

Research Paper

Psychosocial Care for the Disaster-Affected: Assessing the Attitudes, Skills, and Knowledge of Accredited Social Health Activists in Kerala

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ABSTRACT

This study is conducted in a time in which growing concerns over the increasing number of disasters of various forms and intensities across the globe due to climate change. The psychological, emotional and psychosocial after-effects of a disaster may persist for extended periods due to the nature and extent of the loss and trauma associated with it. In a country like India, where there is a severe shortage of mental health professionals to cater for the essential mental health needs of the population, providing psychosocial care to the disaster-affected may be an arduous task. The development of a culturally sensitive and community-based psychosocial care system may be one of the best alternatives in this scenario. It has been proven that trained members in a community can play a crucial role in the psychosocial care of the disaster affected. This study was conducted among the Accredited Social Health Activists (ASHA) of Kerala, to know their attitude, knowledge and skills in providing psychosocial care to the disaster affected. Findings indicate that ASHAs have a favourable attitude towards, and average knowledge about psychosocial care and are highly skilled in providing psychosocial care to the disaster affected. Also, there is a significant positive correlation between attitude and skills and knowledge and skills. This finding emphasises the need for incorporating attitude change and knowledge-imparting components in the psychosocial care training programmes. The findings have policy implications in the identification, organisation and training of people within a community to provide effective psychosocial care.

Keywords: ASHA, Psychosocial Care, Climate Change, Disasters

Disasters have become a complex global issue with an increasing number of individuals and communities being affected every year. These disasters not only have physical consequences but also disrupt the mental health and well-being of the affected population. The burden of disasters is higher in developing countries, where poverty, lack of resources, poor infrastructure, and lack of awareness and knowledge of disaster mental health make the aftermath of disasters more severe. Mental health issues, in general, have been neglected and stigmatized, making it difficult to address mental health concerns after a disaster (The Lancet, 2009; Vigo et al., 2016). India is a country that is

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highly vulnerable to different types of disasters of varying intensities, leading to countless losses in the affected population. The aftermath of disasters has a significant impact on the socio-economic, psychosocial, physical health and mental health of the victims. Though governments and other agencies are taking action to address the socio-economic issues, the mental health concerns of the affected population cannot be addressed without psychosocial interventions.

The psychological and emotional impact of disasters is often neglected, and this neglect can continue for months, years or even decades (Gray et al., 2020; Hayes et al., 2018; Morganstein & Ursano, 2020; Seto et al., 2019; Sherchan et al., 2018). The scars on mental health due to a disaster are often unnoticed or neglected, and effective psychosocial care is often missing. In a country like India, where there is a severe shortage of mental health professionals, providing effective psychosocial care to disaster-affected individuals may be a challenging task. In this context, Community-based psychosocial support is crucial to address the mental health concerns of the affected population. The importance of involving the community in psychosocial care during and after a disaster is crucial, as they can provide essential psychosocial care to the affected individuals. If adequately organized in advance, the community resources can be mobilized to provide essential psychosocial care during and after a disaster, effectively. Moreover, most agencies and governments are currently trying to have an integrated plan to link community-based psychosocial services with disaster risk reduction activities (Gray et al., 2020; IASC, 2021). This shift is based on the Hyogo Framework for Action 2005-2015: Building the Resilience of Nations and Communities to Disasters (UNISDR, 2005) and the Sendai Framework for Disaster Risk Reduction 2015–2030 (UN, 2015). The Sendai framework explicitly emphasizes the need to incorporate the local community in all levels of disaster risk reduction, including psychosocial support. Community involvement in psychosocial care is necessary to provide continuous and sustainable psychosocial care mechanisms for the disaster-affected population. Several studies have identified the significant role of the community in the provision of psychosocial care (Aldrich, 2012; Eisenman et al., 2007; Mathbor, 2007; Tierney, 2014).

