adpc
Asian Disaster Preparedness Center
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Asian Disaster Management News

Recovering from disaster:

mental health and psychosocial support gets people back to everyday life

Building Resilience through Innovation and Partnerships

Editor's Note

Dear Readers,

Asian Disaster Preparedness Center's vision of "safer communities and sustainable development through disaster risk reduction" extends to all aspects of our activities. Our work in Public Health in Emergencies is no exception. By focusing on Mental Health and Psychosocial Support, ADPC seeks to alleviate the trauma felt by individuals in communities who have experienced disaster.

ADPC has initiated its Mental Health and Psychosocial Support initiative, with support from the Norwegian Ministry of Foreign Affairs (MFA) and technical support from the Center for Crisis Psychology (CCP). We aim to continue building capacity regionally in this field and thus hope to reduce the widespread psychosocial consequences of disasters.

The Mental Health and Psychosocial Support in Emergencies Training Program was conceptualized in 2009 by MFA, CCP and ADPC. It was pilot tested in Bangladesh with BRAC, as the lead partner-agency of the program from January 2011 to May 2012. Since then, the program has been implemented in other vulnerable countries, such as Vietnam.

The psychological impacts of disasters, as observed in disaster events such as the Indian Ocean Tsunami in 2004, Cyclone Nargis in 2005, the Pakistan Earthquake in 2005, the Sichuan Earthquake in 2008 and the Tohoku Earthquake and Tsunami in 2011, are immense and are unfortunately often underestimated. Those that are affected, as articles in this edition of Asian Disaster Management News elaborate, hesitate to seek support for fear of being stereotyped as a "mental health patient". Misguided stigmas surrounding mental health support in emergencies are a reality for individuals experiencing trauma throughout South and Southeast Asia. Our work in mental health and psychosocial support in emergencies aims to minimize stigmas associated with the topic.

This edition of Asian Disaster Management News hopes to build an awareness of the mental health and psychosocial support needed in Asia. In the upcoming months, victims of Rana Plaza building collapse of 25 April 2013, like many other individuals in disaster-affected areas across the region, will need continued mental health and psychosocial support. We hope to cooperate with other actors in the region to minimize the psychological impact of disasters and to provide the support required to those in need. In order to strengthen mental health and psychosocial support in our region, we need to focus and direct our efforts in policy development, stakeholder relations, capacity development for health care providers and trauma alleviation for community members.

Sincerely,

N.M.S.I Arambepola
Editor-in-Chief

About us

Asian Disaster Management News is published by the Asian Disaster Preparedness Center, to serve as a channel of communication and source of information for disaster risk management practitioners and development workers in Asia-Pacific.

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Asian Disaster Management News

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Features

In Brief

Check out some of ADPC's recent work in the field of Public Health in Emergencies, from around the region.

Dhaka and Sirajganj, Bangladesh
8-26 September A series of simulations and refresher courses for pilot communities will take place under the Community Action for Disaster Response (CADRE) program.

Dolakha and Hetauda, Nepal
August A series of simulations and refresher courses for pilot communities will take place under the Community Action for Disaster Response (CADRE) program.

Bangkok, Thailand
11 July Hospital assessment on emergency management takes place at Klang Hospital in Bangkok. First time PEER and Bangkok Metropolitan Administration join forces.

19-23 August The 10th International Course on Hospital Emergency Preparedness and Response

16-28 September 11th International Course on Public Health in Complex Emergencies

7-18 October 3rd Regional Course on Nutrition and EMergencies will bring together public health officials from around the region.

Hanoi, Vietnam
12-16 August The PEER Master Instructor Workshop aims to develop course monitors and coordinators for PEER's CADRE program. Participants include disaster preparedness professionals from Cambodia, Lao PDR, Thailand and Vietnam.

Mental health and psychosocial support program for emergencies launches in Vietnam

***HANOI,* Vietnam** – Thirty government officials, and participants from INGOs, NGOs, Vietnam Red Cross from 9 provinces in Vietnam will join in Hanoi on 16 July 2013 to launch Vietnam's first Mental Health and Psychosocial Support (MHPSS) in Emergencies Training Program. Post-launch, the participants will receive training on Psychosocial Response to Disasters with a focus on Children & Teaching Recovery Techniques during the following week at the Hanoi School of Public Health.

Asian Disaster Preparedness Center (ADPC) together with its technical partner agency, the Center for Crisis Psychology (CCP) Norway, and in collaboration with the Hanoi School of Public Health (HSPH) and Vietnam National University (VNU)'s Center for Research, Information and Services in Psychology (CRISP) will jointly launch the program. The program is considered a milestone for mental health and psychosocial support in Vietnam, as there is momentarily limited support for victims in this area in times of emergency.

The course reaches out to Vietnam's professionals that specifically work with children and those that are suitable candidates to act as mental health and psychosocial support counselors to children disaster victims. Participants namely include school teachers, social workers, counselors, psychologists, psychiatrists and health workers. With a commitment to actively learn, course participants' expect to be able to apply their knowledge gained in disaster response scenarios, especially to deal with children victims' mental health and psychosocial support.

The program is a first step to assist with overcoming stereotypes related to mental health conditions in times of emergencies.

> "Stereotypes include that having strong reactions to traumatic events is a sign of weakness and shameful. Whatever stereotypes there are, I believe that knowledge and openness are keys to overcome them. I think that sharing and using good research is crucial."

Madam Ragnhild Dybdahl, Ph.D. Deputy Head of Mission, Royal Norwegian Embassy Vietnam

Media professionals interested in the development of mental health and psychosocial support in times of emergency in Vietnam are encouraged to attend this event.

Plenary photo of all delegates and trainees who joined in the launch of MHPSS Training Program.

Media will have the opportunity to engage a wide-range of related professionals in mental health, and better understand recent efforts in Vietnam to overcome associated stereotypes. ■

The goal of ADPC's Mental Health and Psychosocial Support in Emergencies Training Program is to strengthen community safety and resilience through capacity development of health personnel at various levels to manage psychosocial impacts of all types of emergency or disaster, to be able to increase the survival rate of disaster victims.

The program has 3 fold objectives, namely:
1. To enhance community capacity mental health and psychosocial support to be able to manage victims immediately post-disaster;
2. To strengthen the knowledge, attitude, and skills of health workers in managing children disaster victims; and
3. To enhance the capacity of professionals to manage identified mentally pathologic cases during disaster.

The program was first implemented in Bangladesh with BRAC, as the main beneficiary, from January 2011- May 2012. To date, a total of 122 participants have attended the course, out of which, 53 participants graduated as Master Trainers in the country. Subsequently, roll-out trainings and refresher courses were conducted in the country by 'Master Trainers'. The MHPSS training program has received funding support from the Royal Government of Norway.

After the pilot testing in Bangladesh, ADPC and its main technical partner agency, the Center for Crisis Psychology (CCP) in Norway, envisaged the replication of the program in other countries in Asia, such as Vietnam. Consultative meetings were organized to find out if this program is in line with the country's needs and priorities, and to identify ways to strengthen the country's capacity in MHPSS in Emergencies.

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Why Asia should invest in mental health support in emergencies

In an interview with ADPC, Madam Ragnhild Dybdahl, Ph.D. Deputy Head of Mission, Royal Norwegian Embassy Vietnam shared her perspectives on the importance of prioritizing mental health and psychosocial support in Asia

The Royal Norwegian Government, with technical support from the Center for Crisis Psychology, is reaching out with the aim to reduce the psychological impact of disasters on communities. Together with ADPC, the Mental Health Psychosocial Support Initiative provides trainings to build capacities in this area throughout the region.

Why is there an urgency for governments in Asia to focus on psychological recovery? What are the challenges in this part of the world and how can governments, in your opinion, potentially overcome them?
Mental health and psychological recovery are issues that need to be urgently addressed in many countries in Asia. With an increased focus on non-communicable diseases, the burden of mental health problems and long-term consequences of disasters on people's health- including mental, social and spiritual wellbeing is becoming increasingly clear. This not only causes human suffering, but also has many negative economic and social consequences.

There are a number of challenges for example, the cost of improving services, such as better education and skills for mental health providers, and the stigma that often is attached to mental illness. Governments play important roles in promoting openness and human rights, reducing stigma and including mental health in the health systems. Quality and quantity of education and research in the fields of psychology, psychiatry and other disciplines is very important, and this requires commitment from governments.

