Module-1

National Disaster Management Training Module

Psychosocial First Aid

March 2023

Jointly Developed by

National Disaster Management Authority
(NDMA)

National Institute of Mental Health and Neuro Sciences
(NIMHANS)

National Disaster Management Training

Module-1

Psychosocial First Aid

Authors

Dr. K. Sekar
Dr. Jayakumar C
Dr. Patrick Jude

NDMA, New Delhi
NIMHANS, Bengaluru

National Disaster Management Training Module-1
Psychosocial First Aid

Supported by
National Disaster Management Authority,
Government of India,
NDMA Bhawan,
A-1, Safdarjung Enclave,
New Delhi – 110029.

Published by
NIMHANS, Bengaluru
NDMA, New Delhi.

Layout & Printed by::
Futura Digital Colour Press
4/4, 3rd Main, Tata Silk Farm
Near Yediyur Lake
Bengaluru - 560 082, INDIA.
E-mail: futuradigital1@gmail.com

Edition First, March 2023

When citing this manual, the following citation should be used:
National Disaster Management Training Module-1, Psychosocial First Aid.

www.nimhans.ac.in
www.ndma.gov.in

CONTENT

FOREWORD

India has the world's best demographic dividend in terms of its population. It is critical to be prepared to respond to disaster outbreaks of rising intensity, particularly in highly populated areas. Disaster experiences vary from individual to individual based on the severity of impact, pre-existing vulnerabilities, his/her coping ability, and availability of community resources. Better readiness during a disaster lessens the damage and leads to more efficient resource allocation. This aids in intervention planning and community integration. Hence, there is a need to develop education and IEC materials on psychosocial care and preparedness for disaster in India.

National Disaster Management Authority (NDMA), New Delhi being the apex body of disaster management in India has been actively engaged in taking appropriate steps to mitigate, prevent, and prepare for threatening disaster circumstances. It also envisions to strengthen and empower all the stakeholders to enhance India's disaster management effectiveness. Towards this endeavor, a collaborative effort with the Department of Psychosocial Support in Disaster Management (DPSSDM), NIMHANS, Bengaluru was carried out. NIMHANS being the nodal center for psychosocial support and mental health care services in disaster management in India has been actively engaged in developing manuals on psychosocial care and preparedness. The team has brought out 5 modules targeting different stakeholders namely, community level workers, health care workers, first responders, GO/NGO personnel, and medical officers.

This module on Psychosocial First Aid (PSFA) is developed for the community level workers to equip them to reach out and intervene the affected people efficiently. The training methodology covers different forms depending on the need of the topic. The types of training include virtual, onsite, and blended approach.

In a country like India, where mental health professionals are in smaller proportion, training community level workers to reach the unreached section of the population it is essential to provide psychosocial first aid immediately after the event of emergencies and disasters. PSFA is rooted on the World Health Organization's (WHO) psychological first aid framework. However, this module is articulated in the backdrop of National guidelines on psychosocial support and mental health services. It stands distinct having its focus also on social factors at the individual, family, and community levels. The images, scenarios discussed, and solutions suggested are tailored to the Indian disaster context, making it easier to use the manual at various levels. The community level workers who have the potentials to respond to the infringing psychosocial needs and concerns of the affected community, would able to provide PSFA effectively with the help of this module.

Sh. Kamal Kishore
Member Secretary
Incharge

Sh. Krishna S. Vatsa
Member

Sh. Rajendra Singh
Member

Lt.Gen. Syed Ata Hasnain (Retd.)
Member

PREFACE

National Institute of Mental Health and Neuro Sciences (NIMHANS), Bengaluru, is a premier institute of mental health and center of excellence in Psychosocial Support and Mental Health Services (PSSMHS). NIMHANS has been spearheading the care and services, capacity building, research and policy in the area of Disaster Management for over four decades. In these four decades of journey NIMHANS, working with central, state and local Governments and CBOs was able to reach the affected communities to mitigate psychosocial trauma and promote mental health.

NIMHANS is also involved in developing policies, programmes and information materials, and providing timely services in all the matters related to disaster across the country. As an Institute of National Importance, NIMHANS is associated with National Disaster Management Authority at various levels, including framing of policies and guidelines. The most significant outcome of this association was the release of NDMA guidelines on Psychosocial Support and Mental Health Services (PSSMHS) in the year 2010 culminating in declaring NIMHANS as a center of excellence in Psychosocial Care for Disasters. NIMHANS was also subsequently associated with various guidelines prepared by the NDMA NIMHANS has also actively provided care and support for individuals and communities along with proposing preparedness programs for the country, in the wake of disasters. The devastating Covid-19 Pandemic underscored the need for psychosocial care and has once again brought the crucial aspect of wellbeing to the forefront. NDMA has strived hard to mitigate the stress of the community during this outbreak and initiated an immediate outreach to provide Psychosocial First Aid through community-based organizations, with technical support of NIMHANS.

NIMHANS being the Centre of Excellence in Psychosocial Care has taken a lead in providing psychosocial care during the COVID-19 pandemic through a dedicated National Psychosocial care helpline for the distressed population. Healing of minds is one of the prime aspect of care in any disasters and rendering immediate care aftermath of event ensures the normalization process.

The National Disaster Management Authority (NDMA), Government of India took a major initiative of achieving this crucial form of care by developing this module in collaboration with Department of Psychosocial Support in Disaster Management (DPSSDM), NIMHANS. This manual aims to capacitate millions of community level workers across India in providing the Psycho Social First Aid for the survivors. I congratulate NDMA and DPDSSM, NIMHANS for having undertaken this initiative. I trust the effective dissemination of this important document will plug some of the gaps, particularly of human resources in providing psycho social support during disasters and emergencies.

Dr. Pratima Murthy
Director,
NIMHANS,
Bengaluru.

AUTHORS NOTE

India is highly prone to different types of disasters due to the geoclimatic conditions and socio-economic vulnerability. As given in the book 'Disaster Management in India' by the Ministry of Home Affairs (MHA), Government of India publication, 2021, India is said to be one of the ten worst disaster-prone countries in the world.

International and national guidelines especially the NDMA's guidelines for 'Psychosocial Support and Mental Health Services in Disasters (PSSMHS)' specify the relevance of community level psychosocial support and psychosocial preparedness for enhancing coping and resilience in disaster prone communities. Undoubtedly, there is a large gap in the need for psychosocial intervention and trained human resource to address the concerns of the disaster survivors immediately after disaster. Therefore, through the current project NIMHANS and NDMA are working collaboratively to bridge this gap by developing the capacity-building resources at national, state, district, and block levels. Unless like available Psychological First Aid (PFA) manuals, this manuals and unique with its emphasis on the role of socio-cultural milieu along with the biological and psychological determinants that shape the experiences of the survivors.

Hence, in this manual, the term Psychosocial First Aid (PSFA) is used. This module is written based on the field experiences of the team. For the better understanding of the readers as many as possible case illustrations covering different age group of people in 42 types of disasters is including. To relate better, culture appropriate art works are given.

The entire module is divided into 3 parts. Part-1 is the information module, consisting 7 chapters. The key concepts of this module are the PSFA strategies proposed by WHO, i.e., 'look', 'listen' and 'link'. In the part-2 facilitators guide is given aligning to the part-1 having 10 hours of session plan (both onsite/offsite). Workbook is given in the part-3. The target group of this module includes; community level workers/ community level health workers (CLW/CLH),NGO functionaries, GO grass root personnel, Panchayat Raj members, spiritual institutions, community volunteers etc. The idea is to circulate it to millions of grassroot level workers at block and district level to capacitate them in PSFA

The work feels half done if we fail to acknowledge the immense support received from different people/ organizations in completing this module, 'Psychosocial First Aid (PSFA)' developed as a part of larger project titled 'Preparation of Psychosocial Care and Preparedness Modules and IEC Materials'.

We would like to extend our sincere gratitude to National Disaster Management Authority (NDMA), New Delhi for the funding support, methodical inputs and periodical review meetings in developing this module. We sincerely thank Shri Sanjeeva Kumar, IAS, Former Member Secretary, Shri Kamal Kishore, Member Secretary, Lt. Gen. Syed Ata Hasnain (Retd) PVSM, UYSM, AVSM,SM,VSM & BAR, Shri Rajendra Singh, PTM, TM, Former Director General, Indian Coast Guard, Shri Krishna S. Vatsa, Member, Shri Alok, IAS, Additional Secretary, Ravinesh Kumar, former financial advisor, Col Kirti Pratap Singh Joint Secretary (Mitigation), Ms. Sreyasi Choudry, Shri Harsh Gupta, IAS Former Joint Advisor, Mitigation, Shri Biswarup Das, Joint Advisor (Mitigation) and Ms. Maithreyee Mukherjee, Senior Consultant, Psychosocial Care and Social Vulnerability Reduction for their constant support.

We are thankful to the Director, National Institute of Health and Neuro Sciences (NIMHANS), Bengaluru Dr. Pratima Murthy and Former Directors Dr G Gururaj and Dr B N Gangadhar for their constant guidance and administrative support. We would also like to extend heartful thanks to Dr. Vivek Bengal, Prof. and Head, Department of Psychosocial Support in Disaster Management (DPSSDM) for his continuous support and guidance. Special thanks to Dr. D. Dinakaran, Assistant Professor, DPSSDM for his valuable inputs in shaping this manual.

The insightful discussions from the consultation meeting with different stakeholders, SDMA, DDMA, NGO and experts greatly helped in planning the content of this module. We thank each and every member from SDMAs, DDMAs, first responders, and volunteers who took part in the consultation meeting.

Ms Shoba Ramchandran has done a meticulous job on simplifying the language for the better comprehension of the target population. Mr Govindaraju has contributed in developing the artwork. We thank them both for their time and effort.

We would like to acknowledge all the direct and indirect support received from all the team members of DPSSDM, NIMHANS, Bengaluru. We thank Ms Christella Sowmya for representing different illustration in this module. We would like to appreciate the support rendered by Dr. Balashanthi Nikketha, Dr. Rajamanikandan Savarimalai, Mr. Allen Daniel Christopher, Ms. Sandhya P D, Ms. Jane Maria, Mr. Kannan. M, Mr. Sathish and Ms. Sharmila

LIST OF ABBREVIATIONS

Abbreviation	Explanation
DM	Disaster Management
DDMA	District Disaster Management Authority
DMHP	District Mental Health Programmes
MoHA	Ministry of Home Affairs
NDMA	National Disaster Management Authority
NGO	Non-Government Organizations
NMHP	National Mental Health Programmes
NPDM	National Policy on Disaster Management
NDMTM	National Disaster Management Training Module
PFA	Psychological First Aid
PSFA	Psychosocial First Aid
PSSMHS	Psycho-Social Support and Mental Health Services
SDMA	State Disaster Management Authority
WHO	World Health Organization

LIST OF TABLES

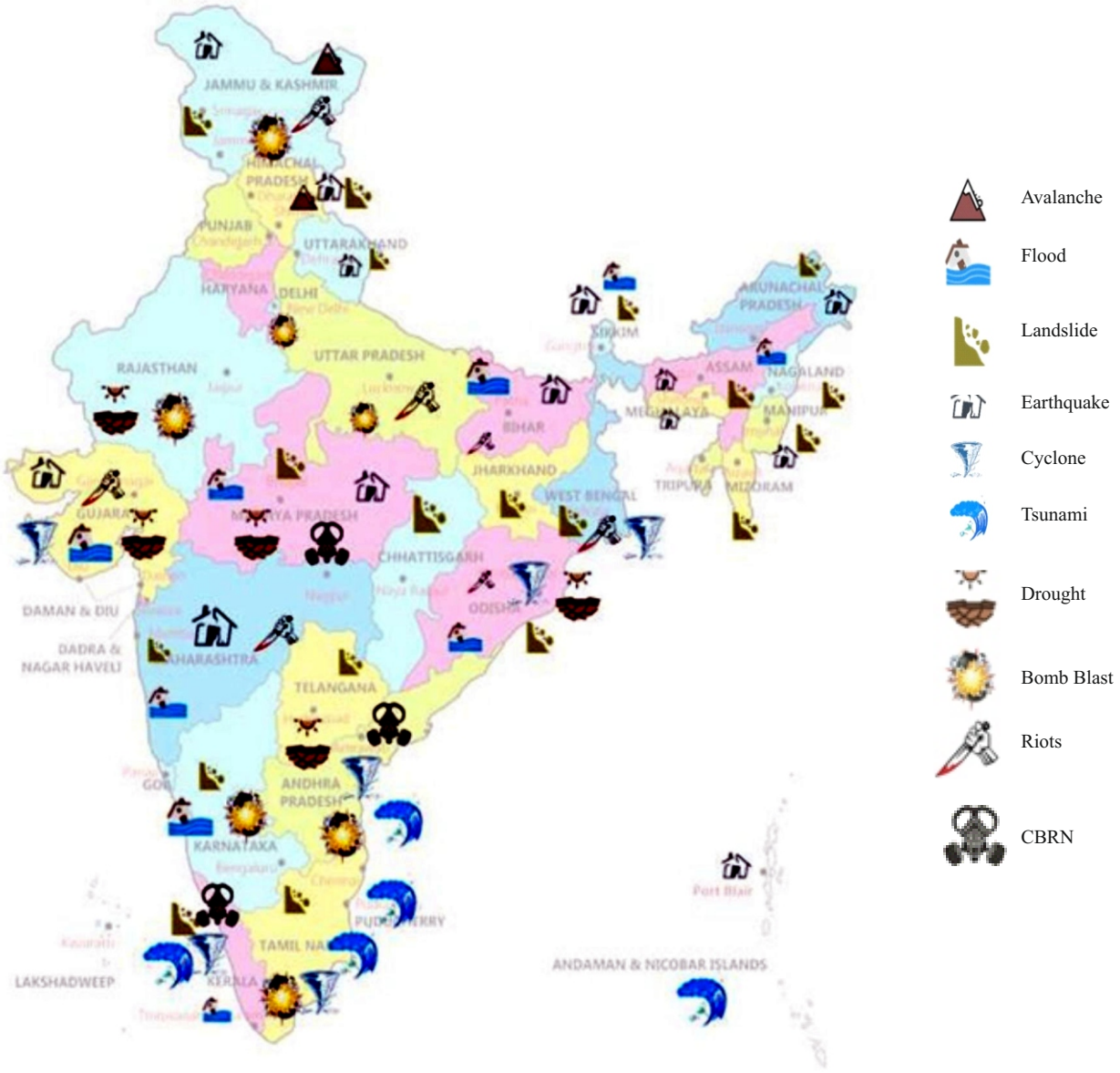
LIST OF FIGURES

CHAPTER 1 INTRODUCTION TO DISASTER

Universally disaster is deliberated as "a serious disruption to the functioning of a community, which causes human, material, economic and environmental losses beyond a community's ability to cope."– UNDRR.

Government of India reflected the same as "a catastrophe, mishap, calamity or grave occurrence in any area, arising from natural or human-made causes, or by accident or negligence which results in substantial loss of life or human suffering or damage to, and destruction of, property, or damage to, or degradation of, environment, and is of such a nature or magnitude as to be beyond the coping capacity of the community of the affected area."– (Disaster Management Act, 2005)

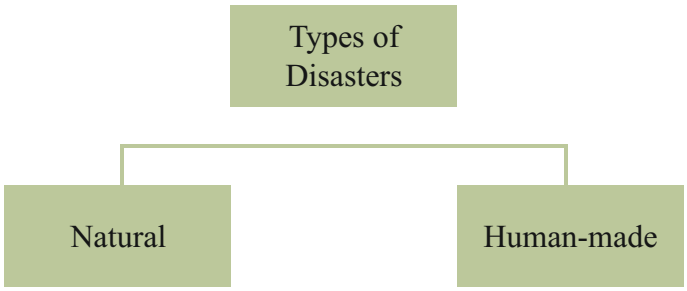
Figure1.1 : Disasters in India



Disaster is not a new phenomenon. Disasters have been taking place world wide constantly with varied degree of severity. Due to the geo-climatic conditions and socio-economic vulnerability India is highly prone to different types of disasters. India is said to be one of the ten worst disaster-prone countries in the world. 30 different types of disasters, including drought, floods, cyclones, landslides, soil erosions, earthquakes have affected Indian communities (NDMA, 2016).

Table 1.1:Examples of deadliest disasters in India	
Bhopal Gas tragedy (Madhya Pradesh)1984	One of the worst chemical disasters; over 10,000 persons died and 55,00,000 injured.
Latur Earthquake (Maharashtra)1993	7928 persons died; over 30000 injured.
Bhuj Earthquake, (Gujarat)2001	25,000 persons impacted; 630000 persons affected.
Indian Ocean Tsunami (Tamil Nadu, Kerala, Pondicherry, Andhra Pradesh, Andaman & Nicobar Islands) 2004	10749 deaths; 5640 persons missing; 27,90000 affected; 11827 ha. crops damaged; 300,000 fisher folks lost their Livelihoods
Kerala Floods,2018	339 persons died
COVID-19 out break (Global), 2019 onwards	COVID-19 pandemic, one of the worst in the 21st century, has, in India, taken the lives of lakhs of people, causing huge socio-economic loss to individuals, families, communities and the nation at large.

Figure 1.2: Types of Disasters



Disasters can be broadly classified into natural and human-made disasters. The severity of the impact, amount of damage and the nature of support required for the affected people indicate if the emergency is a disaster. For example, an earth quake that happens in a desert cannot be termed a disaster as it occurs in a place where people do not live.

Natural disaster: Occur as a result of natural physical phenomena either by rapid or slow onset of natural events (Table1.2).

Human-made disaster: Are events that occur as a result of human actions and settlements. For instance, pollution, environmental degradation, negligence, etc.

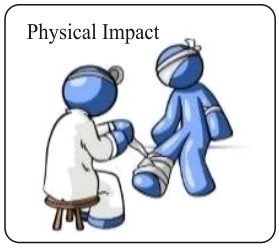
Table1.2: Types of disaster

Natural disasters		
Nature	**Cause**	**Type**
Geophysical disasters	Geological disturbance	Earthquake, Tsunami, Avalanche, Landslide, Volcano, Mass movement (dry), Rock-fall, Subsidence
Meteorological or Climatological disasters	Extreme weather	Storm, Heat/Cold Wave, Drought, Forest Fire, Land Fire, Wildfire, Tropical cyclone, Extra-tropical cyclone, Local storm, Climatological, Extreme temperature, Extreme winter condition
Hydrological disasters	Flooding or movement of water bodies	Flood, General flood, Storm surge / coastal flood, Mass movement (wet), Rock-fall, Landslide, Avalanche, Subsidence
Biological disasters	Micro organisms	Pandemic, Epidemic, Insect infestation, Viral infections disease, Bacterial infectious Disease, Parasitic infectious disease, Fungal infectious disease, Prion infectious disease, Insect infestation, Animal stampede

Human-made disasters		
Industrial accidents	Industrial or infra structural damage or accidents	Chemical Spill, Explosion, Gas leak, Poisoning, Radiation
Communal accidents/ Sabotage	Impatience of humans impacting the safety of other people or destruction of property	Riots, Terrorist Attacks, Bomb Blasts, Stampede
Accidents caused by human negligence	Accident of any transport modalities	Air/ Train/ Road/ Water accidents, Fire Accidents, Building collapse

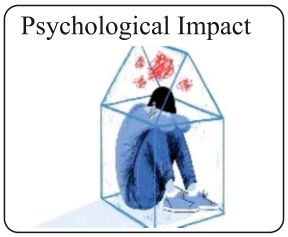
IMPACT OF DISASTER

Irrespective of the type of disaster, any section of society can be negatively impacted- more so individuals, family, and community. Negative impact of disaster is grouped into physical, psychological, economic, and social. Impact must be visualized as a domino effect where disaster triggers a primary impact that can lead to a secondary or tertiary impact.



