ASSESSING THE PSYCHOSOCIAL SUPPORT SERVICES FOR DISPLACED PERSONS IN PAKISTAN BASED ON SPHERE STANDARDS AND INDICATORS

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ABSTRACT

Objective: *To describe the psychosocial services available at a camp in Mardan District.*

Methodology: *This cross-sectional study was conducted at Jalalah Camp in Mardan District with 10,500 displaced persons from June to August 2009. A questionnaire based on sphere handbook was administered to heads of 128 families using systematic random sampling. Camp administration and providers of different facilities in the camp were also interviewed to assess psychosocial support available.*

Results: *The average household consisted of 7.2 persons (including 4.2 children per family). Reported availability of social services varied widely: schools (95%, n=111), mosques (80%, n=96), recreational facilities for children (73%, n=88), nikah (matrimonial contract) reader (56%, n=67), tracing service (52%, n=62), community celebrations (39%, n=47), space for community celebrations (35%, n=42), graveyard (34%, n=41), and funeral service (30%, n=36). 14 (12%) families reported being informed by the camp administration about situation in their hometowns. 47 (39%) families were offered a part in relief activities. 11% of the families with a disabled member, reported availability of activities for them.*

Conclusion: *The study indicates that funeral services, space for community celebrations, tracing services, psychiatric care and information flow need significant improvement.*

Key words: *Pakistan, Sphere standards and indicators, Internally displaced persons.*

INTRODUCTION

Pakistan is still recovering from one of the worst armed conflicts of recent times. Almost 3.7 million displaced persons from Swat, Dir, Buner and Federally Administered Tribal Areas (FATA) were forced to settle in camps and host families due to military operations[1, 2]. In a humanitarian disaster, about 30-50% affected people develop signs of psychological distress in varying degrees due to lack of psychosocial support services. In emergencies, rates of mental disorders, especially mild to moderate, are expected to rise[3, 4].

There has always been a need for the development of a humanitarian charter. To cater this need, Sphere project launched in 1997, produced a "Humanitarian Charter" and identified "Minimum Standards" for relief operations in disasters, in the areas of water supply and sanitation, nutrition, food aid, shelter and health services. Mental Health and Psychosocial Support (MHPSS) has already been discussed as a standard in the 2004 Sphere Handbook on mental and social aspects of health, covering standards and indicators for the acute emergency phase of a humanitarian crisis[5, 6]. The standards describe the minimum level to be achieved in a situation and the indicators determine whether or not a standard has been attained[5].

On detailed literature search, we could not find any study assessing the level of psychosocial support for displaced persons. Considering the ongoing humanitarian disaster in Pakistan, this study was conducted to describe the psychosocial services available and to evaluate them in the displaced persons camp, based on sphere standards and indicators.

METHODOLOGY

This was a descriptive, cross-sectional study conducted at Jalalah IDP Camp in Mardan District of Pakistan, situated in a range of 80-135 kilometers from the affected areas and was formally established on May 2nd, 2009. At the time of the survey, Jalalah camp had a population of 10,500 displaced persons distributed in 1,198 tents. The study duration was June to August 2009. The study unit was a family residing in the camp. 10% of the total camp population was sampled i.e. 1050 which equated to approximately 128 families. Systematic random sampling was done with a randomly generated number and then including every 9th family in the survey. The operational definitions used were based on the sphere handbook. A semi-structured questionnaire, designed in local language, which covered one family, was administered to the head of the family (Available on request). Detailed interviews with camp administration, providers of different facilities and spot observations of the camp were also taken into account to assess health center facilities.

Permission from the Institutional Review and Ethical Board, Postgraduate Medical Institute, Peshawar was obtained to conduct the study. Authorization from the camp administration was also acquired after briefing them with the details of the study and sharing the questionnaire with them. Informed consent was requested from the interviewees, which included an agreement of confidentiality of the respondents' personal and family profile. The socio-cultural norms including right to privacy of the IDPs and their households were maintained.