Humanitarian assistance to areas and groups affected by disasters has rarely resulted in significant reduction in the vulnerability of people. There is growing awareness of the need to reduce vulnerability, combined with the recognition that local capacity is decisive for disaster risk reduction. This has led to a stronger focus on how vulnerable groups perceive their own risk and vulnerability, as well as concrete measures to support local capacity for overcoming this vulnerability. This primarily means a closer international focus on local measures to reduce vulnerability and the development of local capacity to prepare for and respond to disasters. The population's ability to resist and deal with external shocks is a decisive factor in whether a conflict or natural phenomenon has major humanitarian consequences.

What are some of the stereotypes surrounding mental health and psychosocial support, and how should we as practitioners overcome this?
Stereotypes include that stress and grief reactions follow universal phases where people go through shocks and reactions and have to work through their problems or have specific reactions in order to have a sound outcome. Other stereotypes are that having strong reactions to traumatic events is a sign of weakness and shameful. Whatever stereotypes there are, I believe that knowledge and openness are keys to overcome them. I think that sharing and using good research is crucial.

In your opinion, what are some of the psychological disaster interventions that could be a best practice scenario applicable to the Asia-context?
I believe that many countries in Asia have demonstrated that they have amazing resilience and very valuable ways to overcome disaster and hardship. I think that applying interventions with a sound evidence base from other contexts is important. At the same time, these should be applied in a way that is culturally acceptable and incorporates local practices for healing and promoting resilience, while constantly keeping a critical perspective and evaluating possible harms and benefits of these interventions. I think it is important that the interventions and measures are well anchored in the countries and at the government level. ■

Understanding the need for mental health and psychosocial support in times of emergency

by Dr. Pir Mohammad Paya
Senior Technical Specialist
Public Health in Emergencies Unit, ADPC

THE TERM 'PSYCHOSOCIAL' DENOTES THE inter-connection between psychological and social processes and the fact that each continually interacts with and influences the other. The composite term mental health and psychosocial support (MHPSS) is used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder. Social support aims to protect and support mental health and psychosocial well being in emergencies. This type of support should be cross-sectorally approached. (www.who.int)

Mental health and psychosocial support are fundamental requirements for overall health and needs to be integrated and community-based to ensure services are available, acceptable, accessible and affordable that can improve mental health and psychosocial outcomes. And these services should be indiscriminately made available to those in need such as refugees, internally displaced persons with more focus on vulnerable groups (women, children, disabled and elders).

Emergencies – amplifying problems

Emergencies create a wide range of problems experienced at the individual, family, community and societal levels. At every level, emergencies erode protective support that are normally available, increase the risks of diverse problems and tend to amplify pre-existing problems. While social and psychological problems will occur in most groups in times of emergencies, it is important to note that every individual will experience the same event in a different manner and will have different resources and capacities to cope with the event. (www.who.int)

Natural hazards and human-generated disaster significantly impacts (directly and indirectly) the psychological and social health of the population. The sudden injury and loss of loved ones; damaged properties; loss of livelihoods; and the untimely displacements of the affected population undermine their mental health and psychosocial wellbeing.

Polices in most regions of the world support response efforts and focus more on search and rescue and provision of mental health. Psychosocial support services have often been neglected in the emergency management operation.

Everyone's at risk

When disaster occurs, the whole affected population is potentially at risk of psychosocial impacts of disaster. History and experience show that many are resilient and possess the capability to cope well with the adverse situation and bounce back to their expected normal life. However, some develop significant psychological trauma, and if not attended in a timely and appropriate manner, the condition might result in long-term pathologic disorder.

Now, efforts are needed more than ever to come up with a uniform approach and strengthen the level of collaboration and coordination among agencies to ensure proper, on-time and quality services are offered to communities before, during and in the aftermath of disasters.

Complex emergencies challenge mental health systems

Complex humanitarian emergencies, whether arising from armed conflict or disasters caused by natural hazards, challenge the mental health system of a country in many ways. Complex emergencies increase the risk of mental disorder in the population, and under-mine the pre-existing structures of care. They may however, also bring forth new opportunities to create change. In this way, new structures and paradigms may emerge from the midst of a crisis. The probabilities for such a change to occur vary from one setting to another.

Lessons learned demonstrate that interventions in complex humanitarian emergencies should not be limited to the deployment of specialized resources that will disappear once the emergency has lost its urgency, or visibility. Apart from provision of direct services, interventions in these circumstances should also aim to build local capacity and install sustainable systems of mental health care at the time of the intervention. (www.ourmediaourselves.com)

Coping with disaster

The psychosocial impact of emergency or disaster to vulnerable populations such as young children, women, elders and disabled are becoming more serious. Mechanisms need to be established to increase the communities' ability to cope and preparedness. Without coping mechanisms in place, victims of disaster may not be able to cope, testing their psychological thresholds. Depending on the context of the disaster, there are some victims that do not recover from their trauma, despite sufficient initial interventions. These victims may need a high-level of care and interventions to assist their trauma recovery process.

Psychological responses to a disaster are well established; however, little is known regarding how individuals with established psychiatric and mental health needs respond to a disaster. Further research is needed to provide a better understanding as well as to provide data and information that would assist in the provision of timely and adequate intervention and treatment. Addressing the psychological and psychiatric needs of vulnerable populations would assist in the provision of adequate and appropriate psychiatric mental health care in a timely and an effective manner. (www.keepthefaith1296.com)

Communities on the front-line of disaster

As communities are the ones directly affected by any emergency or disaster they are the front-liners or the first responders expected to manage the risks of emergencies or disasters. Their actions immediately save lives before humanitarian aid arrives.

Thus, community capacity to manage mental health and psychosocial impacts of emergencies becomes even more critical with the rising threat of hazards.

On-going efforts to support Mental Health and Psychosocial Support exist. For example, the United Nation's Inter-Agency Standing Committee developed the Mental Health and Psychosocial Support Guidelines that map-out the multi-sectoral inter-agency framework that enables effective coordination, identifies useful practices and flags potentially harmful practices, and clarifies how different approaches to mental health and psychosocial support complement one another. However, these efforts require additional policy support by governments and an enabling environment for stakeholders (private and public) to implement it effectively and efficiently. (IASC) ■

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3) http://www.keepthefaith1296.com/parkinsons/disaster-planning-for-vulnerable-populations--mental-health-MjEwOTU1NTc=.htm

4) Inter-Agency Standing Committee (IASC)

Promoting Mental Health in Bangladesh

BRAC shares their perspectives on the urgent need to improve mental health support and overcome cultural stigmas

by Dr. Babar Kabir, Senior Director
BRAC DECC and WASH Programmes
and

Lusana Anika Masrur, Senior Sector Specialist
BRAC DECC Programme

BANGLADESH MAY RANK 11TH ON THE HAPPY PLANET index, but underneath this statistic lurks shadows of many struggles that the country continues to face since its inception. While it may be true that the young nation has won marathons in the field of social development in some fields, it severely lacks progress in various others. For instance, in terms of our health indicators, the impressive drop in child mortality rates; improved maternal health care and near-elimination of malaria and TB are just a few causes of envy for our neighbors.

However, although the progresses we have made in the public health sector (among many others!) have been remarkable, one challenge that has almost slipped out of our radar includes the lack of mental health services. It is estimated that one in every six persons in Bangladesh suffers from some form of mental illness, a majority of who go undiagnosed. Moreover, Bangladesh is estimated to have only one psychiatrist for every two million of its people. According to a World Health Organisation (WHO) report that was conducted in 2005, the country's health department spent only US$ 1.4 million on mental health, which was less than 0.5 percent of the total annual healthcare budget. Furthermore, the report also highlighted that social insurance schemes in the country did not cover mental disorders and that no human rights review body exists to inspect mental health facilities. It should also be mentioned that the Indian Lunacy Act of 1912, that sanctions discrimination against the mentally ill, still remains operative in Bangladesh. This report was formulated almost a decade ago, but little has changed since then.

