact on policy makers as assessed by increased awareness with corresponding action on mental health and psychosocial (MHPS) issues

Assess WHO's role for each question if appropriate.

Activity to be assessed	Pre-tsunami	Post-tsunami
<p>What was the relative priority assigned to MHPS issues compared to other major programme areas?</p>	<p>Specific neuropsychiatric issues have been given priority by government of Maldives in the past, but there was no overall plan:</p> <ul style="list-style-type: none"> • Survey of prevalence of epilepsy and mental disorders in 1989 in 5 northern atolls. • A national registry that covers mental disorders is maintained at the Ministry of Gender, Family Development and Social Security. Patients once registered with this Ministry are entitled to free medication. • There is one Home for People with Special Needs at Guraidhoo housing approximately 120 patients. • The Rapid Situation Assessment of drug abuse in the Maldives has shown that nearly 20% of drug users reported their primary reason for drug abuse as psychological problems • A recent survey carried out in 2004 by the Ministry. Based on this survey government gave priority to epilepsy. Training of community health workers and nurses has been conducted for epilepsy. • Community-based rehabilitation of the intellectually impaired has not been a government 	<p>After the tsunami MHPS issues have received high priority from the government.</p> <p>Emergency Response</p> <ul style="list-style-type: none"> • The National Disaster Management Centre was established with a Psychosocial Unit in it. • The government launched a well organized community-based campaign to provide psychosocial support to disaster-affected persons. • Emotional Support Brigades were established in each affected island. Through this out-reach programme, all affected islands have been reached, and every affected person has been provided at least some emotional and psychological support. <p>Building a community mental health system:</p> <ul style="list-style-type: none"> • The MoH requested a consultant to be sent by WHO. He spent 3 months and conducted workshops all over the country for health workers, nurses and physicians. These personnel will support the community-

<p>Does the country have a national mental health policy? If yes, how was it developed?</p>	<p>programme but an NGO (Care Society) does training and service delivery.</p> <ul style="list-style-type: none"> • Learning and behavioural problems in children was identified as a priority area and WHO SEARO was requested to develop technical material and send a consultant for training parents and teachers. <p>No</p>	<p>based services.</p> <p>Forum for Partners in Mental Health</p> <p>This Forum is a major initiative of the Government of Maldives. It brought together all stake holders working in the field of mental health. Two of the important recommendations of the Forum were:</p> <ul style="list-style-type: none"> ○ A key agency be identified at the national level to co-ordinate the wide range of mental health related activities ○ Develop a national policy on psychosocial issues. <p>Advisory Committee for MHPS issues:</p> <p>The MoH has proposed the formation of a technical group to serve as an advisory body to the MoH on development of a mental health system in the country.</p> <p>Based on the recommendations of the Forum for Partners in Mental Health and the Advisory Committee, the MoH has initiated the process to develop a mental health policy in Maldives.</p>
<p>Does the country have a national mental health programme? If yes, how was it developed?</p>	<p>No</p>	<p>All individual activities will be combined into a national mental health plan. Mr. Hameed has been appointed the coordinator for mental health in the MoH.</p>
<p>What MHPS services are available at the PHC level and what is the basis of development of</p>	<p>Training of health workers and nurses for identification and management of epilepsy had been done at two Regional Hospitals.</p>	<p>General practitioners, nurses and health workers have been trained in a wide range of mental health issues in all the regions by WHO consultant.</p>

these services?		
Is there a regular budget allocated for providing MHPS services? Define the allocation.	No	Based on the recommendations of the mental health policy a regular budget may be allocated next year.
Are there established training programmes on MHPS issues for different cadres of health care providers?	None	<ul style="list-style-type: none"> • A video based training programme for GPs, health workers and nurses is proposed. This will enable the government to train new staff with minimal expense. • The Faculty of Health Sciences proposes to introduce teaching of essential mental health services in their curriculum for health workers and nurses.
Are common psychotropic medications (ant-psychotics, anxiolytics, anti-epileptics) regularly available at the regional, atoll and island level health care facilities? If yes, are they free.	There is no clear policy on availability of psychotropic medications at regional, atoll and island level. Patients once registered with Ministry of Gender, Family Development and Social Services are entitled to free medications. Many psychotropic medications are available at private chemist shops.	The mental health policy which will be drafted will include a section on availability of psychotropic medications even at the island health centres.
Is there a clear chain of command for decision making and coordination of MPHS services?	Not before the tsunami.	To be clarified in the National Mental Health Programme which will be developed.