Significant physical injury varies from disaster to disaster

- Earth quake results in increased injuries
- In riots are people might be stabbed/ burned/ shot
- Floods increase chances for spread of infectious diseases epidemics and skin allergies
- Non availability of basic resources (food, toilet, clothing, etc.) and unhygienic conditions in relief camps affect the health of the survivors
- Vulnerable persons, and chronically ill persons and persons with disability deteriorate in health due to non-accessibility and/or non-availability of medicines
- Survivors experience other physical illnesses like fever, cold, cough, headache, fatigue, body pain.
- Women have increased urinary tract infections along with other physical complaints mentioned above.
- Pregnant women can have miscarriage, still births, and other maternity complications.
- Increased chances of STIs and HIV due to non-availability of contraceptives and sexual violence towards women in relief camps or emergency settings.



Disaster creates a wide range of psychological issues in survivors.

- Shock, denial, sadness, worry, fear, anger, irritability, poor concentration, and anxiety.
- Hopelessness, helplessness, and worthlessness.
- Maladaptive coping like social withdrawal, place or situation.
- substance abuse, self-harm, blaming self or God, low self-esteem, negative ideas about others and life.
- Grief reactions.
- Flashbacks, nightmares, excessive crying spells, sleep disturbances, appetite issues.

Social Impact

Disasters might affect the routine of the communities.

- In relief camps privacy and routine of the families get affected.
- Displacement and migration.
- Loss of lives in disasters might change the family roles and structures.
- Widows and/or separated from their spouse need to seek work.
- Children need to drop out of school to assist the family's survival.
- Emergence of single-parent family and orphans.
- Increase in social evils like corruption, substance abuse, crime, violence and abuse of children and women, human trafficking.
- Social/family ritual get disrupted resulting in disharmony and change in value systems.
- Stigmatization leading to discrimination.
- Disruption of local governance.

Economic impact

The survivors compromise livelihoods subsequent to disaster:

- Financial loss due to damage of property and death or disability of family members, trauma and shock could prevent people continuing with work.
- Increased chance of unemployment or under employment leading to the family being forced to borrow money and end up in debt traps.
- Transport facilities disrupted.
- Environmental degradation subsequent to earth quake and floods might affect livelihoods of farmers and others who rely up on natural resources.

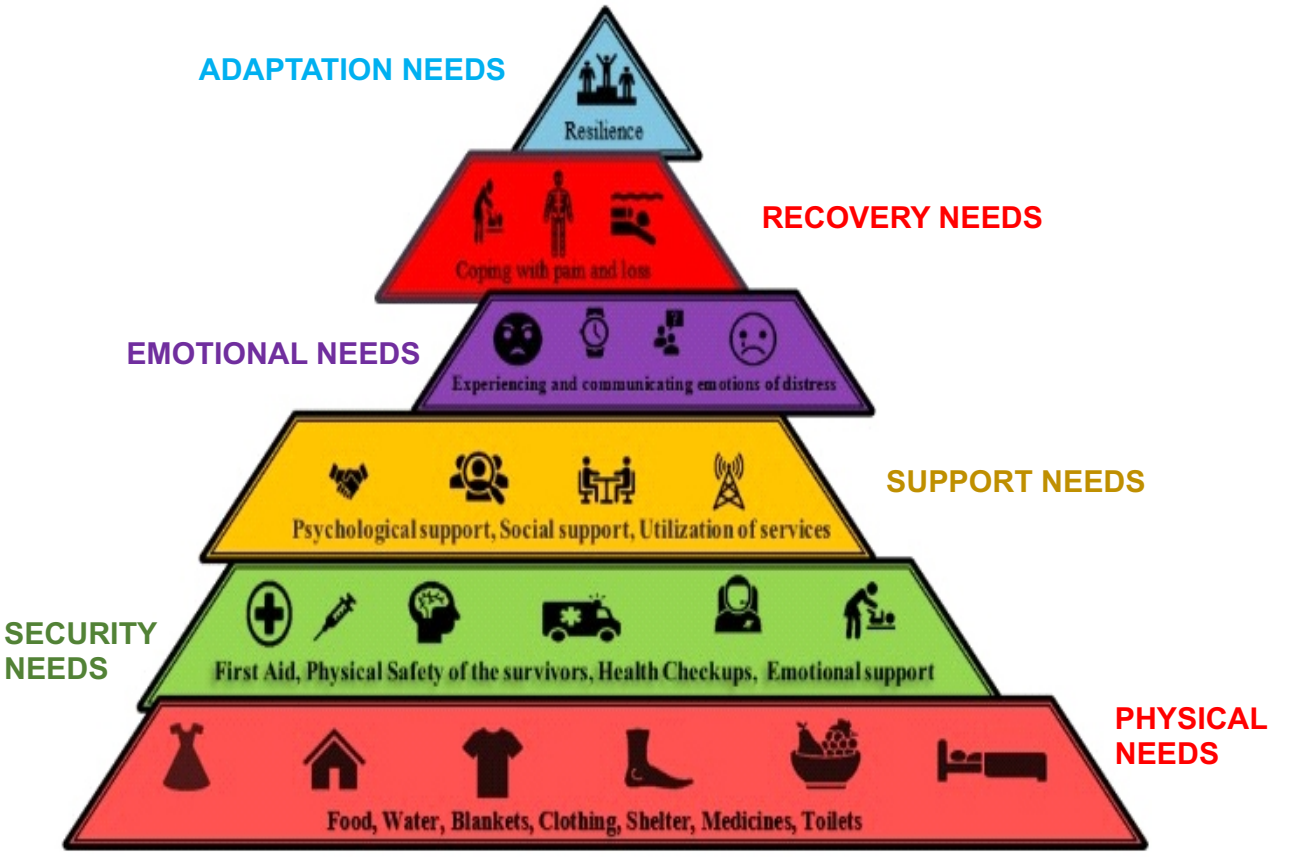
The care provider needs to understand inter linking these impacts and how every thing unites to a psychosocial impact.

- Shock, denial, sadness, worry, fear, anger, irritability, poor concentration, and anxiety.
- Hopelessness, helplessness, and worthlessness.
- Maladaptive coping like social withdrawal, place or situation.
- substance abuse, self-harm,blamingsel for God, low self-esteem, negative ideas about others and life.
- Grief reactions.
- Flashbacks, nightmares, excessive crying spells, sleep disturbances, appetite issues.

NEEDS OF PERSONS AFFECTED IN A DISASTER

People affected by disaster or people living in disaster-hit communities will have diverse needs.

Figure 1.3: Pyramid of Disaster Survivors' Needs



Adapted from: Jordan, 2015

Physical Needs of the disaster-affected communities are basic needs – food, water, clothing, shelter, medicines, and sanitary facilities. These are basic amenities for every individual affected by disasters. Care needs to be taken in being mindful of the physical needs of vulnerable groups (sanitary pads for women, assistive devices for persons with disabilities and life saving medications for chronically ill).

Security Needs aim at improving the safety of the individuals, families, and communities. In any disaster, the safety of the individuals affected might get compromised. As mentioned previously, there maybe increased health needs. Attention has to be taken for medical and psycho social first aid, triaging, and ensuring the safety of disaster survivors especially the vulnerable sections whose safety would be largely affected. Increased crimes and other social evils post-disaster would call for prompt action pertaining to the safety needs of disaster survivors.

Support Needs are tangible and intangible support services for disaster survivors. The loss incurred post-disaster in terms of lives and property need to be compensated with instrumental (money, food, clothing) and expressive support (love, care, affection) services. For many survivors, the primary and secondary support (family, friends, and neighbors) might get largely disintegrated. The available support needs to be retained and linked with tertiary support (Government, NGOs, other institutions, etc.)which would help in enhancing coping and resilience. Care needs to be taken that the survivors are not separated from their families or from the familiar neighborhoods.

Emotional needs help survivors identify the emotions experienced and communicate their distress in a meaningful way. The community members need to be given opportunity to talk about the emotions they are experiencing as an aftermath of the disaster.

Recovery needs are those that help in coping with the loss and pain triggered by any disaster. The healing process might take time and would be different for each individual. Individual, group, and community level practices (cultural practices, rituals, group activities) help in the healing process.

Adaptation needs are the higher order needs for any disaster survivor. Building psychosocial competencies among disaster survivors would yield post-traumatic growth –adaptation, coping and resilience.

It is important to take care of the primary needs (physical, security, support and emotional) be fore focusing on the higher order needs (convalescence and adaptation).

EXPERIENCES OF DISASTER SURVIVORS

Disaster experiences vary from individual to individual and the severity is influenced by the type of loss and exposure, emotional or physical closeness of the individual with the disaster, pre-existing vulnerabilities, his/her coping strategies, and community resources. The experiences of the survivors and their care providers are influenced by the personal factors like, coping, adaptation pattern, bouncing back etc., and immediate environment. The disaster experiences are spread across different phases and help to understand the ‘bouncing back effect’ among the survivors.

Universally disaster is deliberated as "a serious disruption to the functioning of a community, which causes human, material, economic and environmental losses beyond a community's ability to cope."– UNDRR.

Government of India reflected the same as "a catastrophe, mishap, calamity or grave occurrence in any area, arising from natural or human-made causes, or by accident or negligence which results in substantial loss of life or human suffering or damage to, and destruction of, property, or damage to, or degradation of, environment, and is of such a nature or magnitude as to be beyond the coping capacity of the community of the affected area."– (Disaster Management Act, 2005)

Figure 1.4: Phases of Disaster

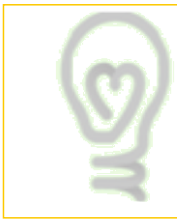
1to3days_____TIME_____1to3years

WARNING PHASE: This is a pre-impact phase. Prompt warnings that are adhered by the individuals or communities reduce the severity of the impact. Adherence to the warnings create a sense of responsibility. Poor adherence results in guilt and self-blame.

IMPACT PHASE: Impact happens unexpectedly and the intensity of loss (life and property) influences the psychosocial consequences of the impact. Predominantly reaction observed among individuals/communities in this phaseis confusion. Poorly prepared communities take longer time to rebound.

HEROIC PHASE: During the evacuation or rescue phase both victims as well as care providers experience high activity levels coupled with low productivity. Keeping family units together and adhering to the cultural ties would help in sustaining the individual/ community heroism.

HONEYMOON PHASE: This phase runs from few weeks to several months after disaster. The affected individuals perceive a sense of positivity through sharing rituals. The expressive and instrumental relief (love, care, money, food, etc.) received from varied sources builds a sense of recovery.



INVENTORY PHASE: The positivity experienced in the honeymoon phase fades and the individuals or community sense inadequacy of resources to rebuild their lives.

DISILLUSIONMENT PHASE: The relief poured in from multiple sources decreases or stops, resulting in physical, psychological, social and economic stressors. The individual/community feels left alone and becomes hostile to others when needs are not matched with there sources.

RECONSTRUCTION PHASE: This phase lasts from months to years where the individuals/community understands the importance of self-sustenance.The individual and community resources facilitate the pathway to reconstruction that generally demands readjustment and integration.

Given below are some of the experiences of disaster survivors:

"When I look back, the horrific images – rising water levels taking us along with our house; no food or medicines; fearing for our lives with my wife and three years old son." 28-yr-old survivor of the Kerala Floods.

"I could not sleep. Anxiety prevailed. More than the fear of death, I was afraid that I might die with out meeting my family and that lone lines haunted me. The only solace were the doctors. It was a moment of hope." 40-yr-old male COVID survivor.

"Locusts came and feasted over the wheat, cumin, mustard, and gram crop. We lost around three lakh rupees. The lock down also added fuel to our suffering." 65-yr-old farmer affected by locusts' attack during COVID.

"Every one was shouting and crying; soil becoming moist with sea water; dead bodies every where; I was shocked, tensed and raged; weeks later they found my husband's dead body; my son … I do not know what happened. I have no one now. I do not know the point of being alive". 32-yr-old female survivor of Tsunami.

"I felt a turbulence; before I realized, the plane crashed; acute pain and distant voices and wailing. When I regained consciousness, I was in the hands of rescuers." 22-yr-old female Mangalore Air Crash, 2010 survivor.

"Uncontrollable coughing; eyes burning; tears pouring out. Outside neighbors were having difficulty in breathing; some were vomiting and some fell. The ambulance rushed us to the hospital". 10-yr-old victim of a toxic gas leak.

The above-mentioned expressions of disaster survivors reveal the overwhelming feelings and emotions the survivors had during different phases of the disaster. One of the key targets of psychosocial support is to allow people to express their feelings, thoughts and emotions. This chapter would be an icebreaker for the participants to share their disaster experiences and to get to know about the experiences of the peers. The facilitator needs to validate the expressions of the participants and should help them in understanding the experience during different phases of the disaster.

DISASTER MANAGEMENT CYCLE

Disaster management cycle involves mitigation, prepared ness, response, and recovery phases. Disasters cannot be prevented completely but the negative consequences of the disaster can be reduced to an extent through coordinated disaster management activities. The emphasis is 'Building Back Better' in all the phases of disaster management. Currently, Disaster Risk Reduction (DRR) has come in to lime light along with relief and rehabilitation approaches. Disaster causes damage to physical, psychological, and social structures. Disaster Management aims at building back the lives of individuals, families, society, and the environment. Along with rebuilding of physical structures, the psychosocial care provider has the role of building psychosocial structures by strengthening the individual's coping abilities, support system, adaptation, and resilience.

Figure 1.5: Disaster management cycle

Source: National Policy on Disaster Management, NDMA, 2009

The disaster management cycle is an ongoing process. Efforts aiming at planning, implementing, and strengthening psychosocial care and mental health services need to be carried out across the disaster management cycle. Psychosocial care planning efforts in the pre-disaster phase accelerate psychosocial care services during and post-impact.

Figure 1.6: Key Phases of Disaster Management

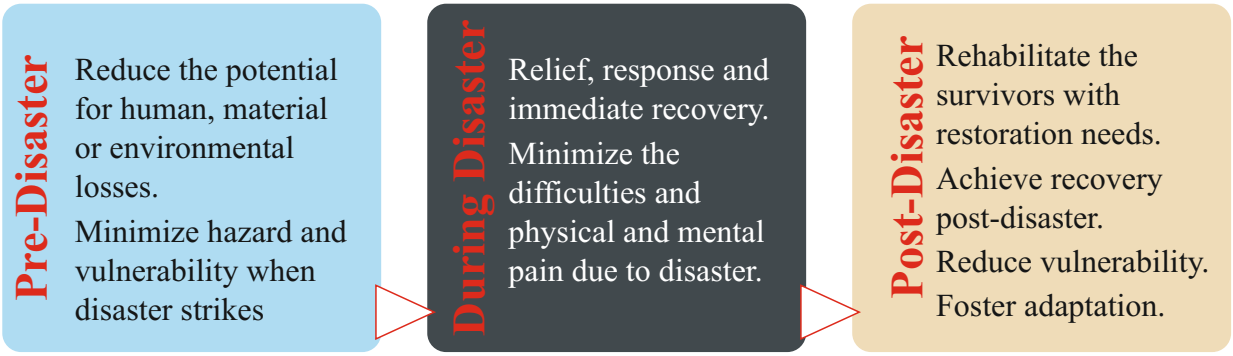
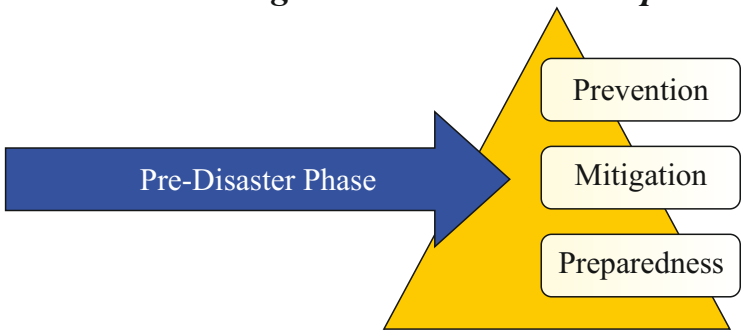


Figure 1.6.1: Pre-disaster phase



Prevention

- Efforts aim at prevention of the probable occurrence of disasters.

Examples: Afforestation (planting of trees), to promote community resilience through healthy coping and by reducing social inequalities (gender, age, caste based discrimination, stigma, poverty, unemployment etc).

Mitigation

- Mitigation is the process of elimination or reduction of the psychosocial impact.
- Mitigation process includes integrating and incorporating psychosocial care plans and policies in the community.

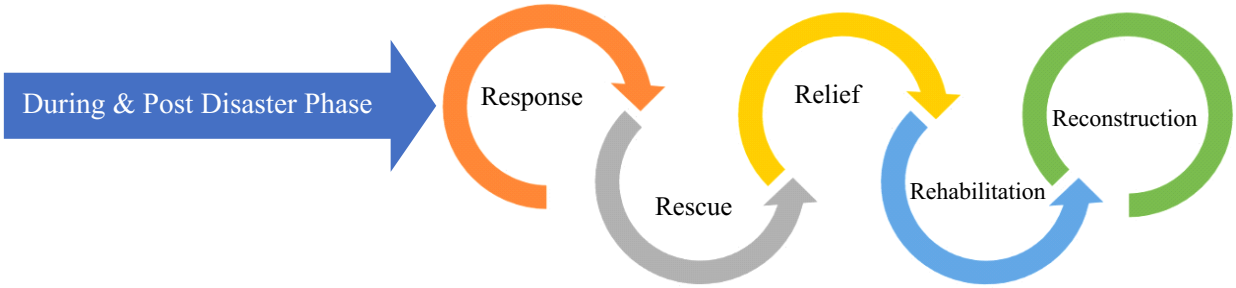
Examples: Effective resource use, analyses of psycho social hazard, risk, vulnerability, capacity building, developing PSSMHS strategies, awareness, and advocacy.