The data was coded, double entered and cross-checked for anomalies. Statistical analysis was conducted using SPSS version 12.0. Variables for key social and psychological indicators derived from the Sphere standards[5] were analyzed as frequencies. Chi-square test was used to test the difference in awareness about tracing and school services between those to whom these were of personal relevance and those to whom they were not.

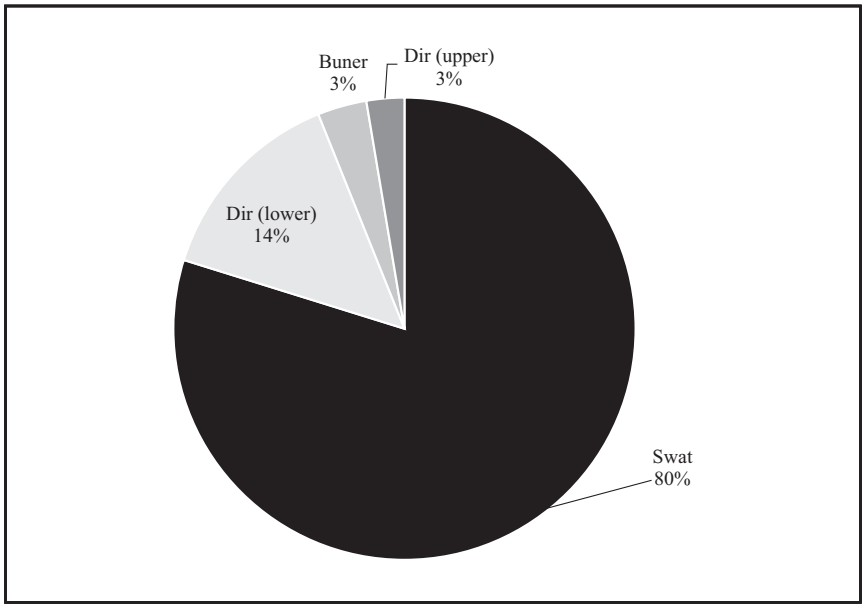
RESULTS

According to the administrative office of Jalalah camp, the healthcare services present at the time of survey were offered by Al-Khidmat Foundation supported by Pakistan Islamic Medical Association (PIMA), Merlin, Peoples Primary Healthcare Initiative (PPHI) and Rahman Foundation. None of these facilities were equipped with mental health services or a supply of psychotropic medicines, and they were referring 4 to 6 psychiatric patients per day to tertiary hospitals.

Heads of 8 families were not available, yielding a final sample size of 120 families (response rate: 93.75%). They arrived on an average, 60 days ago (median = 60), with the earliest arriving 92 days ago and the latest arriving 45 days ago. The average household size was 7.2 persons per family (2-15). The average household had 4.2 children. Figure 1 describes the camp population by district of origin as reported by the camp administration.

The camp administration reported designated services for tracing the missing people

Figure 1: Camp population by district of origin



provided by governmental and non-governmental agencies. On observation, record keeping in both the facilities was incomplete and lacked a standardized format and in addition, the non-governmental service had no staff in the afternoon.

Among the families we surveyed, children of 14 (11%) families did not relocate with them. Of these children of 6 (43%) families are still missing. The ones that reunited with their families took on average 12 days to reach their families. At the time of survey, a total of 9 (7%) families reported having missing members including both children and adults. Of them 6 families (67%) were unaware of a tracing service available at the camp. However, 52 families (47%) without a missing member, were also unaware of a tracing service and difference in awareness between families with missing members and no missing members, was not statistically significant (p = 0.252). When asked about co-location of family members and relatives, 17 (14%) families reported having family members not living within the same household and 42 (36%) reported having most relatives living within the same camp.

According to the administration, there were 8 schools in the camp at the time of survey, four each for boys and girls, established by the Government and UNICEF. Our survey revealed that 100 families (83%) had school going children before they left their hometown. 111 (95%) families were aware of school facilities in the camp and 96 (80%) families reported that their children are using these facilities. However, awareness about school facilities in families with no school going children was significantly lower than other families ($p < 0.001$).