The psychological and emotional responses of the affected population may vary based on personal and community coping strategies, the nature and availability of community support, and other socio-demographic factors like age, gender, marital status, socio-economic status, and family support. The psychosocial impact may also vary based on the nature and intensity of the disaster, the degree of exposure to the disaster, and the perceptions of the individual. Therefore, a culturally sensitive and community-based psychosocial care plan should be there to cater to the needs of different sectors and vulnerable sections of the community. Since the community is the first responder to any disaster, they can play crucial roles in a disaster's response, recovery, rehabilitation, and reconstruction phases. For this, a sustainable and continuous psychosocial care mechanism with the involvement of the local community is essential, (Amaratunga & O'Sullivan, 2006; Bhadra, 2013; Chandra et al., 2006; Diaz et al., 2006; Gailits et al., 2019; Gray et al., 2020; Hechanova & Waelde, 2017; Nahar et al., 2014; O'Hanlon & Budosan, 2015; Pfefferbaum & Klomp, 2013; Rao, 2006; Reyes, 2006; Satapathy & Bhadra, 2009; Weissbecker et al., 2019; Wessells, 2009; WHO, 1992)

To ensure that the help is received by people irrespective of their region, social, cultural, and economic background, gatekeepers must be designated at the primary level. The term gatekeeper refers to “individuals in a community who have face-to-face contact with large

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numbers of community members as part of their usual routine.” (U.S. Department of Health and Human Services Office of the Surgeon General and National Action Alliance for Suicide Prevention, 2012). Gatekeepers are from the same community, so they are aware of the social and cultural setup of the locality. In India, an Accredited Social Health Activist (ASHA) may be the best person to act as a gatekeeper to provide psychosocial care to the disaster affected during and after a disaster.

The Accredited Social Health Activist (ASHA) program was launched in India in 2005 as part of the National Rural Health Mission (NRHM) to provide basic healthcare services and referrals to rural and underserved populations. ASHA is a female community health worker who is selected from the local community and trained to provide basic healthcare services and referrals (ASHA guidelines, 2013). Since ASHA belongs to the local community, they can act as a support system during and after a disaster by eliminating the problem of geographic and cultural limitations and can provide psychosocial care effectively.

This study was conducted against the backdrop of the 2018 and 2019 floods in Kerala. As per the report of the Kerala State Disaster Management Authority (KSDMA, 2018),

"Flooding has affected hundreds of villages, destroyed several roads and thousands of homes have been damaged. 1,259 out of 1,664 villages spread across its 14 districts were affected. The devastating floods and landslides affected 5.4 million people, displaced 1.4 million people, and took 433 lives (268 men, 98 women and 67 children). Several relief camps were opened to save the people from the vagaries of the flood."

ASHAs were actively involved in the psycho-social care services of the disaster affected. ASHAs in the affected Panchayats were given short-term training by the state disaster management authority to provide psychosocial care to the disaster-affected. They visited the disaster-affected houses and relief camps and gave psychosocial support to those in need. Even with minimal training in psychosocial care, they could easily connect with the affected individuals since they were from the affected community.

However, the current training programmes on psychosocial care by various agencies have given importance to skill training over knowledge and attitudes components. The effectiveness of psychosocial care not only depends on the skills of the provider but also on their knowledge and attitude towards psychosocial care. Though ASHAs have undergone training related to various aspects of health and some of them have undergone training in psychosocial care of the disaster affected, there are no studies conducted to assess their attitude, skills and knowledge to provide psychosocial care to the disaster-affected people. Thus, the present study is envisioned to get a better understanding of the existing knowledge, attitude, and skills of ASHA's regarding psychosocial care of the disaster affected. This may assist policymakers in designing appropriate policies and training programs for ASHA's in the effective provision of psychosocial care.

Objectives

1. To identify the nature and extent of ASHA's attitude towards, knowledge about and skills to provide psychosocial care to disaster affected.
2. To find out whether there is any significant relationship between ASHA's attitude towards, knowledge about and skills to provide psychosocial care to the disaster affected.