Preparedness

- Involves actions that are planned to reduce the psychosocial stresses and enhance coping and resilience.
- Efforts aim at increasing the psycho social care preparedness by government, organizations, individuals, local community, and other stakeholders.

Examples: Training on psychosocial care preparedness and disaster risk reduction, psychosocial mock drills, table top exercises, psychosocial triage, psychosocial care information directory, and IEC materials for various populations.

Figure 1.6.2: During& post disaster phase



Response/ Rescue (With in 72 hours after a disaster)

- Steps taken immediately after a calamity to ensure everyone's safety, life sustenance, Empower health condition and support the affected population.
- Providing temporary shelter, food, drinking water, other essentials, clearance of carcass (dead bodies), easing access to health care facilities, maintaining sanitation, power.

Relief (Between 72 hours to 3 months)

- Relief(Between 72 hours to 3 months).
- Provision of humanitarian help based on the psycho social needs assessment essentially designed to enable recovery after disaster.
- Mechanising Psycho social Support and Mental Health Services along with other relief measures.
- Involvement of different organizations providing relief materials, provision of psychosocial care by care providers and installing systems for rendering a bio-psycho-social care.

Rehabilitation (Between 3 months to 2 years)

- Measures aiming at increasing resilience, strengthening livelihoods, quality of life and day-to-day activities.
- Enabling civic utilities, infrastructure building and restoration.
- Monitoring for psychosocial complications, referrals, and follow-ups.

Reconstruction or rebuilding (2 years to lifetime)

- Creating sustainable and resilient communities.
- Rebuilding of individual coping abilities, family structures, livelihood, and environment.
- Entering pre-disaster phase aiming at DRR.
- Disaster management cycle continues from Stage1.

Remember

- Psychosocial disruption caused by the disaster exceeds the normal coping ability of the affected people.
- Disasters can be broadly classified into natural and human-made disaster.
- Disaster will have physical, psychological, social, and economic impacts on the affected community.
- Needs of disaster-affected community varies from basic needs to higher order needs.
- Disaster experiences vary from individual to individual, based on different bio-psycho-social factors.
- Disaster management cycle involves mitigation, preparedness, response, and recovery phases.

CHAPTER 2

PSYCHOSOCIAL FIRST AID STRATEGIES

Psychosocial First Aid (PSFA) is an immediate intervention in the aftermath of any disaster. It can be administered within the first few days of the disaster to three weeks by any person with a minimum or no education. It is practical help provided on a humanitarian basis in a supportive manner to the affected person/family/community.

After any disaster, it is also important to observe that along with the physical (e.g.,fractures, injuries, malnutrition, etc.) and psychological (e.g., shock, sadness, fear, anger, etc.) consequences, social (property loss, loss of job, risk of migration, increase in crime rates) consequences also affect the lives of the people. The physical, psychological, and social consequences are interlinked.

- While returning home from work, lightning struck Manohar and he was severely burnt and hospitalized. His family was in distress and not able to afford the treatment.
- Due to the heavy rainfall, in many areas of Cuddalore, Tamil Nadu, the paddy fields suffered a severe loss of several crops. Farmers were in a state of shock and anger due to loss.
- 11-year-old male child lost his books and toys in the Floods and is unable to sleep. He is unwilling to go to school without his books

While providing PSFA support services are provided immediately after a disaster, the above illustrations clearly indicate that the physical, psychological, and social consequences require simultaneous and equal attention

The idea behind PSFA comes from crisis intervention (helping people to address psychological reactions following a crisis); physical first aid (process of providing immediate assistance to a person suffering a sudden injury, illness and/or bodily reactions); and social interventions (connecting people to the available support with family, friends, relatives, and community) which can be performed by a non-expert.

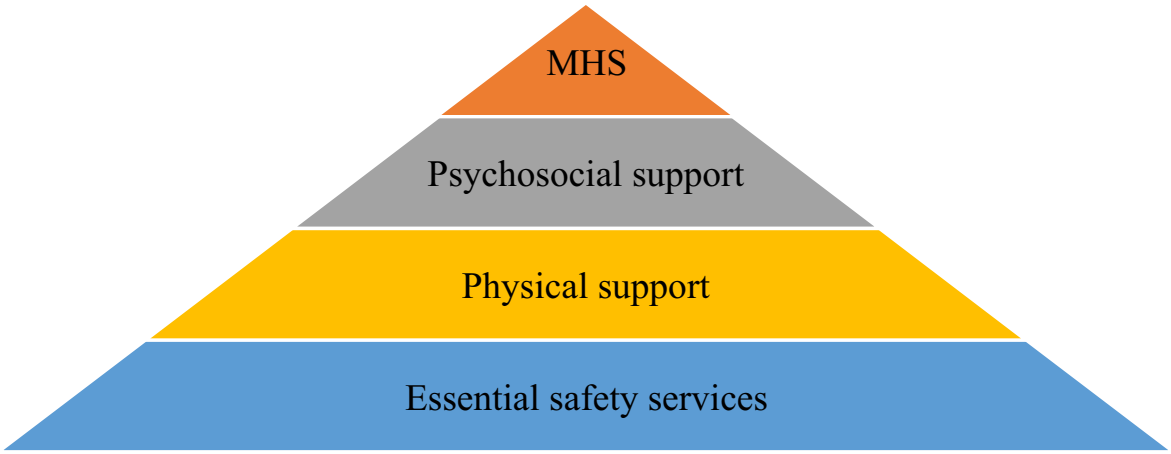
PSFA	*PSFA DOES NOT*
• Is an immediate intervention given to disaster survivors. • Is done without forcing the person. • Provides need-based assistance using available resources. • Makes the people aware that help is available. • Improves personal, family and community support. • Ensures access to necessities such as food, water, clothing, shelter, medicines, etc. • Encourages people to express their concerns freely. • Make need-based services available, accessible, and affordable.	• Address the severe physical, psychological, and social problems. • Require highly qualified professionals. • Provide higher level psychological interventions. • Involve detailed assessments • Include Psychosocial analysis and formulation. • Pressurize individuals to talk about their experiences. • Plan for long-term rehabilitation service.

• Psychosocial needs of the affected people

Disasters induce stressful reactions. Psychosocial First Aid is an instant intervention provided in disaster-affected communities to help individuals/ families/ community mitigate these stress reactions. Let us consider that in a community affected by disaster, there are 100 people. Among these 100 people, around 30 to 50 would suffer from moderate to severe psychological distress. The distress created after any disaster can be minimized by strategies to promote family or community support. Around 15 to 20 people might develop mild to moderate mental disorders.

It is essential to focus on those people using appropriate psycho social support services to prevent further worsening. Only 3 to 4 might suffer severe mental disorders, and such individuals need to be identified early and referred for mental health treatment. But all the 100 individuals would require basic amenities and services to ensure their safety and security. A larger proportion among them will require it either physical, psychological, and social support individually or inter dependently.

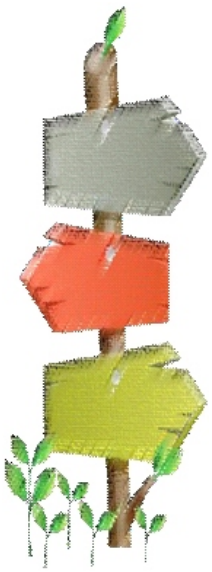
Figure 2.1: Pyramid of Psychosocial needs



PSFA should aim to provide fundamental necessities and essential safety, physical psychological and social support leading to a gate way for higher order interventions of Mental Health Services. The pyramid of psychosocial needs clearly explains the earlier description, and its requirement for the entire community as prescribed in the National guidelines on PSS and MHSs of the NDMA, MoHA, GoI.

- **Pointers to identify the persons requiring higher interventions**

As already mentioned, not all persons might need higher interventions. The following factors would help care providers to know who would need PSS/MHS:



- Age
- Gender
- Marital status
- Educational attainment
- Sexuality
- Personality
- Disability
- Socio-economic condition
- Nature of the disaster
- Culture and traditions
- The severity of the disaster
- Stressful experiences in the past
- Coping skills
- Availability of support
- Past and present physical and mental health conditions
- Family history of physical/ mental illness

The pointers mentioned above decide the level of vulnerability and risk a person might have after any disaster. Along with the bio psychosocial pointers discussed previously, if a person has a severe injury; is highly suicidal; causes harm to others; and is not able to take care of her self/ others; such individuals might need advanced care and not PSFA.

Who needs PSFA?

People who are in distress and need support following a crisis event

When is it provided?

During or immediately after a crisis event. It may last for days or weeks depending up on the severity.

Where is it provided?

In any safe place/ settings where privacy / confidentiality can be ensured

- **Action Principles of PSFA**

KNOW (about the crisis event, available resources & materials and protection and security concerns).

PREPARE (ensure safety, observe people with urgent basic needs and people with severe distress reactions).

HEED (listen to people who might need support, enquire about needs and concerns and make them feel comfortable).

CONNECT (provide basic needs and accessibility to services, adequate information and social support, better coping abilities).

- **Remember Four A's for PSFA:**

Attending to disaster survivors with professional humane behaviour, e.g., being honest, respecting the person, avoiding prejudices/ personal bias, providing reassurances, and facilitating ventilation.

Avoiding non-professional behaviours like asking for personal assistance, making non-formal relationships, providing false information, pressurizing people to talk, not conforming to local traditions or culture, and being judgemental.

Adhering to the cultural sentiments and practices of the community and ensuring confidentiality.

Abiding by the guidelines and giving priority to vulnerable groups, ensuring respect and dignity, foster autonomy with dependence while working with vulnerable groups

Figure 2.2: Key components of PSFA

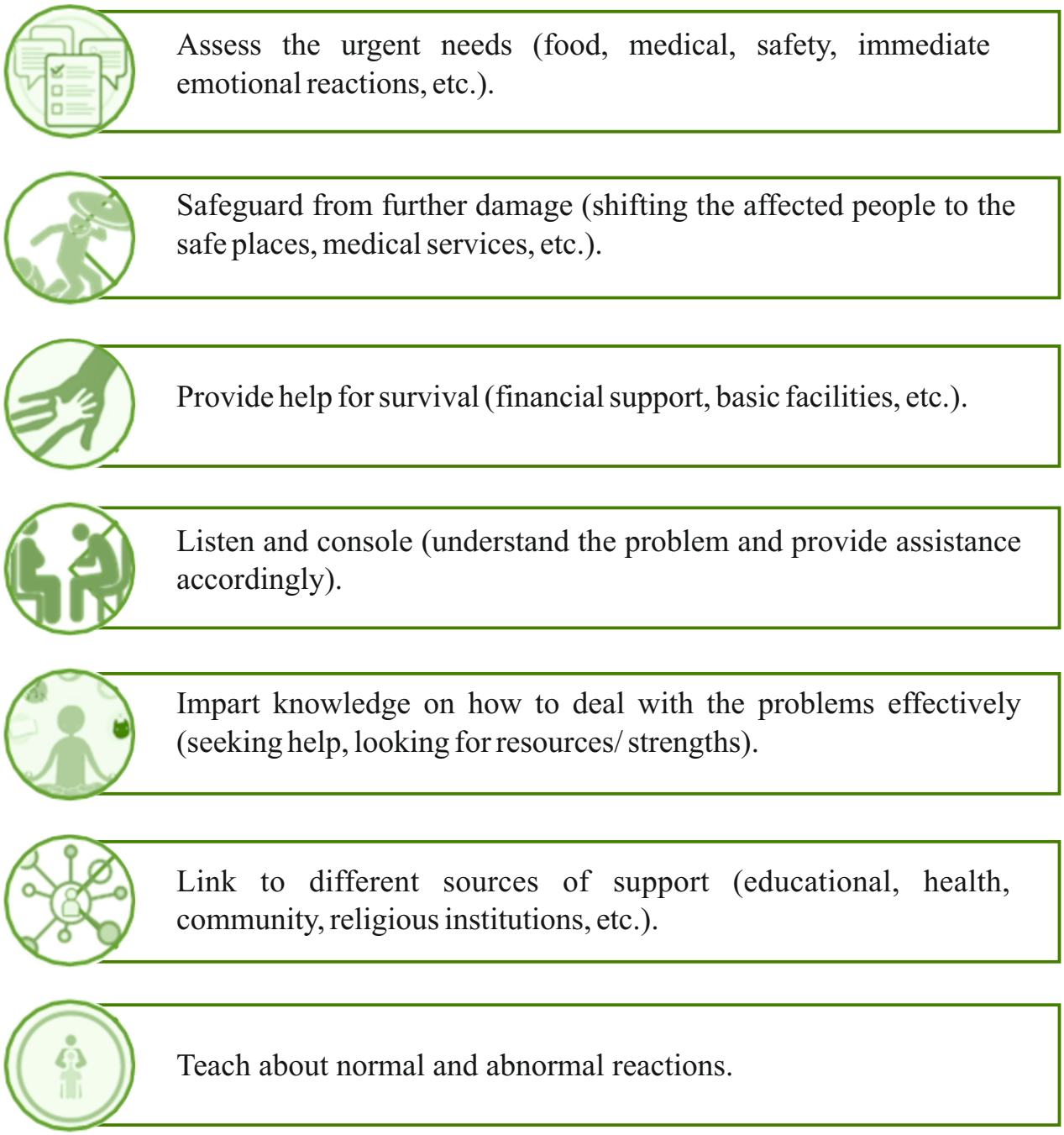


Table 2.1: Outcome of PSFA and ways to achieve

Outcomes of PSFA	Ways to achieve the outcomes
Confirming personal safety	Helping in temporary relocation without separating the individual from the family/ cultural unit, providing necessities, emotional and medical support, and authentic information.
Fostering comfort	Providing peaceful space for survivors to express their feelings and emotions, listening to their stories, and offering reassurance, providing in formation on normal and abnormal reactions during disasters and on adaptive coping measures.
Enhancing socialties	Maintaining family/ community harmony by keeping the social units together, enabling a flow of communication between friends and families, facilitating help-seeking and help-giving behaviours, bridging the social needs of the affected individuals/ communities to resources with due respect to the local cultural or religious norms.
Promoting resilience	Empowering individuals to meet their requirements and focus on building problem-solving and decision-making abilities.
Imparting confidence	Enabling individuals/ families/ communities towards optimistic recovery, making instrumental and expressive support available and accessible, and providing validation and hope to the physical, emotional, behavioral, and relational reactions incurred.

Table 2.2: Cultural factors to consider while providing PSFA. WHO, 2011

Before you intervene, find answers to these questions	
Dress	✓ Do I need to dress in a certain way to be respectful? ✓ Will people in distress require certain clothing items to keep their dignity and customs?
Language	✓ What is the customary way of greeting people in this culture? ✓ What language do they speak?
Gender, Age and Power	✓ Should affected women only be approached by women helpers? ✓ Whom may I approach? (In other words, the head of the family or community?)
Touching and Behavior	✓ What are the customs around touching people? ✓ Is it all right to hold some one' s hand or touch their shoulder? ✓ Are there particular things to consider regarding behavior around the elderly, children, women, or others?
Beliefs and Religion	✓ Who are the different ethnic and religious groups among the affected people? ✓ What beliefs or practices are essential to the people affected? ✓ How might they understand or explain what has happened?

External persons coming from outside the community to provide PSFA might need to consider the cultural factors. However, PSFA provided by the community level worker coming from with in the community would be the best choice available.

Remember

- PSFA is a first level intervention given to disaster survivors.
- Every one affected by a disaster does not require PSFA.
- PSFA provider should be culture sensitive while relating to the affected individuals.

CHAPTER 3 PSYCHOSOCIAL FIRST AID STRATEGIES: PREPARE AND LOOK

People affected with a crisis event experience a wide range of emotions such as sadness, confusion, fearfulness, anxiousness, irritability and so on. These are the normal reactions following a disaster. As discussed in Sessions 1 and 2, most often such experiences are the result of underlying social (financial loss, death of an earning member of the family, loss of job, etc.) and physical (injury, fractures, sleep disturbance, etc.) factors.

It is important for the care providers to understand such experiences of the people and their underlying causes. Some people may express their distress, and some may remain silent. In the process of providing practical support like providing basic needs (food, shelter, clothing, etc.) and addressing their emotional disturbances (denial, shock, anger, fear, etc.), care providers must be respectful. Understanding the cultural background of the people and responding accordingly plays an important role. World Health Organization (WHO) has given following four first aid strategies to guide the care providers to deliver their service effectively.

This chapter covers the **'Prepare'** and **'Look'** strategies of the four.

- **PREPARE**

Any crisis can create a lot of confusion in the community due to its chaotic nature. Therefore, care providers need to act actively. Before stepping into a crisis site, the care provider should understand the nature and severity of the disaster and its impact, the needs of the community, and services that the community might require to recover. Apart from that, the care provider should also be aware of the personal safety measures and prepare themselves to work in a chaotic environment.

Before you begin, remember…

- Respect the dignity and individuality of the affected individual/s.
- Be sensitive in your intervention process considering their cultural background.
- Be genuine and avoid giving false reassurances.
- Be open to the persons and their situation (be nonjudgmental).
- Acknowledge their concerns and emotions.
- Acknowledge their strengths and resources.
- Do not use any demeaning/offensive language ('crazy', 'mad', 'useless', etc.).
- Use simple and direct language and avoid jargons.
- Wherever possible, opt for a place that is has privacy.

Table 3.1: Questions to prepare before entering the site, WHO, 2011

Areas	Questions
The crisis events (Nature, impact, the persons affected)	✓ What happened? ✓ When and where did it take place? ✓ How many people are likely to be affected, and who are they?
Available services and support (Type and nature of service)	✓ Who provides basic needs like emergency medical care, food, water, shelter, or tracing family members? ✓ Where and how can people access those services? ✓ Who else is helping? ✓ Are community members involved in responding?
Safety and security concerns (Areas to be avoided)	✓ Is the crisis event over or continuing (aftershock from an earthquake or continuing conflict)? ✓ What dangers may be in the environment? (Rebels, landmines, or damaged infrastructure)? ✓ Are there areas to avoid as they are not secure (obvious physical dangers or because have no permission to be there)?

All the above preparedness questions help the care providers understand the situation better before entering the field and ensuring self-safety.

- **LOOK**

This strategy focuses on the different psychosocial aspects that need to be looked for in the disaster-affected community. It helps in understanding the needs and concerns of the affected people. Knowing what to look for also enables the care providers to provide practical support to the people in need.
Though the care provider might have prepared her/himself adequately by securing necessary information, the actual situation in the field might vary because of the dynamic nature of the circumstances caused by a disaster. It is always advisable for the care provider to be calm before easing others in distress. Being proactive in understanding the needs of the people would enable the care provider to serve the affected people efficiently.