Trauma and history: a closer look at Bangladesh's past

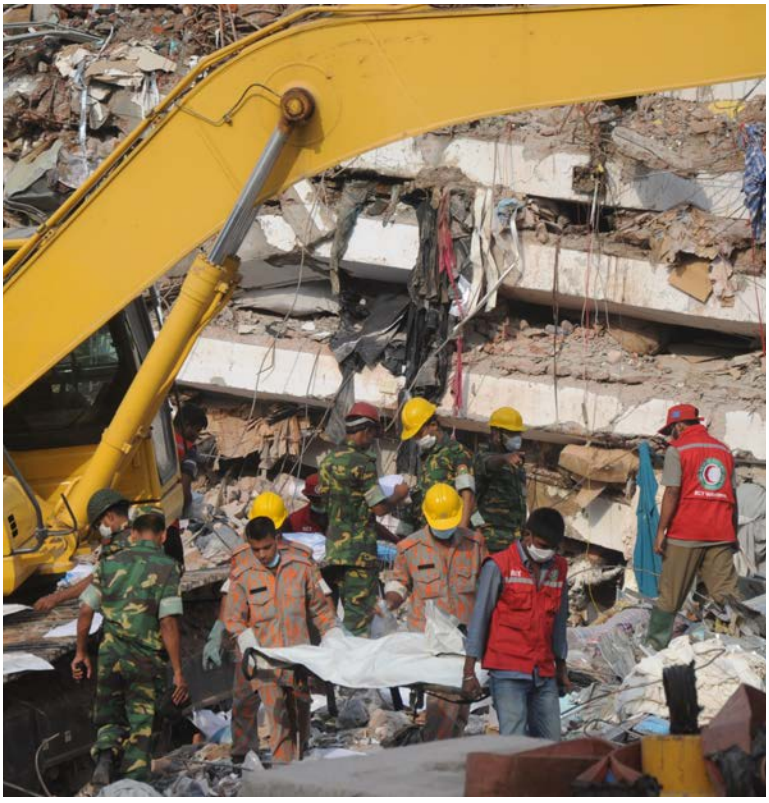
An analysis on the current mental health status of Bangladesh would be incomplete without looking at our brutal birth. The mental trauma experienced by people of all backgrounds across what was once East Pakistan is only about three generations old. As such, the traces of a population-wide post-traumatic stress disorder have been transferred onto the descendants of millions of war victims. This trauma has now manifested itself in the form of not just mental disorders, but can also be attributed to widespread acts of domestic violence, anger management issues and physical and verbal abuse (taking MANY other external factors into consideration too, of course!). Back then, the crippled state of our country prevented us from addressing mental health issues because immediate physical needs were prioritized.

However, we have now come to a point where although issues like poverty still linger, it does not to the extent that people are dying from starvation like they used to. Yet the treatment of mental patients still remains highly disregarded. Seeking mental help is also considered a taboo.

Yet the treatment of mental patients still remains highly disregarded. Seeking mental help is also considered a taboo. Consequently, anybody doing so is considered to be a 'pagol' (lunatic) and is hardly recognized as a functional entity with fundamental human rights.

Although it may be true that the trials of war are no longer faced here [in Bangladesh] today, traumatic incidents are on the sharp rise. Among others, crimes in the form of sexual violence and manslaughter have gone up. Both natural and man-made disasters result in hundreds of deaths every year. At the individual or family level, other traumatic situations like domestic violence, substance abuse and exploitation at the workplace are pervasive. An ever-growing population living in close proximity to each other in 'chicken coops' as a result of urbanization, also contribute to deteriorating mental health and increasing stress levels.

A contrasting phenomenon from the just-mentioned factor, a survey conducted by the National Institute of Mental Health in 2011 concluded that mental disorders were more common in rural children. Occurring in concentrated pockets, these factors impact overall public health and national performance. They also raise important questions about the direction we ought to take to address this inexcusable missing link in our public health sector.



Although it may be true that the trials of war are no longer faced here [in Bangladesh] today, traumatic incidents are on the sharp rise.

Mental Health Support in Emergencies: The case of Rana Plaza

Among others, the pressing need for this, especially during times of emergency, has surfaced in the recent tragedy of the Rana Plaza collapse in Savar (an industrial area in the outskirts of Dhaka, Bangladesh) that is said to have caused the death of 1,130 garment factory workers. Despite the country being quite used to consecutive adversities, the intense and gruesome nature of this particular catastrophe, which could have easily been avoided, cut deep into the lives of thousands. It was probably the worst man-made calamity since our Liberation War. The emergency response measures carried out at this time brought various issues into the limelight.

Topping that list was the dire need for provision of mental health support in times of emergencies for victims whose post-disaster signs of mental health issues did not even come not close to being adequately addressed. While rescue operations, medical services, rehabilitation needs and humanitarian aid poured in, the thousands of surviving victims hardly received any form of mental health care for the trauma they experienced. BRAC, a leading social development organization was not only one of the first responders at the site, but it continues to provide support for the Rana Plaza victims. Among others, it also provided counseling services for disaster survivors at the hospitals they were admitted in. Recognizing the need for mental health support during emergencies back in 2011, BRAC began Training of Trainers on psycho-social support with the help of ADPC for promising candidates who were handpicked for their past experience and relevance in appointed fields. Till date, the roll-out trainings have been conducted for 210 personnel from the BRAC staff body and other renowned organizations like Dhaka University, BRAC University and IED, among others.

Traditionally, focus has been given to material needs in providing assistance as opposed to treatment for posttraumatic incidents. However, often enough, the damage is more to the mental psych of a victim rather than any physical damages. Given that BRAC has supported victims of traumatic events from its inception, this measure has been introduced to further enhance the process through a more holistic approach. It will greatly boost its organizational capacity to effectively address and professionally respond to emergencies through a wide spectrum of activities and events and allow victims to lead normal lives again.

Overcoming stigmas and stereotypes

However, BRAC has faced some challenges in implementing such mental health support. Again, the best example is with the case of Rana Plaza. Its team of counselors have had limited success because of a number of unavoidable

and intricate issues. Firstly, patients themselves were not welcome to the idea of being treated for 'mental issues'. Because of the social stigma associated with it, seeking mental help was viewed as unnecessary and unless someone had any tangible support to give them, they were not interested. As such, it took the counselors a very long time to build an adequate rapport with them. Secondly, creating a conducive environment, which is essential for counseling trauma victims was almost next to impossible. The lack of space in crowded rooms, constant distractions and ever-present bystanders were a major barrier. Thirdly, many patients were either continually being transferred or they were released at the very onset of recovery which made it extremely difficult to follow up on the treatment. The ratio of counselors to the amount of trauma victims was also a concern.

Furthermore, the gravity of the situation requires long-term mental health support where patients can sit one-on-one with counselors for considerable stretches of time at each session. Otherwise, the underlying issues that take a long time to surface will never be addressed sufficiently. Furthermore, due to the limitations, family members of victims are not currently being attended, which also prolongs the recovery of overall mental health.

'Mainstreaming' mental health support

It is crucial that mental health support is not just recognized but also mainstreamed not just locally (both at the policy and implementation level), but also within the international community. Especially given the fact that we are such a vulnerable country to the impacts of disasters that are both natural and man made, there will be more and more people requiring counseling support over the years. In relation to disaster situations an assessment by the Government of Bangladesh assisted by World Bank, UN Agencies and the International Development Community (2008) listed psychosocial health support and training in psychosocial support for mental health care workers as recommendations on early recovery under the sector of health. Thus, Bangladesh has miles to travel when it comes to addressing mental health issues… and NOT just in times of emergencies when it is especially needed! ■

CADRE volunteers work together with Bangladesh civil defense teams during the Savar building collapse response

After Savar

As victims in Bangladesh cope with loss, fears of an uncertain furture surface

by Shamima Akhter
ADPC Bangladesh

TODAY, WE KNOW THE APRIL 24th SCENARIO WELL: around 9.30 am in the Savar area outside of Dhaka, a 9-story building named "Rana Plaza" collapsed, without notice. Within moments, the incident resulted in the deaths of more than 1,100 people – mostly women garment workers. The Savar tragedy now ranks as one of the most severe and human-made disasters in South Asia.

Two-months on, victims are beginning to cope with the disaster they encountered that day and are experiencing new fears as they confront the reality of their physical and financial situations. Mental health support for these victims is limited at this crucial point of time as, suriviors grapple with their unknown futures. In recent interviews with ADPC, hospitalized victims shared their experiences, anxieties, and worries of future uncertainties.

Feelings of hopelessness

On that morning, Rabeya's husband asked her not to go to work; even she was hesitating. Her mother, also employed at Rana Plaza's readymade garment factory, acknowledge their hesitance as the building was feared to be unsafe, but the family's financial reality influenced them to go to work.

"We needed to pay our housing rent and other expenses. If we did not go, then we would not receive our salary. How would we survive the rest of the month?" Rabeya's mother explained to ADPC.