Does the government have a long-term plan for MHPS services?	None prior to tsunami	There is active interest in developing all aspects of MHPS services in the long-term including legislation, policy, programmes and services.
Is there any mental health legislation in the country?	None prior to tsunami, but there is one section in the health act on mentally ill persons which needs substantial revision.	WHO consultant has reviewed the health act and has strongly recommended that the mental health section be revised and separate mental health legislation be created. This recommendation has been accepted in principal by the Attorney General's Office.

Conclusion: The tsunami has been instrumental in motivating the government of Maldives to give high priority to MHPS services. Moreover such services will be delivered in a coordinated manner in the long-term. The government should be complimented on the well organized immediate response to the tsunami and development of clear plans for the long-term. For a small country like Maldives to consider modern mental health legislation reflects the farsightedness of the government.

WHO' role in providing technical support for training of all levels of health care providers has been greatly appreciated. An official of MoH commented that this support will be sustainable in the long-term and assist the government in developing a comprehensive plan. A WHO consultant has been involved in the meeting of the Mental Health Forum and providing input to the formation of the Advisory Committee.

SECTION 2: ASSESSMENT BASED ON INFORMATION TO BE OBTAINED FROM GOVERNMENT DEPARTMENTS

Government's plan of action for mental health and psychosocial (MHPS) aspects of disasters

Assess WHO's role for each question if appropriate.

Item to be assessed	Response	Comments
Was there a pre existing disaster preparedness plan of action for the health sector?	No	-
If yes, what was its MHPS component?	N.A.	-
If yes, was the plan implemented as designed? Please specify the experience with its implementation.	N.A.	-
If no, was a new plan of action for the health sector prepared after the tsunami?	A national disaster preparedness plan is under development.	Under development with the assistance of a WHO consultant
Does the new plan have an MHPS component.	The new plan will have an MHPS component.	The disaster health plan will include a MHPS component. A national workshop for disaster preparedness on MHPS was held in September. Recommendations were made for MHPS component. Mental Health Unit, WHO SEARO facilitated the workshop. Deputy Health Minister attended the workshop and provided input to the recommendations.

Was the new plan implemented as designed? Please specify the experience with its implementation.	N.A	There was no new plan, but MHPS activities were implemented in a well coordinated manner.
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Conclusion:

The government assigned high priority to MHPS activities after the tsunami. Emergency response was appropriate and well implemented and long-term plans for mental health aspects of disaster preparedness has been initiated.

The national workshop (facilitated by WHO) made a significant contribution to the planning process. Maldives is the first country to conduct a national level workshop in which different ministries, UN agencies, NGOs and affected community members participated. Every person and agency had the opportunity to present their views in a open and cordial manner. Significant conclusions emerged which will be of great help to the country in long-term planning for MHPS services.

SECTION 3: ASSESSMENT BASED ON INFORMATION OBTAINED FROM MULTIPLE SOURCES AND REVIEW OF DOCUMENTS

Evaluation of efforts for building MHPS systems and assessment of quantum of services provided

Assess WHO's role for each question if appropriate.