- **What to 'LOOK' for?**

Safety

Dangers in the locality

Safety sites

A 55-year-old widow was found to have sleep disturbances and worries about her house damaged by floods. During the floods she stayed in the relief camp for about a week, during which and even after going back to her house she kept on thinking about how her damaged house can be repaired as she did not have any financial support from the relatives or Government agencies.

Individuals who need basic needs

Food, shelter, clothing etc.

A group of people affected by earthquake who stayed at a relief camp for 4 days expressed 'though it was challenging, we adults could somehow tolerate the hunger and the pain, but we couldn't see our young children and elderly persons

Individuals experiencing serious distress

Fear, low mood, irritation, etc.

A 45-year-old man from Bangalore called at the national helpline 20 times a day, and expressed his concern saying, 'both I and my wife are infected with Covid-19 virus and home isolated. I am worried that my oxygen level might drop and might have to be hospitalized. Because of me others should not be affected'.

Vulnerable groups

Children, elderly, women, persons with disability, economically weaker sections, etc.

Due to the Tsunami, a 75 years old lady who had mobility issues lost her wheelchair and staying away from her daughter who is the caretaker. At the relief center she was found to be low as she was finding it hard to manage without the support of her daughter.

Individuals requiring advanced care

Impaired functioning, suicidal tendency, impaired self care, etc.

35 years old lady lost her husband on a train accident. She survived the accident. She is crying the whole day and not able to sleep. She is getting the repeated images of the incident and having the thoughts of end her life.

Normal and abnormal reactions

When a care provider starts providing PSFA, she should look for reactions among the survivors. Disasters abruptly disturb the routine of the community. The survivors' reactions are normal to an abnormal situation. The care provider should be able to distinguish between understanding the difference between normal and abnormal reactions would help care providers in early identification of the problems and giving appropriate referrals for individuals who might require advanced psychosocial care.

Table 3.2 gives a distinction between normal and abnormal stress reactions during different stages of disaster (Kasi et al., 2005):

Table 3.2: Distinction between normal and abnormal stress reactions

Time	Normal reactions	Abnormal reactions
Immediate	Outcry (fear, sadness, rage)	Overwhelmed (being swept away by immediate emotional reactions)
One to two weeks	Denial (refusing to face the memory of the disaster)	Panic/Exhaustion (from the escalated emotions)
Six months	Intrusion (repeated thoughts about the event)	Extreme avoidance (avoiding persons/ place/ circumstance)
Six months onwards	Working through (facing the reality of what has happened)	Flooded states (disturbing images and thoughts about the event)
Lifelong	Adjustment (getting adapted to the situation)	• Psychosomatic response (bodily complaints) • Character distortions (long-term disorders)

The crisis-affected people may experience a diverse set of reactions listed below. Nature and intensity might vary from person to person. Therefore, the care provider should carefully identify such experiences and take further actions to deal with them effectively.

Common reactions after disaster

Physical reactions: Palpitation, multiple pain, changes in sleep/appetite, nausea, etc.

Emotional reactions: Fear, irritability, sadness, guilt, etc.

Behavioural reactions: Angry outbursts, poor self care, substance use, etc.

Relational reactions: Lack of trust, poor help seeking, withdrawn,etc.

Most of the survivors would experience these reactions. Only a few survivors would experience abnormal reactions like being withdrawn, disoriented, having long term mood disturbances, increased substance use, causing harm to self/others, poor self care (not brushing the teeth, taking bath, etc.), difficulty to work (lack of concentration, disinterest, etc.). If the reactions mentioned above as normal persist for a longer time, these reactions can be termed abnormal mainly when they affect their day-to-day routine (misunderstanding in the family, decreased quality of work, decreased quality of social life, etc.)

Remember

- PSFA strategies help the care providers to render their service in a structured manner.
- Before entering a disaster-hit site, care provider should understand the nature/severity of the disaster and ensure safety of self.
- Looking for the needs/concerns of the affected people is the primary step in PSFA.
- Everyone in the affected community need not have abnormal stress reactions.
- Common reactions after disaster

CHAPTER 4

PSYCHOSOCIAL FIRST AID STRATEGIES-LISTEN

When disaster survivors talk about their issues and concerns, and if they feel that they are being listened to by someone who understands their emotions, they would feel safe and calm. Listening is an important part in establishing and maintaining rapport (being able to relate to) with the disaster survivors. The affected people express their willingness to talk only when they feel confident that whatever is being shared is understood by the care provider and support is available in response.

Dos of effective listening

- ✓ Select a place having privacy.
- ✓ Maintain appropriate distance (not too close/far).
- ✓ Use non-verbal gestures to express your understanding (head nods, eye contact, body posture, etc.)
- ✓ Use prompts (aaaa, ummmm).
- ✓ Stay calm and listen patiently.
- ✓ Use simple and direct language.
- ✓ Acknowledge their feelings and emotions.
- ✓ Give reassurances whenever necessary.
- ✓ Maintain strict confidentiality.
- ✓ Talk about their strengths and resources.
- ✓ Summarize and clarify if you are unsure of what they communicated.
- ✓ Maintain soft and non intimidating tone.

Active listening is the key for effective communication. Undoubtedly, paying undivided attention, genuinely listening to their concerns, and expressing the understanding foster effective communication with the survivors.

Don'ts of effective listening

- ✓ Do not force the survivor to talk.
- ✓ When s/he is talking do not interrupt.
- ✓ Do not be judgmental or show your personal biases.
- ✓ Do not give your personal opinions.
- ✓ Do not touch the person until and unless it is culturally sanctioned.
- ✓ Do not talk about your personal problems.
- ✓ Do not give false promises.
- ✓ Do not make the person feel that s/he is powerless.
- ✓ Do not imagine that you need to solve all the problems of the person.
- ✓ Do not get distracted

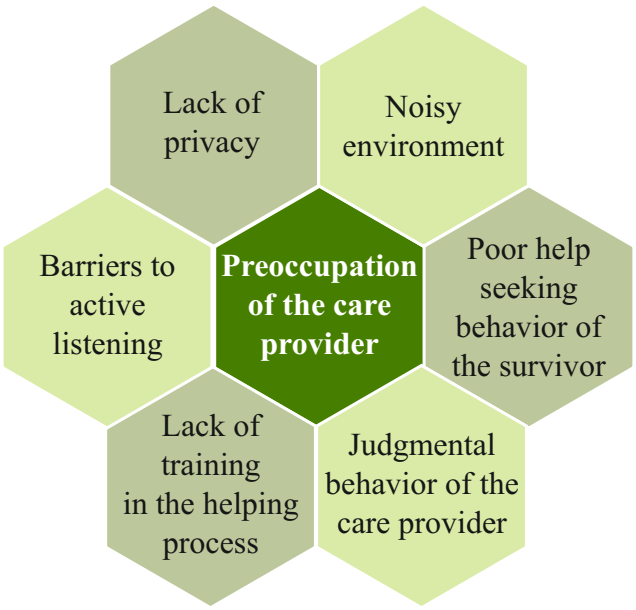
Strategies to foster active listening

People affected by disasters want to be heard. Creating opportunities to communicate their feelings and emotions is important.

Initial dialogue	Explore issues	Listen, listen & listen
• Care provider must approach people respectfully according to their culture and introduce oneself. • If needed, practical assistance can be provided (offering food or other relief materials). • Ensure their sense of safety.	• Identify the needs of the survivors based on observation and past experience in the field. • Ask about their needs and concerns. • With the help of the survivors, grade their concerns (most to least important).	• Listen to the survivor with patience and ensure that support is available despite the loss. • Let the emotions flow freely. • Don't interrupt or force the person to talk. • Provide culture specific positive affirmations (e.g., connecting to proverbs). • Make sure to avoid false promises

The initial dialogue will help the care provider to establish rapport with the affected individual/s. Having the connection intact, exploring the issues, and prioritizing the concerns will enable the care provider to develop the 'LINK' to appropriate sources in the PSFA process. 'LISTEN' is the primary tool for the practical identification of the needs of the affected people and provide appropriate PSFA.

Figure 4.1: Barriers to active listening



Techniques that might help the care provider while engaging in active listening:

S - Soft tone
E - Eye-to-eye contact
R - Reassurance
C - Calming exercise

The care provider should use a soft and gentle tone while talking to the disaster survivor/s, should maintain eye-to-eye contact, and provide reassurances (e.g., 'help is available'; 'it is a difficult time, however, things will get better'; 'there is hope for positive change') without making false promises wherever necessary. When the disaster survivor feels anxious or fearful, the care provider can teach specific calming affirmative exercises to help the person stay in reality.

Calming exercises:

Technique 1: Make the person feel him/ herself (feeling the feet on the floor or clapping of hands or tap hands/ foot).

Technique 2: Make the person feel his/ her surroundings (look around).

Technique 3: Make the person focus on his/ her breath (breathe slowly).

Remember

- Listening is a key ingredient in establishing and maintaining rapport with the survivors
- Effective communication and active listening go hand in hand.
- People affected by disasters want to be heard and opportunities need to be created for disaster survivors to vocalize their feelings and emotions.

CHAPTER 5

PSYCHOSOCIAL FIRST AID STRATEGIES-LINK

Subsequent to a disaster, the survivors often may fail to identify the available resources to cope with the demands emerging out of their distressing situation. They are most likely to develop the sense of being vulnerable, powerless, and excluded. In such a situation, 'LINK' is a process in which the care provider assists the affected individuals in accessing practical support. Different types of disasters bring out various requirements/ needs for the affected people, depending upon the nature and severity of the impact. Some of those common requirements are:

Undoubtedly the routine of the affected people gets disturbed secondary to the crisis event. During such unusual situations, linking people to the appropriate services and providing practical support form a significant part of PSFA. Such services must be immediate and, in the long run should enable them to help themselves or be self-sufficient by gaining control over the new normal. It is also vital that the care provider needs to remember that she cannot solve all the problems of the survivors. The care provider should also know that his/ her level of expertise in helping the client is minimal. When the survivor has issues beyond the care provider's experience/ knowledge/ skills, appropriate referral to higher support needs should be facilitated.

During the process of LINKing remember…

- ✓ Look into the provision of basic/practical needs.
- ✓ Understand the needs/concerns of the affected people and available resources.
- ✓ Help the people to prioritize their needs.
- ✓ Pay special attention on the vulnerable groups (women, elderly, persons with disability, religious/ethnic minorities, etc.).

What to do while helping distressed individuals/ family/ community?

• Basic amenities and safety

In the process of applying the 'Look' and 'Listen' strategies, the care provider would by now have understood the needs of disaster survivors/ families. Initially, the linking process should focus on attending to the physical demands (food, clothing, shelter, medical supplies, blankets, mosquito nets, safe drinking water, etc.) of the disaster survivors. When care providers help in attending to the physical needs of disaster-affected individuals/ families, they will be better positioned to understand other psychosocial and recovery needs like their staple food to be made available or the type of dress they wear. It is also crucial to make them feel safe in the environment they are settled on a temporary basis.

• Enhancing coping among disaster survivors/families/community

Though the problems of disaster survivors/families might be overwhelming, adaptive coping patterns (identifying the problems, finding solutions to problems, seeking help from others, etc.), and resources help them bounce back faster. The care provider must understand the coping abilities of disaster survivor/ families in the past (pre-disaster) and prescribe the adaptive coping patterns mentioned below under Well of Coping. The care provider should also discourage harmful coping practices like over use of substances, social isolation, self-blame, denial, aggression, self-harm, etc.

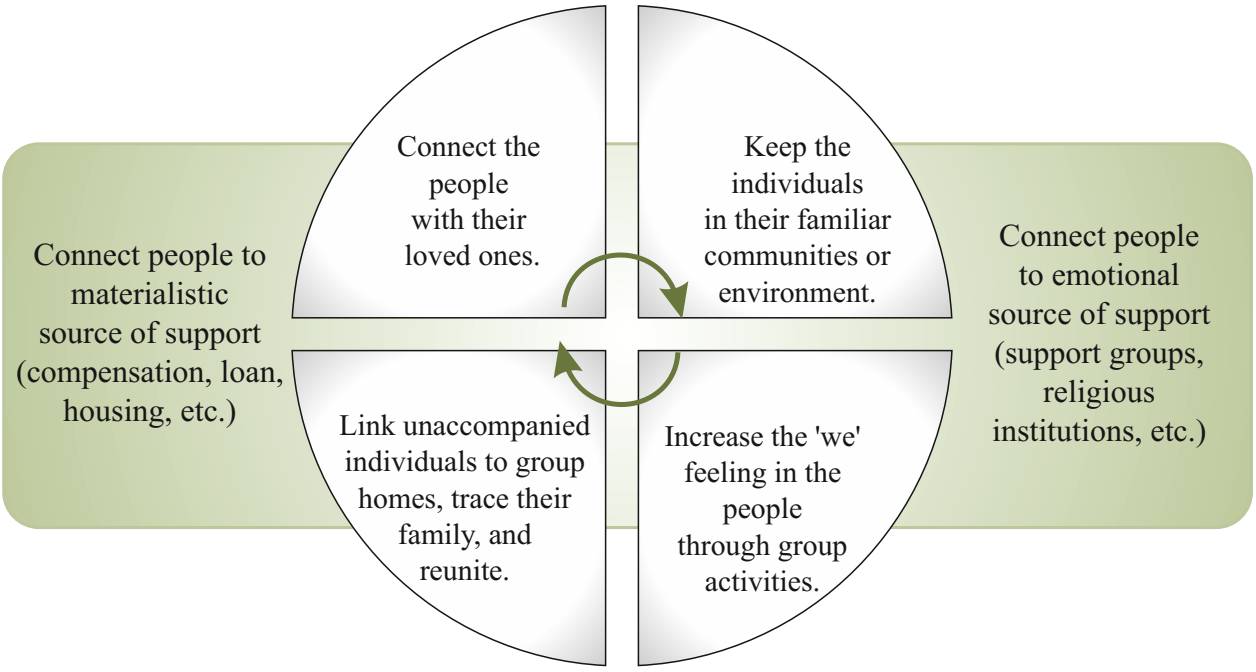
• Dealing with rumors and providing authentic information

During disasters, rumors spread like wildfire because of technological devices and social media in today's times. The care provider, along with providing the correct information, should also look at whether any rumors in the community exist and take appropriate steps to control them. This can be done by giving valid information and being consistent with that information to everyone. Considering the dynamic nature of the disaster, care providers should make sure to be updated with government advisories.

Tips while linking persons with information

- ✓ Know the source of getting correct information before approaching the affected people.
- ✓ Keep the people updated about the information and plan of action.
- ✓ Provide the verified contact details of the available sources to the people.
- ✓ Don't give false information.
- ✓ Be genuine and transparent.
- ✓ Be calm when people express their irritability/frustration about the transfer of the information.
- ✓ Information can be made in multiple modalities such that varied individuals with vulnerability can assess them easily.
- ✓ The information needs to be simple and direct and has to be repeated again and again.

• Connecting to support systems



Social support is one of the important factors that lessens stress and promotes adaptation. Therefore, connecting people to the support network like family, relatives, friends, community, and local institutions play a significant role in PSFA.

Termination

PSFA being an immediate support service, it must be terminated on the following grounds:

- When the expected outcome has been achieved.
- When there is an indication of advanced care for the survivors.
- When there are issues between the care provider and survivor/s.

The care provider must ensure continuity of care to the needy by linking him/her to another individual who can continue the service. If the outcome has been achieved or not, bid farewell to the individual by saying that the care provider will not be coming to visit the survivor/s further and wish them success towards the road to recovery.

Remember

- 'LINK' is a process in which the care provider connects the affected individuals to practical support.
- Understand the needs/concerns of the affected people and available resources before establishing a link.
- Social support is one of the key factors that mitigate stress and promote adaptation among affected people.

CHAPTER 6 PSYCHOSOCIAL FIRST AID WITH VULNERABLE GROUPS

What is Vulnerability?

Characteristics and circumstances of a person or a group of people influence their ability to anticipate, cope, respond and recover from the impact of crisis events or disasters. When there is a threat of disaster, the vulnerable sections such as pregnant women, orphan children, persons with disability and uncared aged of the population need special attention. There is a wide range of biological (sex, health conditions, disability), social (poverty, gender, age, education), and environmental (place of stay) factors that make a person vulnerable. Factors that determine vulnerability might vary based on the disaster. For instance:

- Some of the vulnerable groups identified during the first wave of the COVID-19 pandemic were the elderly, persons with specific health conditions, and migrants.
- During cyclones or storms, people living in coastal areas/fisherfolk can be vulnerable.
- In gas leaks, people residing in or around the gas/ nuclear plant.
- During droughts and insect infestations, farmers need special care and attention.

Though vulnerable groups keep changing, vulnerability based on age (children, elderly, etc.), gender (women, LGBTQIA+ etc.), socio-economic status (lower income status, homeless, etc.,), ethnicity (religious minorities, indigenous group etc.), displaced population (migrants, refugees, etc.) and health conditions (persons with severe medical and psychological illness) remains the same. Generally, children, women, the elderly, and persons with disabilities are sections of population who might require special assistance during emergencies. This chapter would orient the readers on how the needs of vulnerable groups can be addressed using PSFA. Understanding the factors influencing the vulnerability of a group of people or community and their needs during an emergency is important to plan and implement psychosocial care.

Table 6.1: Vulnerable groups, require special attention during different types of disasters

Factors	Vulnerable Groups
Age	Children (unaccompanied children, orphans, child labourers and children in conflict with law).
	Adults
	Elderly (older adults not cared for in families, older adults in elderly homes and elderly living alone).
Gender	Women (pregnant women, single women, widow and divorced women).
	LGBTIQ+
Occupation	Farmers; fisherman; daily wagers; bonded labour; first responders; mine workers; commercial sex workers.
Status	Socio-economically disadvantaged; homeless; slum dwellers; unemployed.
Family	Single parents; families with younger children; families with large dependents.
Health	Chronic medical condition; addiction; immune compromised state; persons with limited life span; persons in palliative care.
Trauma	Intimate partner violence; previous experiences of trauma; violence in the family/community; victims of sexual/physical violence and abuse; bereavement.
Ethnicity	Indigenous groups; cultural, linguistic, and religious minorities; nomads.
Displacement	Immigrants; migrants; environmentally displaced; internally displaced; refugees.
Disability	Children in conflict with law; low vision; locomotor disability; dwarfism; intellectual disability; mental illness; cerebral Palsy; Specific learning disability; autism spectrum disorders; speech and language impairment; hearing impairment; muscular dystrophy; multiple disability; others (thalassemia, hemophilia, sickle cell disease, chronic neurological disorders).
Others	Tourists; prisoners; undocumented; workers; retired people.

Why do care providers need to focus on the vulnerable groups?
These people are the ones who are away from mainstream society. Most often because of various psychosocial factors, they are prone to;

PSFA helps these population to feel safe, access essential resources, feel listened to, and ensure opportunities to enhance support. It also empowers people in need for special attention to extend support and minimize the negative consequences of a disaster.

