

**Report on of the
Psycho Social Support Programme
in the Tsunami Affected Areas of
Cuddalore District in Tamil Nadu, India**

A Report

Prepared and Submitted By

The Schizophrenia Research Foundation (India)



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List of abbreviations used

1. CLW – Community Level Worker
2. Dept. – Department
3. GH – General Hospital
4. Govt. – Government
5. NGO – Non Governmental Organization
6. PSS – Psycho Social Support
7. SCARF – Schizophrenia Research Foundation
8. SHG – Self Help Group
9. SPSS – Statistical Package for Social Sciences. Version. 10
10. WHO – World Health Organization
11. Yrs – Years

Executive Summary

1. The aim of the study was to assess PSS programme offered to the affected population in some of the Tsunami affected areas in Tamil Nadu, India, including training given to Community Level Workers (CLW), utility of the training and its impact on the community. Based on this information, it can be expected to evolve a series of guidelines for future work .
2. The objectives were (a) To assess the nature, quality and quantum of psychosocial interventions delivered to a sample of the tsunami affected population in Cuddalore and Pondicherry. (b) To evaluate the impact of psychosocial interventions on a sample of subjects who have received it during the last year. (c) To assess the current needs of the population for psychological support. (d) To assess the nature and quality of training in psychosocial support received by various groups of community level workers after Tsunami. (e) To assess nature and frequency of assistance currently provided by a sample of the CLWs originally trained.
3. It should be kept in mind that PSS intervention through CLWs is an unusual approach that has been used only in a limited manner previously, and certainly not on the present scale in any previous post disaster situation.
4. The CLWs be they Government employees or personnel from other sectors had no mandate to do PSS and it was not part of their regular work. The entire process was on voluntary basis. The concept of using CLWs has been largely experimental till the tsunami disaster and the present study offered a unique opportunity to evaluate its strength and weaknesses.
5. Three groups of persons were interviewed: CLWS, families affected by Tsunami, and community leaders. From a total of 58 affected villages in Cuddalore district, 19 were chosen for the study along with 3 villages from the 12 tsunami affected villages of

Pondicherry. A total of 376 interviews (319 from Cuddalore & 57 from Pondicherry) were conducted in 22 villages.

6. The 376 interviews comprised of 165 CLWs (127 from Cuddalore & 38 from Pondicherry) and 226 community interviews (207 from Cuddalore District & 19 from pondicherry) Comparisons were made between CLWS working with Govt., NGOs and Self Help Groups (SHG).
7. CLWs in Govt. employment were older (Cuddalore 44 yrs; Pondicherry 41.32 yrs) than NGO (26.64 yrs) and SHG CLWs (40 yrs).
8. The Govt. CLWs had more experience working in the field and had been working in the affected villages for at least 5 years in contrast to the NGO CLWs whose experience ranged from 6 months to 2 years.
9. More than 47% of the NGO CLWs were drawn from the local community and had in varying measures personally borne the brunt of Tsunami as against only 6 % of the Govt. CLWs.
10. 74% of the CLWs had attended multiple training programs with Govt. CLWs having attended the most at an average of 4.07 training programs per person compared to the overall average of 3.19.
11. The content of the multiple training programs was sometimes repetitive and had been provided by multiple sources. It is also worth noting that audio visual aids were used in about 60 % of the PSS training programs. Most CLWs were satisfied with the quality of the training programs and said that it was useful and would recommend it to others.
12. 80% to 90 % of the NGO and Govt. CLWs put their training to use in comparison to only 31% of the SHG CLWs.

13. 88% of the PSS Service was provided by the CLWs as part of their regular work. Only 12% of the service was provided on a non-remunerative or voluntary basis.
14. Reasons identified for the non utilization of the PSS training included
 - (a) The time that had lapsed from the disaster to the training was long and variable.
 - (b) Some CLWs were not inclined to provide PSS when it had to be provided on a purely voluntary basis.
 - (c) Individuals who were not interested in providing PSS were also trained.
 - (d) Duplication of services and rivalry between service providers especially NGOs
 - (e) Changes in responsibilities, duty hours, transfers, etc.
15. Over 75% of the tsunami affected individuals and families stated that they had received some form of PSS programmes.
16. Villages that had suffered damages in terms of only loss of livelihood had received PSS support for about 50% of the cases , while those that had suffered severe damages (loss of life, property & livelihood) received PSS for 85 % of the affected .
17. About 84% of the individuals interviewed reported having psychological problems after the tsunami. This includes 72% of the individuals from villages that lost only their livelihood – demonstrating that loss suffered and psychological trauma are not necessarily proportionally linked.
18. The most frequent problems seen in adults were (a) Not going for work or handling their responsibilities (b) Fear of the tsunami recurring (c) Avoiding their homes by the coast/beach (d) Lack of interest in everything (e) Poor and disturbed sleep (f) Feeling sad and crying all the time (g) Increased alcohol intake by men. (h) Multiple somatic complaints by women.

19. The most frequent problems seen in children were (a) school refusal (b) disturbed sleep (c) night terrors (d) bed wetting.
20. The most frequent mode of PSS intervention was on a one to one basis with the structure being informal with frequent contact by the CLWs. In most situations this seemed to be all that was required. Group therapy/ group sessions for adult survivors were held generally once in each village, and in many of the villages which had suffered minimal damage this was often the only PSS intervention provided. About 15 % of those interviewed reported that they had received medication.
21. Children had received intervention targeted at them both in schools as well as in their villages. These were generally in terms of recreational and play therapy.
22. The most frequent provider of PSS was the NGO CLW. The Govt. CLWs also provided PSS but as they had multiple responsibilities and were nodal points for many of the Govt. schemes and other types of relief measures their role was diluted. Only about 30 % of the SHG CLWs provided PSS.
23. The CLWs were not trained to distinguish between preexisting psychiatric morbidity in the community and post-disaster, acute grief reactions. Most were not informed about referrals to mental health professionals, who were also very few in number.
24. The duration of PSS provided varied markedly, depending on the severity of damages (loss of livelihood; loss of livelihood & property; loss of livelihood, property & lives) suffered by the village and the type of CLW (Govt; NGO; SHG) providing the service Villages that had suffered only loss of livelihood received PSS intermittently for 1 or 2 days during the first 3 months. Villages that had lost property and lives along with livelihood received PSS for 6 months continuously.

25. Govt. and SHG CLWs had provided PSS for 3 to 6 months. They believed that the affected people had recovered by then. NGO CLWs were providing PSS even at present (almost 2 yrs).
26. Estimates of the number of individuals who currently require PSS varied from 10% to 40 %. Majority of the persons who were thought to require PSS were suffering only from a heightened sense of anxiety.
27. In Pondicherry, all respondents have returned to work while in Cuddalore about 70 % of the survivors have returned to work. In more than 90 % of those who have not taken up work, the reasons were lack of opportunity rather than fear.
28. Some sections of the population suffering from psychological distress after the tsunami will require interventions of a socioeconomic nature rather than PSS to mitigate their suffering. This is particularly so in the case of agricultural laborers.
29. It was the opinion of majority of the survivors and relatives that PSS was useful, about 45% of the village leaders felt that what was done was effective although only about 22% were satisfied with the quality of PSS offered.
30. This low level of satisfaction was seen primarily as a result of the fact that most respondents were not able to clearly distinguish between PSS and other relief services, as the providers were frequently the same. Poor level of satisfaction with other relief measures delivered by the CLWs has led to lower rating of satisfaction on all services delivered by them, including PSS.
31. PSS delivered along with other relief measures seemed to be accepted better than when given in isolation.
32. A section of the population primarily the dalit agricultural laborers have received very little intervention, including PSS. Psychosocial intervention alone will not mitigate

their problems, their issues are deep rooted and require interventions at social, economic, political and psychological level.

33. At present about 85% of the NGO CLWs are still engaged in providing PSS while the Govt. and SHG CLWs are involved in other community based activities and are not providing much PSS.
34. There is an overwhelming opinion that PSS measures have helped many such persons in distress and needs to be part of crisis intervention measures, albeit secondary to those addressing issues of livelihood, housing etc.
35. The strengths of the PSS program included the identification and setting up of a central coordinating agency which in the case of Tamil Nadu was the Dept. of Social Welfare, Govt. of Tamil Nadu. The training of the village level health workers in PSS has ensured that all villages have access to a person with training in PSS. Strengthening the hands of the nodal agency with supportive local agencies will ensure smother functioning of PSS programmes in the future.
36. A very useful spin off of this has been the heightened awareness in the local community about mental health problems, which should facilitate early detection and intervention even in non-disaster times.

RECOMMENDATIONS : The recommendations of the study are:

- a) Structured training programs should be offered to eliminate inconsistencies and repetition in the information provided.
- b) Modules for children, women, elderly, disabled, and other groups should be made available to nodal government agencies and important NGOS which are community based so that quick action is possible in times of crises.
- c) It is good to have a core group of persons in each area well exposed to PSS training.