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3. To find out whether trained and untrained ASHA's differ in their attitude towards, knowledge about and skills to provide psychosocial care to the disaster affected.

Hypotheses

1. There will be a significant positive correlation between ASHA's attitude towards and knowledge about psychosocial care of the disaster affected.
2. There will be a significant positive correlation between ASHA's knowledge and skills to provide psychosocial care to the disaster affected.
3. There will be no significant difference in the attitude towards the psychosocial care of trained and untrained ASHA's.
4. There will be no significant difference in the knowledge about psychosocial care of trained and untrained ASHA's.
5. There will be no significant difference in the skills to provide psychosocial care of trained and untrained ASHA's.

METHODOLOGY

Sample

Two hundred and twenty-two respondents with an average age of 39 were randomly selected through multistage sampling from 60 panchayats of the five flood-affected districts of Kerala- Pathanamthitta, Alappuzha, Kottayam, Idukki and Ernakulam- constituted the sample of the study. Out of the 222 respondents, 71 got basic psychosocial care training, 125 were affected by a disaster, and 93 stayed in a relief camp due to a disaster. Randomly selected 400 ASHAs were approached for data collection, out of which 260 responded proactively (response rate is 0.65) and gave their consent to participate in the study. Among the 260 respondents, 38 were removed because of incomplete data, incomplete responses to the items in the survey instrument, multiple answers to the items and lack of reliability of responses.

Instruments

This study employed a specially developed survey instrument to collect data from the respondents about their attitude toward, knowledge about and skills for the psychosocial care of the disaster affected. The survey instrument has five parts: Part-I to elicit socio-demographic details of the respondents; Part-II to understand the respondent's experience and exposure to various aspects of disasters and psychosocial care; Part -III to identify the attitude of the respondent towards the psychosocial care of the disaster affected; Part-IV to understand the respondent's knowledge about psychosocial care and Part-V to identify the skills of the respondent to provide psychosocial care.

Procedure

During the visit to the selected Panchayats, the investigator met the ASHA coordinator and collected the contact details of ASHAs in that panchayath. After randomly selecting ASHAs of the panchayath, the field investigator met them directly after taking prior appointments. During the meeting, the field investigator explained the details of the study and answered the queries raised by ASHA. Once they had given their consent to participate in the study, the survey instrument was given to them, and after completion, it was collected.

RESULTS

Table No. 1 ASHA's attitude towards, knowledge about and skills to provide psychosocial support to the disaster affected

Variable	n	M	SD	Nature of Attitude/Knowledge/Skill
Attitude	222	59.14	12.41	Favourable
Knowledge	222	12.55	2.97	Average
Skills	222	71.73	14.78	High

Attitude scale: Less than 28-Highly Unfavourable; 28-45 – Unfavourable;

46-54 – 55-72 –Favourable; More than 72- Highly Favourable

Knowledge scale: Below 9 – Poor; 9-14- Average; above 14- Good

Skills scale: Less than 28-Very Low; 28-45 – Low; 46-54 – Average; 55-72 – High; More than 72-Very High

Table No. 2 Relationship between ASHA's attitude towards, knowledge about and skills to provide psychosocial support to the disaster affected

	Knowledge	Skills
Attitude	.09	.15*
Knowledge		.25**

** Significant at 0.01 level

* Significant at 0.05 level

Table No. 3 The difference in Attitude, Knowledge and Skills of trained and untrained ASHA to provide Psychosocial Care

Variable	Trained	N	Mean	SD	df	t
Attitude	No	151	57.91	12.02	220	2.16 *
	Yes	71	61.73	12.90		
Knowledge	No	151	12.21	3.03	220	2.42*
	Yes	71	13.23	2.73		
Skills	No	151	71.22	14.73	220	.46
	Yes	71	72.80	14.93		

*Significant at 0.05 level

DISCUSSION

One of the major findings of the study is that ASHAs have a favourable attitude towards the psycho-social care of the disaster affected. As part of their regular work, an ASHA has to undergo various training programmes related to the general health of people. Due to the influence of these training programmes, ASHAs might have developed a favourable attitude towards psycho-social care of disaster-affected people. Also, their regular interaction with people suffering from various health-related issues might be instrumental in developing a favourable attitude towards the care of such people in general and towards the care of the disaster affected in particular. Since ASHAs have a favourable attitude, it may enhance the quality and effectiveness of the care they provide.