Families were asked about presence of various social services. Their awareness varied widely for various services, and is shown in Figure 2. The camp administration also reported presence of all these services with special emphasis on sports, child excursion and community meetings.

Only 47 (39%) families reported that they were offered to take part in relief activities. In deciding a place for construction of mosques, schools, sanitation facilities and water pumps respectively, 21 (18%), 21 (18%), 20 (17%), and 19 (16%) families reported being consulted by camp administration.

Of 120 families, 14 (12%) reported that the camp administration had informed them about the situation in their hometowns after arrival, although a television is available in the camp. When asked about the mode of information about daily activities, 53 (44%) mentioned directly through administrative office, 24 (20%) said pamphlets, 23 (19%) said mobile teams, and 18 (15%) mentioned mosques.

28 (23.3%) families had orphaned or members with disability, of which only 3 mentioned social involvement activities available to involve them. The camp administration also reported absence of any rehabilitation and recreation facilities for the disabled. The camp does not maintain a database of disabled and orphaned individuals.

25 (21%) reported a family member experiencing vivid imagery related to a violent memory. 19 (16%) families reported a family member with a previously diagnosed mental disorder, of which 13 (68%) are still receiving

Figure 2: Awareness about social services in the camp

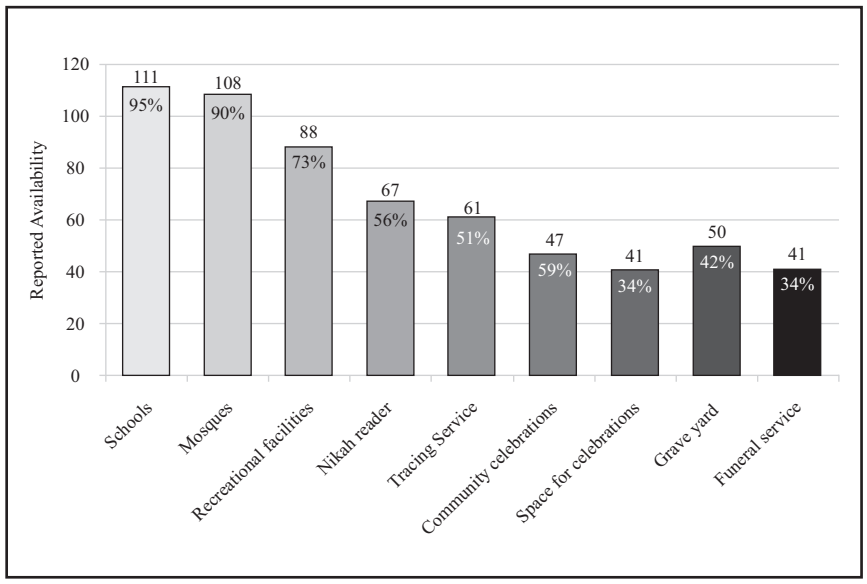


Table 1: Details of all the camps for displaced persons in Khyber Pakhtunkhwa, Pakistan