- d) Reinforcer sessions once in 6-12 months will help them update their knowledge and information base
- e) Venue of programmes should be such that travel time is cut down
- f) Training programs stretching over two-three days that necessitates staying over makes it difficult for the female CLWs as they have other responsibilities as well. Hence, shorter programmes interspersed in time may be better.
- g) Audio-visual aids to be used more frequently to illustrate points and break monotony of the training programs. They also have better recall value.
- h) Impart practical solutions - less emphasis on theory.
- i) Training programs should be held in the local language as much as possible and when it is used care must also taken to see that the language is non-technical to facilitate better comprehension.
- j) Training programs to be held as soon after the disaster as possible – a time lapse can make the service redundant.
- k) Simple hand-outs offering practical tips in the local language will help.
- l) Role-play and demonstration of cases seems to make a greater impact.
- m) A list of mental health services in the region should be provided to the trainees to facilitate appropriate referrals.
- n) Care to be taken in the selection of the CLW – train people who are interested.
- o) CLWs must be remunerated in some way for the work done – either as regular employment or an honorarium. Voluntary selfless acts over prolonged periods cannot be expected- as required in delivering PSS.
- p) Create a forum for CLWs from different sources i.e., GOvt. NGO, SHG to come together, this will facilitate sharing of responsibilities and avoid duplication of services.
- q) Better recording of the contact details of the trainees to facilitate follow-up and recall in times of need.
- r) Make appropriate provisions to update database on a regular basis to facilitate follow-up and recall in times of need.

Introduction

On December 26, 2004 a massive earthquake measuring 9.0 on the Richter scale, with its epicenter off the coast of northern Indonesia triggering a catastrophic tsunami with waves ranging from ten to thirty feet, that traveled at speeds upto 500 miles per hour and striking countries as far as 4000 miles away from the epicenter. The tsunami resulted in the death of over 280,000 people spread over 14 countries.

In India the Andaman and Nicobar islands were the first to be struck by the tsunami with the mainland being hit around 9.50 am. The costal districts of Tamil Nadu, Andhra Pradesh, Kerala, and the Union Territory of Pondicherry were battered by the tidal waves that incused upto 2 miles in some places destroying lives and property. The tsunami affected a total of 2,260km of India's coastline besides the entire group of Nicobar Islands resulting in about 12,500 deaths in India with the state of Tamil Nadu accounting for about 65% of the death toll. The districts of Nagapattinam followed by Kanyakumari were the worst hit in terms of mortality.

The disaster caught both the central as well as the state governments unprepared but they quickly rose to the challenge and set in motion the state machinery to identify and dispose the dead, remove debris, rescue and move the affected individuals to safer locations and provide medical care to the survivors. It was exemplary in its management in the prevention of outbreak of epidemics for which it has received universal acclaim.

Following the timely action of the government agencies along with the NGOs and the countless volunteers who turned up to help, much of those who suffered physical injuries were attended to immediately. Also the very nature of the disaster meant that it did not leave in its wake too many physical health problems, or injuries and accidents.

Consequently it is no surprise that the attention of medical specialists, public health experts, epidemiologists, international relief teams and NGOs was quickly focused on mental health. Tears of anguish and sorrow over lost near and dear, damaged property,

suicidal attempts due to sheer inability to cope with the losses, anxiety and panic in (fisher)men about going back to the waters, women reluctant to return to their homes by the sea, children clinging on to their parents and avoiding school - these were all vivid sights confronting all relief workers. The electronic media also captured many of these sights reiterating the importance of emotional support and psychological interventions.

This resulted in a number of organizations including NGOs, institutions, UN and government agencies raring to provide training and psychosocial support. Financial aid for counseling, training and psychosocial support also poured in from all over the world.

This is reflected in the records of the Dept of Social Welfare, Govt. of TamilNadu which indicate that they have facilitated the training of about 5,000 CLWs. It is however not clear as to how many of the trained CLWs are currently working in the field and information regarding their current level of functioning and the effectiveness of their intervention was lacking..

The present study is aimed at addressing this issue by following up a stratified random sample of CLWs, trained through the Department of Social Welfare Govt. of TamilNadu, and by NGOs , community leaders and a sample of individuals affected by the tsunami. The current study assessed the effectiveness of the PSS program and the present level of functioning of the trained CLWs working in the affected regions.

It should be kept in mind that PSS intervention through CLWs is an unusual approach that has been used only in a limited manner previously, and certainly not on the present scale in any previous post disaster situation.

The CLWs be they Government employees or personnel from other sectors had no mandate to do PSS and it was not part of their regular work. The entire process was on a voluntary basis. The concept of using CLWs has been largely experimental till the tsunami disaster and the present study offered a unique opportunity to evaluate its strengths and weaknesses.

SCARF assessed the PSS program implemented in the tsunami-affected regions of Cuddalore and Pondicherry.

Aim

The aim of the study was to assess PPS training given after Tsunami to CLWs, their utility and impact in the community and evolve a series of guidelines for future work.

Objective

The objectives of the study had two dimensions – one population based and the other CLW based.

POPULATION BASED:

1. To assess the nature, quality and quantum of psychosocial interventions delivered to a sample of the tsunami affected population in Cuddalore and Pondicherry.
2. To evaluate the impact of psychosocial interventions on a sample of subjects who have received it during the last year.
3. To assess the current needs of the population for psychological support.

COMMUNITY LEVEL WORKER BASED:

4. To assess the nature and quality of training in psychosocial support received by various groups of community level workers after Tsunami.
5. To assess nature and frequency of assistance currently provided by a sample of the CLWs originally trained.

The Methodology of the study and sample selection is described in the next chapter.

Methodology

In order to meet the objectives of the study, the methodology included:

- a) Formulation of structured questionnaires
 - For Community Level Workers
 - For General community: local leaders, key informants & self help group members
 - For Families affected By The Tsunami
 - For Individuals affected by Tsunami
- b) Field testing of questionnaires
- c) Recruitment and Training of staff in the administration of questionnaires
- d) Sampling:
 - Consolidating lists of subjects from databases for sample selection in all four groups
 - Sample size estimation using sound statistical procedure, for a stratified random sample of subjects to be interviewed.
- e) Identification of subjects in the field
- f) Conducting interviews
- g) Data compilation and analyses

I. Formulating Structured Questionnaires

Structured questionnaires were developed to assess the nature, quality, quantum, source and frequency of training/ interventions/ assistance received.

Separate questionnaires were created for the four different target groups

- i. Community Level Workers:
- ii. Families affected By The Tsunami
- iii. General community: local leaders, key informants & self help group members
- iv. Individuals affected by Tsunami

Questionnaire development

For each of the groups, the research team, based on the experience of having worked in these areas for over a year, put down a set of questions pertaining to training, interventions and assistance received. Focus Group discussions with all staff involved in SCARF's Tsunami projects were held to evolve items for the questionnaire and refine the questions. The questions centered around

- **Training in PSS Strategies:** Content, duration, use of audio-visual aids, comprehensiveness, trainers, training materials, ways of counseling.
- **General community:** Recognition of psychological problems in the community, the felt need for psychosocial intervention, resources for PSS interventions, perceived consistency and effectiveness of the intervention by the general community, etc.
- **Families and Individuals affected by Tsunami:** Nature of loss, perceived psychological problems in family members/ self, coping strategies adopted, the help received for psychological problems, time lapse between the disaster situation and receiving help, usefulness of the help, the gaps in the PSS programs that they received.

All the questionnaires had provision for documenting qualitative responses from the respondents. Qualitative information was sought on the usefulness of the training and the extent of utilization by the trainees, the nature of impact of the disaster, usefulness of PSS strategies and any other general observations.

The first drafts of the various questionnaires were circulated amongst other mental health professionals (psychiatrists, psychologists and social workers) working in the field of mental health and /or disaster management). Modifications were incorporated based on the suggestions. These included additions /deletions/ change in the language of questions etc. The next draft was once again circulated, before field-testing.

The instruments were developed in English and translated into the local language Tamil.

II. Field Testing

The questionnaires were field tested in the tsunami-affected areas of Chennai and Nagapattinam. The purpose of field testing was to test suitability and ease of questionnaire administration, the time required to administer the tool on the various target groups and identification of areas/questions requiring modification/ deletion.

In general, the team involved in field-testing the questionnaire, did not face major difficulties in administering the questionnaire or eliciting responses. The responses collected from the interviews were deemed satisfactory.

However, the team felt that it was difficult to administer and elicit valid responses to the question dealing with ranking of the “training program”, in the Questionnaire for CLWs. This question was deleted and replaced by another, which focused satisfaction/dissatisfaction with the various aspects of the training program that they had undergone.

The final versions of the tools were then used for data collection in the field. The questionnaires are appended (Appendix-1)

III. Recruitment And Training Of Staff

The staff deployed were essentially from Mental Health background, with experience in community based service and research. They were briefed on the project and its objectives. They were then trained on the questionnaires to be administered by the team, which developed the instruments.

The training was done:

- At the center: Focus was on project descriptions, objectives and the methods of data collection
- On the field: Identification of subjects, interview processes and administration of questionnaires

Inter-rater reliability of the raters was established. This reliability was checked at periodic intervals. The project co-ordinator also checked on the interview process, from time to time, through observations during data collection.

IV. Sampling Process

Consolidating List From Databases

Community Level workers

Community level workers were defined as “Significant persons in the community who were trained in PSS and closely involved with the population such as village health workers & nurses, school teachers, staff of non-governmental organizations in the area and members of the Self Help Groups”. What about Govt.CLWs?

A list of all CLWs who received training was consolidated from the database made available by the Dept. of Social Welfare, Govt. of Tamil Nadu and SCARF records of all trainees. List from other NGOs

Exclusions: An initial analysis of the database showed that

- A majority of the individuals who received PSS training were from outside the project area, i.e, not from Cuddalore or Pondicherry.
- The list of trainees also comprised of students from various educational institutions in Tamilnadu who had worked in the tsunami affected areas for a short period of time (approximately 2 months).
- Some of the lists contained only names of individuals who had received training with no mention of their institutional affiliation

Since it would have been virtually impossible to locate (a) individuals from outside the project areas of Cuddalore or Pondicherry, (b) students from the educational institutions or (c) those whose institutional affiliation was not known, it was decided to exclude these groups from the sampling frame.

