Session 2.10 Reproductive, Maternal and Child Health:

Effects of the Tsunami on the Health of Thai Children

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Abstract

Thousands of children were psychologically affected by the tsunami disaster of December 26, 2004. Most of the affected children were reunited with families. Khon Kaen University sent a paediatric care team which delivered psychosocial first aid to 830 of the most directly affected children. Therapeutic child-art revealed persistent anxiety and some children expressed anger. Of concern, children at home and in school were easily accessed by the media, resulting in repeated traumatisation. Teacher training and assistance have been initiated to promote the community's recovery, to ensure media adherence to child rights, and to provide child security.

Background

Prior to December 26, 2004, Thailand had a reputation for being free of severe natural disasters. The tsunami disaster, therefore, took the nation by surprise as it resulted in thousands of fatalities and thousands more casualties. One-third of the victims were children. More than 1 000 children lost a parent, and 100 lost both parents. Only two of those 100 children needed care from the state as the others were 'adopted' by extended family, a tradition in Thai culture. Children who lost their homes and were placed in temporary shelters totalled 2 000. Unicef-Thailand estimates that 50 000 children were psychologically traumatised by this event, either directly or because of recurring, repetitive media coverage.

Pre-Disaster Family Structure (Table 1)

Item		Ranong		Phang-Nga		Total	
		#	%	#	%	#	%
Marital status of adults	Single	5	4	20	7	25	6
	Married	116	91	261	86	377	87
	Widowed, divorced or separated	7	6	24	8	31	7
	Total adults	128	100	305	100	433	100
Families		128		305		433	
	Average size	4.8 (1.6)		4.7 (1.7)		4.7 (1.7)	
Comprising	Head	40	4	123	40	163	38
	Spouse	75	59	146	48	221	51
	Grandparents	0	0	3	1	3	1
	Son/daughters	10	8	26	9	36	8
	Relatives	3	2	7	2	10	2
	Children between 0 and 18 (boys/girls)	**252 (131/121)**		**578 (288/290)**		**830 (419/411)**	
	Mean age (SD)	**8.3 (1.9)**		**9.1 (1.8)**		**9.3 (1.3)**	

Khon Kaen University (KKU) (based in Northeast Thailand some 1 500 km away from the disaster), with financial support from Unicef-Thailand conducted a *Rapid Needs Assessment Survey* of children affected by the tsunami. KKU has a worldwide reputation for its Rapid Rural Assessment techniques and its Health Science Consortium is one of the country's top centres for community medicine, paediatrics, and public health epidemiology.

In Ranong, 71% of the population depended on fishing; while in Phang Nga 43% earned their living through casual employment, mostly working at the hard hit Kao Lak tourist areas. People in these communities lived with extended families. Consequently, while parents were at work or absent, grandparents and/or other relatives took care of the children.

Methodology

The quantitative, rapid survey of Ranong and Phang Nga was conducted two weeks after the waves hit. It comprised 433 households with children so that altogether 830 children were included. A qualitative survey using focus group interviews of key informants complemented the quantitative survey.

To deal with psychological intervention, Unicef sponsored and coordinated a psychological first-aid program with the cooperation of Khon Kaen University, Prince Songkhlanagarind University, and Walailuk University, and the Centre for the Protection of Children's Rights Foundation. This program covered more than 1 100 students in 70 schools. The Department of Mental Health of the Ministry of Public Health and the Thai Paediatric Society provided counselling at the schools.

A follow-on was a psychosocial training course for teachers launched by the DMH, with support from Unicef. At the end of February with Unicef support, Khon Kaen University and the DMH conducted a psychosocial conference with an goal to establish provincial strategic psychosocial disaster response protocols.

Results

About one-third of the victims in the survey were children. Thirteen percent of children in the affected area suffered injuries. Seventeen percent of women who headed households had died or were missing. Vulnerable children in the affected areas included handicapped children (1.6 percent), and orphans or children whose parents were divorced or separated (7%); (although, based on the interviews this figure might be higher).