	Camp	No. of Families	No. of Individuals	Organization working in Health
1.	Kacha Ghari 1	1,514	8,850	Merlin, CERD, PAIMAN
2.	Kacha Ghari 2	924	5,466	Merlin, Edhi Foundation, CERD, PAIMAN, PVDP
3.	Jalozai	2,122	14,857	PPPHI, PIMS, Ummah Welfare Trust, Benazir Shaheed Hospital, Al-Khidmat Foundation, Hamza Foundation, Pak Army, PAIMAN
4.	Palosa	586	3,577	EDO Health, PPHI, Relief International, Hashoo Clinic, UNFPA, PVDP
5.	Jalala	1,198	7,239	Ummah Welfare Trust, Aghaz, Rehman Foundation, Hamza Foundation, Merlin, Merck, Al-Khidmat Foundation, Khubaib Foundation, PPHI,
6.	Shiekh Shehzad	1,372	8,153	Ummah Welfare Trust, IMC, Hamara Foundation, EDO Health, Frontier Foundation, PPHI, Muslim Hands, Merlin, Pak Army, UHS Lahore
7.	Shiekh Yaseen	1,074	10,226	FPHC, Merlin, Ummah Welfare Trust, FATA, NHA, EDO Health, Al- Khidmat Foundation, PPHI
8.	Rangmala	1,326	8,059	PRCS
9.	Palai	198	1,592	PRCS
10.	Shah Mansoor	3,329	21,022	ICRC/PRCS, PPHI
11.	Yar Hussain	6,094	274,968	Health Department, Bahria Town, PPHI, PVDP
12.	Mazdoorabad	889	4,840	Merlin, CRDO, MSF, CERD
13.	Banazir	400	2,550	PRCS
14.	Sakhakot	151	874	Health Department
15.	Degree Coll. Timergara	375	2,708	Al-Khidmat Foundation, I CRC/ PRCS
16.	Sadbar Kalay	545	3,361	UNFPA, EDO Health
17.	Samarbagh	518	3,865	MSF
18.	Larama	847	4,323	PPHI, Al-Khidmat Foundation, UNICEF, Abaseen Foundation
19.	Saleem Sugar Mills	704	3,753	Health Department, PAIMAN, PPHI, Al-Khidmat Foundation
20.	Commerce Coll. Timergara	426	2,857	ICRC/ PRCS, Health Department, Al-Khidmat Foundation
21.	Girls Coll. Timergara	375	2,708	PRCS, District Government, Al-Khidmat Foundation
22.	Technical Coll. Timergara	273	1,951	ICRC/ PRCS
23.	Kund Park	1,000	5,722	Mobilink, UN Habitat
24.	Pitao	500	3,008	PRCS

1. CERD = Center of Excellence for Rural Development
2. PAIMAN = Pakistan Initiative for Maternal and Neonatal Health
3. PVDP= Pakistan Village Development Program
4. PPHI= Primary Peoples Healthcare Initiative
5. PIMS= Pakistan Institute of Medical Sciences
6. EDO Health= Executive District Officer Health
7. UNFPA= United Nation Population Fund
8. UHS Lahore= University of Health Sciences Lahore
9. IMC= International Medical Corps
10. FPHC= Frontier Primary Health Care
11. FATA= Federally Administered Tribal Areas
12. NHA= National Highways Authority
13. PRCS= Pakistan Red Crescent Society
14. ICRC= International Committee of the Red Cross
15. CRDO= Community Research and Development Organization
16. MSF= Medicine Sans Frontier
17. UNICEF= United Nations Children's Fund

regular medications and 3 (16%) had abruptly stopped their medications upon leaving town.

DISCUSSION

Pakistan's dismal budget allocation for mental health is insufficient to cater the mental health problems of the country which is mounting to an alarming proportion periodically under the effect of traumatic situation including terrorism and counter terrorism[7]. Investment is therefore imperative, in effective health care that proves to be sustainable over long term under limited resources to tackle such crises[8].

Magnitude of the Problem

Table 1 provides a list of various governmental and non-governmental relief camps setup for the IDPs along with their population figures[9]. Only a small proportion of the population typically resides in the camps while the rest lives with the host families, as stated by the camp authorities. While most of these camps do have some form of health care services running, only one (Pakistan Islamic Medical Association working with Al Khidmat Foundation) reported having launched a Community Mental Health Pilot project (CMHP) and were planning on extending the facility to other IDP Camps including the one being studied[10, 11].