After exclusions, a total of 589 individuals were included in the sampling frame.

Population Based

A list of 70 villages affected by tsunami in the districts of Cuddalore and Pondicherry were compiled. From this list, 25 villages were randomly selected.

Three groups of individuals were selected from the randomly selected villages. These included:

- Survivors: Those who had been psychologically traumatized following the tsunami.
- Families affected by the tsunami: Family members of individuals suffering emotional trauma following the tsunami.
- Community leaders: significant members of the community like village leaders, self help group leaders, school teachers or political /administrative persons.

Stratification Of Sample And Randomizing Selection Of Subjects

1. Community Level Workers:

The stratification was done on the basis of gender, age and the occupational affiliation of the individual, with expert advice from Prof. Raman, Prof of Statistics, Dept of Statistics, Loyola College, Chennai. The occupational affiliation included employment in the government, a non-governmental organization or being a member of the Self Help Group.

Available Units

	Male	Female	Total
Govt	29	105	134
NGO	44	62	106
SHG, Others	24	325	349
Total	97	492	589

A sample of 296 was chosen from the above list for interviews.

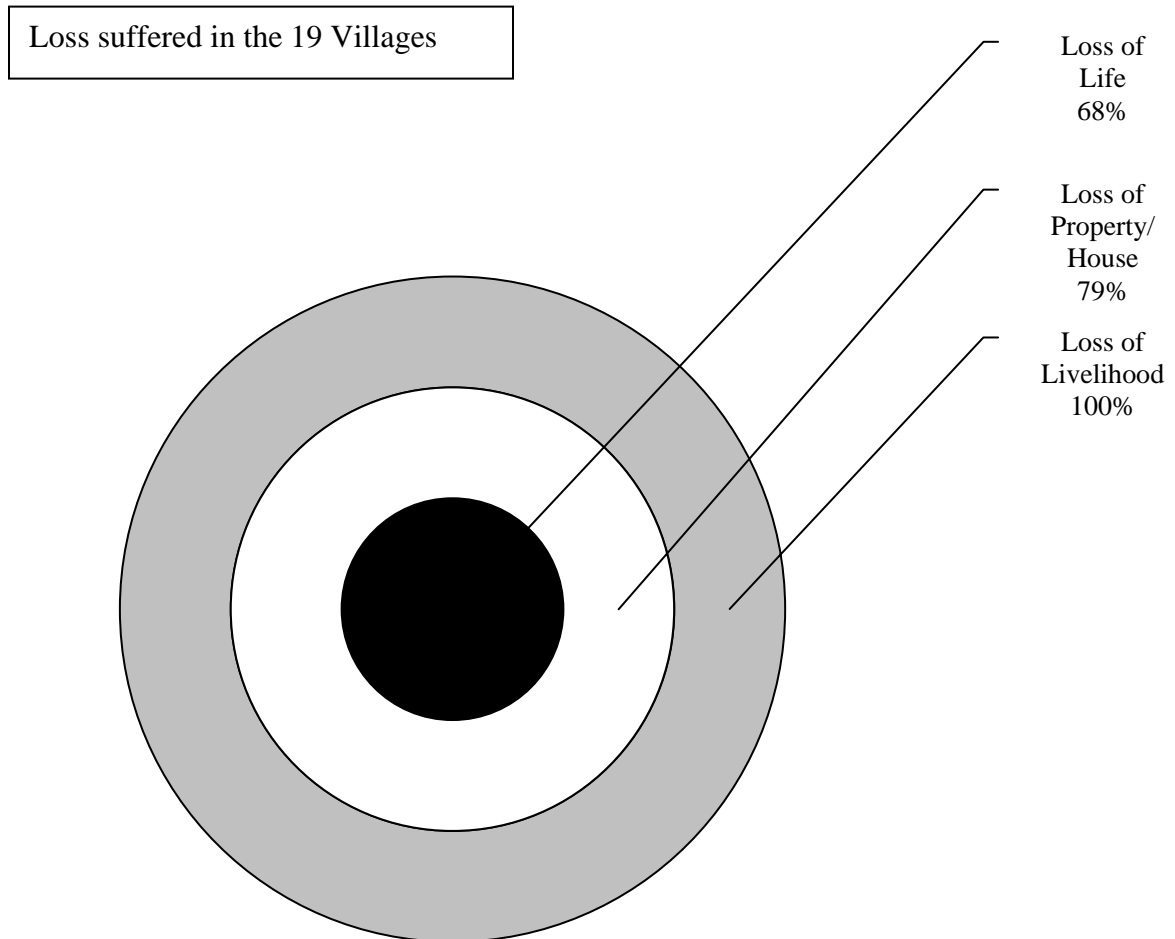
Population Based

Of the 58 tsunami affected villages in Cuddalore district and 12 tsunami affected villages in Pondicherry, 25 villages (19 from Cuddalore and 6 from Pondicherry) were selected for evaluation. The villages were selected randomly after giving due weightage to population, damages suffered during tsunami and geographical location.

The 19 villages selected from Cuddalore are

S.No.	Name of the Village	Population				Total	No. of families affected	No. of house hold
		Adult		Children				
		M	F	M	F			
1	Thazanguda	1026	785	95	81	1987	275	335
2	Nanamedu	975	615	123	96	1809	37	631
3	Sothikuppam	1301	875	78	34	2288	41	631
4	Kudikadu	3693	1897	796	363	6749	275	1018
5	Thiyagavali	420	315	182	180	1097	200	284
6	Chittirapettai	290	160	173	170	793	150	189
7	Periyakuppam	683	576	413	230	1902	250	372
8	Kamblimedu	296	273	160	150	879	50	302
9	Reddiyarpettai	203	152	109	110	574	75	98
10	Kumarapettai	198	211	29	26	464	75	151
11	Chinnur	663	790	50	41	1544	300	600
12	T.S.Pettai	452	471	23	28	974	250	400
13	Sonankuppam	967	1025	242	255	2489	563	498
14	Enikarianthottam	364	371	90	89	914	226	183
15	Ammankoil	15	18	6	5	44	11	11
16	Athankarai Street	45	55	19	21	140	28	35
17	Santhaikada Street	165	185	64	66	480	5	120
18	Muzhukkuthrai	164	174	84	90	512	155	155
19	Pillynmedu	44	47	17	12	120	45	45
	Grand Total	11920	8948	2753	2047	25759	3011	6058

Profile of the 19 Villages selected in Cuddalore District for the PSS follow-up study



Nineteen affected villages were selected for the study, of these all of the villages had its livelihood affected. Thirteen villages (68%) had fishing as their major occupation while agriculture was the main occupation in 5 (26%) villages. In 2 villages (6 %) there was an equal mixture of individuals earning a living from farming as well as fishing.

Of the selected villages 80% of the farming villages did not have Tsunami related deaths and 60% did not have their houses damaged, however all of them suffered from loss of livelihood.

From these 19 villages (32.7%), 603 families/individuals (20%) were to be interviewed.

For the category “Community leaders from tsunami affected areas” 2 individuals were to be interviewed from each of the selected villages.

VI. Identification Of Subjects In The Field

Individuals selected after stratification and randomization from the database were followed up and identified in the field. Subsequently appointments for the interviews were fixed at a time and location convenient for the interviewees in the case of CLWs. Survivors and family members were identified in the field directly and interviewed.

VII. Conducting Interviews

The breakup of the interviews conducted in Cuddalore District are as follows

Groups	No of individuals interviewed
Govt Employees	55
Self Help Group Members / Others	42
Non Governmental Organizations	30
Individuals affected by Tsunami	143
Families affected by Tsunami	49
Community Leaders	15
Total	334

VIII. Compilation Of Data For Analyses

The data was compiled and entered into a programmed SPSS database for analyses.

Sample Description

Based on the randomization of the sample, 296 Community Level workers (CLWs) were selected for the study. They were divided into three groups, Govt. Employees, NGO employees and members of the local Self Help Groups (SHG).

While tracing the 296 trained CLWs as per the records made available by the Dept. of Social Welfare, Govt. of Tamil Nadu and the data base from SCARF it became apparent that in the two years since the training had been imparted, a lot of changes had occurred in the field, especially in the NGO sector. Grossly inadequate data collected at the time of training was another factor contributing to the low identification rate. There were many instances when only the name of the individual and their area of operation given with no mention of their affiliation.

A significant number of government employees had been transferred, promoted or had retired and were therefore unavailable. And in the case of SHG members, very often there was no information in the record as to where they were from rendering it almost impossible to trace them.

In view of these limitations it was decided that subject selection would be done directly in the identified study area (i.e the 19 villages) and that every attempt will be made to interview as many respondents as possible to achieve the recommended number for each of the three groups.

One hundred and twenty seven (127) CLWs were therefore interviewed as against the originally selected number of 296.

One hundred and ninety two (192) community interviews were conducted as against the 600 interviews originally envisaged. The interviews were discontinued in villages when thematic saturation was reached and it was believed that no new information would be forthcoming. Approximately 10 interviews per village were conducted. In addition, community leaders from 15 villages were also interviewed. This was the reason why the number of interviews was less than the estimated value.

In an effort to correlate PSS provided with the extent of loss, 19 villages were categorized as those, which had (1) loss of livelihood only (2) loss of livelihood and property and (3) loss of livelihood, property and life in increasing grades of severity.