The National Institute for Trauma and Orthopedic Rehabilitation (NITOR) in Dhaka, posted signs of all Savar victims for relatives to easily access. Hospital staff at NITOR have undergone emergency preparedness training with ADPC and are well able to cope with mass-casuality incidents.

Human-made disasters: are they more difficult to cope with?

In the immediate aftermath of a disaster such as with Rana Plaza, almost every victim will fixate on the incident, instigating Post Traumatic Stress Disorder (PTSD). The victims' cases shared in this article may be experiencing intrusion symptoms, and are experiencing high levels of arousal as they retold their stories with high emotion. For most, fear, anxiety, re-experiencing the tragedy, and avoidance, will gradually decrease over time (USDVA, 2010).

The prevalence of PTSD documented in studies as a result of natural hazards is generally lower than rates documented in studies from human-made disasters. For example, it is suggested that cyclones, flood and earthquakes may have less psychological impact than a road accident, industrial explosion, conflict, or in this case, a building collapse.

Additionally, women are often more vulnerable to develop PTSD than men, independent of exposure type and level of stress. A history of depression in women increases may exacerbate symptoms, further delaying mental health recovery after emergencies (Kessler, 1995).

As they approached their workplace, many people, specifically men protested outside. One day prior, officials investigated the building structure and identified areas of failure, which were of potential danger.

Not long after 9 am Rabeya, 18 years old, felt the first 'jerk' beneath her feet as the building shook. The earthquake-like tremors led to the collapse, which turned Rabeya's life upside down. "When I opened my eyes, I found one of my coworker on top of my legs and a building column on top of both of us. My co-worker died right away, and I felt severe pain. I started screaming but realized no one could help me," she recounted.

"I survived under the column for two days. During those 2 days I called my mother's name, but she never replied. If I could only find her body I would be at rest. Since rescue, I have cried a lot," she admitted.

Out of 9 family members, Rabeya lost 7 that day. She lost both legs and is now questioning her future. Feelings of hopelessness overwhelm her.

Without taking a breath between sentences, Rabeya openly described her fears for her very uncertain future and resentment for loosing her legs, "Whenever I look at my legs I feel like I am in the dark, there is no light that can show me a way to walk further."

She asked herself, "Look at my body, how can I expect that my husband will carry his disabled wife for the rest of his life? After all, I will not be able to earn money to contribute to the family. I have lost all other close relatives who could support me."

"Why did I not die that day?" she continued in grief.

One and a half months later, Rabeya is still recovering in the hospital. Her recovery is overshadowed with depression. As she openly recounts her situation, she searches for answers that are momentarily unclear, but after mentioning, "I have to survive, that is what I know", it is understood that she is trying to cope with the situation and has not given up. For Rabeya, talking about her feelings is a very constructive way to cope with the tradegy.

Dealing with social stigmas

The day Rana Plaza collapsed, Shirin's husband called her brother to tell him that his sister was seriously injured. This was the first news Shirin's brother received of his sister in nearly two years after she eloped with a man from a near-by village, which her parents would not allow her to marry.

That night, Shirin's mother and brother rushed to Dhaka to see her in the hospital, where they remain today throughout her recovery.

The following day, Shirin's husband left her after receiving news that she may not fully recover from her injuries. Internal bleeding led to near failure of her kidneys, and after several surgeries, her legs will still not be able to function normally again. Without fully functioning legs, she will no longer be able to be a primary income generator for her family.

"I left my family to marry, bringing dishonor into our household," Shirin said. Shirin was studying for her bachelor's degree when she decided to elope, consequently abandoning her studies and seeking employment at Rana Plaza.

"My husband rejected me after the accident. I received some money from a donor to cope with the expense of being in the hospital without an income, but he took half and left. If I go back now, how will our neighbors treat us? My dreams have turned into nightmares." Shirin discusses her current situation, laughing loudly at moments, while at other moments breaking down in tears.

Shirin's mother and brother recent her decision to marry a man without family consent, and believe that dealing with social stigmas in their community is ultimately her responsibility and fault.

Invisible injuries viewed as unproductive

Nazrul Islam, 28, is one of 6 of the 15 men that survived from his team at Rana Plaza. The eldest in his family, he worries about his 3 year-old son's future, as his spinal injuries will prohibit him from working a regular job again. Unlike other survivors from Rana Plaza that lost their limbs, Nazrul suffers from paralyzing spinal injuries, invisible to the eye.

"The doctor told me that I might not be able to do any heavy work for the rest of my life. My wife will have to take responsibility to support our family. She will have to work in a ready-made garment factory since she does not have any other empoyment option," he explained.

Nazrul's father elaborated that many victims that have lost their limbs are receiving support, but his son's injuries are not visible and therefore he's receiving 'less'. "Gradually he [Nazrul] will be unable to do anything by himself. His future is going to be very uncertain. An unproductive man is shameful, and the experience is frustrating," Nazrul's father shared.

Fear of an uncertain future

Many people who go through traumatic events have difficulty adjusting and coping for a while. But with time and support, such traumatic reactions usually improve. In some cases, though, the symptoms can become worse, or last for months or even years. Sometimes they may completely shake up life. In cases such as these, victims may develop post-traumatic stress disorder (PTSD) if their symptoms go untreated. Anyone can get PTSD at any age.

This includes war veterans and survivors of physical and sexual assault, abuse, accidents, disasters, and many other serious events.

In the case of Rana Plaza's victims, it's not only the event that is traumatizing survivors. After the injuries heal, survivors are plagued with confronting social stigmas that are as worrisome as their physical injuries. The trauma experienced from the fear of social exclusion, being a family burden, and financial uncertainty, may lead to a higher risk of mental health complications in the future and expose the victim to more social vulnerabilities.

Additionally, as with Rabeya, an inability to find closure with her mothers' unknown death may hinder her mental health recovery. Studies have mentioned that not seeing the body of the dead may further add to the risk of adverse outcomes, which disrupts opportunities for farewell (USDVA, 2007).

As these victims recover in the hospital nearly 2 months on, the stress they will experience from their spouses due to the onset of financial instability, and conflicts between family members are still speculative. This is the moment when mental health support intervention could make a day-or-night difference in these victims' recovery. Without an outlet to express their experience and fears, mental illness may hinder their physical recovery and instigate longer-term ailments. ■

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The Impact of Natural Disasters on Psychosocial Health

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Recent Efforts in Vietnam to Understand and Strengthen Post-Disaster Psychosocial and Mental Health Recovery

by Amie Allie Pollack, PhD

NATURAL DISASTERS ARE COMMON ACROSS THE world, and represent a major global public health threat. Each year, earthquakes, floods, typhoons, and other natural disasters cause tens of thousands of deaths, hundreds of thousands of injuries, and billions of dollars in economic losses. In 2011, 196 natural disasters were reported worldwide, killing about 28,800 people, affecting more that 85 million people, and causing over US $290 billion in economic damages (Asian Disaster Reduction Center Natural Disasters Data Book, 2011). In 2012, 310 natural disasters were recorded in the EM-DAT database. They claimed 9,930 lives, affected over 106 million others and caused economic damages of US$138 billion.

People exposed to natural disasters are at increased risk for psychosocial difficulties, serious mental health problems and a range of physical health problems. Impaired interpersonal relationships, financial and work-related stressors, and continued life disruption during rebuilding are common among disaster survivors; exacerbating these problems is a decline in a variety of psychosocial resources, including perceived social support, social embeddedness, self-efficacy, optimism, and perceived control (Benight et al., 1999). A study of Turkish earthquake survivors, for instance, found rates of acute stress disorder at a 6-10 month follow-up after the earthquake of 27% of the effected population (Karamustafalioglu et al., 2006). Increased rates of posttraumatic stress disorder (PTSD), major depressive disorder (MDD), generalized anxiety disorder (GAD), panic disorder, and substance abuse are also found subsequent to natural disasters (Norris, 2005; Tsai et al., 2007). Physical health problems and concerns related to stress and anxiety are also high post-disaster, with disaster survivors reporting higher levels than non-affected individuals of somatic complaints, sleep disturbances, etc. (Norris et al., 2002). Thus, disaster survivors would benefit from post-disaster community-based psychosocial supports. Greater access to psychosocial support post-disaster promotes effective recovery and resiliency among survivors. Furthermore, post-disaster psychosocial support systems can assist with the early identification of mental health problems, linking people to appropriate social and mental health services.