PSFA for vulnerable groups

PREPARE

- Understand vulnerable populations specific to a disaster.
- Understand the biopsychosocial factors that make people vulnerable.
- Locate vulnerable groups in the disaster area.
- Identify resources within the community.

LOOK

- Immediate emotional reactions (anxiety, confusion, anger).
- Physical health issues.
- Psychosocial needs and concerns.
- Availability of support within the family.
- Availability of local/community resources.
- Strengths of the vulnerable person and their family/ community

LISTEN

- Listen to their views on the situation and their concerns.
- Acknowledge their strengths.
- Normalize thoughts their feelings and thoughts.
- Give reassurance.
- Ensure their safety.
- Provide basic needs.

LINK

- Always keep them with their primary caregivers or loved ones.
- Link with a protection agency or other support (unaccompanied child with the child protection agency, an older adult having no caretaker to the old age homes).
- Connect them to a safe place for shelter and fulfill their basic needs.
- Connect them to medical care facilities based on their physical and psychological concerns (persons with mental illness to respective district mental health programs; and hearing aid for persons with hearing impairment).

Tips for effective listening

- ✓ Listen attentively without any interruptions.
- ✓ Understand their pain and distress.
- ✓ Empathize by placing yourself in their difficult positions.
- ✓ Make them feel understood by leaning forward and using head nods.
- ✓ Look into their eyes while interacting.
- ✓ Make them feel comfortable (provide water, food or talk politely).
- ✓ Give a pat on their shoulder, touch or hold their hands (ensure they are of your gender and are comfortable).
- ✓ Allow and respect their silence.
- ✓ Do not ask them to stop crying.
- ✓ Do not pressurize them to talk.

Case scenarios indicating the need for PSFA

Case 1: During COVID-19, a five-year-old boy was tested positive. He was asked to be in a quarantine center for 15 days. He was scared and not willing to stay away from the family. The family was not ready to leave the child.

Case 2: During a landslide, a 14-year-old girl lost her father, mother, and her house. She has two younger brothers. She was grieving and feeling lost, thinking of herself and her sibling's future.

Case 3: During a flood, a 45-year-old unmarried lady was left alone and was waiting for the rescue team in her flood-affected house. A resident brutally raped her. By the time the rescue team came, she was lying unconscious on the floor.

Case 4: During Tsunami, a 30-year-old person with a locomotor disability was severely injured and lost his wheelchair. Since he was from a poor socio-economic background, his family could not arrange for a new wheelchair.

Case 5: During an earthquake, a 37-year-old woman with chronic mental illness was rescued by the disaster team. She was left alone as her mother, the primary caretaker, was severely injured and critical.

Case 6: During a building collapse, a 69-year-old lady was rescued by the rescue team. She was crying and was in shock as she could not find her son and family. She had no one to depend on since she was new to the place and found it difficult to ask for help from others at the camp.

PSFA strategies to help the vulnerable group of people

PSFA strategies to help Children

- Emotional reactions (irritability, sadness).
- Physical reactions (aches pains, sleep difficulties, injuries).
- Cognitive issues (difficulty to concentrate, worthlessness).
- Needs and concerns (education, safety).
- Whether the child is unaccompanied.
- Whether the child is unattended.
- Whether the child is in a disturbing environment (gruesome scenes, injured people, unpleasant exposures).
- Forced to play adult roles because of situational pressure due to death of parents, mobility issues in primary caregivers.
- Presence of emotional and behavioural disturbances.
- Risk of physical or sexual exploitation.
- Strengths and resources.

- Views on the situation and concerns.
- Fear and worries.
- Upsetting thoughts and memories.
- Experiences and distress.
- Relate to them at their level and stay calm in the process.
- Help the young children to verbalize their feelings, perceptions and concerns through play activities (sentence completion, doll play, storytelling, etc.).

- Primary care givers or loved ones.
- Unaccompanied child to child protection network.
- Children with acute health conditions to health care facility.
- Children with mental health concerns to mental health professionals/ DMHP.
- NGO/GOs catering to the needs of the children in crisis.

- Reach to the child at her/ his level.
- Do not provide the child with too much information.
- Make the information simple and direct.
- Enable care givers to address the needs of the children.
- Inform about the child care services.
- Empower parents to look for abnormal reactions in children.
- Enable play and other creative activities.
- Do not confront adolescent children.
- Make the child feel that she/ he can trust you.

PSFA strategies to help the vulnerable group of people

PSFA strategies to help Women

- Emotional reactions (irritability, sadness)
- Physical reactions (aches pains, sleep difficulties, injuries,
- menstrual/reproductive difficulties)
- Cognitive issues (difficulty to concentrate, worthlessness,
- negative thoughts)
- Needs and concerns
- Domestic violence
- Homelessness
- Reproductive health issues
- Privacy concerns
- Role burden/role multiplicity
- Financial instability
- Presence of mental and physical health conditions
- Risk of physical or sexual exploitation
- Strengths and resources (support system)

- Views on the situation and concerns
- Fear and worries
- Upsetting thoughts and memories
- Experiences and distress
- Listen with empathy and compassion, and acknowledge their
- feelings
- Culture specific demand to play their role as a woman

- Basic needs
- Women's organizations to protect their rights
- Women with acute health conditions to the health care facility
- Women with mental health concerns to the mental health
- professionals
- NGO/GOs catering to the needs of the women in crisis

- Create support groups.
- Encourage routine religious or cultural practices.
- Facilitate engagement in community kitchens.
- Encourage women to talk freely and boldly about their concerns.
- Provide gender sensitive and gender specific care.
- Use their skills in rebuilding the community.
- List en to their unheard voices.
- Appreciate their talents.
- Ask women to focus on restarting their routine.
- Facilitate empowerment by enabling active involvement.

PSFA strategies to help the vulnerable group of people

PSFA strategies to help elderly

- Emotional reactions (irritability, sadness, guilt).
- Physical reactions (aches pains, sleep difficulties, injuries, comorbid health conditions).
- Cognitive issues (difficulty to concentrate, forgetfulness,
- worthlessness).
- Needs and concerns (mobility, functionality, dependance).
- Financial burden/stability.
- Presence of mental and physical health condition.
- Strengths and resources (support system).
- Elderly abuse/ neglect.

- Views on the situation and concerns.
- Fear and worries.
- Upsetting thoughts and memories.
- Experiences and distress.
- Listen with empathy and acknowledge their feelings.
- Treat them with respect and dignity.

- Basic needs.
- Connect them to the primary care takers or loved ones.
- Institutions/individuals supplying the necessary aids.
- Organizations working for the elderly.
- Health care facilities in case of acute health concerns.
- Mental health professionals in case of psychological concerns.
- Governmental policies and schemes.

- These people have a lot of experience so value their experience.
- Use their experience in helping people in distress.
- They might talk the same thing again and again. Listen to them patiently.
- Talk to the caregivers who are looking after them.
- Provide respite care services for the caregivers.
- Provide assistive devices to enhance communication and mobility.
- Encourage them to participate in activities that they are capable of Ask caregivers to be polite and sensitive to their needs.
- Focus on safety of elderly (educate on services available in terms of emergency, breach of security).
- Encourage support from community to prevent elderly abuse/ neglect.

• PSFA strategies to help the vulnerable group of people

PSFA strategies to help persons with disability

- Emotional reactions (irritability, sadness).
- Physical reactions (aches pains, sleep difficulties, injuries).
- Cognitive issues (difficulty to concentrate, worthlessness, negative thoughts).
- Needs and concerns (mobility, dependance).
- Financial burden/ stability.
- Presence of mental and physical health condition.
- Risk of physical or sexual exploitation.
- Strengths and resources (support system).
- Care giver burden.
- Stigma and discrimination.
- Modalities of communication.

- Views on the situation and concerns.
- Fear and worries.
- Upsetting thoughts and memories.
- Experiences and distress.
- Listen with empathy and acknowledge their feelings.
- Treat them with respect and dignity.
- Use modalities in which the person is comfortable to communicate.

- Basic needs.
- Assistive devices.
- Connect them to the primary caretakers or loved ones.
- Organizations working for the persons with disability.
- Health care facilities in case of acute health concerns.
- Mental health professionals in case psychological concerns.

Remember

- Set of biopsychosocial factors make some people vulnerable in the wake of disasters
- Vulnerability is a fluid concept liable to change
- Vulnerable people need special attention

CHAPTER 7 CARING FOR THE CARERS

Community front line workers, volunteers and other civil society personnel being the first responders play the role as care givers during disaster. First responders include Anganwadi workers, ASHA workers, NGO outreach workers, student/youth volunteers, faith-based organisations, social defense personnel, police, fire fighters and people from the community etc. Care givers deliver PSFA for the survivors of a hazard or crisis event at the heroic phase and play a significant role in rebuilding their lives and the community.

The overall goal of a care giver is to remain empathically connected, present, and engaged to help the survivors. Many care givers may consider their role of providing PSFA as a privileged and finding purpose in life by helping others. From the initial enthusiasm of the heroic phase, in the helping process care givers may go beyond their limits to serve people, risking their health and safety. Responding immediately to a crisis may be physically and emotionally challenging.

Therefore, taking care of self and balancing the roles/responsibilities as a caregiver is essential to function effectively in the field.

Impact / Consequences of being a caregiver

- Psychological and physical reactions such as irritability, feeling low, lack of energy, problem in sleep and appetite etc.
- Neglecting physical, emotional, and spiritual needs
- Inability to find time for self
- Feeling of being unacknowledged
- Inability to focus on expected roles
- Inability to be empathetic
- Decreased sense of purpose in life
- Decreased satisfaction in doing PSFA
- Diminished quality of PSFA services
- Interpersonal issues with the team and family
- Sense of being trapped
- Increased substance use (cigarette, tobacco etc.)
- Over drinking of coffee/ tea
- Social withdrawal

Reasons for the negative impact

- Witnessing the pain and suffering.
- Disturbed structure of the affected community.
- Self doubts on one's ability as a caregiver.
- Fear of rejection by the survivors.
- Fear of being intrusive.
- Threat to personal safety.
- Demanding roles.
- Inability to find time for self.
- Inadequate training in providing.
- PSFA

Ask yourself…

- How do I take care of myself?
- How does my team take care of each other?

Reflect and understand

- Before providing PSFA Are you ready to help?
- During How can I stay physically and emotionally healthy?
- After How can I find time for myself?

PSFA strategies for caring the cares

- ✓ Emotional reactions (worry, irritability, fear, sadness etc.).
- ✓ Physical reactions (aches pains, sleep difficulties etc.).
- ✓ Cognitive issues (difficulty to concentrate, worthlessness etc.).
- ✓ Coping pattern.

Listen and talk to caregivers on;

- ✓ Needs and concerns.
- ✓ Fear and worries.
- ✓ Upsetting thoughts and memories.
- ✓ Distressing experiences.

- ✓ Affiliated agency or safety net.
- ✓ Buddy within and/or outside the agency.
- ✓ Family and friends.
- ✓ Support groups of PSFA providers.
- ✓ Medical and psychological health services.

- Do what you like the best (go for a walk, listen to music, maintain a dairy, play games, gym) Connect with your friend face-to-face or telephone.
- Plan your activities ahead to manage the time.
- Say NO when you feel it's too much.
- Take a break whenever there is a chance.
- Be proactive in making your plans with others Monitor your daily stress level.
- Establish a routine to find time for yourself Stay connected with your agency or group to ensure your safety and coordination.
- Take tips from your fellow co-workers.
- Talk about your experiences with the supervisor, or someone you trust.

Remember

- Caregivers play a significant role in rebuilding their lives and the community.
- Caregivers may develop physical and psychosocial disturbances while engaging in the care giving process.
- Caregivers also need care to keep oneself balanced.
- It is important to practice strategies for self-care daily.

Level -1: Certificate Course on Psychosocial First Aid

The PSFA module can be provided as a certificate course. The CLWs (GO/NGO grassroot level workers, civil society representatives and community volunteers) would be considered for the training. The training spans for 6 hours or one day. It would orient participants on disasters, its impact, PSFA at individual, family and community level, self-care and team-care. On completion of 30 individual PSFA service provision and updation on an excel sheet to be sent back to the DPSSDM, NIMHANS will entitle for a Certificate from NIMHANS and endorsed by NDMA/SDMA.

National Disaster Management Training Module -1
Facilitators Guide

Psychosocial First Aid


March 2023

Jointly Developed by

National Disaster Management Authority
(NDMA)

National Institute of Mental Health and Neuro Sciences
(NIMHANS)

CONTENT

PROGRAMME SCHEDULE

No	Name of Session	Methodology	Duration
1	Introductory session		30 mins
2	Introduction to disaster	Group activity and free listing	30 mins
3	Introduction to psychosocial first aid	Presentation and discussion	30 mins
4	Psychosocial first aid strategies: Prepare & Look	Brain storming	30 mins
5	Psychosocial first aid strategies: Listen	Group activity and discussion	30 mins
6	Psychosocial first aid strategies: Link	Brain storming	30 mins
7	Psychosocial first aid with vulnerable group	Brain storming, role play and discussion	150 mins
8	Psychosocial first aid forcare providers	Brain storming and free listing	30 mins

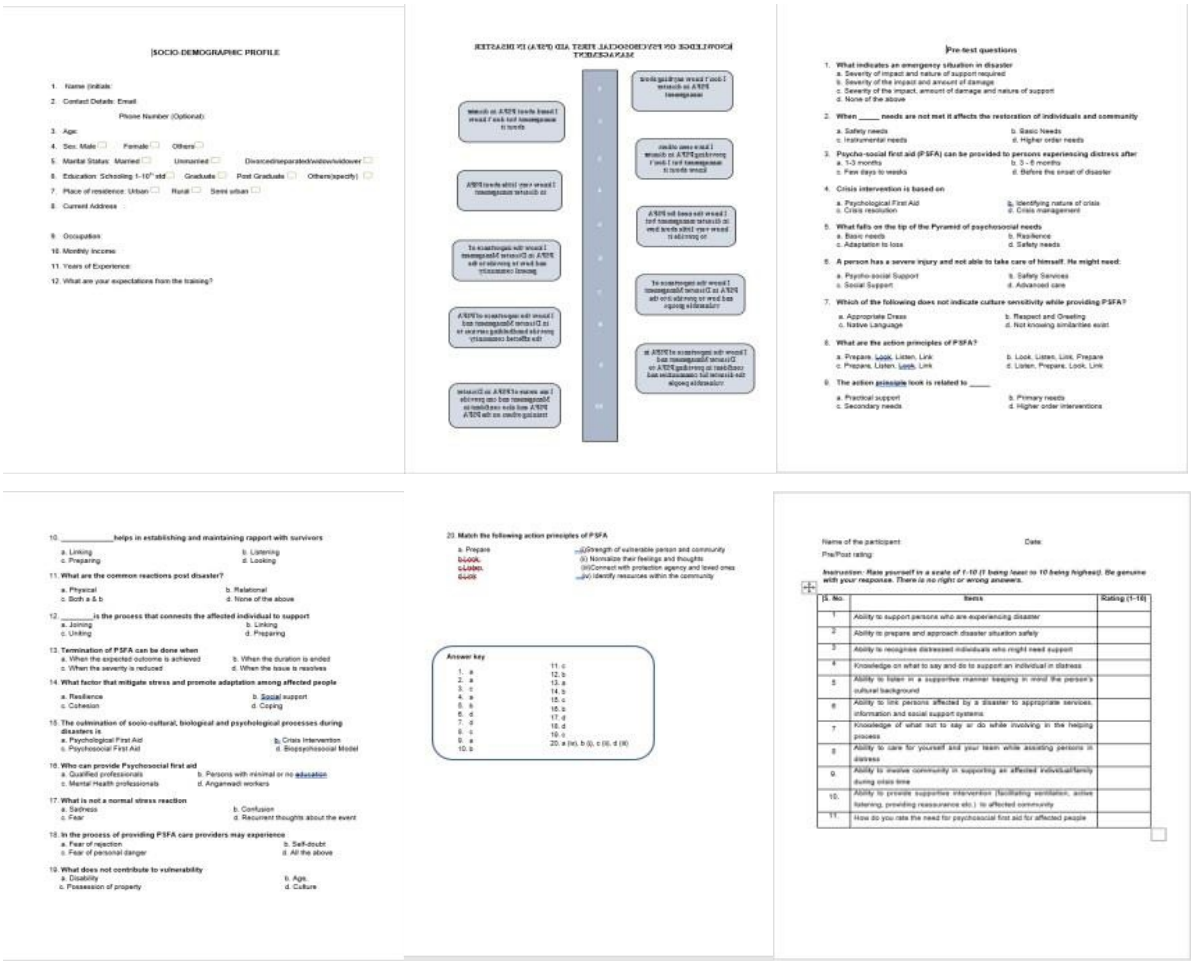
INTRODUCTORY SESSION: BEFORE YOU BEGIN

Introduction: Before any training programme, it is important to assess the existing knowledge and attitude of the participants. This would guide the facilitator in understanding the participants and the effectiveness of the training programme.

Aim: To assess the knowledge and attitude of the participants on PSFA.

Duration: 30 minutes.

Process: Facilitator begins with the self-introduction and asks the participants to do the same. The background information sheet (socio-demographic details of the participants), visual analogue scale (to assess the attitude) and pre-post assessment questionnaire (to assess the knowledge) will be distributed and instruction will be given to fill them. Once all the participants fill the tools (refer annexure) the facilitator starts the first session.



Note: At the end of all the 7 sessions, Pre/ post assessment questionnaire will be administered again. In addition, evaluation sheet will be given to get the feedback of the participants.

FACILITATORS GUIDE- Session 1

Session Name: Introduction to disaster (Refer chapter-1 in manual and workbook).

Aim: To give an overview of the disaster to the participants.

Methodology: Group Activity and free listing.

Duration: 30 minutes.

Process: Followed by the self-introduction, facilitator will give a brief introduction to disaster with examples of disaster took place in India and mapping of disaster. Types of disaster will be explained asking a set of brain storming question (Have you ever encounter a disaster? What type of disaster was it? Can you name different types of disaster?) The activity given below (see activity 1) will be conducted to explain the impact of disaster. Followed by the activity needs, experiences of persons affected by disaster, and disaster management cycle will be discussed.

Outcome of the session: The participants will get an overview of meaning and types of disaster, impact of disaster on affected people, needs and experiences of disaster survivors, and disaster management cycle.