Item to be assessed	Response	Comments
Role of community-based health care providers for MHPS services		
1. How many training programmes were conducted and for which category of health worker?	<ul style="list-style-type: none"> • Training programmes for counsellors (2 day session in Male') • Training programmes for Emotional Support Brigade in each island (one training session in each affected island) • Training programme of all levels for health staff (health workers, nurses, GPs; 8 workshops covering all Regions) 	<p>Training programme facilitated by many agencies. (American Red Cross, UNICEF, UNFPA etc)</p> <p>WHO consultant conducted training of all health staff.</p>
2. How many health care providers were trained and how were they identified?	<p>70 counsellors from within Maldives were trained for psychosocial support. All trainees were local Maldivians, many were previously trained counsellors working in different agencies, everyone was requested to volunteer for the relief efforts.</p> <p>CLWs/nurses from all regions were trained in the identification and care of common mental health problems.</p> <p>GP's from all regions have been trained to provide basic mental health services.</p>	<p>Using local staff who speak the language and are familiar with the culture is a very important prerequisite for effective psychosocial relief efforts.</p>
3. Was there a structured training format?	<p>Yes. Training programme for psychosocial first aid provided by American Red Cross. WHO technical material partly used.</p> <p>WHO consultant used didactic lectures and case studies along with technical material developed in SEARO in training programmes for health staff.</p>	<p>Training material of the WHO consultant may be converted to a video based training to facilitate training of new staff at minimal cost.</p>

4. Who provided the training material?	WHO and American Red Cross. UNICEF and UNFPA contributed logistical support..	Funding from UNICEF, UNFPA, American Red Cross and WHO
5. Who did the training?	American Red Cross to counsellors, WHO to paramedical health staff and GPs.	Funding from UNICEF, UNFPA, American Red Cross and WHO
6. Was there a programme for stress management for CLWs?	No.	WHO has provided the technical material but the programme has not specifically been implemented. This should be considered in future plans
7. Number of persons given psychosocial interventions	Pre-training; None	-
	Post-training; Each and every person in all affected islands was reached through the Emotional Support Brigade in each island.	This community outreach programme implemented by local Maldivians and reaching each affected person is exceptionally good.
8. Type of intervention provided	Psychosocial first aid by Emotional Support Brigade and mental health services by trained GPs.	

Conclusion: The psychosocial first aid provided by CLWs was exceptionally good for the emergency phase. Each and every person in every affected islands was reached. Back-up mental health services have now been created in all regional, atoll and island health centres. The community level work and clinical services are closely linked.

SECTION 4: ASSESSMENT BASED ON INFORMATION OBTAINED FROM TECHNICAL FOCAL POINT

Assessment of psychosocial distress in the community using a structured format eg., GHQ/Other instruments

Assess WHO's role for each question if appropriate.

Item to be assessed	Response	Comments
Initially assessment Qualitative/Quantitative	<p>Multiple assessments were carried out by different agencies (UNICEF, Care Society, IFRC, Save the Children, Ministry of Planning, Ministry of Gender, Family Development and Social Services).</p> <p>Ministry of Planning as part of the Tsunami Impact Assessment (Psychosocial and Reproductive Health module) has conducted a survey – results pending.</p>	<p>Essentially each agency was trying to assess the field situation in terms of its own mandate. The surveys used different methods in sample selection and study design (quantitative and qualitative measures). People working with the relief efforts point out that these surveys often duplicated information. Also, the lack of normative data made interpretation of the findings difficult.</p> <p>Data analysis for this questionnaire is complicated and special expertise will be needed. WHO has offered to help.</p>
GHQ Scores/Other instruments used	Initial mean score: ____ Date: _____ NA	
	IIInd mean score: ____ Date: _____ NA	
	IIIrd mean score: ____ Date: _____ NA	

Was it validated	GHQ-12 was validated for use in Maldives with WHO support	Initially not used. But now being implemented by an NGO in some affected islands. WHO has provided support for data analysis.
Experience with its use	Remains to be seen.	

Additional Comments:

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

Conclusion:

- A clear plan should be in place to determine which instruments for assessment of psychosocial distress will be used, when and by whom
- Validated questionnaires (quantitative) for needs assessment and mental health status of the affected population should be readily available to all partners.
- Technical support needed for data analysis and interpretation should be identified.