Developing countries in Asia are at heightened risk

Low and middle income countries (LMIC) in general and particularly in Asia experience a disproportionally high burden from natural disasters. Compared to other continents, Asia consistently experiences the highest annual frequency of natural disasters, the highest number of deaths, victims and economic damage.

Nguyen, 45 years old and local disaster management authorities point to the where the Cu Dê River rises to each year due to coastal storms. The Healthy Communities Typhoon Recovery Project is gathering quantitative data regarding cultural, social, health, and other factors related to risk and resiliency in response to typhoons in central Vietnamese coastal communities.

Almost 40% of all natural disasters between 1975 and 2011 occurred in Asia. Asia dominates and ranks first in all natural disaster impact categories across regions of the world accounting for over 50% of disaster-related deaths, almost 90% of affected people, and nearly 50% of disaster-related damage in the world between 1975 and 2011. (Asian Disaster Reduction Center Natural Disasters Data Book, 2011) Seven out of the ten deadliest disasters worldwide of the last decade occurred in Asia. This region of the world is especially vulnerable to disaster due to large land area, high population density, and geophysical and meteorological factors. The Asian region is likely to be impacted more severely in the future due to factors such as population growth, poverty, environmental degradation and weak infrastructures. (Centre for Research on the Epidemiology of Disasters, February 2013).

Individuals in LMIC also face the greatest risk of negative consequences from natural disasters. Although 111 countries were affected by natural disasters in 2009, 18 countries accounted for 79% of the reported of deaths, 95% of the victims, and 86% of economic damage. This reflects the unequal distribution of occurrence of natural disasters, and the tendency for LMIC to experience greater impact. LMIC are more likely to have low building standards and quality of construction, less developed disaster response infrastructure, and LMIC citizens are more likely to work in employment sectors easily disrupted by natural disasters (e.g., farming, fishing). Consequently, individuals living in LMIC face increased risk of unemployment and disability post-disaster (Hobfall, 1991).

Impact of global warming

There is mounting evidence of a relationship between global warming, climate change and increasing weather extremes (Van Aalst, 2006). Paralleling the increase in average global temperature, the frequency of natural disasters has been steadily increasing over the past 30 years (Asian Disaster Reduction Center Natural Disasters Data Book, 2011) and there is evidence that typhoons in the northeast Pacific region are becoming increasingly intense (i.e., a greater percentage of category 4 and 5 level typhoons over the past 30 years; Emanuel, 2005; Webster et al., 2005). The increased frequency and severity of natural disasters places the world's vulnerable LMIC communities at ever greater risk for the development of trauma-related mental health problems such as PTSD and depression, and there thus is a need for increased trauma-related mental health prevention and interventions services for LMIC.

Research and development: Areas of need and recent progress in Vietnam

While the need for increased mental health support is highest in LMIC,

most of the development and research on trauma-related psychosocial and mental health prevention and intervention programs has taken place in high income countries (HIC) in Europe or North America. Important cultural and socioeconomic differences between LMIC in Asia and HIC found in Europe and North America (e.g., differences in individualism and collectivism) likely impact victims' response to natural disasters, effective methods for identifying those people in need of help, and the types of psychosocial and mental health services that may be beneficial. However, too often domestic and international disaster-related humanitarian efforts lack scientific evidence to determine what resources and supports are most needed, and by whom. More evidence is needed to guide policy development and humanitarian efforts to support vulnerable people in their efforts to recover from disasters.

In Vietnam, one project that addresses this need is the Healthy Communities Typhoon Recovery Project (HCTRP). Led by Drs. Amie Pollack and Bahr Weiss of Vanderbilt University, USA and Dr. Lam Trung of the Danang Psychiatric Hospital, Vietnam, the HCTRP is funded by the US National Institute of Health and the Royal Norwegian Embassy in Hanoi with the goal of gathering quantitative data regarding cultural, social, health, and other factors related to risk and resiliency in response to typhoons in central Vietnamese coastal communities. The project has been following a group of 1,000 people from 5 central Vietnamese provinces for the past 4 years to identify culturally-relevant predictors of risk and resiliency in communities vulnerable to frequent disaster. This information will be useful for the development of culturally-appropriate mental health assessment tools and intervention programs. Study results will inform local and foreign support systems to a) promote preparedness and resiliency within these vulnerable communities; and b) guide post-disaster response efforts to identify and support people at greatest risk.

Another current project that addresses this need is the Mental Health and Psychosocial Support (MHPSS) in Emergencies Training Program. This project is led by the Asian Disaster Preparedness Center (ADPC) with funding support from ADPC donors and the Royal Norwegian Embassy in Hanoi. Partnering organizations in Vietnam include the Hanoi School of Public Health (HSPH) and the Center for Research, Information and Service in Psychology, Vietnam National University (CRISP-VNU). The goal of this project is to strengthen community safety and resilience through capacity development of health personnel at various levels to manage psychosocial impacts of all types of emergency or disaster to be able to increase the survival rate of disaster victims. Specific program objectives include the following:

1. To establish system for enhancing the capacity of the community on mental health and psychosocial support to be able to manage victims immediately post-disaster.
2. To strengthen the knowledge, attitude, and skills of health workers in managing children disaster victims.
3. To enhance the capacity of professionals to manage identified mentally pathologic cases during disaster.

This project is actively working towards enhancing MHPSS in Vietnam through building an effective network of community, health and social service providers, providing education and facilitating discussion regarding the development of MHPSS in Vietnam. In July 2013 the project will provide the first training to Vietnamese health workers in community-based psychosocial support of disaster victims.

Disasters - psychosocial follow-up

by Atle Dyregrov, PhD
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Disasters cause loss and destruction and pose many challenges for affected individuals, families, local communities and society at large. People may be grouped according to their psychological and physical exposure, i.e., in bereaved family members and friends, survivors (injured and uninjured) and their families, helpers (professional and voluntary), and others. Disasters vary in their magnitude, their casualties, and in their effects on the health system and society. Disasters are grouped in man-made and natural, although the demarcation is difficult due to the interaction between man-made technology and structures, and the forces of nature. Man-made disasters can be further differentiated into unintentional and intentional events. Regardless of cause disasters present with initial chaos, stretching available resources and both man-made and natural disasters can have serious effects on the psychological well-being of those affected.

Over many decades studies have been undertaken to better understand the nature and scope of disaster effects on individuals, families and society. While sociological studies have emphasized societies' ability to rebound and pull together following disasters (Qarantelli, 1988), psychological studies have emphasized the negative mental health consequences of such events. Lately, psychological research has included the study of psychological growth and resilience following disasters (Bonanno et al., 2010). The research literature can be quite diverse in its findings and depending on the eye of the beholder, negative or positive consequences are emphasized. Variations in methodology, type of disasters studied, cultural context of studies undertaken, and the scope and breath of studies can explain some of the diversity in findings.

The psychological consequences of disasters can be observed on many levels; in disruption of social bonds, grief reactions in bereaved, increased anxiety and depression, but are often assessed in relation to how many that go on to suffer from posttraumatic stress reactions. Most notably, the percentage of people with diagnosable posttraumatic stress disorder (PTSD) has been measured. People suffering from PTSD experience a high level of intrusive memories of what happened, struggle to avoid reminders about the disaster as well as experience aroused bodily reactions. In review studies, the prevalence of PTSD in children resulting from natural disasters varies from 5-43%, while in man-made disasters the prevalence varies between 30-70% (Kar, 2009). Prevalence of PTSD in adults usually ranges between 30-40% in direct victims, between 10-20% in rescue workers, while in the general, population PTSD ranges between 5-10%. In general rates are higher following man-made and technical disasters than following natural disasters (Neria, Nandi, & Galea, 2007), with intentional events (terror) having the highest impact.

While percentages may not be extreme, even in the lower range of these percentages the number of people affected can be large as so many people are exposed to disastrous events. Many factors influence the magnitude of effects experienced, with exposure to life threat, losses and strong sensory impressions regarded as risk factors, in addition to a history of previous trauma, loss or psychiatric problems.

A good social support network and family, a healing societal climate and a robust personality may be protective factors after disasters.

Adequate responses to and promoting resilience following disasters

How can we promote the positive consequences resulting from disasters, such as reinforcing social fabric, cohesion and altruism, empathy and understanding, resilience and responsibility? Or put in another way; how can we prevent fragmentation of human bonds, conflict, individualism, erosion of the sense of community, vulnerability and pulverization of responsibility. This is not an easy task. From different parts of the world it is clear that people in crisis often express the same wishes regarding the help they want: they want immediate help, help that reach out to them, continuity in helpers and help that continues over the time there is a need. Our psychosocial disaster assistance should work to embrace these wishes.