On the whole, 334 interviews were conducted in 19 villages in the district of Cuddalore. The profile of the CLWs, Affected Individuals, Relatives of Affected Individuals and Community Leaders interviewed for the study are presented below.

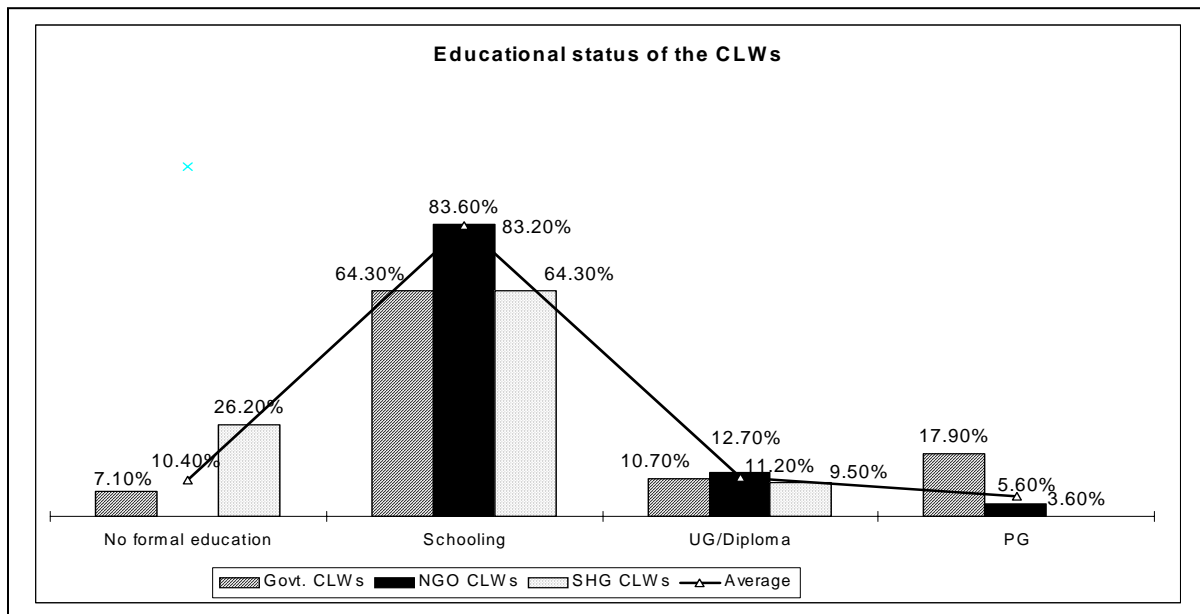
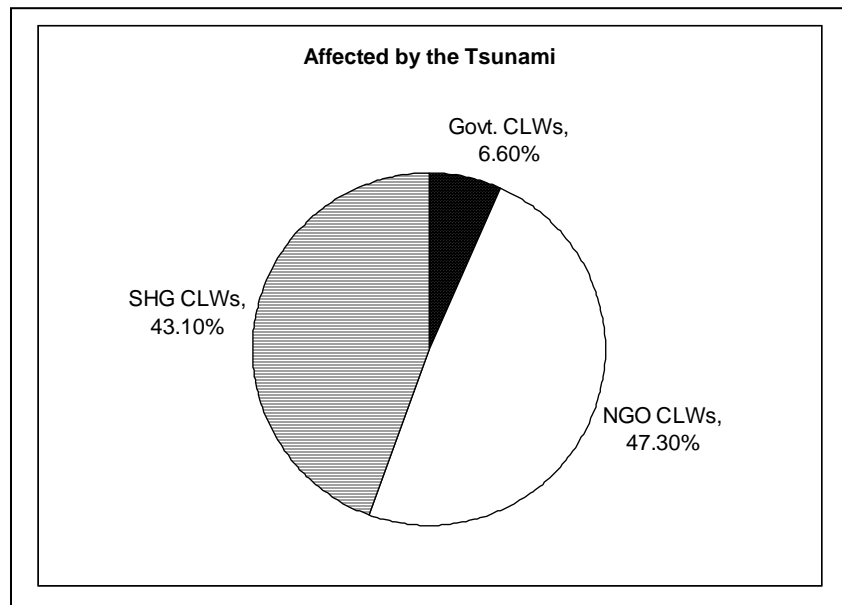
Profile of CLWs interviewed

CLWs in Govt. employment were older than NGO and SHG CLWs. They had more

	Govt. Employees	NGO Employees	SHG Members	TOTAL
Number of Interviews	30 (23.6%)	55 (43.3%)	42 (33.1%)	127 (100%)
Average Age	44 yrs	26.64 yrs	40 yrs	35.25 yrs
Gender				
Male	10 %	16.4 %	2.4 %	10.2 %
Female	90 %	83.6 %	97.6 %	89.8%
Education				
No Formal Education	7.1 %	-	26.2 %	10.4 %
Schooling	64.3%	83.6% ^a	64.3% ^b	83.2 %
UG/Diploma	10.7%	12.7%	9.5%	11.2 %
PG	17.9%	3.6%	-	5.6 %
Marital Status				
Unmarried	3.3%	52.7%	-	23.6 %
Married	90 %	47.3%	88.1 %	70.9 %
Widowed/Divorced	6.7%	0 %	11.9 %	5.5 %
Affected by the tsunami	6.6%	47.3%	43.1 %	32.3 %
^a Majority had completed 10 th Std				
^b Most of them had completed till 8 th Std				

experience working in the field and had been working in the affected villages for at least 5 years. In contrast, majority of the NGO CLWs interviewed had started working in the affected areas only after the tsunami and it was often their first job. Their work in the

affected areas ranged from 6 months to almost 2 years. However many of the CLWs at the NGOs had been drawn from the local community and had therefore, in varying measures personally borne the brunt of Tsunami as against only 6 % of the Govt. CLWs. The Govt. CLWs were better educated and more likely to be married than NGO and SHG CLWs



Profile of Survivors Interviewed

	Damage suffered by the village			
	Only Livelihood	Livelihood & Property	Livelihood, Property & Life lost	Over All
Number of Interviews	25 (17.5 %)	26 (18.2 %)	92 (64.3%)	143 (100%)
Average Age	35.50	36.96	35.15	35.55
Gender				
Male	20 %	19%	12 %	15 %
Female	80 %	81 %	88 %	85 %

Most of the respondents were from villages that had lost lives, property and livelihood. Villages that had lost livelihood were primarily dependent on agriculture and in some cases had both agriculture as well as fishing as their occupation.

Loss suffered by Survivors

	Lives lost	Property	Livelihood
Damage Suffered	27.3 %	63 %	87.9 %

The loss of property includes damage to houses, loss of household articles, damage to agricultural land, loss of income generating animals such as goats etc.

Profile of Family members interviewed

	Families Interviewed
Number of Interviews	49
Average Age	38.9 yrs
Gender	
Male	10.2 %
Female	89.8 %

Most of the respondents were female as men were away at work and not available when the interviews were conducted. When available they were reluctant to speak, were sleeping or in an inebriated state which did not facilitate meaningful interviews.

Loss reported by the family members of persons affected by the tsunami

Profile of Community Leaders

Community leaders were identified by asking the villagers who their village head was.

	Lives Lost	Lost / Separated	Livelihood Lost	Injuries Suffered	Other Problems
Loss reported by the Family members	8.2 %	6.3%	69.4 %	43.7 %	4.2 %

Other opinion makers and influential persons in the village such as, school headmasters and leaders of self help groups were also included under this category.

	Male	Female	Total	
Average Age	49 yrs	33.50 yrs	41.85 yrs	
Gender	9 (60%)	6 (40%)	15 (100%)	
	Damage suffered by the village			
	Only Livelihood	Livelihood & Property	Livelihood, Property & Life lost	Over All
Number of Interviews	13.3 % (2)	26.7 % (4)	60 % (9)	100% (15)

Training Program

This section deals with information pertaining to the PSS training programmes themselves. Some CLWs had methodically maintained registers with details of these programmes, while others only had a rather sketchy recall of details.

	Govt	NGO	SHG	Over All
Average No. of Training Programs attended	4.07	3.71	1.88	3.19
Audio Visual Aids used	76 %	63 %	48 %	62 %
Multiple Trainers	97%	97 %	97 %	97 %
Handouts given	64%	83 %	52 %	66 %
Case illustrations used	86 %	93 %	86 %	88 %
Time for feed back & discussion	89 %	93 %	93 %	92 %
Evaluation form given	85.2 %	84 %	64 %	78 %
Satisfaction with training	97 %	100 %	100 %	99 %

Most of the CLWs had attended multiple training programs with some individuals attending about 8 to 10 such programs and an individual attending upto 20 such training programs. The content of the multiple training programs were repetitive and had been provided by multiple sources.

Venue : About 20 % of the CLWs opined that the training program could have been better if the venue should have been closer to their place of work, involving less travel. Quite often, the travel itself left them so tired that they were unable to take in all the inputs of the sessions. SHG CLWs also felt that training programs that were spread over two and three days were difficult as it meant leaving behind their responsibilities at home. Many of the respondents also subscribed to the view that Field based training would have helped.

Content: a section of the respondents felt that the trainers spoke at length about psychological problems, but said little about how they should be managed by the trainees. There were also other sessions that focused only on disaster management and merely glossed over psychological issues.

