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Basic versus focused psychosocial interventions for community wellbeing: lessons following the Nargis cyclone interventions in Burma/Myanmar

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Psychosocial interventions in Burma/Myanmar are a new phenomenon. Following the Nargis cyclone in Burma/Myanmar, assessments highlighted a clear need to address the psychosocial issues in local communities. Within the existing socio-political constraints, nongovernmental organisations (NGOs) tried to address these issues in different ways. National NGOs tried to help communities by organising community based psychosocial support programmes. This paper describes and analyses two models of psychosocial interventions. One project was purely focused on community and group interventions, while the other project had also targeted interventions for individuals and groups within a multi-layered approach. These psychosocial projects are not just an end in themselves, but form the basis for further development programmes and coordination with other actors on the ground. It is important that public health providers are involved in the service delivery process from the beginning.

Keywords: Burma/Myanmar, Christian Aid, community based psychosocial services, integrated and focused approaches, Inter-Agency Standing Committee (IASC) guidelines

Introduction

Burma/Myanmar: post Nargis cyclone context

The Nargis cyclone, which hit Burma on 2 May 2008, created large scale devastation. As a result, an estimated 84 537 persons died and 53 836 were missing. The disaster had a severe impact on more than 2.4 million people, mostly in the Delta region (Post-Nargis Recovery and Preparedness Plan, 2008). Around 800 000 houses were destroyed or severely damaged, 1400 schools were destroyed and 783 000 hectares of farmland flooded. There were also many indirect impacts, including limited livelihood security for the poor. The people of the Delta area mainly depend on farming, fishing and casual employment, with about 60% of families involved in agriculture as their primary source of livelihood.

The Post Nargis Joint Assessment (PONJA, 2008) and Post-Nargis Recovery and Preparedness Plan (PONREPP, 2008), report that 23% of the respondents had a family member with psychological problems associated with the Nargis cyclone. Of these, only 11% reported having received treatment. The PONREP reports that 7% of the households reported at least one deceased family member. Save the Children also reported that teachers and children had difficulties to concentrating since the cyclone. (IRIN, 2008). Other NGOs, such as Médicines Sans Frontières, highlighted the need for psychological assistance in Burma/Myanmar (Médicines Sans Frontières (MSF), 2008).

The effect of the natural disaster came on top of the existing political challenges and a *'culture of fear'* that continues to affect the psychosocial wellbeing of communities in Burma/ Myanmar.

While the psychological impact of natural disasters can be long lasting, psychosocial programmes are generally the first ones to be *'completed and closed'*. During our field visits in May 2009 in Labutta, we observed that some community members still had psychological difficulties associated with the cyclone. For example, when there was a weather forecast for a tropical cyclone in April 2009, most of the community members were very anxious and appeared to be overwhelmed by sad and distressing memories associated with the Nargis cyclone. One villager in Labutta reported that even now, a *'normal'* wind can create *'abnormal feelings'* in the village.

Most national NGOs in Burma had little experience in field of psychosocial interventions, Within the *'socio-political constraints'* in Burma/Myanmar, some national NGOs developed innovative and culturally appropriate intervention methods to deal with the psychosocial problems created by Nargis. It is interesting to analyse the efforts made by these national organisations as they are familiar with local culture, support systems and coping mechanisms of the affected communities. This article will describe and analyse two psychosocial programmes implemented by national NGOs in Burma/ Myanmar.

Psychosocial interventions in Burma/Myanmar

In the initial months after the disaster, many national agencies did not know how to foster psychosocial support for the survivors of cyclone. Most agencies were preoccupied with addressing basic physical needs. When some national agencies started managing the relief camps, they observed that many people in the camps and communities had problems in terms of social functioning. There were reports that some were not eating, or not interested in any activities, and this continued even 6–12 months after the cyclone. Some were afraid to go out, as many dead bodies remained scattered throughout the Ayerawadi delta. In the initial needs assessment by national organisations, the social functioning of the survivors appeared severely affected. One year after the cyclone, some individuals reported problems with coping with the death of loved ones, the inability to accept the death of family members and other losses and thereby leading a normal life, and/or a total feeling of hopelessness even up to nine months after Nargis (Shalom Foundation, 2009). The tendency in the rural context of Burma/ Myanmar is to ignore the people and to brand the symptoms as a permanent syndrome associated with the impact of cyclone. In this way, the assumption is that people will overcome these problems naturally. This may be true for many survivors, but some people continue to face difficulties.