Preparation for disasters should not only include technical and tactical plans for handling disastrous events, but also include mental preparedness in helpers, psychosocial care as an integrated part of disaster plans, and training and exercises to secure that these measures can be effectively put in place when disasters happen. Developing shared mental models of human behaviour among different collaborating agencies will ease cooperation and communication.

Co-training and co-ordination between agencies participating in psychosocial follow-up must be instigated as such interaction provides both new and corrective experience that will improve response in real disasters. Both formal and informal training, exercises and drills create the silent knowledge that optimizes the handling of a disaster situation as well as allow improvisation when that is needed.

Hobfoll et al (2007) have, based on existing research and experience, promoted the following principles to prevent untoward mental health effects in disasters: Promote sense of safety, calm anxiety and decrease physiological arousal, increase self- and collective efficacy, encourage social support and bonding and instil hope and sense of positive future. These principles fit well with promoting resilience and need to be operationalized in different cultural settings. Good leadership by local community leaders as well as leaders at a national level can facilitate several of the principles mentioned above.

Leaders frame the crisis by their words and help citizens defining the situation and grasp what has happened. Their symbolic, ritualistic behaviour of reaching out to the affected people send strong signals that the society at large is caring and thus provide hope for the future. In fact, support from the larger society, both support from leaders and others, has been found to reduce negative mental health effects to a significant degree. Wang et al (2000) studied the effects of an earthquake in China on one village near the epicentre of the quake and one 10 kilometres away (but still with substantial damage). The village with highest exposure evidenced lower levels of PTSD over time.

Providing opportunity for culturally appropriate rituals is an important aspect of early psychosocial intervention following a disaster.

The authors conclude that this was due to higher support from outside society to this village, compared to the more distant one. Support from others, be that family or friends or from one's own community or the wider "world community" can alleviate distress and represent hope for the future.

Psychosocial help following a disaster

There are several manuals for how to undertake psychosocial follow-up (see http://www.trauma-pages.com/disaster.php). Among the most important aspects of early psychosocial intervention following disasters are:

- Creating climate of care (warmth) to reduce physiological activation;
- Rapid, honest provision of information from trusted sources;
- Interventions at the community levels to secure maintenance of social bonds including reconnection with families and social networks;
- Stimulation of family communication – including explaining events to children;
- Providing a map for the practical and psychological terrain (orientation and hope – what will happen and what are expected reactions);
- Providing opportunity for culturally appropriate rituals;
- Keeping people active and in control: Resuming normal routine activities as soon as possible, including schools for children; and.
- Simple advice to parents to empower them in their parental role

Radio, TV and the internet (where that is applicable) can be used to educate public about normal reactions and coping. Specific coping advice can be targeted to those with stronger reactions. If resources are available for mental health follow-up, screening can be undertaken with survivors after a month to secure that those in need get adequate help. In modern psychology there are empirically validated treatment methods for PTSD and complicated grief that work across different cultures. Most methods are based on cognitive behavioural therapy and manuals can be found for both child and adult traumatherapy (see www.childrenandwar.org).

People are resilient, but resilience has to be cultivated. Societies and its leaders have to foster this resilience by mobilizing community care and social support. Capacity building starts in the preparation for a disaster.

Systems must be in place to provide help for those that go on to suffer from the consequences of their loss or exposure. We often underestimate the effects that disasters have on children and therefore both authorities, schools and parents often neglect the need for helping them to cognitively and emotionally process what has happened.

Outreach to children from teachers and other adults that provide adequate information and explanations should be an integral part of disaster intervention. Groups can help those who continue to show reactions or show lower levels of functioning over time.

Rapid early mobilization of psychosocial responses can accelerate normalization of the situation for individuals, families and society, and lead to less health impairment among affected survivors and bereaved. Adequate responses can stimulate social support and cohesion, create potential psychological growth in individuals, families and communities, and with feedback, improve systems for future disasters. ■

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Feature

Psychological burden of complex emergencies: the case of Afghanistan

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Afghanistan is a disaster-prone country with frequent natural hazards of different scales, as well as prevalent longstanding conflict. Depending on severity and scale, every disaster has adverse health impacts. In addition to social reactions and population displacement, the most common health problems experienced in disasters include; increased morbidities, mortality, epidemics, and psychological problems. Additionally, the damage to health and social infrastructures and disruption of health service delivery results in decreased access to health care at all levels. The ongoing insecurity affects large areas of the country, which adversely influences preparedness and coping capacity, thus increasing the vulnerability and impacts on communities.

Mental health, a 'public health' issue

All rapid onset disasters like earthquake, flash floods, landslides and conflict negatively affect the mental health of affected populations. Those not directly injured will be vulnerable to mental disorders due to death of loved-ones, separation, damage to properties and deprivation. Therefore, mental health problems of acute and chronic nature should be considered a public health issue to be addressed in a short and long-term basis.

Mental disorders account for around 14% of the global burden of disease (Prince et. al: 2007). Mental health is recognized as a key public health issue in conflict-affected populations (IDMC: 2007). The prevalence of mental disorders is much higher among war-affected populations as compared to others. With this in mind, symptoms of Post-Traumatic Stress Disorders (PTSD) and depression are observed in 30-70% of people who have lived in war-affected areas (Mollica et.al:2004).

More than three decades of conflict have led to widespread human suffering and population displacement in Afghanistan. A study conducted in Afghanistan revealed that 62% of respondents experienced at least four trauma events during the preceding ten years (Cardozo et.al: 2004). Symptoms of depression, anxiety and PTSD were found in 67.7%, 72.2% and 42% of respondents respectively (Cardozo et.al: 2004). The disabled and women had a poorer mental health status, and there was a significant relationship between the mental health status and traumatic events (Cardozo et.al:2004).

Another study conducted in Nengarhar province found that almost 50% of the population had experienced traumatic events (Scholte et.al: 2004). Symptoms of depression, anxiety and PTSD were observed in 38.5%, 51.8% and 20.4% of respondents respectively (Scholte et.al: 2004). High rates of symptoms were associated with higher numbers of traumatic events experienced. Women had higher rates than men (Scholte et.al: 2004). Similar findings are reported from other parts of the world for example, a study in South Sudan found that over one-third of respondents had symptom of PTSD and half of them met symptom criteria for depression (Roberts et.al: 2009).

This study reported a strong association between gender, marital status, forced displacement, and trauma exposure with outcomes of PTSD and depression (Roberts et.al: 2009).

In Afghanistan and most developing countries, response to any disaster focuses mainly on immediate relief, maintenance of essential health care delivery, provision of health services for internally displaced people and refugees, prevention and response to epidemics, and some nutritional interventions. However, mental health and psychosocial support is frequently neglected.

Numerous factors contribute to the prevailing poor response to mental health and psychosocial problems in emergencies in Afghanistan. These factors include absence of policy and strategy on psychosocial support in emergencies; a lack of clarity on procedures, role and responsibilities; unavailability of standard guidelines; poor planning; inadequate technical capacity; poor institutionalization of emergency preparedness and response; scarcity of qualified staff at different levels; weak government structure at provincial and district levels; poor coordination and collaboration; andinadequate capacity to monitor the program implementation. Additionally, weak community-level disaster risk reduction mechanisms, inadequate emergency preparedness at the community level, poor organization of communities and an absence of a risk pooling mechanisms also negatively affects emergency response.

Ministry of Public Health and its partners recognize the challenges, which hamper the provision of quality mental health services to the Afghan population, particularly during emergencies. In order to address these challenges, the Ministry plans to review the mental health strategy; identify the main barriers and address them accordingly; train professional counselors to be deployed at Comprehensive Health Centers; and initiate a nursing diploma in professional counseling at the Ghazanfer Institute of Health Sciences.

Additionally, the National Disaster Management Plan recognizes mental health and psychosocial issues as one of the main problems occurred during emergencies. Though, due to competing priorities and insufficient capacities, interventions addressing psychosocial problems are hardly planned and implemented during emergencies.

The incidence of psychological problems in the populations affected by conflict is widely recognized. Therefore, populations facing war and conflict should receive mental health care as part of the total relief and reconstruction process. ■

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How community leaders can contribute to psychosocial support in times of emergency

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IN TIMES OF EMERGENCY, LOCAL COMMUNITY leaders are on the front-line to provide psychosocial support. When utilized effectively, these individuals may be the liaison between local people and health care workers, or emergency responders.