Most of the families surveyed had lost their homes, fishing gear and boats. Since fishing was the main source of income in most of the villages and this was devastated,

families lacked purpose, income and food. Therefore, 42% of families lacked food, 23% of potable water, and 17% proper sanitation.

Minority populations included the “Morgan” people, native islanders from nearby Ko Surin and other islanders. Another significant minority were the illegal, migrant workers from neighbouring Burma.

Thailand coped relatively well with the disaster as volunteerism from around the country and from visitors supplied labour, money and consumables. The provision of water, sanitation and shelter were adequate.

The Thai Ministry of Public Health responded with rapid and effective surveillance to control any outbreak of disease and none occurred. Measles vaccinations were given to children living in the shelters.

Several preschool daycares were established by the Department of Social Development and Human Security and NGOs. Three weeks after the tsunami, some schools, which had been destroyed, were replaced with new temporary facilities. The World Food Program complemented the government’s existing school lunch program.

Tsunami damage to schools in southern Thailand (Table 2)

Schools damaged In Province	Destroyed	Severe damage	Mild damage	Total
	#	#	#	
Phuket	1	-	9	10
Phang Nga	3	1	-	4
Krabi	**-**	***4***	***2***	***6***
Ranong	1	2	1	4
Trang	-	-	-	-
Satun	-	-	-	-
Total	**5**	**7**	**12**	**24**

Discussion

The broad sense of reciprocity gave the southern communities resilience in the face of disaster. Helpful too in responding to the disaster was religious faith. The far South has a large practising Muslim population and this group demonstrated a unified community response through surveillance and resource sharing. The Buddhist temples and monks were active, too, in providing refuge and facilitating identification and disposal of the dead.

From a paediatrician’s perspective, an alarming statistic was that post-disaster only 59% of the children were staying with parents, 20% with a single mother, and 1% did not have any caregiver at all. So, the big, unaddressed issue was the psychosocial problems.

The most common psychological response to any disaster among young children are eating and sleeping problems. By comparison, adolescents express fear. Indeed, the tsunami-affected children showed an on-going fear of the sea, which was remarkable for children who had grown up by the sea; now they avoided it. The therapeutic child-art reflected this persisting anxiety. Children drew houses with many stories and built on a hill. Some children expressed anger. Grief and bereavement were severe, especially among children whose parents were still missing with so many unidentified bodies found.

Families' Post-tsunami Response (Table 3)

Item	Ranong		Phang-Nga		Total	
	#	%	#	%	#	%
Fear	102	80	224	74	326	75
Shock	78	61	195	64	273	63
Sad	70	55	161	53	231	53
Passive	2	2	11	4	13	3
Stunned	4	3	4	1	8	2
Fear repeat	4	3	6	2	10	2
Anxiety	1	1	2	1	3	1
Depression	2	2	1	0	3	1

- Children between 0 and 5 years had eating problems (8%), disturbed sleep (6%), nightmares (1%), clinging to caretaker (6%), irritability and crying (5%), fear (0.5%), and depression (1%)
- Children between 6 and 12 had eating problems (12%), sleeping problems (10%), nightmares (2%), clinging to caretaker (2%), irritability and crying (1%), fear (9%), and depression (6%).
- Children between 13 and 18 had eating problems (11%), sleeping problems (8%), nightmares (2%), fear (18%) and depression (7%).

Regarding psychosocial issues among the children, the survey found that they were receiving little psychological support from caregivers, because those people, too, were grieving, suffering loss and/or were busy trying to restore order to their lives.

Actually, most caregivers and teachers lacked knowledge on the psychological reactions of children and means of responding therapeutically. Moreover, the situation had became chaotic due to several different organizations launching competing psychiatric programs; the lack of coordination and screening resulted in inappropriate use of psychometric testing and medications.

It is well established that classroom- and/or community-wide therapy is the best approach for treatment of post-disaster trauma. Concurrent screening can then be done for cases needing specific psychiatric care. Previous (underlying) mental disorders result in more serious reactions to trauma.