PSYCHOSOCIAL SERVICES IN THE LIGHT OF SPHERE STANDARDS AND INDICATORS

KEY SOCIAL INTERVENTION INDICATORS

a) Flow of credible information

According to our survey, few families were receiving information regarding the situation in their hometowns, and it was largely via the administrative office. In the context of humanitarian disasters, it is believed that the level of distress is decreased by providing information following disasters as the possibility of rumors, speculation and misinformation is reduced and this flow of information also creates trust between the community and relief workers[12]. The gap which is evident from the survey needs to be bridged.

b) Maintenance of normal cultural and religious events

The awareness about cultural and religious services and events varied widely in our survey, suggesting either absence or non communication of some of the services. The participation in cultural and religious events not only helps adults but this can be a very positive factor in the children's lives as it can help in the use of traditional coping resources, which in turn reduces the distress in them[13].

c) Access to schooling and recreational activities for children and adolescents

The establishment of schools in camps has always been considered a priority and United Nations Children's Fund (UNICEF) and the United Nations Educational, Scientific and Cultural Organization (UNESCO) even developed the "school in a box" programme in Rwanda in an emergency situation[14]. Also in similar situations, even the suffering youth have pointed out the need for the continuity of education as was the case in Eritrean and has been proved effective in reducing humiliation and stigma, augmenting social support networks and providing safe space as happened in Ingushetia, Chechnya [15,16]. During the interview with the administration, we were informed that there were 8 schools in the camp.

The survey showed a positive trend in parents about sending their children to school and this was a ray of hope among otherwise disappointing statistics. It has been seen that recommencing school sends children the message that they are expected to restart their normal roles as students, offering positive expectations for adaptation [17].

Restoring normal recreational activities for children is important in terms of showing consistency with the continuity principle which stipulates that, "through all stages of disaster, management and treatment should aim at preserving and restoring functional, historical and interpersonal continuities, at the individual, family, organization, and community levels"[18]. In our survey, most families were aware of recreational facilities although they were not satisfied with these. Positive outcomes including improved behavior and attendance at school and decreased isolation, violence and aggression were found when a psychosocial programme was assessed in Angola, involving recreational facilities such as drama and football[19].

d) Participation in emergency relief activities

Although most of the IDPs were assumingly jobless, and could have been actively involved in the rehabilitation process, our survey showed that only 39% families were offered a part in relief activities. There have been examples where useful strategies have been employed, as in Sri Lanka in 2002, youths aged 12–18 assumed an active role in developing community projects, such as constructing schools and re-establishing bus services[20]. Also in children, in otherwise disempowering circumstances, participation in community activities is believed to assist them in developing a sense of efficacy[21].

e) Inclusion of orphans, widows/widowers and persons with disability, in social networks

Only few of the families with orphaned or disabled members mentioned any social involvement activities. The camp does not maintain a database of these individuals. Recommendations, contrastingly, suggest that such activities should be freely available to the community. However, activities and programmes for widows or orphans should be carefully designed to avoid the stigma associated with these [22].

f) Establishment of a tracing service

Our study revealed that while there was a tracing service available in some form, no formal survey had been conducted to actively detect missing persons in the different households and consequently there was no database of those missing.

Few families had their children separated during relocation, and many were still missing. The ones that reunited took on average 12 days to reach their families, which is reasonably quick in terms of preventing long term separation effects.

Reunification is a difficult process and if delayed may increases distress[23]. Therefore, a quick, consistent and coherent approach is required to facilitate and speedup the tracing process.

g) Keeping family members and communities together

The attachment theory suggests that people in high stress times, have a biological instinct to seek proximity to attachment figures which in turn can offer a sense of security and diminish distress [25]. In our study, most families had their immediate family members living within the same household, although the relatives of many were not situated in the same camp. The figures suggest another area for improvement of psychosocial support.

h) Involvement of community in decision making

The involvement of community in decision making process was minimal as was evident from low rates of consultation in planning the construction of facilities. Evidence shows that a sense of control and agency is created in the community members when they are consulted and this also helps in the cultural context of the programme[12].