Leadership in times of emergency requires select individuals to be prepared to boost the morale, and resilience of not only the effected, but for responders that may be faced with the reality of the situation and limited psychosocial support options. Ideally, leadership in times of emergency would be integrated into hospital emergency response plans, or Incident Command Systems. However, in areas of the world such as in Thailand, mental health support is a relatively new topic in disaster management.

There is a space for community leaders to fill in mental health support in the after math of a disaster. They can provide clear messages for community members to follow, as local people trust them. Community leaders may also take a role in providing information on where to receive mental health support, and work towards making the topic less taboo.

Additionally, there may be a role for community leaders to work more closely with, for example, volunteer emergency responders. If trained on the subject matter, community leaders may be able to offer emotional support to those that are faced with traumatic images during the response period. They may, for example, support with starting a 'buddy system', to ensure that responders have another individual in their same situation to discuss what they are experiencing with.

What's the role of a community leader in times of emergency?

Leadership in times of emergency limits damage and can dramatically reduce negative psychosocial impacts if utilized correctly. However, leaders are only able to lead in times of emergency if they can pinpoint and confront their own psychosocial weaknesses, for example, if a family member has been directly impacted by the disaster.

Leadership is not only about having the tools available, but its knowing how to use the tools in order to meet your community's needs. It's about understanding their needs and taking a lead to ensure vulnerabilities are kept at a minimum.

Leaders in times of emergency must also stay informed on whom to seek guidance from. In the case of schools it may mean knowing the principals, This is especially important in many countries in South and Southeast Asia that lack a centralized incident command system. With many options for emergency response, local leaders can influence their communities to contact appropriate agencies.

A call for leadership

In Thailand, leaders in times of emergency are needed. Disaster management officials in the future may consider the value community leaders can contribute to emergency response, and keep these individuals informed so they feel ready to respond if a disaster happens. ■

ADPC in Action

APDC is working around the region and beyond with officials, communities and others to reduce vulnerabilities to natural hazards. The following activities are examples of ADPC's recent activities, over the past few months.

BANGLADESH

A Training of Trainers on "Multi Hazard Risk and Vulnerability Assessment (MRVA), Modeling and Mapping" was organized from 11 – 13 May in Dhaka as part of the *Multi Hazard Risk and Vulnerability Assessment (MRVA)*, Modeling and Mapping project in Bangladesh under the Department of Disaster Management funded by the World Bank. During the 3-day training, 37 participants from 24 different agencies, organizations, and institutions were trained on different hazard types, vulnerability and risk assessment.

Since 2009, ADPC has taken an initiative to develop a methodology to forecast potential impacts of natural disasters using econometric model with the funding support from the Ministry of Foreign Affairs, Norway. The methodology to integrate disaster risk in to economic model has been developed with the technical assistance from Centre for Economic and Public Policy, Deakin University, Australia. A one-day workshop was held in Dhaka, Bangladesh on 30 July to introduce the methodology to Bangladesh technical experts and to familiarize participants with analyzing different economic policy options. Further the idea of the workshop was to identify the way forward to integrate disaster risks into national economic planning process in the country.

CAMBODIA

Provincial Training of Trainers Course on Strengthening the Emergency Response Capacity of Humanitarian NGOs in Cambodia, held in Prey Veng Province, Cambodia: This training course was co-implemented by the Royal University of Phnom Penh, Provincial Committee for Disaster Management in Prey Veng, Cambodian Red Cross Society branch in Prey Veng and the National Committee for Disaster Management. Twenty-six participants successfully completed the training. This activity was conducted under the "Strengthening Emergency Response Capacity of Humanitarian NGOs in Cambodia" project funded by USAID/OFDA.

An early warning systems gaps assessment mission took place in Cambodia. Assessment results will be used to develop a road map for developing an end-to-end early warning system and strengthening the capacity of the National Committee for Disaster Management, to improve disaster management in Cambodia. World Bank provides support to this project.

ETHIOPIA

A Master Course on Disaster Risk Management was held in Addis Ababa, Ethiopia. The course was organized from 22 April – 03 May 2013 by the African Center for Disaster Risk Management with funding support from United Nations Development Programme. Twenty-five practitioners attended the training from Ethiopia and the horn of Africa region. ADPC facilitated the course under its on-going partnership with Disaster Risk Management & Food Security Sector (DRMFS) of the Ministry of Agriculture, Ethiopia.

INDIA

The "Earthquake Vulnerability Reduction Course," jointly organized by the Gujarat Institute of Disaster Management and ADPC took place at the training wing of Gujarat State Disaster Management Authority, Gandhinagar. The 5-days training aimed to further strengthen capacity of the State, gearing towards safer and resilience development through Earthquake Vulnerability Reduction at different levels and across sectors. Forty-seven government officers nominated by line departments, involved in planning and implementation of development plans and projects/programs from various development sectors attended the training.

KYRGYSTAN

ADPC is currently supporting the United Nations Asian and Pacific Training Centre for Information and Communication Technology for Development (UN-APCICT/ESCAP). Recently, ADPC finalized the module *ICTs, Climate Change and Green Growth* and provided a resource person for a training workshop held in Bishkek on 7-8 June.

LAO PDR

The Lao People's Democratic Republic (Lao PDR) is among the few countries to establish a national disaster damage reporting database hosted and maintained by the Government, based on the DesInventar methodology. ADPC with funding support from the United National Office for Disaster Risk Reduction (UNISDR) assisted the Lao Government to establish an Inter-Ministerial Technical Working Group (TWG) in standardizing the disaster data collection and assisting the 16 provinces in collecting the disaster incident and reviewing the report.

In May 2013, the Lao PDR National Assessment Report (LNAR-2012) on Disaster Risk Reduction was launched at the 4th session of the Global Platform in Geneva to reiterate the commitment of the government of Lao PDR to use disaster risk reduction measures as a means to alleviate poverty and to achieve the priorities of the Hyogo Framework of Action (HFA) to secure a sustainable development which does not create new vulnerability and hazards.

Riverine and flash floods pose a prominent risk to the communities in Thailand and Lao PDR. In a recent rapid assessment conducted in Prachinburi Province, Thailand and Luangprabang Province, Lao PDR, ADPC with support from the World Meteorological Organisation (WMO) and the national disaster management offices of Thailand and Lao PDR are developing community resilience enhancement programs to deal with flood. The multi-year initiative aims to increase flood disaster resilience of flood prone communities in selected vulnerable areas, reducing the negative impacts of floods, while enhancing the positive effects annual floods bring to riverine communities.

MYANMAR

A series of hands-on trainings for National Hydro-meteorological Services and related professionals have recently taken place around the region. This includes a weather forecasting training for seconded DMH-Myanmar professionals in Bangkok (April-May); Storm surge modeling training in collaboration with Japan Meteorological Agency in Bangkok (June); Training for on the CLIMSOFT and RClimDex data archiving in Myanmar (June 2013), Climate Change Downscaling and Scenario Development Trainings in Sri Lanka and Myanmar (May and July).

Over the last two years, ADPC has provided technical support to the Relief and Resettlement Department (RRD) in Myanmar, which is building the capacity of Government officials across the country, through comprehensive "Disaster Management Courses". During April-July 2013, with the funding support from CARE Myanmar, ADPC continued the technical and facilitation support to the RRD, and also prepared national training analyses and evaluation documents. In July 2013, ADPC facilitated a multi-agency national workshop in Nay Pyi Daw, in order to review the progress, lessons learned, and next steps for fully institutionalized disaster management courses.

With the lead of the Information and Public Relations Department (IPRD) and Relief and Resettlement Department in Myanmar, ADPC has assisted the Myanmar Government to develop a pioneering concept called "information resource centers for DRR at township levels". This activity fosters partnerships between information management and disaster risk management and builds capacities at the local level. During April-July 2013, ADPC assisted IPRD in the demonstration township to establish the information resource center, and provided guidance to IPRD and RRD in Nay Pyi Daw, to develop a case study and supporting technical documents. The Norwegian Ministry of Foreign Affairs provides support to this activity.

NORWAY

ADPC facilitated a training of DMH scientists for the River Flow Measurement Training in Oslo (June-July) supported by the Norwegian Water Resources and Energy Directorate.