The international NGO Christian Aid used its previous experiences in Sri Lanka and other countries (Paratharayil, 2005), to support local faith based organisations affiliated to Buddhism, Christianity and Islam to organise community rituals, bereavement support and burial in Burma/Myanmar. These activities were part of the early phase relief programmes. More systematic interventions were developed at a later stage. In the following section, we will analyse two community based psychosocial intervention models in Burma/Myanmar.

The *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings* advocate for a multilayered support system, consisting of different levels of interventions (Wessells

& Van Ommeren, 2008). One of the projects described model focused mainly on *'basic services and security'* (level 1) and *'community family support'* (level 2), while the second model leaned towards *'focused non-specialised support'* (level 3).

Model 1: a community kitchen to promote community wellbeing

This programme was implemented and managed by Metta Development Foundation, popularly known as Metta (loving kindness), a national NGO based in Burma/Maynmar. With a total of more than 500 staff, Metta reached a large number of communities in the aftermath of the cyclone with different programmes.

One of their psychosocial programmes was the *'community kitchen'* where communities were provided with nutritious meals, while at the same time the intervention intended to facilitate community care and support. This intervention provided space and opportunities for community members to share their personal experiences and encourage each other to move forward. Story telling, recognition of shared pain, grieving together and listening to each other's hopes and aspirations proved to be a collective healing and recovery process. This initiative was owned by the community, and the facilitators of the project were key stakeholders in the village, mostly religious leaders. The first community kitchen started in August 2008 in Bogale township, in three villages, where 75–80% of the infrastructure had been damaged.

The process of establishing community kitchens (Metta Development Foundation, 2008) included: consultation with community leaders and field facilitators about the concept of a community kitchen; selection of sites based on needs and demands of the communities; identification of most vulnerable groups and their needs in villages where community kitchens were to be initiated. Metta supported the villages in activities such as: planning, design and implementation of their own community kitchen programme; provision of inputs to set up community kitchens; launching of community kitchen programmes in selected villages; orientation workshops for all facilitators; development of common minimum operational guidelines through a participatory workshop; monthly updates from the field and documentation team; review meeting and experience sharing on implementing operational guidelines. The community gathering also provided opportunities to share their significant experiences. Those community members would otherwise have not had many other opportunities to discuss these issues and to get mutual group support. While there is a tendency for the community members to be disaggregated in the aftermath of disaster, this community focused intervention provided an opportunity to bring the community together and to strengthen the mobilisation process. As part of this, Metta field staff would facilitate community discussions, focusing on the general situation and the mechanisms to manage the community kitchen. Within this context, the intervention would not be specifically labelled as *'psychosocial'* but, nevertheless, had a *'therapeutic'* impact.

Metta reached more than 4000 people in Bogalay and Ngaputaw. Everyone had a role in the community kitchen. While women and young girls helped to prepare the food, men did the cooking. Children and elders helped with arranging dining areas and feeding domestic animals. Young men helped with collecting water, firewood and shopping for food items. In addition to the cooking of meals, community members also organised activities like: singing, celebration

of local festivals like full moon day (an auspicious occasion in Buddhist tradition), friendship football matches and other sports activities. The project was phased out in a systematic way with less support from Metta and more contributions from the community.

Most of the project beneficiaries were those who had lost some of their relatives in the cyclone, or those who were severely affected by it. The community kitchen provided opportunities for them to come together and to develop a collective support system. For the communities, this was an opportunity to support one another. Other elements that contributed to improved psychosocial wellbeing of communities included recreational activities, enhanced motivation for parents to send their children to school and community companionship for the aged and lonely.