KEY PSYCHOLOGICAL AND PSYCHIATRIC INTERVENTION INDICATORS

a) Access to psychological first aid

Psychological first aid is a "non-intrusive emotional support, assistance in covering basic physical needs, protection from further harm, and when appropriate, providing or mobilizing social support"[26]. Psychological first aid may reduces distress and prevent development of psychiatric disturbance[27], but unfortunately in this camp, no psychological first aid was available as revealed by the interviews with the camp administration and the survey.

b) Availability of care for urgent psychiatric complaints and provision of essential psychiatric medications at primary health care level

Health prevention and promotion activities at primary health care level in the camp have had virtually no psychosocial component, so no care of urgent psychiatric complaints was possible, despite the fact that 21% families reporting a member experiencing violent memory related vivid imagery, this is obviously a significant gap in care. Also, there was lack of essential psychiatric medications at the primary health care level facility in the camp. The WHO stresses on the integration of mental health care into primary health must not be forgotten in this context[28], which helps provide a non stigmatizing environment for the treatment of mental disorders[29].

c) Treatment provision to individuals with pre-existing psychiatric disorders

According to our survey, there was no treatment provision for people with previously diagnosed mental disorders. Some had to stop their medications abruptly due to unavailability of psychotropic medications in the camp. Mental health needs may be greater in those with pre-existing psychiatric conditions and they may be the first to seek help from mental health services after an emergency, as seen among children in Kosovo and adults in East Timor[30,31]. Financial constraints may be a factor in limiting patients' purchasing power, which makes the patients, especially children, prone to premature discontinuation and worse clinical outcomes[32] and increase the risk of psychiatric relapse[33].

d) Plans for post-disaster phase

During the detailed interview with the camp administration, the aftermath and plans were discussed for providing mental health and psychosocial services in the camp. This involves not only the provision of services to the patients but also local "context-driven" *training in mental health to the available PHC staff to improve their knowledge and practice*[34]. Several authors suggest that these trainings should begin with the onset of exigency[35-37], and still others suggest their continuation after the exigency[6-29]. Continuous supervision and support, however, is mandatory to

achieve effective mental health care in primary-care settings[38] and the researchers and international agencies should focus on the interventions to change health professionals' behavior and practices in developing countries[39].

CONCLUSION AND RECOMMENDATIONS

Given the high burden of psychiatric disorders and an already low level of access to psychosocial services in these areas, a national strategy to deal with psychosocial needs of displaced populations is imperative. The authors propose that this strategy should aim at integrating psychosocial services with primary care in disaster situations. This can be done by training the primary health care workforce through a disaster preparedness program. In addition, agencies managing IDP camps should ensure provision of psychosocial first aid, psychotropic medication and appropriate referral to specialist centers. There is a lack of evaluative studies of the field operations based on Sphere standards in Pakistan. The authors thus suggest that multicenter studies in this area be conducted to validate the sphere standard tools on a transcultural basis and help in relevant revisions of sphere handbook.

LIMITATIONS

1. This is a descriptive study evaluating various areas of psychosocial component of sphere handbook. Further studies comparing refugees in different settings across the world are needed to compare services and look at outcomes.
2. The assessment of psychiatric disorders in this survey is limited to a service level and does not involve patient assessment. As such this survey reveals the general lack of psychiatric services but does not quantify specific disorders or the quality of care.
3. The study focused on assessing basic psychosocial framework with less regard to comprehensively assessing the meso and micro levels.

ACKNOWLEDGEMENTS

The authors would like to pay their heartfelt gratitude to the management of Peshawar Medical College for the overall support. The volunteers of Social Welfare Society of the College (Adeel, Jawad, Kashif, Nasir, Naveed, Niqad, Qasim, Sajjad, Sameer, Sardar and Waqar) also merit special mention for their hard work in data collection process. The study would have been a hard task to realize without the help of Dr. Muhammad Sharif, Focal Person for community service projects of the College. The authors are equally thankful to Naila Riaz Awan and Kashmala Awal Khan, who entered and cross-checked the data.

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