Format: Many felt that audiovisual material should have been used more and case vignettes and actual case demonstrations would have helped. It however worth noting that audio visual aids were used in about 60 % of the PSS training programs especially when we consider the fact that major academic programmes in the country still depend on black board as the main teaching aid. About 10 % of the trainees felt that more time could have been allotted for discussions and questions. They also felt that if more role-play had been used and handouts in Tamil distributed it would have been helpful as one of respondents put it “ For many of us, this was the first time we were exposed to description of mental problems”.

Language: Most of the respondents also mentioned a session or two in English did not pose problems provided translation into Tamil was done. However many of the respondents felt that there were frequent use of technical terms (in Tamil) that they were not familiar with and this resulted in difficulty in grasping some of the concepts.

Children: During the interview a number of respondents expressed interest in dealing with children. More than 60% felt that more information on problems in children and management strategies could have helped them. They also wanted to know more about legal rights of children.

Other areas: What should future programmes incorporate?

How to deal with the disabled, how to engage in public speaking and training in community awareness programmes. They also believed that training should be imparted to workers in interior villages also and not just those near the sea. This they felt will serve to increase awareness about these problems

Utilization of PSS Training Received

It was probably a more challenging task to cull out information on how the training had been put to use on the field.

	Used PSS Traing Knowledge		Total
	Yes	No	
Govt	27 90.0%	3 10.0%	30 100.0%
NGO	46 83.6%	9 16.4%	55 100.0%
SHG	13 31.0%	29 69.0%	42 100.0%
Total	86 67.7%	41 32.3%	127 100.0%

NGO and Govt. CLWs have utilized their PSS training, while only 31 % of the SHG CLWs have put their training into practice. 88% of the PSS Service was provided by the CLWs as part of their regular work. Only 12% of the service was provided on a non-remuneratative or voluntary basis. This seems to suggest that regular and sustained contact with the survivors that is required in the delivery of PSS services cannot be realistically expected on a purely voluntary basis.

It should be kept in mind that the delivery of PSS through CLWs be they Government employees or personnel from other sectors was voluntary as they had no mandate to deliver as it was not part of their regular work. The concept of using CLWs for PSS was largely experimental till the tsunami disaster.

Some of the reasons give by SHG CLWs for non implementation of their training knowledge included the fact that the initial training was provided about two to three months after the tsunami struck, they would have been able to respond better if the training had been provided earlier. A section of the respondents felt that their training

was redundant, as much of the community had recovered by the time they had received training.

Many youngsters with some basic education had been offered jobs by NGOs. The older women not so recruited did not seem particularly inclined to receive PSS training. As an elderly lady opined: “like sheep, we were all taken for training without bothering to determine if we were interested or not”.

Another aspect about the SHGs was that post tsunami many NGOs had started SHGs in the affected villages, the women who joined these SHGs (They were already members of preexisting SHGs in their villages) primarily did in the belief that they would benefit from the membership in terms of receiving relief and rehabilitation packages. For most of SHG members, attending PSS training programs was just another opportunity to gain monetarily as most organizations were paying them to attend the training programs.

Other reasons for not being able to provide PSS include the fact that their responsibilities were changed and that it was no longer possible for them to work in the field on a regular basis. As one Anganwadi Health Worker put it “Duty hours keep changing, so we are unable to help anybody.” Others also reported that they were “Scared to talk to affected persons”

Some of the CLWs also stated that the local community wanted only material benefits and did not appreciate PSS as one of them said “ A woman had lost 3 children and was very depressed- but as soon as she received money, her behavior changed”. Another CLW emphasized this point by saying “They don’t take *aarudhal* (consolation) seriously.”

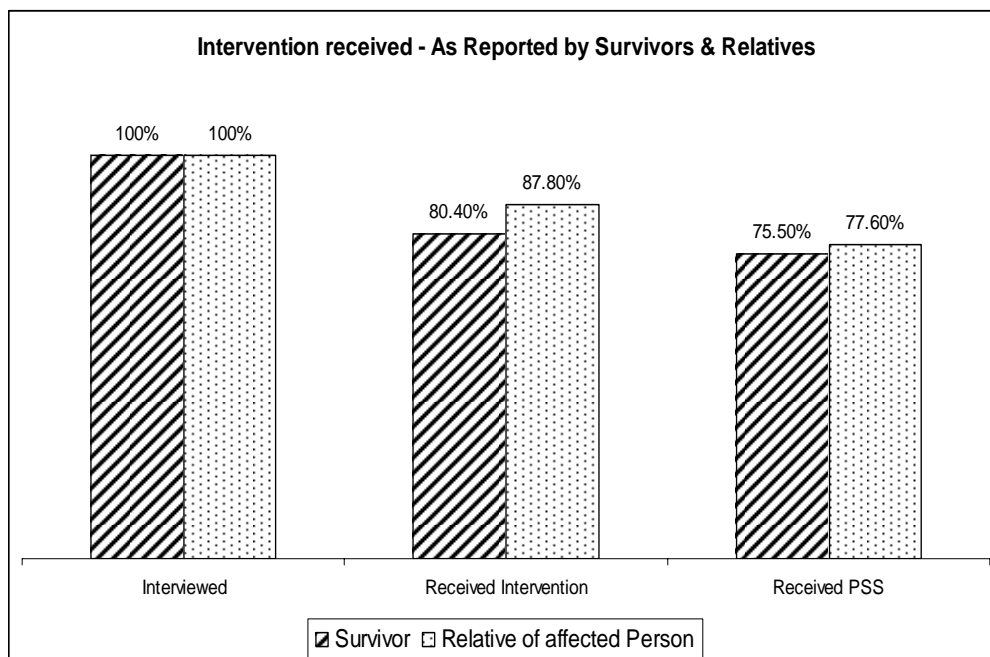
Other problems in the field arose due to duplication of services provided and rivalry between different service providers. This has led to the suggestion as exemplified in this statement, “If CLWs from a particular area are trained together, it becomes easier to share responsibilities. Field visits can also be arranged this way”.

About 15% found this training and counseling to be personally useful, as about 30% of them had been affected by the tsunami themselves. Those who lost family/property were more motivated to use their training to provide support. The CLWs also stated that initially, “We cried along with the families, but later started being more professional and were able to help them.”

These skills also came in use to manage the victims of floods in October 2006

Response to Intervention as reported by Affected Individuals and Relatives

Of the 127 survivors (affected individuals) and 49 relatives of other affected individuals interviewed, about 80 % of the survivors and about 88 % of the relatives reported receiving some support and intervention. PS support was received by 75.50 % and 77.60 % respectively. Thus indicating that about 25 % individuals/families did not receive PSS intervention. This is depicted in the graph below.



Who received the PSS interventions and Who Provided it?

As reported by the Community

Both the survivors as well as relatives of affected persons reported that about 75% of the

Group	Question	Damage suffered by the village			
		Only Livelihood	Livelihood & Property	Livelihood, Property & Life lost	Over All
Survivors	Seek Help	56 %	68 %	68.2 %	65.9 %
	Received Intervention	60 %	76.9 %	88.9 %	80.4%
	Received PSS	52 %	65.4 %	84.8 %	75.5 %
	Who Provided it ^{a,c,d}	1.NGOs – 40 % 2. SHG – 30 % 3. ^b Others-20 %	1.NGO- 64.3% 2. SHG–21.4 % 3. ^b Others–7 %	1.NGO- 81.7% 2 SHG-1.7 % 3. ^b Others–6.7%	1.NGO- 73.8% 2 SHG-8.3% 3. ^b Others-8.3%
Relatives	Received PSS				77.6 %
	Who Provided it ^{a,c,d}				NGO - 48.9 % SHG - 28.6 % Mental Health Professionals - 20.4 % Govt.- 16.3 % Others - 6.1 %
Community Leaders	Seek Help				13.3 %
	Who Provided it ^{a,c,d}				(1) NGOs ^e (2) Govt. ^e (3) SHGs ^e

^aMost respondents could not name the organization providing PSS

^bMostly religious organizations

^cFor individuals who have received intervention

^d PSS received from multiple providers

^e Ranked by frequency of response

affected individuals had received PSS services. Villages that had suffered extensive damages in terms of lives, property and livelihood lost had received the most PSS. Villages with progressively less damage suffered received less PSS with only 52% of the individuals in villages that had lost only livelihood receiving intervention.

Interviews with all three community groups indicated that the CLWs from NGOs were most frequent providers of PSS.

Govt. CLWs were also reported to have provided PSS but as each of them had multiple villages to cover they were not able to meet everyone on a regular basis. The problems were also compounded by the fact the fact the affected population was highly mobile during the first few months after the tsunami moving from one location to another, initially as their homes were destroyed, then in response to rumors, then to temporary shelters and then to their permanent housing developments. There was also a section of the population that migrated from the area after the disaster and returned once relief measures were being implemented.

As the Govt. CLWs were the nodal point for many of the schemes announced by the Govt. they had multiple responsibilities, the community did not associate PSS with them though cross verification with the survivors in the community indicated that many had received some support from the Govt. CLWs.