SECTION 5: ASSESSMENT BASED ON INFORMATION OBTAINED FROM COMMUNITY LEADERS

Impact of mental health and psychosocial (MHPS) relief efforts on the community

Assess WHO's role for each question if appropriate.

Item to be assessed	Response	Comments
Are displaced families now back home? How soon after the disaster did they return.	Immediately after the disaster the affected people lived in houses of the people who were not affected. Temporary shelters were constructed by the government within one month and they shifted to these shelters.	One of the main concerns voiced by IDPs is to get a permanent shelter/home.
Have families returned back to normal way life? How soon did this happen?	In the most affected islands people have not yet fully returned to normal life as they are still living in temporary shelters. Houses are being built for them. Women started doing their daily household chores as soon as they were given their own place to live.	
Have people returned to their occupation? How soon did this happen?	Farm land has been given to the people of the affected islands in their new island of residence. Some were employed by fisherman from the community of non-affected islands. Some have their own boat so they started fishing soon.	Most people want to resume their means of livelihood. Some people appear to be happy just receiving aid for as long as possible.
Have children returned to school? How soon did this happen?	Most children returned back to school on the first day of school in the new island they had been shifted to.	This is a particularly vulnerable group which still has signs of psychosocial distress. Resuming normal school activities and helping the entire family settle down will greatly help the children.

Did the community get psychosocial support?		
When	Very soon after the disaster when the Emotional Support Brigades were established in each island.	Almost immediately after disaster the psychosocial unit was established by the government. This unit recruited 70 counselors who were trained by the American Red Cross in psychological first aid and immediately went to each affected island. This outreach programme is highly commendable. WHO consultant has trained health workers and nurses based in government health facilities in providing mental health and psychosocial support to affected communities.
What type	Psychological first aid, counseling and assistance in returning to normal way of life	
By whom	By members of the Emotional Support Brigade	
How often	As often as needed since the Emotional Support Brigade was from within the local community and always present	
Was the community satisfied with the psychosocial support provided	The community members were satisfied, but most expressed the desire to return to a permanent house as soon as possible.	
Did the community get mental health support?		
When	Soon after the tsunami	Based on information provided by the atoll hospital doctor, some patients did come to him with anxiety and depressive symptoms.
What type	Prescriptions were provided by atoll hospital doctors but medicines had to be purchased from the private chemist shop.	
By whom	Prescription given by GPs in the island health centre.	Immediately after the tsunami GPs posted to the island health centres, many of them who have minimal exposure to mental health, were treating patients with all kinds of mental health problems. After the tsunami all GPs have received training by a WHO consultant on treatment of common mental disorders and should be better prepared to handle the needs of patients.
How often	Patients in need usually went to see the doctor once.	

Is the community satisfied with the mental health support provided	Most patients were not fully satisfied as no psychotropic medications are available in the health centre.	
Were adequate amount of psychotropic medication available in the clinic?	Psychotropic medications are not routinely available at island health facilities.	The government is now aware of this issue, and availability of psychotropic medications will be included in the mental health plan being developed.
Did the community get adequate and appropriate information from the media?	Reliable, timely and frequent information was provided by senior government officials on television and radio. Most people greatly appreciated this information as it reassured them.	Many people have pointed to the need for reliable information to be made available in times of emergencies, specifically what services are available and where these services can be obtained.

Conclusion The community outreach programme through which psychosocial support was provided to each and every person is highly commendable. Also this psychosocial support was provided by local Maldivians who were appropriately trained. The initial limitation was lack of awareness of mental health issues among GPs and the non-availability of psychotropic medications. GP training has now been completed, but because of the high turnover, new GPs will again need training. A proposal has been made to prepare video-based training for new GPs. If accepted, this will provide the training at minimal cost. Availability of psychotropic medications in the long-term remains to be considered by the government. Providing appropriate information to the community was also a plus point of the programme.