Though ASHAs have a favourable attitude towards the psycho-social care of the disaster affected, their knowledge about psychosocial care is average only. The reason may be that the general training they have undergone has minimal or no information about psychosocial care. This point is further substantiated by the finding that the knowledge of psychosocial care of ASHAs undergone at least some kind of training related to the psychosocial care of

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the disaster affected is higher than compared to those who have not at all undergone any such training programmes. This finding indicates the need for systematic training programmes for ASHAs in the delivery of psycho-social care to the disaster-affected. Through such training, the knowledge level may increase and which in turn equips ASHAs to provide quality care more effectively. This finding also indicates the need to incorporate information about different aspects of psycho-social care of the disaster-affected in the training programmes for ASHAs.

One of the most important findings of this study is that ASHAs have a high level of skills to provide psychosocial care. Though the data is gathered through self-reported measures, with all its limitations, this finding is a promising one. This may be due to the influence of various training programmes they have undergone, including programmes related to psycho-social care of the disaster affected. Most of the training programmes of ASHAs focus on the development of their skills to effectively deliver various health-related services to the community. This argument is further supported by the finding that there is no significant difference in the level of skills of ASHAs who received some training in psycho-social care of the disaster affected and those who did not.

Yet another finding is important in the context of psycho-social care. Significant positive correlations are found between attitude and skills and knowledge and skills of ASHAs. Thus, an ASHA with a favourable attitude may have the potential to develop the necessary skills to provide psycho-social care to the disaster affected. Similarly, ASHAs with better knowledge of psychosocial care may have a high potential to develop the skills needed to provide care to disaster-affected people. This implies that the training programmes of ASHAs not only focus on the skill training part but have to focus on incorporating and strengthening the attitude and knowledge components too.

Implications

Most of the findings of this have significance in terms of policy-making. First, in a country like India, where there is a severe shortage of mental health professionals is there to cater to the general mental health needs of people. If we have a national policy to train ASHAs to provide psychosocial care to the disaster affected then it has two advantages: one, there will be a number of trained people to provide psychosocial care during and after a disaster; two, we will have trained people in the local community level to provide psychosocial care in the event of a disaster.

Second, since ASHAs are potential gatekeepers in the unfortunate event of a disaster, they have to be trained scientifically and organised systematically following a top-down and bottom-up approach so that effective, timely and sustainable psychosocial care can be provided to the disaster-affected people in the community. Third, government, agencies, organisations and institutes can think of incorporating information about the psycho-social care of the disaster affected while designing general training programmes for ASHAs. Finally, specific training programmes focusing only on psychosocial care of the disaster affected have to be provided to ASHAs so that they effectively deliver their services during and after a disaster. Although such programmes are there at present, most of them focus on the enhancement of skills only. Along with skill enhancement training, if adequate focus is given to attitude change and knowledge enhancement components, then it will equip ASHAs to provide psychosocial care to the disaster affected in a more efficient, effective and sustainable manner.

CONCLUSION

This study aimed to identify Accredited Social Health Activists' (ASHA's) attitude, knowledge and skills to provide effective psychosocial care for the disaster affected. The findings underline the importance of ASHA as a gatekeeper to provide community level psychosocial care during a disaster. Also, the findings indicate the need to reframe the existing policies and training programmes in psychosocial care for the disaster affected by the inclusion of attitude and knowledge components.

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Conflict of Interest

The author(s) declared no conflict of interest.

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