Extent of Psychological Problems seen in the community

Trauma / Loss suffered by the Survivors

	Damage suffered by the village			
	Only Livelihood	Livelihood & Property	Livelihood, Property & Life lost	Over All
Witnessed tsunami	48 %	92.3%	96.7 %	87.4 %
Caught in the waves	16 %	61.5 %	83.7 %	67.8 %
Saw others being affected	33.3%	76.9 %	94.6 %	81 %
Loss of friends/family	4 %	3.8%	40.2 %	27.3 %
Loss of livelihood/property	56 %	96.2 %	94.4 %	87.9 %

Psychological Symptoms experienced by the Survivors

	Damage suffered by the village			
	Only Livelihood	Livelihood & Property	Livelihood, Property & Life lost	Over All
Anxiety	18 (72 %)	24 (92.3%)	77 (83.69 %)	120 (83.92%)
Depression	13 (52%)	9 (34.62%)	47 (51.09%)	78 (54.55%)
Sleep Disturbances	16 (64 %)	24 (92.31%)	82 (89.13%)	122 (85.31%)
Nightmares	8 (32%)	14 (53.85 %)	66 (71.74%)	87 (60.84%)
Fear	10 (42%)	21 (80.77%)	74 (80.43 %)	107 (74.83%)
Others	1 (4%)	-	-	1 (0.69%)

As can be seen from the above table individuals from villages with extensive damages suffered from more psychological problems. It is however worth noting that even villages with minimum/ limited damage in terms of property or lives lost, significant number of people had psychological problems.

Psychological problems reported by the family members

Respondents : Adult Relatives

	How many families had individuals with psychological problems after the tsunami?	95.9 %
Problems	Anxiety	75.5 %
	Depression	53.1 %
	Sleep Disturbances	81.6 %
	Nightmares	53.1 %
	Fears	51 %
	Increased alcohol intake	6.1 %
	Others	8.2 %

	Not going for work / not doing house work	19.6 %
Reason	Physical problems/injuries	4.3 %
	Severe mental disorders	6.5 %
	Fear	8.7 %

Children

	How many families had children with psychological problems after the tsunami?	28.6 %
Problems	Bedwetting	8.2 %
	School refusal	18.4 %
	Disturbed sleep	18.4 %
	Night terrors	12.5 %
	Others	4.2 %

Interviews with family members seem to indicate that adults had more psychological problems than children as shown by the fact that more than 95 % of the family members reported that an adult was psychologically affected while less than 30 % of the children were deemed to be adversely affected by the tsunami.

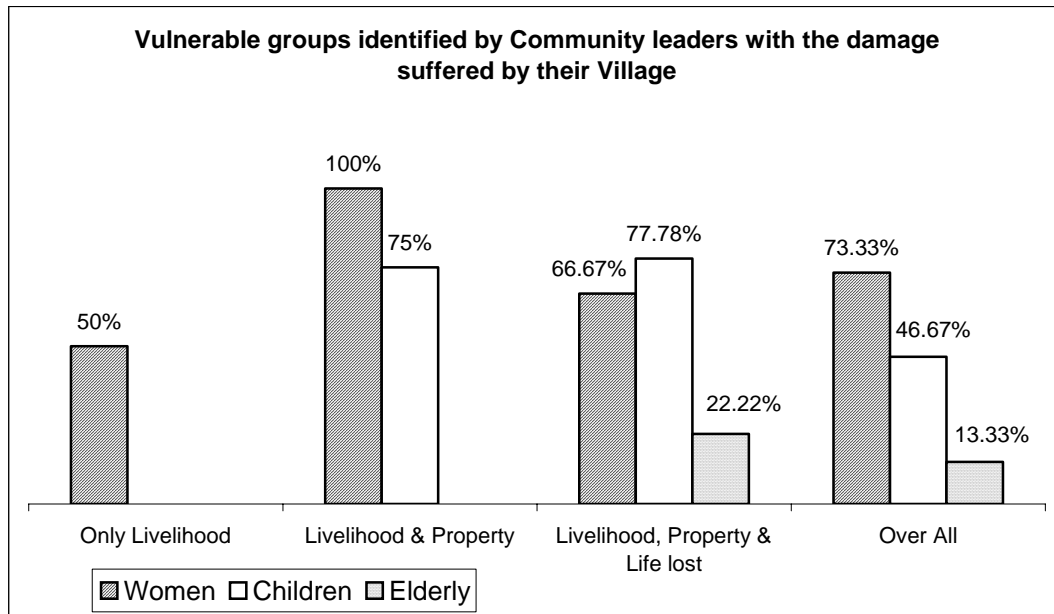
As reported by Community Leaders

S.No	Questions asked to the Community Leaders	Responses		
		Yes	No	
1	Were there a lot of psychological problems in your village after the tsunami?	Yes	No	
		86 %	14 %	
2	What were these problems? What were their indicators?	The most frequently mentioned problems and their indicators were (1) Not going for work or handling their responsibilities (2) Fear of the tsunami reoccurring (3) Avoiding their residence/beach (4) Lack of interest in everything (5) Poor and disturbed sleep (6) Feeling sad and crying all the time (7) Increased alcohol intake by men		
3	What percentage of the community was affected?	Average	Min	Max
		16 %	10 %	50 %
4	Who had the maximum problems ?	(1) Women (2) Children and (3) the Elderly (<i>Ranked by frequency of response</i>)		
5	Did the affected individuals/ community realize that they required psychological support?	Yes	No	
		40 %	60 %	
6	How many of these individuals sought help?	13.3 %		

Differences were seen in the opinion of the community leaders based on the severity of damage faced by their villages with respect to who the vulnerable groups were and who had been most affected psychologically by the disaster. Only villages that had suffered extensive damage saw the elderly as being a vulnerable group, while villages that were affected only in terms of livelihood saw only women as being adversely affected.

However across all three types of villages, women were seen as being affected. Community leaders from villages that have suffered damages in terms of lives, property and livelihood lost of the opinion that children were the most affected group.

This is depicted in the graph presented below.



As reported By CLWs

The women were largely depressed, especially those who had lost their children, spouse or close members of the family. At the same time, they were also most anxious about getting relief measures and often were engaged in squabbles and quarrels with other women. They also visited doctors a lot and kept complaining of aches and pains and tiredness, poor appetite (felt the fish was different).

Among the men, it was generally alcoholism, day and night drinking in what they describe as “an effort to drown our sorrows”. After the money arrived, a good amount was spent on this.

The children who initially feared going to school gradually started doing so. Some of them still have a lot of problems at nights such as nightmares and bedwetting. Other problems include crying spells and reduced levels of concentration.

Fear of recurrence of the tsunami was seen in all ages, both genders. Some blamed the media for blowing out of proportion relatively trivial issues, all of which compounds the anxiety.

It was also seen that many of the CLWs did not distinguish between individuals with pre-existing mental illness FROM those traumatized by the tsunami. There were instances of CLWs providing PSS to individuals with chronic mental illness and becoming frustrated with their apparent lack of success.

What type of PSS Interventions were provided?

From Community Interviews

Group	Type Of PSS Received	Damage suffered by the village			
		Only Livelihood	Livelihood & Property	Livelihood, Property & Life lost	Total
Survivors	Counseling	32 %	50 %	72.83 %	61.54 %
	Medication	4 %	15.38 %	20.65 %	16.78 %
	Group therapy	24 %	23.08 %	22.83 %	20.98 %
	Recreational therapy	12 %	11.54 %	17.39 %	13.29 %
	Others	4 %	-	5.43 %	4.2 %
Relatives of affected persons	Counseling				79.6 %
	Medication				51 %
	Hospitalization				6.1 %
	Group therapy				16.3 %
	Play Therapy				24.5 %
	Recreational Therapy				10.2 %
Community Leaders	What did the CLWs do in your village ?	(1) They came and spoke to the people (2) They organized games and programmes for children (3) Medicines were given and some of them were taken to hospital			

The majority of the survivors had one to one interaction with the CLWs, and in most situations this was all that was required. A significant portion of the survivors also received pharmacological intervention.

Individuals with severe problems were admitted and treated in hospitals. The relatives were quite often not able to name the hospital and a statement made by one of the relatives “They came and took her away to a hospital in Chennai, and then dropped her back after 3 months. We do not know to which hospital she was taken to but they gave us some medicines and asked us to continue giving it. We have not seen them since” exemplifies this.

More than 20% also participated in ‘Group Activities’, which were generally awareness programs conducted in their villages during which they were asked to enact experiences and role-play. In most instances it was conducted only once or twice in their village. It is of significance that the most of these programmes were conducted in villages that had suffered minimal damage.

‘Play therapy’ was imparted to children during which group games and activities were organized. The children enjoyed it and many of the children were given play material. The activities were organized both at the village level as well as in schools. The interventions provided for children were much appreciated by the community in general.

As reported by the CLWs

Most of them counseled individuals, largely women and children. This was done on a one to one basis and not in groups. It was highly unstructured and amounted more to giving emotional support and reassurance. Many times, as the respondents were passing by a home/hut, they would peep in to ask if all was well.

The CLWs took people who refused to go out, for a walk to the beach or temple. If they had major physical problems, they were referred to the nearest hospitals/health centers. In case of depression or psychological problems, they were not sure where to refer them . A few went to Cuddalore GH. Some workers arranged for recanalization for those who had

lost their children. They in general stopped talking about tsunami and focused their attention on the daily aspects of living, initiated group interactions and also helped in securing loans. People also often sought help for education of their children.

While adults had reservations in talking about their psychological problems, the trainees had better access to children. Their techniques with children included story telling, activities such as drawing pictures, coloring, initiating games and group singing. The primary motive was to instill confidence in children. The children had sometimes to be attracted with eatables.

It is worth noting that hardly 5% of the CLWS had referred any of the survivors, adults or children to mental health professionals for intervention. The general opinion was that none of the survivors needed such intervention. Further interaction with the CLWs also revealed that many did not know to whom they could refer such cases if they came across any. This needs to be correlated with the very low number of mental health professionals or specialized services in the affected regions.