Additionally, the programme might not end here. In most villages, communities are exploring the possibilities of continuing the community kitchen, either with a kitchen garden or '*rice bank*', thereby initiating some development work. Kitchen gardens focus on initiating back yard gardening and generating food yield for the community members. Rice bank aimed to create community owned rice farming, with the assumption that after the harvest farmers would return the seeds, and these would then be distributed to other farmers for the next sowing season. Communities are aware of the need to have some technical support to manage both the Kitchen Garden and Rice Bank. This was to be facilitated by Metta. It has been observed that the group focused livelihood work would be encouraging community members to continue with group sharing and self help mechanisms. These development interventions emerged from the community mobilisation that had occurred through the community kitchen intervention.

Discussion

A similar model to the community kitchen was successfully tested in the aftermath of a super cyclone in Orissa, India in 1999. Action Aid India identified the need to provide community based psychosocial services for the survivors of the Orissa super cyclone. This resulted in the development of '*Sneha Abhiyan*' ('*Campaign of Love*'). As part of this concept, Action Aid provided psychosocial support to those vulnerable sections of the population that were suffering from the psychological impact of the cyclone. (Kishore Kumar, Chandrashekar, Chowdhury, Parthasarathy, Girimaji, Sekar & Srinivasa Murthy, 2000; Bharath, Chandrasekar, Kishore Kumar, Chowdhary, Parthasarathy, Girimaji, Sekar & Srinivasamurthy, 2000). There was an important element of psychological care, and this was provided by lay volunteers with limited professional involvement and supported by the Government of India and Orissa (Lakshminarayana, 2006). This was one of the first models in India to integrate psychosocial services with community care and recreational activities in a post disaster context. The evaluation of this programme showed that this community based psychosocial intervention resulted in decreased emotional distress, increased self confidence, enhanced school attendance for children, and better understanding of the needs of women, especially single women.

In Burma/Myanmar, this community based programme has been purely NGO led and managed, without any government support. It was not just an end in itself for psychosocial wellbeing, but was a means for further community development programmes in the target locations. This model focused on

the basic security provision, as well as activities to foster community and family support. Initial observations show that this has positively contributed to community wellbeing. Although the programme appeared to be very simple and easy to manage, this experience reaffirms the importance of promoting community recovery and self help through an integrated approach in delivering psychosocial services (Inter-Agency Standing Committee (IASC), 2007).

It is important to have adequate trained personnel in organisations to manage and provide leadership for community based psychosocial interventions. This was not explicit in this programme. It was essential to build the capacity of those staff to manage a psychosocial programme. Similar to observations in Bangladesh by Dash & Christensen (2008), the *IASC guidelines* were not available to most of the national agency staff in Burma. It is also important to note that a system for specific impact assessment of psychosocial intervention was not well planned at the outset of the project.

Model 2: focused trauma care for community wellbeing

Since 2002, Shalom Nyein Foundation has been providing psychosocial support and trauma care in Burma/Myanmar. Immediately after the cyclone, the Shalom Nyein Foundation started psychosocial services and community trauma care in the affected areas. The aim of the programme was to help those people traumatised by the Nargis cyclone and to help them accept the realities of the aftermath and to ensure a durable and complete healing (Shalom Nyein Foundation, 2009a). Christian Aid and two other European agencies jointly funded this programme. Shalom carried out an assessment of the psychosocial needs in Mawlamyianggyun and Phyarpon, some of the worst affected villages. One important aspect of the assessment was the coordination with the local agencies and authorities. This paved the way for the entry of the staff to the community, as Shalom was not working in these areas prior to the cyclone.