Activity 1

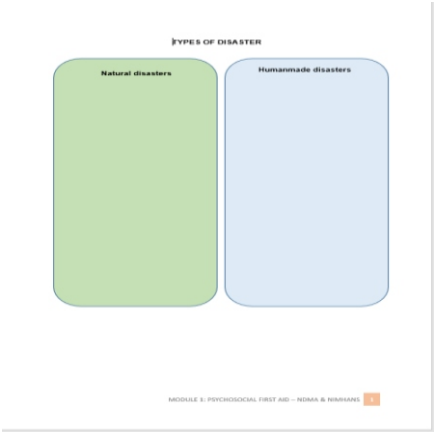
Description of the activity: Impact of disaster.

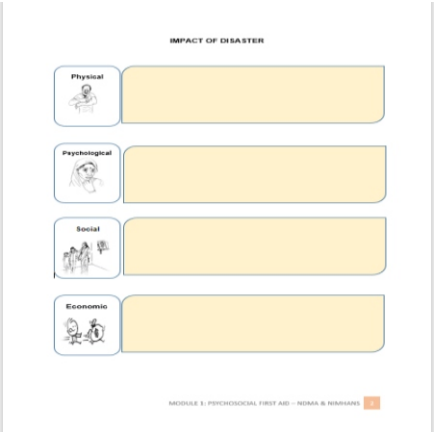
Aim: To understand the impact of disaster.

Duration: 30 minutes.

Materials required: Chart papers and marker pens.

The facilitator divides the participants into four groups and each group will be given the following topics: physical impact, psychological impact, social impact and economic impact. The participants would be allotted time to discuss on the themes and the groups present the points to the overall group. Once the groups present, the facilitator adds on points that would enrich the participants' understanding. The facilitator concludes the session by explaining about the interconnection between the impacts and how one leads to the other. The same activity will be conducted through breakout rooms w hen the session is happening in an online mode.





FACILITATORS GUIDE- Session 2

Session Name: Introduction to psychosocial first aid (Refer chapter-2 in manual and workbook).

Aim: To introduce the key components of Psychosocial First Aid.

Methodology: Presentation and discussion.

Duration: 30 minutes.

Process: The facilitator explains the concept of Psychosocial First Aid and its evolution. Psychosocial needs of affected people, indicators to identify the higher order needs, action principles and key components, ways to achieve the expected outcome and significance of culture in providing PSFA will be discussed. For further understanding of the participants about PSFA the activity shown below will be conducted.

Outcome of the session: The participants will be able to understand the key concepts related to PSFA.

Activity 2

Description of the activity: Psychosocial First Aid.

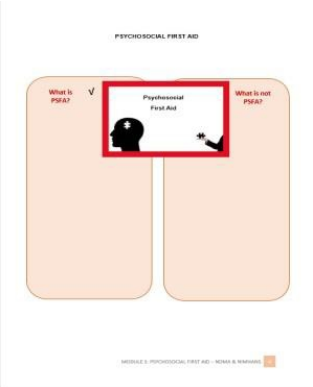
Aim: To help participants understand about Psychosocial First Aid.

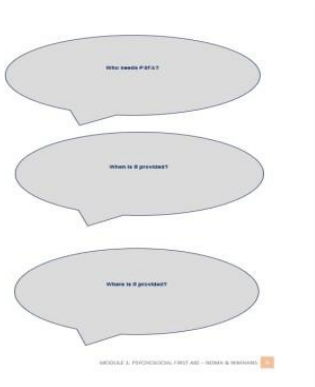
Duration: 30 minutes.

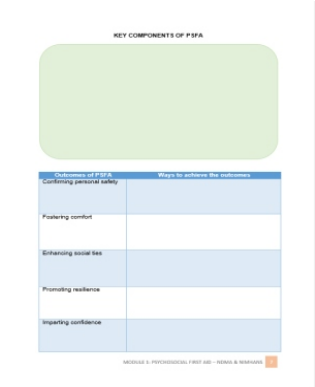
Materials required: Role play cards, A4 sheets, pen, PPT (online mode).

10 individuals are asked to volunteer and are paired into groups of two. In each group, one individual has to act like a care provider and the other as a victim of a recent disaster. The victims to be intervened based on the case scenarios given in table 2.1. Rest of the participants will be divided into groups and allotted with one of the 5 role play team each and will be asked to make a note of their observation from the role play. Once the role play is done, based on their understanding from the session they would be asked to tell their observation.

In case of online session case scenarios will be displayed one by one in the PPT and participants will be invited to tell what they would do as a PSFA provider.







FACILITATORS GUIDE- Session 3

Session Name: Psychosocial first aid strategies: prepare and look (Refer chapter- 3 in manual and workbook).

Aim: To facilitate understanding on strategies of PSFA with special focus on 'PREPARE' and 'LOOK' strategies.

Methodology: Brain storming.

Duration: 30 minutes.

Process: The facilitator introduces the PSFA strategies. This session would focus only on first 2 strategies i.e., 'Prepare' and 'Look'. After discussing about these 2 strategies and stress reactions of affected people (normal and abnormal) at different stages of disaster, an activity will be conducted to ensure participants clearer understanding about 'Look' strategy (see the box below). Followed by this activity facilitator discusses briefly on common physical, emotional, behavioural and relational stress reaction during disaster (For detailed session on this topic refer Module 2; Session 4) and concludes the session.

Outcome of the session: The participants will get oriented about the PSFA strategies, particularly 'PREPARE' and 'LOOK' strategies.

Activity 3

Description of the activity: Application of strategy

Aim: To understand the application of strategy in providing PSFA

Duration: 30 minutes.

Materials required: Images of disaster hit areas, List of probing questions

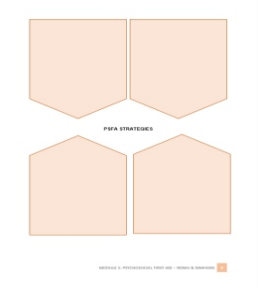
The facilitator displays the images of a disaster scenario one by one. The facilitator would ask the participants to observe the images carefully. Then the participants will be instructed to make a note of their observation and present it to the group. In the onsite class room session the same activity

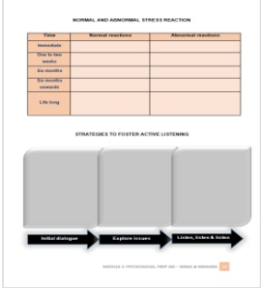
could be conducted on group/individual basis.

Probing questions:

1. What have you seen in the picture?
2. Name the sign of danger you have observed?
3. List the needs you could point out?
4. Were you able to notice any abnormal stress reactions? What are those?

The facilitator will integrate all the answers given by the participants and conclude the session providing information on cardinal strategies to prepare and look during disasters.





FACILITATORS GUIDE-Session 4

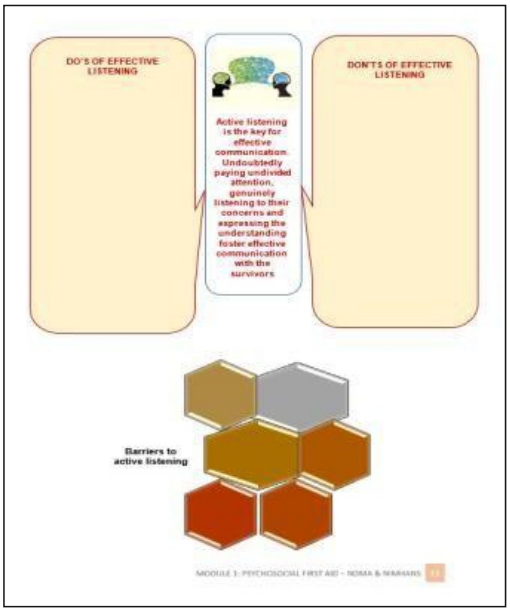
Session Name: Psychosocial first aid strategies: Listen (Refer chapter-4 in manual and workbook).

Aim: To facilitate understanding on strategies of PSFA with special focus on LISTEN.

Methodology: Group activity and discussion.

Duration: 30 minutes.

Process: Facilitator will give a brief introduction to 'Listen' strategy in PSFA. Activity given below will be conducted. After concluding the activity, the facilitator initiates discussion on do's and don'ts on effective listening, strategies for foster effective listening, barriers to active listening and techniques of active listening.



Outcome of the session: The participants will be able to understand the significance of 'Listen' strategy in PSFA and apply the same in the field.

Activity 4

Description of the activity: Importance of 'LISTEN' strategy in PSFA.

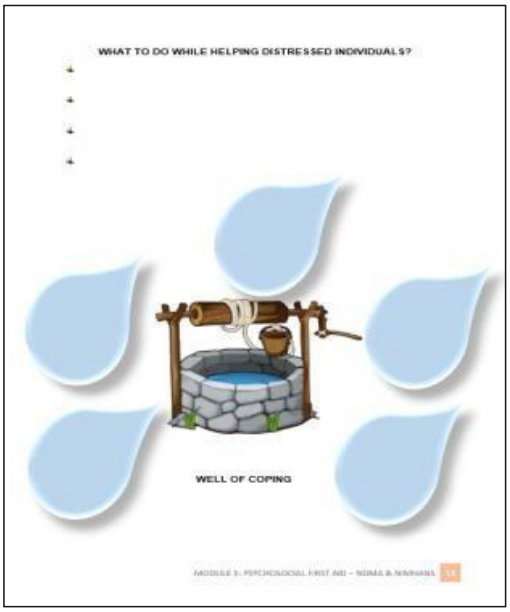
Aim: To orient the participants on significance of active listening.

Duration: 30 minutes.

Materials required: Not applicable.

Facilitator will divide the participants into two groups. Half of them (e.g., 20:10) will be asked to remain outside the hall. Rest of half will be asked to play the role of a listener. They will be given the choice of playing the role of an active listener or passive listener. Those who agree to play the role of passive listener will be told not to pay complete attention (look into phone, look around when the other person is talking without making the person realize that its part of the role play). Those who are made to stand outside will be called back and they will be instructed to share their experience (professional or personal experiences) with the listener. After 10 minutes, feedback on how they felt while sharing their experience, what went well and what did not will be taken. Then the facilitator will reveal that it was pre planned and did not intend to hurt anyone.

FACILITATORS GUIDE-Session 5



Session Name: Psychosocial first aid strategies: Link (Refer chapter-5 in manual and workbook).

Aim: To facilitate understanding on strategies of PSFA with special focus on LINK.

Methodology: Brain storming.

Duration: 30 minutes.

Process: Significance of 'Link' in PSFA, relating it to the needs of the disaster affected communities will be discussed. Different areas which could be targeted while helping the distressed individuals followed by a disaster and application of LINK strategy in doing so will be explained. An activity to ensure the better understanding of the participants will be conducted. Participants will also be given insights on when and how to terminate the PSFA. The participants will be given a chance to clarify the doubts before concluding the session.

Outcome of the session: Participants will be enabled to understand and apply 'Link' strategy while providing PSFA.

Activity 5

Description of the activity: Application of ' strategy.

Aim: To enhance the understanding on application of ' in PSFA.

Duration: 30 minutes.

Materials required: Images of disaster, cards having list of needs, chart papers and marker pens.

Facilitator will display the image of a disaster and participants will be requested to volunteer to pick up the cards having list of needs, what they find it appropriate to the given disaster. Based on it they will be asked to write down how would they establish 'LINK'. Others will be invited to add on the points if they find something is Same will be repeated with all the disasters. Participants will have to justify their point and others can question if they feel it's not appropriate in the given situation. Same exercise will be applied in online mode of training. Images of disaster and list of needs will be displayed in the slide, and participants will be asked to tell how would they establish LINK.

FACILITATORS GUIDE- Session 6

Session Name: Psychosocial first aid with vulnerable group (Refer chapter-6 in manual and workbook).

Aim: To facilitate the application of PSFA strategies while working with vulnerable group.

Methodology: Brain storming, role play and discussion .

Duration: 150 minutes.

Process: Facilitator gives an overview about the vulnerability and factors contributing to vulnerability during different disasters. After highlighting the need for focusing on vulnerable groups, the facilitator discusses the PSFA strategies that could be applied with these groups in general and specific PSFA strategies while working with children, women, elderly and persons with disability. With a group exercise given below the session will be concluded.

Outcome of the session: Participants will be able to provide PSFA for vulnerable groups of people.

Activity 6

Description of the activity: PSFA with Vulnerable Group.

Aim: To make the participants apply PSFA strategies while working with vulnerable groups.

Duration: 150 minutes.

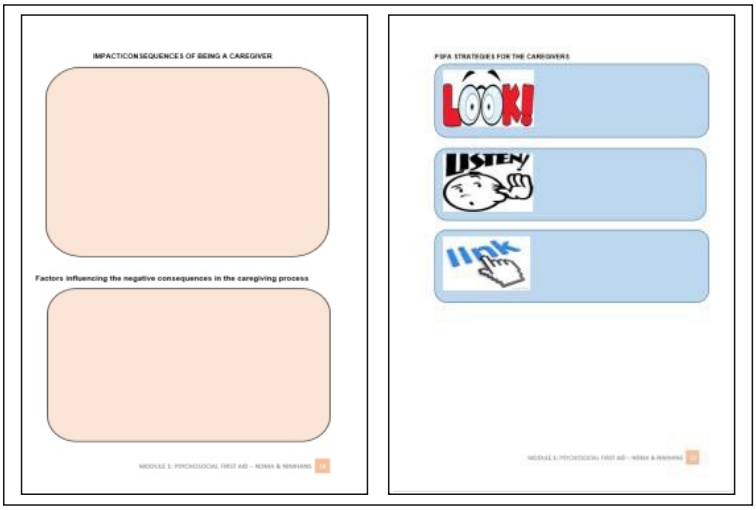
Materials required: Case scenarios, chart papers and marker pens.

Facilitator will divide the participants into 5 groups. Each of the group will be given the case scenario listed below, for which they will be instructed to plan PSFA. 10 minutes will be given for the group activity. Once all are done, they will be asked to present it to the floor. Others will be encouraged to ask questions or add their views on the PSFA plans. In the end facilitator will add on the points left out and concludes the session. When the activity done online, case scenarios will be displayed one by one and members will be invited to volunteer to express their PSFA plans for the given scenario.

Case scenarios

1. A 8 years old child tested positive for COVID 19 and witnessing unpleasant events.
2. A 17 year old girl is expected to play the role of a parent due to the death of both the parents in building collapse at the construction site.
3. A 32 years old woman sexually harassed during communal violence.
4. A 54 years old man having mobility issues lost his house due to flood and lost his livelihood.
5. A 73 years old elderly person who stays at a relief center, away from his family after the earthquake and longing to reunite with the family.

FACILITATORS GUIDE- Session 7



Session Name: Psychosocial first aid for care providers (Refer chapter-7 in manual and workbook).

Aim: To make the participates understand the need for self-care

Methodology: Brainstorming and free listing.

Duration: 30 minutes.

Process: Facilitator introduces the topic and the activity given below will be conducted to brainstorm the participants on the psychosocial consequences of being a care provider. Once the activity is done, the facilitator adds on to the list consequences and also discusses about the PSFA strategies that could be utilized for the care providers to take better care of themselves.

Outcome of the session: Participants will understand the need for self-care and PSFA strategies that could be applied.

Activity 7

Description of the activity: Consequences of caring.

Aim: To facilitate understanding among participants about the consequences of caregiving.

Duration: 30 minutes.

Materials required: Story cards and a list of probing questions.

The participants will be shown the story cards depicting the images of their everyday stressors. They will be asked probing questions that would help them understand the consequences of caring and identify/express if they have experienced/experiencing the same. Finally, the facilitator would conclude the session by suggesting PSFA strategies to deal with the stressors.

Probing questions

1. What do you see in the picture?
2. What does this picture mean to you?
3. How could you relate yourself to this picture?

National Disaster Management Training Module -1
Workbook

Psychosocial First Aid


March 2023

Jointly Developed by

National Disaster Management Authority
(NDMA)

National Institute of Mental Health and Neuro Sciences
(NIMHANS)

CONTENT

SOCIO-DEMOGRAPHIC PROFILE

1. Name (Initials):.....

2. Contact Details: Email: .....

Phone Number (Optional): .....

3. Age: .....

4. Sex: Male ☐ Female ☐ Others ☐

5. Marital Status: Married ☐ Unmarried ☐ Divorced/separated/widow/widower ☐

6. Education: Schooling 1-10th std ☐ Graduate ☐ Post Graduate ☐ Others (specify) ☐

7. Place of residence: Urban ☐ Rural ☐ Semi urban ☐

8. Current Address:.....

.....

9. Occupation: .....

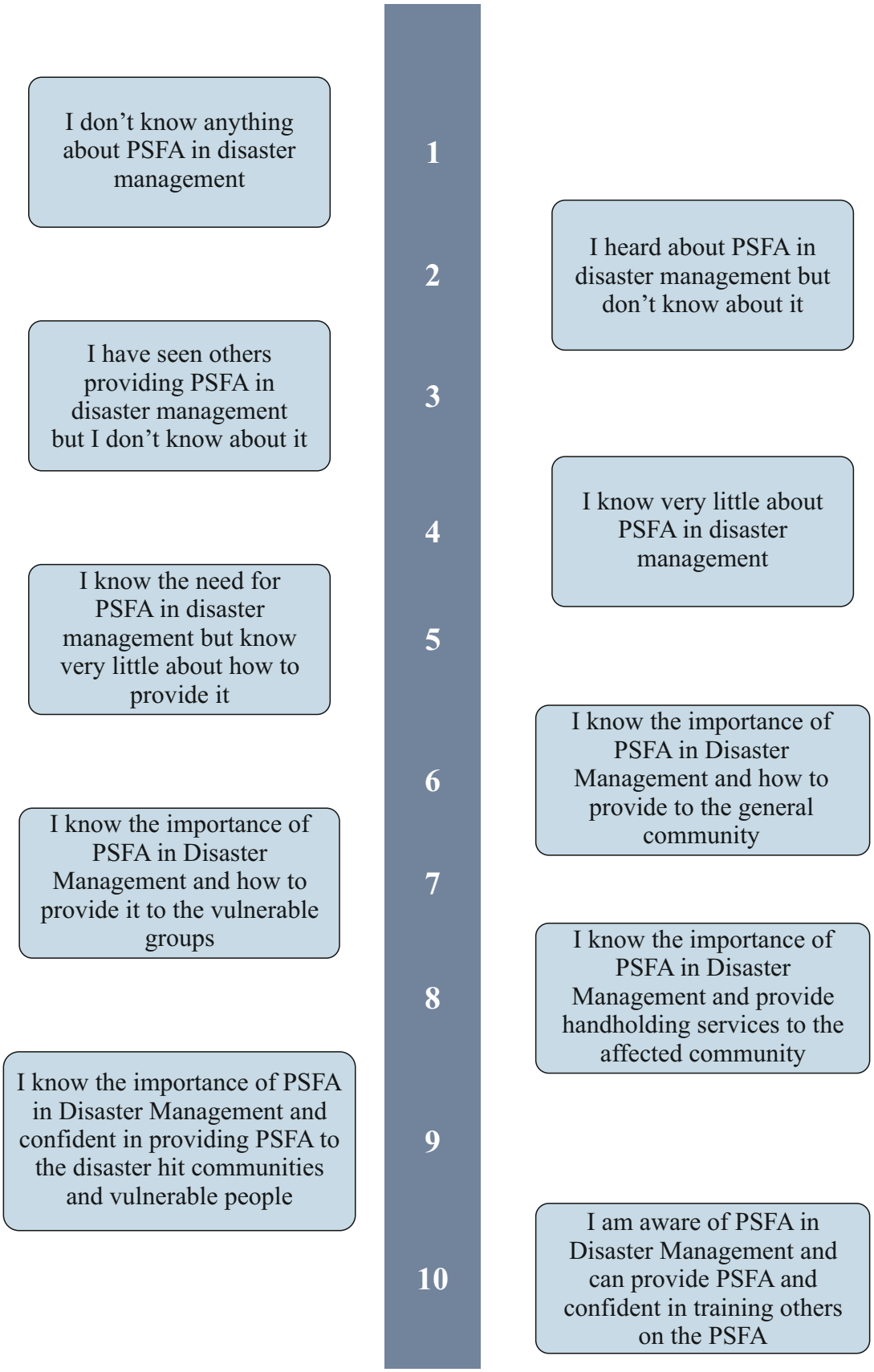
10. Monthly Income: .....