Most schools lacked any preparedness program. Unicef, therefore, assisted so that, wherever possible, all of the schools in the affected area were re-opened within two weeks sometimes in teachers' homes or under the trees. This was crucial as schools and peer groups played an essential role in the psychological recovery of the community. Indeed, schools *should* be involved in disaster management, but we observed an influx of visitors; the well meaning, the curious and the media. Teachers were overloaded with requests from visitors, who forgot that the teachers were also victims of the disaster, and children were easily accessed and classroom order disrupted. Evidently, the Children's Rights Convention (CRC) was not being adhered to.

The issue of Children's Rights is an obvious concern, what with children being repeatedly interviewed in the media and frequently without consent. The most severely affected children were brought to journalists for interviews, which the children could not (culturally or cognitively) refuse. Some children repeatedly retold of their loss and grief, which resulted in re-traumatisation.

Relatedly, several organizations recruited children into their research without proper assent from the children and/or consent from the families. Some children affected by tsunami reside in the other parts of the country (notably in Nakorn Phanom in the Northeast), and they have received little or no support.

Prior to the disaster, the far South had a pre-existing background of violence in many of the communities, in part due to sectarian violence. Serious drug abuse was also a pre-existing problem. The disaster disrupted the normal (albeit minimal) child protection mechanisms due to loss of caregivers, living in temporary shelters, and disruption of communities. These disaster-induced problems, coupled with an already weak child protection system, meant that post-disaster child protection was going to be a serious concern. Post-tsunami, the Department of Social Development and Human Security, with the support of Unicef, conducted a registration of affected children.

Children's Needs (Table 4)

Children's needs	Ranong		Phang-Nga		Total	
	#	%	#	%	#	%
Psychological	15	12	43	14	58	13
Educational	103	80	274	90	377	87
Supervision/security	28	22	62	20	90	21

Consequently, it was noted that teachers needed training on how to recognise the post-trauma psychological needs of their students. They also needed curricula to address the needs in class. The Ministry of Public Health needed to set up a screening program for individuals needing psychiatric interventions and to provide access to psychological /

psychiatric consultations and treatment. Treatment would be needed for the adults in the affected communities so that the treatment of the children would succeed. Therefore, the establishment of appropriate psychosocial programs is essential to the restoration of development opportunities of both affected children and their caregivers. This approach requires mapping and zoning so that there will be no repetition, and no missed areas so that children have equal access to care and programs.

A clearly defined, long-term, follow-up program has yet to be developed. To date, there is no confirmed report of child trafficking, though the risk of child abuse, neglect and exploitation appears high. In order to achieve adequate child protection, it is essential that effective, long-term monitoring and psychosocial programs be established. Serious effort should be made to strengthen mechanisms that protect the family and community, especially through restoration of family and community livelihoods. The opportunity should be taken to strengthen the provincial child protection system; to bring it in line with the 2004 National Child Protection Act.

In conclusion, though Thailand has coped well with this disaster by providing basic survival support and disease control, a non-systematically-addressed area involves psychosocial and child protection issues. To ensure that financial and psychosocial supports are equally distributed to all of the affected children, efforts need to be made to track down and register all of the children. Protection needs to be provided for disadvantaged children. All the aid programs need to involve and integrate children into their programming. The restoration of socioeconomic status and community livelihood is a significant challenge, whose resolution would help resolve and/or attenuate these issues. Illegal immigrants working in Southern Thailand and their children were ***not*** receiving sufficient support and health care.

Recommendations

1) The nutritional status should be monitored closely;
2) Long-term psychosocial support must be provided;
3) The establishment of an effective child protection system is essential to ensuring the safety of the children; so too is building teachers' abilities to promote child recovery and security;
4) Re-establishing family incomes and restoring community livelihoods would promote the recovery at all levels, except the loss of life; and,

5) A potential post-recovery benefit for the South and perhaps all of Thailand would be the improved co-ordination between national organizations providing support to children and their families.

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