Duration of Intervention Received and Present Status

As gathered from the community interviews

Group	Question	Damage suffered by the village		
		Only Livelihood	Livelihood & Property	Livelihood, Property & Life lost
Survivors	For how long was the intervention provided?	Intermittently for 1 or 2 days during the first 3 months	Continuously for the first 6 months	Continuously for the first 6 months
Relatives		Continuously for 2 yrs by 53.1 % of the respondents ; Intermittently by 46.9 % for 6 months		
Community Leaders		About 50 % of them reported that the services were available consistently while 50 % responded that it was not.		

Most of the affected individuals reported that they had received PSS intervention more or less on a regular basis for the first 6 months. The services had stopped almost completely once they had moved into permanent shelters.

Villages that had suffered minimal damage i.e. only lost livelihood, received PSS only for a day or two during the first three months. Villages with more extensive damages received regular PSS support.

As reported by CLWs

When PSS intervention was provided by Govt. employees and SHG members the average duration of intervention was 4.56 and 4.46 months respectively. CLWs employed by NGOs were continuing to provide PSS in the community at the time of the interviews.

	Present Level of PSS offered			Total
	No pss offered	Follow-up stopped	Continueing followup	
Govt	3 10.0%	27 90.0%		30 100.0%
NGO	8 14.5%		47 85.5%	55 100.0%
SHG	29 69.0%	13 31.0%		42 100.0%
Total	40 31.5%	40 31.5%	47 37.0%	127 100.0%

On an average each CLW (inclusive of Govt., NGO & SHG) had provided PSS services to about 21 persons. On an average each NGO CLWs was providing PSS along with other services to 25.61 individuals.

As depicted in the 85 % of the NGO CLWs were continuing to offer PSS support in the field while none of the CLWs from the other group deemed it necessary. CLWs drawn from Govt employees and SHG members believe that the community had recovered in 3 to 6 months time after the disaster and it was not necessary to provide PSS services any more.

The NGO CLWs however reported that there were still many individuals who have not recovered and that they required PSS intervention. The explanation for this probably lies in the fact that the NGOs are funded to carry on with the work and the CLWs would be unemployed if PSS program did not continue.

It was also evident that many of the NGO CLWs were now primarily focused on their core competencies such as working on issues such as AIDS, etc.

**Efficiency of The Intervention Program &
The Current Mental Status of The Affected Individuals**

As gathered from Community Interviews

Group	Question	Damage suffered by the village			
		Only Livelihood	Livelihood & Property	Livelihood, Property & Life lost	Over All
Survivors	Was PSS useful?	78.6 %	88.2 %	94.6 %	91.4 %
	Continue to have problems	22.7 %	40.9 %	43.5 %	39.5 %
	Are you working, now?	60 %	57.7 %	71.9 %	67.1 %
Relatives	Was it useful?				75.5 %
Community Leaders	Were the PSS offered effective?				44.4 %
	Are you satisfied with the quality of the PSS offered?				22.2 %
	Do you think PSS is necessary?				77.8 %
	Continue to have problems?				15 %

Majority of the survivors believed that the intervention received by them was useful. This view was reflected across individuals from all three categories of villages. This was also supported by the relatives of affected persons. However while 77.8 % of the community leaders believed that PSS support was necessary and useful and helped individuals recover faster, only 44.4 % believed that the PSS received was effective and only 22.2 % were satisfied with the quality of the PSS received.

This low level of satisfaction was seen primarily as a result of the fact that most respondents were not able to clearly distinguish between PSS and other relief services, as the providers were frequently the same. Poor level of satisfaction with other relief measures delivered by the CLWs has led to lower rating of satisfaction on all services delivered by them, including PSS.

The problems experienced currently by the survivors include a heightened sense of anxiety and the fears of the tsunami reoccurring. As one of the fishermen interviewed put it “We worry about things that we did not worry about earlier”. While another said “The sea has changed after the tsunami, it has become very violent and you can hear the roar of the waves in the night. It never used to be like this”. These statements were put in perspective by a wife of a fisherman, “The men are scared to go fishing, when the sea turns even slightly rough. Before the tsunami it would not have bothered them.”

About 70 % of those interviewed reported going back to work. Of those who have not, in more than 90% of the cases it is the lack of opportunity. Many of the women not presently working had not been working even prior to the tsunami. Also several of the women were involved in marginal occupations such as goat and chicken rearing, were now not able to continue with it as they had lost their livestock during the tsunami.

There are other problems pre dating the tsunami especially socio economic problems. Some of the problems were specific to the villages that were agriculture based. A good case in point is one of the villages where the interviews were conducted. All members of the village belonged to the dalit community and had earned a living as daily wage earners working in the agricultural fields of their village. They owned none of the land. When the tsunami struck it cause no damage to their huts or property and in fact no water entered their living area but the agricultural fields were inundated with sea water and is no longer fit for cultivation. However as they were “not affected” because there was no loss of life or property (they did not own the fields, the individual who did was paid compensation) they did not receive any compensation or intervention. As one elderly lady from the village put it “They came here once, told us to be brave and then moved on”. The

livelihood of these villagers have been affected and now they are in abject poverty and yet technically are not eligible for compensation. PSS support alone will not mitigate their problems.

However in the majority of the villages the Community leaders were of the opinion only about 15 % of their village required sustained intervention.

As gathered from interviews with CLWs

There is a sharp contrast in the opinion of the Govt. & SHG CLWs and NGO CLWs. 85 % of the NGO CLWs are continuing to provide PSS support in the community. Consequently this is reflected in their opinion on when they deemed the tsunami affected individuals sufficiently recovered to withdraw psycho social services.

CLWs who were Govt employees and SHG members believe that the community had sufficiently recovered in 3 to 6 months time after the disaster and it was not necessary to provide PSS any more. The NGO CLWs however reported that there were still many individuals who have not recovered and that they require PSS intervention.

The CLWs also reported that the survivors were not receptive to only PSS being offered and that it was possible to deliver PSS only along with other services. As one of CLWs said of her experience “When I went to the village they asked me what was it I could do for them, and when I told them that I was there to talk to them, they just walked away saying that it was not going to help them solve their problems.”

In Conclusion

We believe that this exercise of evaluating PSS programmes and efforts after Tsunami was indeed worthwhile, throwing up as it did many important issues relevant for future training and support.

It was very clear that training various groups of CLWS was an important activity of Government and NGOS, from within and outside Tamil Nadu. Considering the very low levels of awareness about psychological problems, the training seems to have provided at least an overview of this dimension of human suffering. Most CLWs seem to have felt it a useful tool in their armamentarium, and many wanted more of such training programmes on a periodic basis. This was specially true of their desire to know more of what ails children and how to handle them. Understandably, there were lacunae in the content, format and delivery of such programmes, considering that most of them were put together in a short span of time. This study has elicited enough information to enable a robust and consistent PSS module to be developed and integrated with other relief activities.

About 15 % of the surveyed population had some degree of psychological problems following the tsunami. This included a sub set of those with mental health problems prior to the tsunami and those suffering from a heightened sense of anxiety, which does not interfere in their day to day living. A small percentage of this group needed medicines for varying periods of time to tide over their depression and anxiety.

There is an overwhelming opinion that PSS measures have helped many such persons in distress and needs to be part of crisis intervention measures, albeit secondary to those addressing issues of livelihood, housing etc.

The strengths of the PSS program included the identification and setting up of a central coordinating agency which in the case of Tamil Nadu was the Dept. of Social Welfare, Govt. of Tamil Nadu. The training of the village level health workers in PSS has ensured that all villages have access to a person with training in PSS. Strengthening the hands of the nodal agency with supportive local agencies will ensure smother functioning of PSS progarmme sin the future. A very useful spin off of this has been the heightened awareness in the local community about mental health problems, which should facilitate early detection and intervention even in non-disaster times.

Limitations Of the Study

One of the major limitations has been the time frame – this study was started more than a year after Tsunami and by the end of the data collection it was two years after the event and hence there was a problem with recall of information by the CLWs. We have suggested that such an exercise is best undertaken 6 months after a disaster.

Although we had originally wanted to cover a sample size of 600 survivor families, we restricted ourselves to 150 community interviews as thematic saturation was achieved. Since no new information was coming in, we stopped the process, as is done in qualitative research work. With regards to CLW interviews we had looked to interview 296 but were able to reach only 127 due to the unavailability of some of the respondents and unwillingness on the part of some of the respondents to participate in the process .

Of the three areas affected by tsunami, the main area Nagapattinam was not included in this study. Cuddalore was covered completely and in Pondicherry, we were only able to interview the teachers who had received training.

Recommendations

As mentioned earlier, this study has given us useful insights into the process of training and intervention for post-disaster psychosocial problems. The recommendations are grouped under distinct activities

1. PSS is an important facet of all post disaster interventions and should preferably start as soon as possible. Its duration can be variable, depending on the magnitude of the disaster and the needs of the population, but a minimum period of 6 months is desirable.
2. A central nodal agency should coordinate all PSS activities and any agency that wishes to offer PSS should first register with this nodal agency. This will prevent multiple trainings to some groups and ensure lack of duplication of efforts.

Training

General

3. Structured training programs should be offered to eliminate inconsistencies and repetition in the information provided.
4. Modules for children, women, elderly, disabled, and other groups should be made available to nodal government agencies and important NGOS which are community based so that quick action is possible in times of crises.
5. It is good to have a group of persons in each area well exposed to PSS training.
6. Reinforcer sessions once in 6-12 months will help them update their knowledge and information base.