11. Years of Experience: .....

12. What are your expectations from the training?

.....

KNOWLEDGE ON PSYCHOSOCIAL FIRST AID (PSFA) IN DISASTER MANAGEMENT



PRE/POST ASSESSMENT - KNOWLEDGE

1. What indicates an emergency situation in disaster

a. Severity of impact and nature of support required
b. Severity of the impact and amount of damage
c. Severity of the impact, amount of damage and nature of support
d. None of the above

2. When needs are not met it affects the restoration of individuals and community

a. Safety needs
b. Basic Needs
c. Instrumental needs
d. Higher order needs

3. Psycho-social first aid (PSFA) can be provided to persons experiencing distress after

a. 1-3 months
b. 3 - 6 months
c. Few days to weeks
d. Before the onset of disaster

4. Crisis intervention is based on

a. Psychological First Aid
b. Identifying nature of crisis
c. Crisis resolution
d. Crisis management

5. What falls on the tip of the Pyramid of psychosocial needs

a. Basic needs
b. Resilience
c. Adaptation to loss
d. Safety needs

6. A person has a severe injury and not able to take care of himself. He might need:

a. Psycho-social Support
b. Safety Services
c. Social Support
d. Advanced care

7. Which of the following does not indicate culture sensitivity while providing PSFA?

a. Appropriate Dress
b. Respect and Greeting
c. Native Languaget
d. Not knowing similarities exist

8. What are the action principles of PSFA?

a. Prepare, Look, Listen, Link
b. Look, Listen, Link, Prepare
c. Prepare, Listen, Look, Link
d. Listen, Prepare, Look, Link

9. The action principle look is related to

a. Practical support
b. Primary needs
c. Secondary needs
d. Higher order interventions

10. Helps in establishing and maintaining rapport with survivors

a. Linking
b. Listening
c. Preparing
d. Looking

11. What are the common reactions post disaster?

a. Physical
b. Relational
c. Both a & b
d. None of the above

12. Is the process that connects the affected individual to support

a. Joining
b. Linking
c. Uniting
d. Preparing

13. Termination of PSFA can be done when

a. When the expected outcome is achieved
b. When the duration is ended
c. When the severity is reduced
d. When the issue is resolves

14. What factor that mitigate stress and promote adaptation among affected people

a. Resilience
b. Social support
c. Cohesion
d. Coping

15. The culmination of socio-cultural, biological, and psychological processes during disasters is

a. Psychological First Aid
b. Crisis Intervention
c. Psychosocial First Aid
d. Bio-psychosocial Model

16. Who can provide Psychosocial first aid

a. Qualified professionals
b. Persons with minimal or no education
c. Mental Health professionals
d. Anganwadi workers

17. What is not a normal stress reaction

a. Sadness
b. Confusion
c. Fear
d. Recurrent thoughts about the event

18. In the process of providing PSFA care providers may experience

a. Fear of rejection
b. Self-doubt
c. Fear of personal danger
d. All the above

19. What does not contribute to vulnerability

a. Disability
b. Age,
c. Possession of property
d. Culture

20. Match the following action principles of PSFA

a. Prepare — (i) Strength of vulnerable person and community
b. Look — (ii) Normalize their feelings and thoughts
c. Listen — (iii) Connect with protection agency and loved ones
d. Link — (iv) Identify resources within the community

Answer key

1	a	11	c
2	a	12	b
3	c	13	a
4	a	14	b
5	b	15	c
6	d	16	b
7	d	17	d
8	c	18	d
9	a	19	c
10	b	20	a (iv), b (i), c (ii), d (iii)

PRE/POST ASSESSMENT - ATTITUDE

Name of the participant:

Pre/Post rating: Date:

Instruction: Rate yourself in a scale of 1-10 (1 being least to 10 being highest). Be genuine with your response. There is no right or wrong answers.

S. No.	Items	Rating (1-10)
1	Ability to support persons who are experiencing disaster	
2	Ability to recognise distressed individuals who might need support	
3	Knowledge on what to say and do to support an individual in distress	
4	Ability to listen in a supportive manner keeping in mind the person's cultural background	
5	Ability to link persons affected by a disaster to appropriate services, information and social support systems	
6	Knowledge of what not to say or do while involving in the helping process	
7	Ability to care for yourself and your team while assisting persons in distress	
8	Ability to involve community in supporting an affected individual/family during crisis time	
9	Ability to provide supportive intervention (facilitating ventilation, active listening, providing reassurance etc.) to affected community	
10	How do you rate the need for psychosocial first aid for affected people	

CHAPTER 1 INTRODUCTION TO DISASTER

TYPES OF DISASTER

Natural disasters

Human-induced disasters

IMPACT OF DISASTER

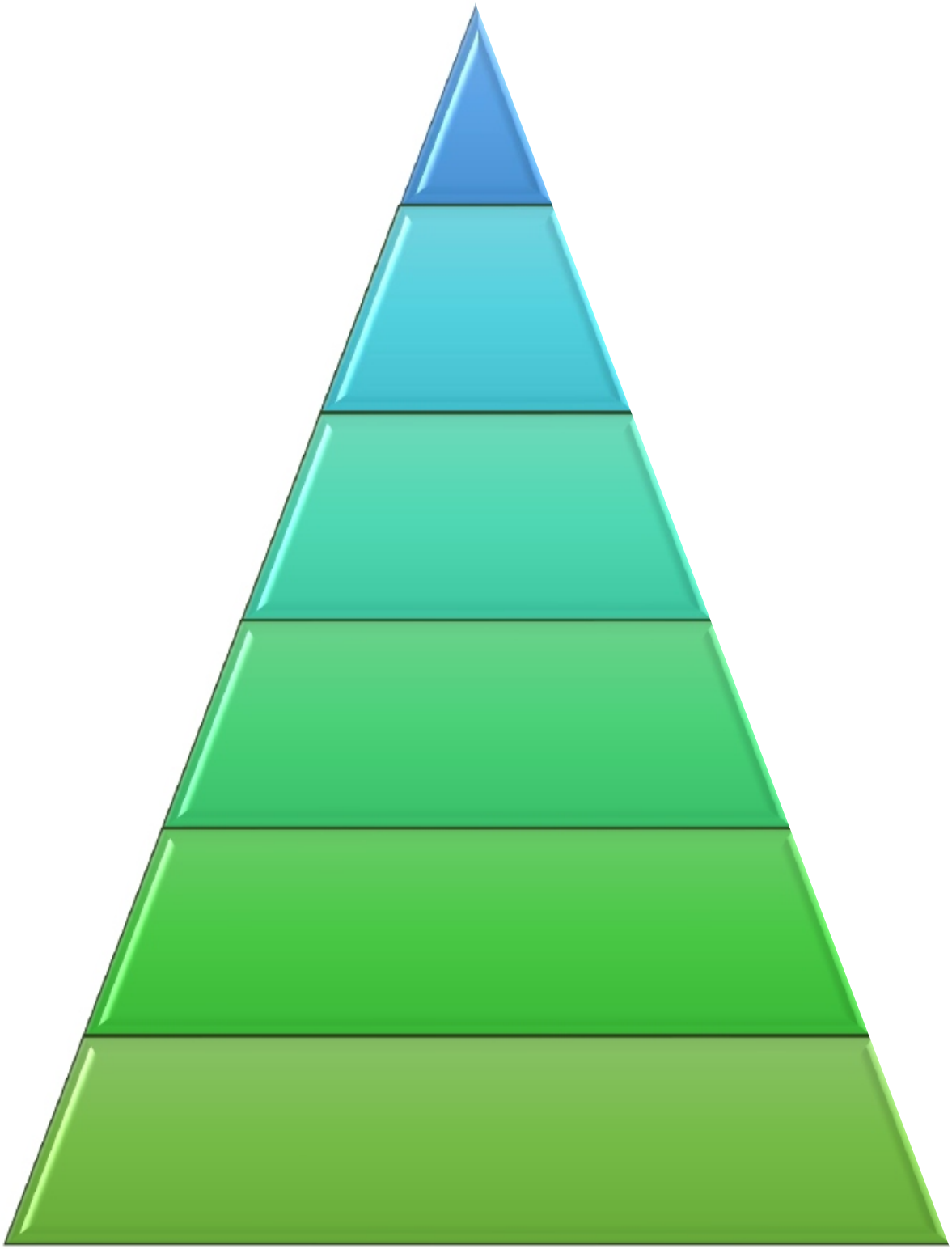
Physical

Psychological

Social

Economic

NEEDS OF PERSONS AFFECTED IN A DISASTER



CHAPTER 2 INTRODUCTION TO PSYCHOSOCIAL FIRST AID

PSYCHOSOCIAL FIRST AID

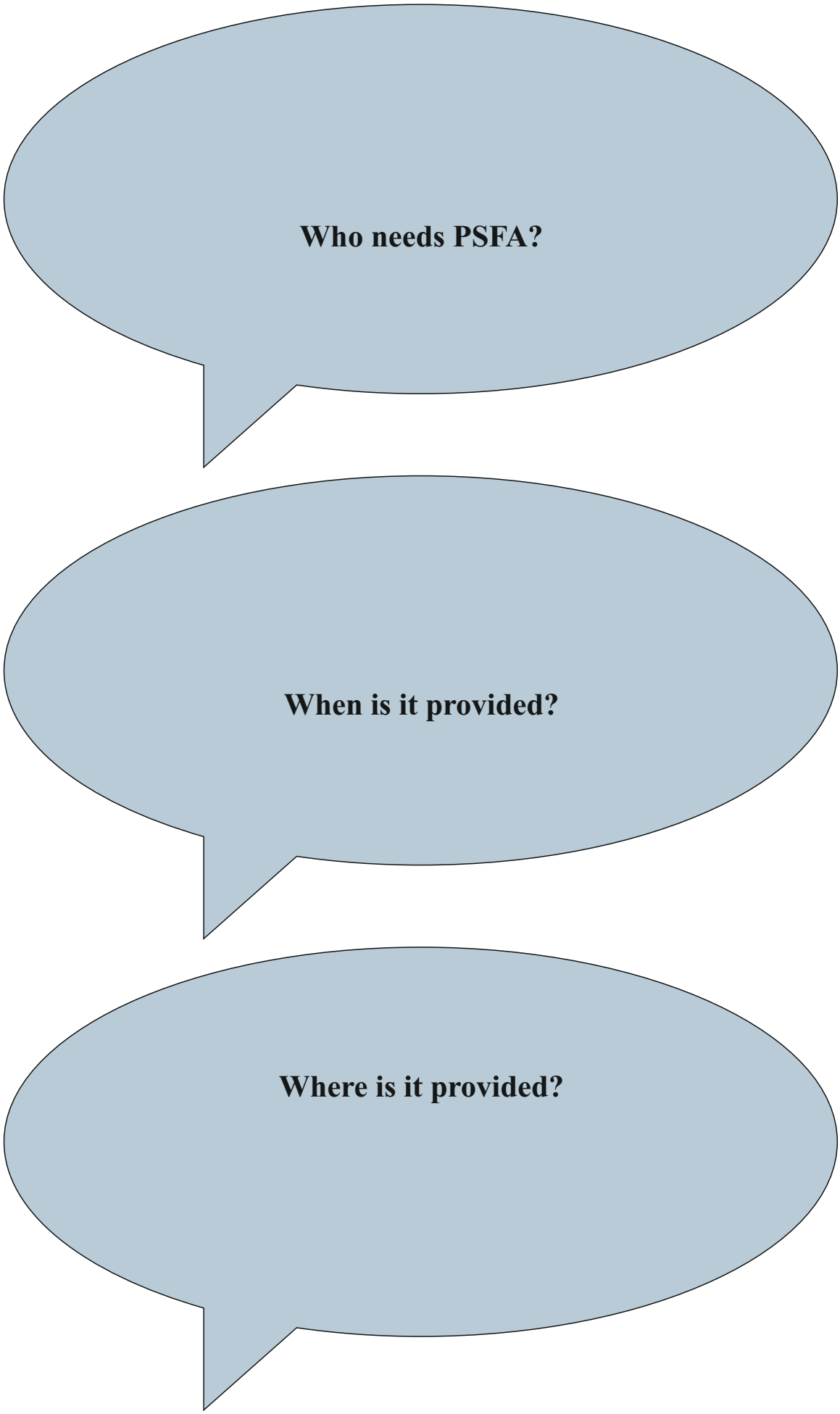
What is PSFA? ✓

What is not PSFA? ✗

INDICATORS TO IDENTIFY THE PERSONS REQUIRING HIGHER-ORDER INTERVENTIONS

-
-
-
-
-
-
-
-
-
-

-
-
-
-
-
-

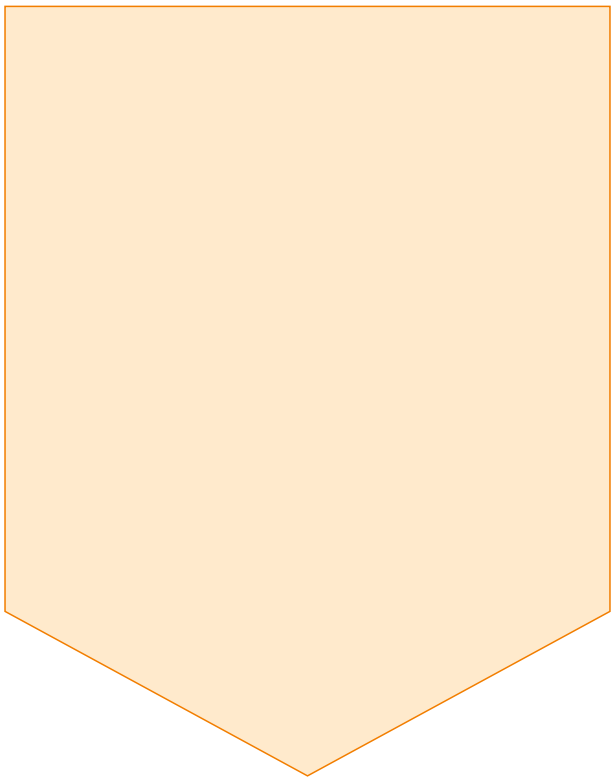

Who needs PSFA?
When is it provided?
Where is it provided?

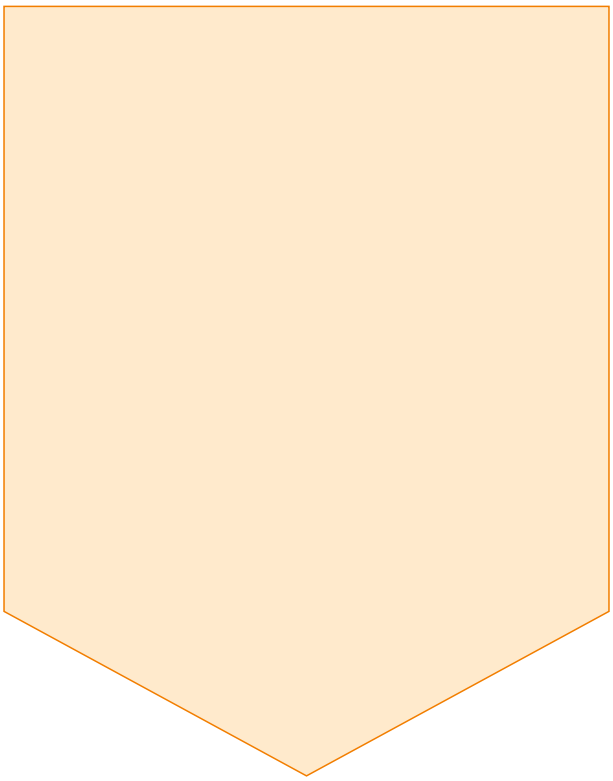
KEY COMPONENTS OF PSFA

Outcomes of PSFA	Ways to achieve the outcomes
Confirming personal safety	
Fostering comfort	
Enhancing social ties	
Promoting resilience	
Imparting confidence	

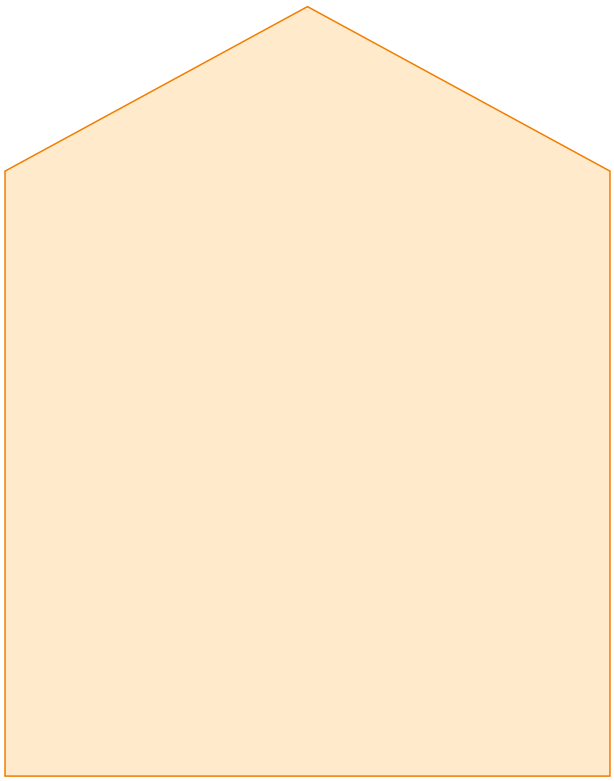
CHAPTER 3

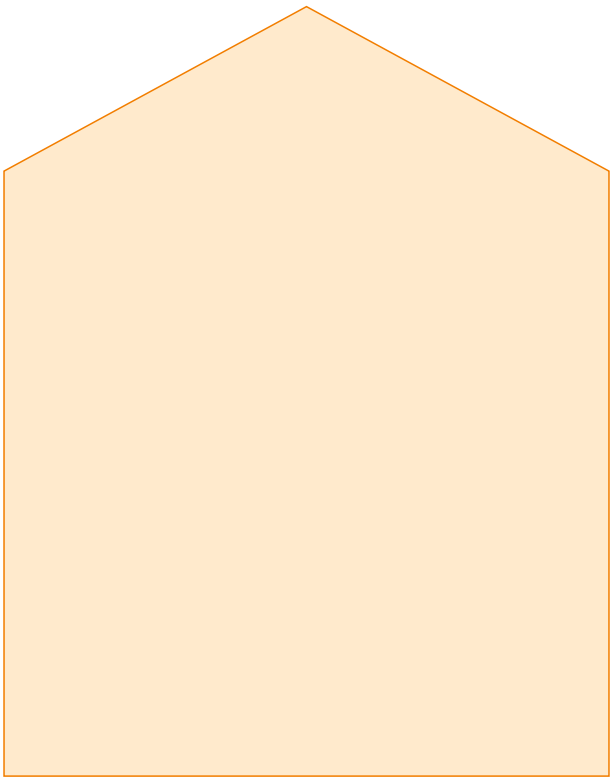
Psychosocial first aid strategies: prepare and look