The trauma care givers came from the community and were usually educated and respected people like teachers, religious leaders and clergy men, Buddhist monks or NGO field workers who were the most educated people in their villages. Caregivers were trained by experienced Burmese trainers. The training included both international methods, such as psychological first aid, basic needs assessment, listening skills and group work, as well as Myanmar Buddhist meditation methods (Shalom Nyein Foundation, 2009a). A total of 229 staff were trained over the course of one week as trauma caregivers. Internationally trained trainers supervised these caregivers and facilitated their refresher training and debriefing. The trainers and other senior project managers were trained either abroad, or by international trainers who were familiar with the Buddhist meditation methods practised in Burma/Myanmar.

At first, healers met with the village heads and elders, and made home visits. They explained the purpose of the visit. For the initial rapport building, they identified a public place like a monastery, school or video hall for organising community and group activities. They organised different community events, like: story telling, action songs, drawing pictures with children and public discussions. They also provided food and recreational materials for the children and adults to get them involved in some of the community focused psychosocial activities. It was also a necessity in the first three months after the cyclone, to gain acceptance by the community. During the first three

months of an emergency, *'hardware'* emergency assistance dominates the service delivery of most of the national and international NGOs. In this context, it is very hard to convince community members to take part in *'soft'* programmes like psychosocial services. To generate interest among community members for psychosocial services, which were not included in the relief packages of most of the aid agencies, the Shalom team arranged talks and supplied leaflets highlighting the need to address the psychological difficulties associated with Nargis. They brought the following general activities in the initial visit to the community: organised entertainment activities for children, organised community discussions on general topics and specifically on issues related to relief and rehabilitation. Contacts established with the existing NGOs were beneficial in initiating discussions. Once accepted by the community members, caregivers could then plan more focused activities. Initial entry and gaining the trust of the community was a challenge in this context.

The caregivers organised community gatherings as an entry point. In these gatherings, they would also organise special activities for children and adults, during which they met adults at night in their house, or another private location. During the initial contacts, caregivers also organised community focused discussions. Once the adults show interest in one-to-one sessions, caregivers could use their Impact of Event Scale (IES). Based on the score of the IES, individual sessions, with a maximum of 12 sessions, were planned. (Shalom Nyein Foundation, 2008).

During follow up discussions, the project staff identified those who needed additional focused interventions. Sometimes, individuals would come forward spontaneously. In other cases, individuals were referred by religious or community leaders. For example, there was an individual who lost more than 12 family members. Though he himself was a religious leader, he could not cope with the deaths in his family. He came forward to have individual sessions. (Shalom Nyein Foundation, 2009b).

Three to six months after the cyclone, many people were still unable to accept the reality that their family members were dead, and did not participate in social events. Some felt so hopeless and grief-stricken that they could not perform daily labour to earn a living wage. Six months after the cyclone, some children were still afraid to go near the sea. As a result of these persistent problems the Shalom staff, decided to organise focused psychosocial services for those who could not cope.

For individual sessions, finding a private space was a challenge, particularly in the initial phase, as other community members were curious to know what was being discussed. The project staff encouraged use of Buddhist meditation methods, particularly a form of transcendental meditation that is widely practised in Burma/Myanmar. People in Burma/Myanmar often go to a Buddhist monastery to meditate and pray. However, the memories of their deceased relatives would often occur when a survivor started meditating about the life of Buddha and his teachings. Some people approached the project staff with the complaint that *'they could not meditate properly'*. They could not overcome the death of their loves ones and this affected their social wellbeing. After four to five individual sessions with the Shalom staff, many were able to better deal with their grief.