Format and content

7. Venue of programmes should cut down travel time.
8. Training programs stretching over two-three days that necessitates staying over makes it difficult for the female CLWs as they have other responsibilities as well. Hence, shorter programmes interspersed in time may be better.
9. Audio-visual aids to be used more frequently to illustrate points and break monotony of the training programs. They also have better recall value.
10. Impart practical solutions - less emphasis on theory
11. Training programs should be held in the local language as much as possible and when it is used care must also taken to see that the language is non-technical to facilitate better comprehension.
12. Training programs to be held as soon after the disaster as possible – a time lapse make the service redundant
13. Simple hand-outs offering practical tips in the local lanaguge will help.
14. Role-play and demonstration of cases seems to make a grater impact.
15. A list of mental health services in the region should be provided to the trainees to facilitate appropriate referrals.

Selection and functioning of CLWs

16. Care to be taken in the selection of the CLW – train people who are interested.

17. CLWs must be remunerated in some way for the work done – either as regular employment or an honorarium. Voluntary selfless acts over prolonged periods cannot be expected- as required in delivering PSS.

18. Create a forum for CLWs from different sources i.e., GOvt. NGO, SHG to come together, this will facilitate sharing of responsibilities and avoid duplication of services.

Documentation

19. Better recording of the contact details of the trainees to facilitate follow-up and recall in times of need.

20. Make appropriate provisions to update database on a regular basis to facilitate follow-up and recall in times of need.

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Appendix

SCARF - WHO

Efficacy of PSS programs in tsunami affected areas

For Community Level Workers

Name: _____ Age (in years): _____

Gender: Male (1) Female (2)

Address:

Home: _____ Office: _____

Education : Schooling (1) UG(2) PG (3) Others (4)

Occupation :

Marital status: Unmarried (1) Married (2) Widowed/Divorced (3)

Were you/your family/ friends affected by Tsunami in any way- explain.

Training details:

1. If you were trained more than once, furnish all details for each Training Programme:

Place of Training (locality/venue)	Trained by (organ./Ind.)	Period of training (in days)	Content of Training (areas covered)	No. of people Trained	Date, Month, Year

2. Mode of training (last attended) :

- a) Audio-visual aids used : No (0) Yes (1)
- b) Single trainer (1) Multiple trainers (2)
- c) Hand out given: No (0) Yes (1)
- d) Case illustrations : No (0) Yes (1)
- e) Time for feedback and discussion: Insufficient (1) Sufficient (2)
- f) Was an evaluation form given at the end of the programme? No (0) Yes (1)

3. Characteristics of the group (last Training Programme):

- Only CLWs (1) Self help members (2) Students (3) NGO staff (4)
Govt. employees (5) Heterogeneous (6)

4. Were you Satisfied (1) Unsatisfied (2) with

- (A) Content____(B) Venue____ (C) Basic comforts ____ (D) Expertise of trainer____
(E) His/her ability to communicate and interact with the group____
(F) Nature of audio-visual material____ (G) Nature of hand-outs____
(H) Practical tips____ (I) Language used____

5. What could have been better according to you to make it more effective?

6. What have you been doing after the training programme?

I) Used the knowledge to provide PSS to Tsunami victims	II) Knowledge was useful, but did not have a chance to use it on the field because: a) Did not have a job after tsunami b) Had a job, but no opportunity to use the skills learnt c) Could not offer PSS since I was personally affected by the process.
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If I), then proceed if II) stop here

7. How did you provide this support:

- a) As part of your regular JOB: describe in a paragraph the kind of job.

- b) After office hours in a regular way (part-time/volunteer):
 - c) Did it informally in neighbourhood and known places.
8. If intervention provided
- a) How many people did you provide intervention for?
 - b) What were their problems?
 - c) What was the intervention and How did you provide it?
 - d) What was the improvement/change seen in persons who received your help? Give example.
 - e) How often did you follow-up the same person after initial contact?
 - f) When did you deem him/her sufficiently recovered to withdraw services?
 - g) What happened to cases that you felt that you were not equipped to handle?
 - h) Have you referred cases that you have seen in the field?
 - i) Who did you refer them to?

9. How do you think this training was useful to you as an individual (to handle crises etc.)?
No (0) Yes (1)

10. Would you like to undergo some more training ? No (0) Yes (1)

11. If yes, specific areas (mention)

12. How did you think your PSS was effective? Provide one or two case illustrations.

13. Did the local community appreciate the help you were rendering them?
No (0) Yes (1)

14. Did you recommend this to others? No (0) Yes (1)

15. Do you think this training will be useful to you in future disasters if any?
No (0) Yes (1)

16. Would you like to become a professional counselor if possible?
No (0) Yes (1)

Efficacy of PSS programs in tsunami affected areas

Families affected by Tsunami

Name: _____ Age (in years): _____

Gender: Male (1) Female (2)

Address:

Home: _____ Office: _____

Education : Schooling (1) UG(2) PG (3) Others (4)

Occupation :

Marital status: Unmarried (1) Married (2) Widowed/Divorced (3)

1. How many members of your family were affected by Tsunami? List them below with relationship.

- Death (1),
- Separation (2),
- Loss of work (3),
- Physical health problems (4),
- Mental health problems (5),
- Others (6)

2. What were the psychological problems that members in your family faced?

- (A) Anxiety(1), Depression(2), Sleep disturbances(3), Nightmares(4),
Fears(5), Exacerbation of pre-existing mental illnesses alcohol intake(6),
Others specify.....(7)
- (B) Children: Bed wetting(1), Refusal to go to school(2), Sleep problems(3),
Night terrors(4) Others specify.....(5)

3. Not going to work (why):

4. Did you receive any psychological interventions for the problems faced?

No (0) Yes (1)

5. What help did you receive:

Counseling(1), Medication(2), Hospitalization(3), Groups therapy(4),
Play therapy(5), Recreational therapy(6), Combinations(7), Others specify(8)

6. Who provided help: (name org):

Self help group members(1), Religious groups(2), Mental health professionals(3),
Local field workers(4), Volunteers(5), Other social groups(6)

7. How long after tsunami was intervention provided for:

Continuous(1) Intermittent (2), duration in days:

8. Did you find it useful ? No (0) Yes (1)

If Yes, How ?

Efficacy of PSS programs in tsunami affected areas

General community: local leaders, key informants & self help group members

Name: _____ Age (in years): _____

Gender: Male (1) Female (2)

Address:

Home: _____ Office: _____

Education : Schooling (1) UG(2) PG (3) Others (4)

Occupation :

Marital status: Unmarried (1) Married (2) Widowed/Divorced (3)

Were you/your family/ friends affected by Tsunami in any way- explain.

- 1. Do you think there were a lot of psychological problems in the community after tsunami
No (0) Yes (1)

- 2. What were they? Can you give some: examples.....

- 3. What were their indicators?

- 4. Roughly what % of the local community had these problems?

- 5. Who had more : men(1), Women(2), Children(3), Elderly(4), Disabled(5)

6. Did they realize they had a psychological problem needing help?
No (0) Yes (1)
7. Did they seek help- if so, from whom?
8. Were there pss groups in your community?
No (0) Yes (1)
9. What did they do?
10. Was their support consistent?
No (0) Yes (1)
11. Was it effective?
No (0) Yes (1)
12. Do you think there should be locally trained people to offer pss after crises?
No (0) Yes (1)
13. Were you satisfied that these pss groups did enough?
No (0) Yes (1)
14. Mention any three good aspects of PSS Programmes:
1.....
2.....
3.....
15. Do you think psychological first aid is an important component of disaster management programs?
No (0) Yes (1)

Efficacy of PSS programs in tsunami affected areas

Individuals affected by Tsunami

Name: Age (in years):

Gender: Male (1) Female (2)

Address:

Home: Office:

Education : Schooling (1) UG(2) PG (3) Others (4)

Occupation :

Marital status: Unmarried (1) Married (2) Widowed/Divorced (3)

1. Received Intervention? No (0) Yes (1)
2. Were you affected ? No (0) Yes (1)
3. Did you witness the tsunami? No (0) Yes (1)
4. Were you swept away/injured by the waves? No (0) Yes (1)
5. Did you witness others being affected? No (0) Yes (1)
6. Loss of family, friends No (0) Yes (1)
7. Loss of livelihood, property, No (0) Yes (1)
8. How did it affect you? (Describe)

9. Did you suffer from
Anxiety (1), depression(2), sleep disturbances(3), nightmares(4), fears(5),
exacerbation of pre-existing mental illnesses alcohol intake(6),
Others specify.....(7)

10. Are you going for work? No (0) Yes (1)
If No, Why ?

11.How did you cope (with the problems)?

12.Did you seek any help? No (0) Yes (1)
If yes, from where?

13. Did you receive any psychological interventions for the problems faced?
No (0) Yes (1)

If Yes,

(A) What help:
Counseling (1), Medication (2), Hospitalization (3), Groups therapy (4),
Play therapy (5), Recreational therapy (6), Combinations (7),
Others specify(8)

(B) Who provided help: (name org),
Self help group members (1), religious groups (2),
Mental health professionals (3), Local field workers (4),
Volunteers (5), Other social groups (6)

(C) How long after tsunami was intervention provided for:
Continuous (1) Intermittent (2), duration in days:

14. Did you find Psychological intervention useful? No (0) Yes (1)
Why

15. What are the ps needs that were not addressed in the ps services provided to you?
Please list out:

16. Do you continue to have problems? No (0) Yes (1)

If yes, specify the type of problem.....