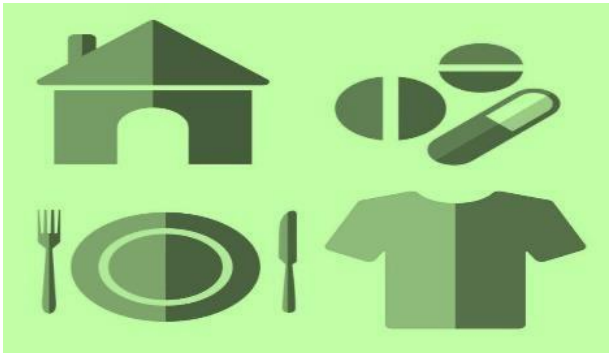


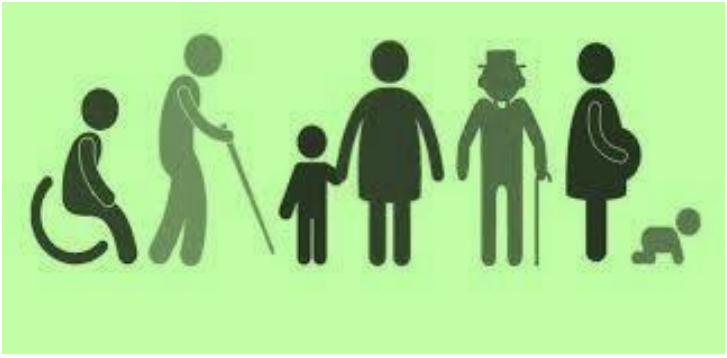
PSFA STRATEGIES





WHAT TO LOOK FOR WHILE PROVIDING PSFA

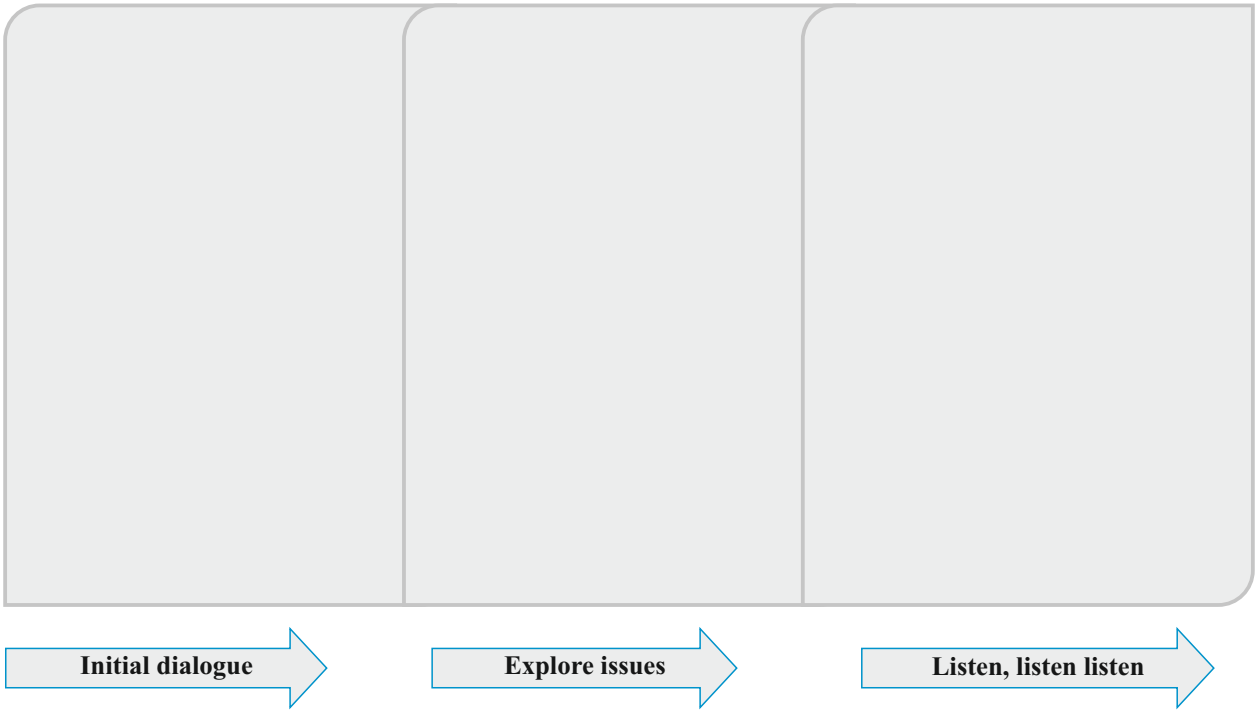




NORMAL AND ABNORMAL STRESS REACTION

Time	Normal reactions	Abnormal reactions
Immediate		
One to two weeks		
Six months		
Six months		
onwards Life long		

STRATEGIES TO FOSTER ACTIVE LISTENING



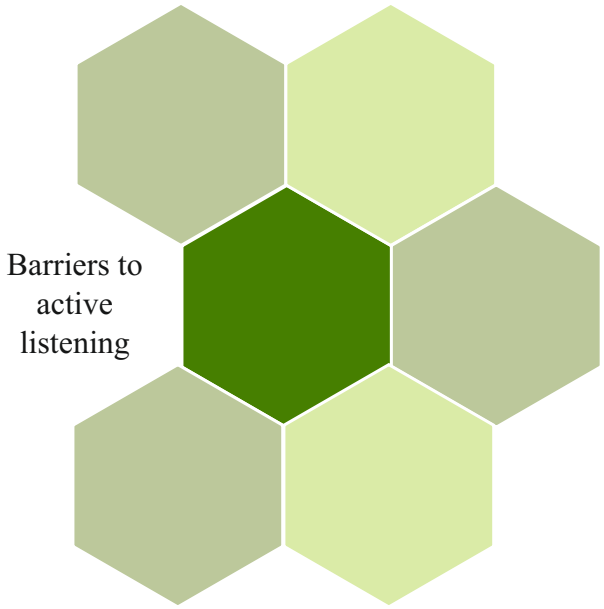
CHAPTER 4

PSYCHOSOCIAL FIRST AID STRATEGIES: LISTEN

Do's of effective listening

Active listening is the key for effective communication. Undoubtedly, paying undivided attention, genuinely listening to their concerns, and expressing the understanding foster effective communication with the survivors.

Don'ts of effective listening



CHAPTER 5

PSYCHOSOCIAL FIRST AID STRATEGIES: LINK

WHAT TO DO WHILE HELPING DISTRESSED INDIVIDUALS?

WELL OF COPING

CHAPTER 6

PSYCHOSOCIAL FIRST AID WITH VULNERABLE GROUP

INDICATION FOR TERMINATION

FACTORS CONTRIBUTING TO VULNERABILITY

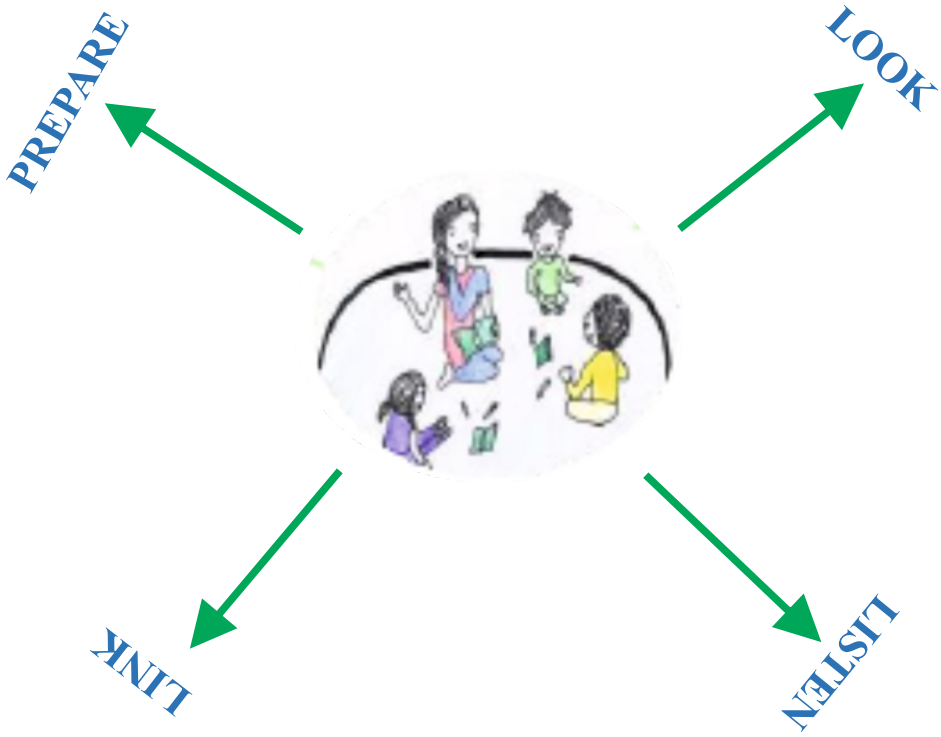
WHO ARE THE VULNERABLE GROUPS OF PEOPLE REQUIRING SPECIAL ATTENTION?

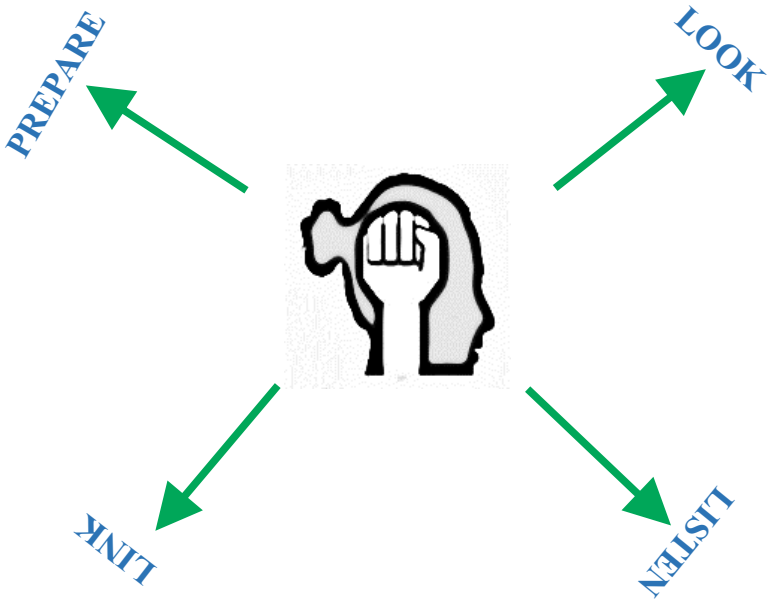
PSYCHOSOCIAL FIRST AID FOR VULNERABLE GROUPS

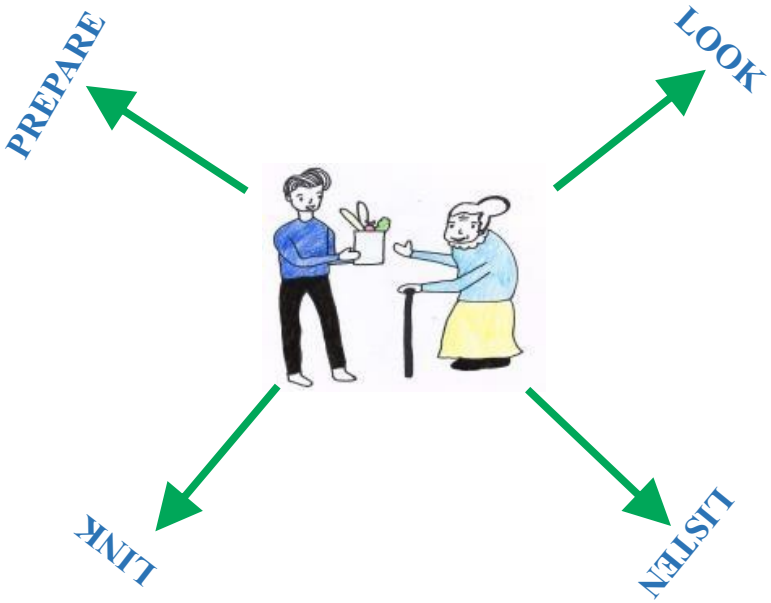

LOOK!

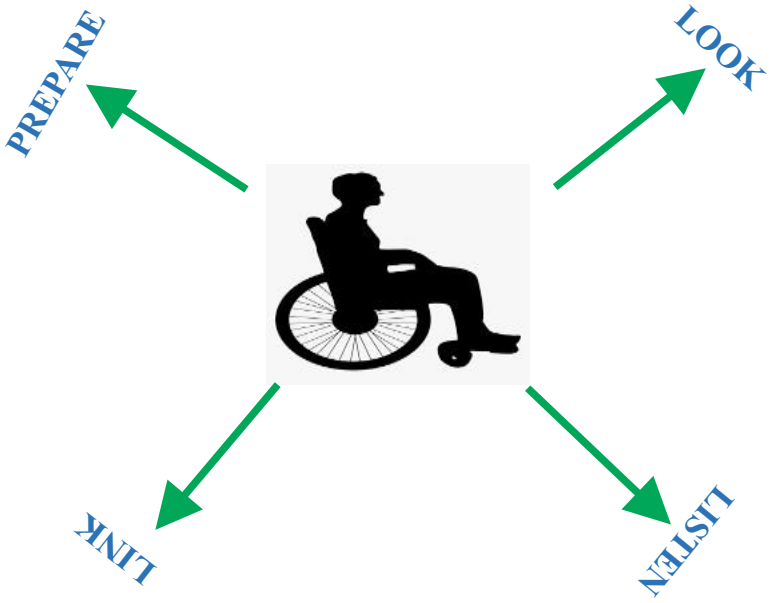

LISTEN!


LINK


PREPARE
LOOK
LINK
LISTEN


PREPARE
LOOK
LINK
LISTEN


PREPARE
LOOK
LINK
LISTEN


PREPARE
LOOK
LINK
LISTEN

IMPACT/ CONSEQUENCES OF BEING A CAREGIVER

Factors influencing the negative consequences in the caregiving process

CHAPTER 7 PSYCHOSOCIAL FIRST AID FOR CARE PROVIDERS

References

1. IASC Reference Groups MHPSS. IASC Guidance on Operational Considerations for Multisectoral Mental Health and Psychosocial Support Programmes during the COVID-19 Pandemic; IASC: Geneva, Switzerland, 2020; Available online: https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-guidance-operational-considerations-multisectoral-mental-health-and-psychosocial-support (accessed on 6 May 2022)(In Multiple Languages).
2. Jordan, K. (2015). The disaster survivor's hierarchy of needs: What every disaster mental health worker should know. American Counseling Association: Alexandria, VA, USA, 7.
3. National Disaster Management Guidelines: Psycho-Social Support and Mental Health Services in Disasters, 2009. A publication of the National Disaster Management Authority, Government of India. ISBN 978-93-80440-00-2, December 2009, New Delhi.
4. NDMA. (2009). Retrieved from National Disaster Management Policy: https://ndma.gov.in/sites/default/files/PDF/national-dm-policy2009.pdf
5. NDMA. (2015-2016). Annual Report. New Delhi: National Disaster Management Authority.
6. NDMA. (2021). Annual Report. New Delhi: National Disaster Management Authority.
7. World Health Organization. (2011). Psychological first aid: Guide for field workers. World Health Organization.

Project Advisory Committee (PAC)

1. **Shri. Krishana S Vatsa,** Member, National Disaster Management Authority, and PAC Chairman, New Delhi.
2. **Dr. Nimesh Desai,** Director, Institute of Human Behavior and Allied Sciences (IHBAS), Delhi.
3. **Dr. Jacqueline Joseph,** Professor, Centre for Disaster Management, Jamsetji Tata Institute of Social Sciences, Mumbai.
4. **Ms. Sindhuja Khajuria,** UNICEF, Communication Consultant, New Delhi.
5. **Dr. Atreyi Ganguli,** National Professional Officer, Mental Health and Substance Abuse, WHO, India.
6. **Dr. Saurabh Dalal,** National Professional Officer, Emergency Risk and Crisis Management, WHO, India.
7. **Shri. Maître Mukerji,** Senior Consultant, National Disaster Management Authority, New Delhi.

Project Team

Dr. K. Sekar, Former Prof. and Head, Department of Psychosocial Support in Disaster Management, National Institute of Mental Health and Neuro Sciences, Bangalore.

Dr. Jayakumar C, Associate Professor, Principal Investigator, Department of Psychosocial Support in Disaster Management, National Institute of Mental Health and Neuro Sciences, Bangalore.

Dr. Patrick Jude, Project Coordinator, Department of Psychosocial Support in Disaster Management, National Institute of Mental Health and Neuro Sciences, Bangalore.

Dr. Veena Sree, Project Coordinator, Department of Psychosocial Support in Disaster Management, National Institute of Mental Health and Neuro Sciences, Bangalore.

Mrs. Jayashree, Project Associate, Department of Psychosocial Support in Disaster Management, National Institute of Mental Health and Neuro Sciences, Bangalore.

Mrs. Aleena Mathai, Project Associate, Department of Psychosocial Support in Disaster Management, National Institute of Mental Health and Neuro Sciences, Bangalore.

Ms. Irien Joe, Project Associate, Department of Psychosocial Support in Disaster Management, National Institute of Mental Health and Neuro Sciences, Bangalore.