The programme helped communities understand the reasons behind certain behaviour in the post cyclone phase, and how to deal

Table 1. Main differences between two psychosocial projects after the Nargis cyclone

Model 2: focused trauma care	Model 1: community kitchen	
Specialised organisation used contacts of other national organisations as their main entry points.	Organisation used their existing development programme,	Community entry
Focus on individual methods (behavioural interventions) and limited community oriented interventions and group activities.	Started with community activities and had (limited) individual activities. Strong emphasis on group activities.	Intervention base
Specific documentation and monitoring methods for trauma focused psychosocial interventions	Used existing development programme monitoring system, which has the advantage that it is readily available, but the disadvantage that it is less specific.	Monitoring mechanisms
Specialised staff with significant investment in staff training and follow up	Existing and additional development staff with fewer specialised staff, and some capacity building support	Staffing
Coordination with nine NGOs in the service delivery mechanisms. Limited links with existing public health providing structures	Strong coordination with other local actors such as community based organisations and local religious institutions.	Coordination with other health providers
Project is still implemented and does not have a withdrawal plan yet. It is challenging to make these services sustainable due to dependency on external training and supervision	Clear withdrawal strategy and clear communication on fewer inputs from the agency side. Relatively high change for sustainability	Withdrawal strategies & sustainability
Tries to link with other agency development programmes and plan to continue the interventions with further funding	Organisation explores further development programmes within their existing model like community garden and rice bank,	Future developments

Table 1. (continued)

Model 2: focused trauma care	Model 1: community kitchen	
No significant relief programme, apart from trauma care. Difficult to convince the community members that the project was only providing psychosocial services.	With this intervention the individuals who are highly symptomatic and in need of more specialised care cannot be helped	Challenges

with it. Children felt more comfortable to go out and play with others. In some of the most severely affected areas, schools were not fully functional. Group activities, play and drawing sessions with the children helped them to get back to a normal routine. In the first phase, Shalom reached almost 30 000 people in around 5000 households.

Discussion

The approach of Shalom appears to be an individual focused approach. It is, however, contextualised by incorporating Burmese cultural and religious practices and involves the community. An important element of the approach is to *'promote hope'*. This is one of *'five principles of psychosocial interventions after disasters'* highlighted by Hobfoll et al. (2007). It is important to generate a sense of hope in Burma where communities strongly believe in *'karma'* (the belief that actions in a previous life or tat of ancestors determines the current situation), which could lead to demoralisation. It is also important to promote hope in the context of political suppression.

Since Shalom's core expertise lies in psychosocial services and had staff trained in western psychological intervention techniques. In the post cyclone programme, they targeted those individuals who required more focused interventions. I believe there was a genuine need for this. However, a major challenge was that trained caregivers had limited capacity to really absorb western psychological methods. The shortage of appropriately trained staff is a well-known challenge immediately after a humanitarian crisis, and it would have been helpful if caregivers had been trained as part of emergency preparedness measures. There should be caution in the expansion of individual focused psychosocial programmes, given the specific requirements for the scaling up of service delivery, supervision and documentation.

Shalom made use of nine national NGOs in their operational areas. As the organisation does not have other development programmes in these geographical locations, it is unclear how this will be sustained beyond the existing project period. Shalom has plans to integrate psychosocial services within education programmes, but it is not certain to what extent public health providers and the educational sector in the locations are being involved in the psychosocial service delivery process.

Comparative analysis

When we analyse both the programmes, there are interesting observations. Model 1 focused purely on community based interventions. Model 2 had individually focused,

as well as some community focused interventions. In model 1, the implementing agency is a development organisation involved in different development and humanitarian interventions, while the partner agency in model 2 is a specialised agency in providing trauma care services. Table 1 summarises the main differences of the two models.

There were also similarities. For example, both models used existing religious structures such as Buddhist monasteries, Christian churches and affiliated community based organisations. In both methods, the special needs of children was given due attention and physical materials were also provided along with psychosocial services.

Conclusion

The impact of the Nargis cyclone on the lives and livelihoods of communities in Burma/Myanmar will last for a long time. Community based psychosocial interventions, such as community kitchens and trauma care programmes are stepping stones for the communities to cope with the impact of cyclone and to rebuild their lives and livelihoods. The two psychosocial projects described in this article have generated positive results in some of the worst affected villages, which are very remote and inaccessible. While community based approaches were developed, it is important to integrate these interventions with existing public health delivery mechanisms and also other development actors. Existing health care delivery system should be strengthened to carry out similar type of interventions.

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