PAKISTAN

ADPC has completed a Multi-Hazard Risk and Vulnerability Assessment for Sindh Province, Pakistan, funded by the World Food Programme, Pakistan. The project provided a dynamic planning tool for disaster risk management officials at provincial and district levels to improve disaster risk reduction, preparedness and contingency planning. ADPC has developed multi-hazard risk and vulnerability atlases for the provincial level, as well as for 5 selected districts in Sindh Province. Additionally, a spatial database and web portal for retrieving and sharing data was developed.

SRI LANKA

Seventeen senior leaders in disaster risk reduction joined for the "Disaster Resilience Leadership" Training Program, in partnership with the Disaster Resilience Leadership Academy (DRLA), Tulane University, USA, Ministry of Disaster Management, and the Postgraduate Institute of Science, University of Peradeniya. The workshop was funded by Bill & Melinda Gates Foundation under its program on Strengthening Disaster Resilience Leadership with DRLA, Tulane University. Participants were from national level technical agencies, ministries, academes, district administration, media and NGOs.

THAILAND

The 22nd Regional Course on Community Based Disaster Risk Reduction with a changing climate was organized from 24 June – 05 July 2013. Twenty-one practitioners attended the course from 13 countries. This is one of ADPC's flagship courses conducted annually.

A special training course on Chemical Accident Prevention & Preparedness was organized for the Task Force on Chemical Accident Prevention and Preparedness

Programme of Sri Lanka was held from 07-10 May 2013 in Bangkok, Thailand. Thirteen senior taskforce members from Sri Lanka and 6 senior policy makers from Thailand attended the training course. The training was organized under the Chemical Accidents Prevention & Preparedness Program of Sri Lanka implemented by Central Environmental Authority, Sri Lanka and the United Nations Environment Programme, with technical support from ADPC and the funding support from Strategic Approach to International Chemicals Management.

Following the Thailand Floods in 2011, ADPC is working with private sector to improve disaster resilience among Small and Medium Enterprises (SMEs), supporting SMEs to engage effectively with local government in risk reduction activities. In July 2013, a year-long initiative on "Private Sector Engagement in Natural Disaster Risk Reduction for Resilient Economies through Business Continuity Planning and Management" was initiated with the financial support from JTI Foundation. More than 200 SMEs will join this initiative to strengthen their Business Continuity Planning with technical support from ADPC, the Office of Small and Medium Enterprise Promotion, Thailand and the Department of Disaster Prevention and Mitigation.

VIETNAM

A two-day workshop on "Sub-national Level Consultation on Early Warning Systems for strengthening Forecasting, Dissemination and Decision Making for Coastal Hazards" was held in Da Nang from 1-2 April. Around 35 government officials and other representatives including media attended the event. These activities were conducted under the support of the Royal Norwegian Government's Ministry of Foreign Affairs

Senior officials from Morocco visited Vietnam from 19-25 June 2013 to exchange experiences with the Government of Vietnam on community-based disaster risk management. Over the 1-week trip, officials from Morocco interacted with community leaders, national and local officials, and development partners, to discuss the operationalization of disaster risk management in local development plans, associated challenges and opportunities. ADPC with funding support from the World Bank facilitated the visit in collaboration with the World Bank and the Disaster Management Center, Vietnam.

REGIONAL

Under the UNESCAP Trust Fund supported regional initiative, two national workshops and one national workshop have been conducted to strengthen the coastal hazard early warning systems in the region. ADPC has grown collaborations with various regional systems including the Typhoon Committee, Panel of Tropical Cyclone, IOC Indian Ocean Tsunami Early Warning Systems, UNESCAP Tsunami Trust Fund Secretariat, Asia-Pacific Broadcasting Union, GAATES, and Japan Meteorological Administration to enhance the national hydro-meteorological services of Myanmar, Sri Lanka, Philippines and Vietnam. ■

Brian Ward Memorial Lecture 2013: ASEAN's lessons learned since Nargis

12 October 2013
17:30
The Siam Society
Bangkok, Thailand

Join us in the dialogue with Dr. Surin Pitsuwan, former Secretary General of Association of Southeast Asian Nations (ASEAN), on lessons learned since Cyclone Nargis hit Myanmar in 2008.

This event is sponsored by the Royal Norwegian Ministry of Foreign Affairs (MFA-Norway).


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THE SIAM SOCIETY
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In Brief

19-21 June The Community Action for Disaster Response (CADRE) course trained community leaders and community based disaster professionals from Ayutthaya, Thailand in basic disaster response in order for them to transfer these skills to members of their local community. The course covers 10 different topics, ranging from Incident Command Systems (ICS) to fire emergencies. On the final day of the CADRE course, participants were evaluated on their ability to execute these skills in a final exercise.

17 July The Mass Casualty Incident Simulation Drill held in Iloilo City of the Western Visayas region of the Philippines was a city wide simulation designed to practice cooperation between intergovernmental bodies during a disaster situation. The simulation was the first city wide simulation held in the Western Visayas and was developed in cooperation with the Health Emergency Management System under the Ministry of Health. It tested the ability of the fire department, law enforcement, the millitary, and the red cross among other local institutions to cooperate among one another to cohesively rescue and respond during a disaster situation.

16-21 July The pilot course for ADPC's Nurtrition in Emergencies was organized for the first time in Dhaka, Bangladesh. The aim of the course is to strengthen the capacity of the limitted available human resource availables during a disaster to alleviate malnutrition emergencies on the ground. This course was developed for Hellen Keller International's (HKI) Nutrition in Emergency Training Initiative and directed towards HKI's field staff.

24-26 July The Hospital Incident Command System Workshop (HICS) held at Pathumtani Hospital, Thailand is designed to create functional preparedness for hospitals. The workshop explores potential impacts of disasters on hospitals, and works to explore ways to best mitigate risk factors. The workshop is conducted with ADPC support by national HOPE instructors from the Bangkok Metropolitan Administration and the Ministry of Public Health.

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Wilton Park
Harnessing the power of dialogue

RIVER DELTA Conference:

Challenges in flood risk management in urban areas of river deltas in South and South East Asia

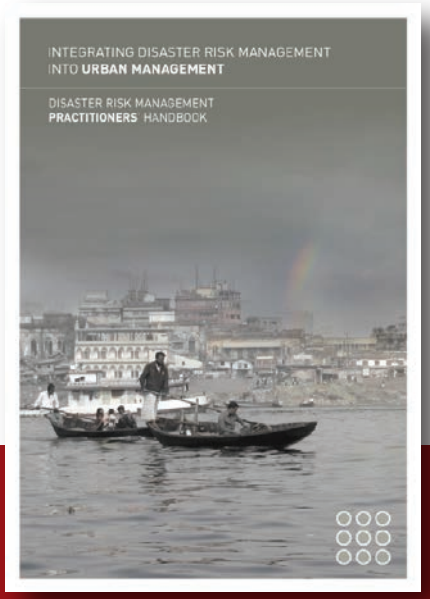
Wed 6 - Thu 7 November 2013

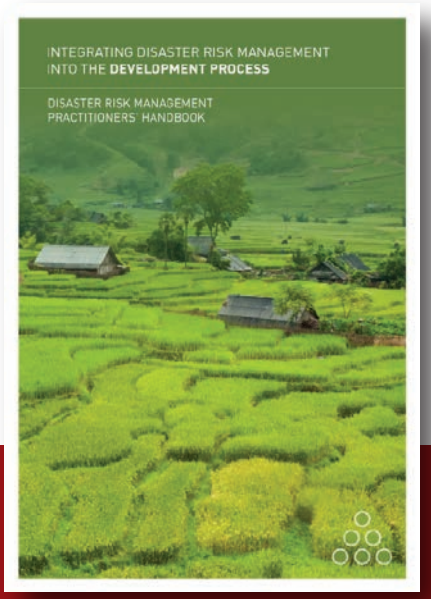
Swissotel Nai Lert Park
2 Wireless Road Bangkok
10330 Thailand

A round-table conference on the challenges of flood risk management in urban areas of river deltas in South and South East Asia.

Organized jointly by Asian Disaster Preparedness Center and Wilton Park, and with support from the Royal Norwegian Ministry of Foreign Affairs, the conference will act as a forum for sharing the knowledge, good practices, and experiences on building the resilience of delta regions in Asia to floods and other hydro-meteorological disaster events.

www.adpc.net
www.wiltonpark.org.uk





Announcing the **Disaster Risk Management Practitioners' Handbook Series**

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