

Translated from Spanish



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PROGRAMME ON EMERGENCY PREPAREDNESS AND DISASTER RELIEF

MENTAL HEALTH PROGRAMME

**SUBREGIONAL MASTER PLAN FOR THE PROTECTION OF MENTAL
HEALTH DURING EMERGENCIES AND DISASTERS**

HEALTH SECTOR / CENTRAL AMERICA

August, 2004

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I. INTRODUCTION

This Plan is the outcome of a process involving the participation of the countries of Central America (Ministries of Health and other national institutions), with technical and financial support from PAHO/WHO. The Coordinators of the Disaster (or Risk Management) units and the Heads of Mental Health Programmes in the Ministries of Health played a decisive part.

The document is a contribution to attaining the objectives of the Strategic Framework for Reducing Vulnerability to Disasters in Central America, which was approved at the Twentieth Ordinary Meeting of the Presidents of Central America, the Dominican Republic and Belize, of the Declaration of Guatemala, (October 1999) and of the Regional Plan for Disaster Reduction (PRRD) approved by the Centre for Coordination of the Prevention of Natural Disasters in Central America (CEPREDENAC) in 2000. At the Nineteenth Meeting of the Health Sectors of Central America and the Dominican Republic (RESSCAD, 2003) the ministers of health approved the Subregional Plan for Reducing the Vulnerability of the Health Sector, which serves as a frame of reference for the Plan.

The Plan involves those institutions that make up the health sector and its purpose is to provide mechanisms for technical cooperation among countries, to enhance National Plans and to develop response capacity. A broad and comprehensive vision has been developed, encompassing actions for health promotion, prevention of mental disorders, curative care and psychosocial rehabilitation during disasters.

II RATIONALE

In each country, the health sector is responsible for incorporating mental health within a comprehensive strategy for reducing vulnerability and enhancing preparedness for disasters. The Subregional Plan provides a frame of reference and a methodological framework and defines those strategic areas for action, whose priority status was made even more apparent by the impact of hurricane Mitch.

Our countries are faced by similar threats; these include seismic activity, volcanoes, hurricanes, flooding, landslides, tidal waves and drought. Threats of human origin, and above all social and political conflicts, forced displacement and emergencies caused by technology and terrorism also call for our attention. Moreover, environmental degradation, ever more rapid and disorderly population growth, poverty and other factors have all helped to make the population more vulnerable. Nevertheless, there are particular circumstances in each country that make them different.

Natural disasters and emergencies not only cause deaths, physical disease, damage to the infrastructure and economic loss; they also have a deep impact on the population's mental health. In the past, the response to critical events was viewed from a purely biomedical angle, emphasizing the identification of symptoms, treatment with drugs and hospitalization. However, with the changing trend in the pattern of health care during disasters, a more comprehensive and community-based approach to psychosocial problems has evolved.

In the last two decades, our understanding of and approach to mental health in Latin America has undergone an evolution. The Caracas Declaration (1991) and subsequent resolutions of the Directing Council of PAHO (1997 and 2001) have stressed the development of decentralized and community-based mental health services.

As a result, psychiatric hospitals are no longer the cornerstone of action to provide mental health care.

Most of the countries of Central America are engaged in efforts to redirect psychiatric services and to develop models centred on primary health care. Thanks to the reorganization of services, it has been possible to change work patterns so that they are better able, when faced with disasters or other emergencies, to tackle the challenges they face. Moreover, integration of risk management, seen in terms not only of the threat, but also of vulnerability, has helped to reinforce the community approach to mental health, relying preferably a group approach.

During disasters and emergencies there are three main groups of psychosocial problems:

- Fear and distress.
- Psychological disorders or psychiatric illnesses.
- Social disorder, violence and consumption of addictive substances.

This finding holds three messages:

- It is not sufficient to consider psychological disorders alone; the whole range of social problems also calls for attention.
- The area of competence of mental health professionals needs to be broadened.
- Psychosocial problem can and must be dealt with - to a considerable extent - by non-specialized staff.

III BACKGROUND

Throughout history the countries of Central America have suffered a multitude of traumatic events such as natural disasters (hurricanes, earthquakes, volcanic eruptions, etc.) and domestic armed conflicts (such as those in Guatemala, Nicaragua and El Salvador) against a background of high levels of poverty and social inequity. As a result, the region has seen the development of numerous attempts to provide psychological and social support in a variety of situations; many are the lessons that have been learned.

In April 2000, PAHO/WHO began to implement the "Central American Project to Reduce Vulnerability to Disasters in Countries Affected by Hurricane Mitch", which has focused its efforts on three components: community organization during disasters, vulnerability reduction in health facilities and strengthening the capacity of the health sector to prevent, prepare for mitigate and respond to disasters.

Before the Subregional Plan for the Protection of Mental Health during Disasters was written, an evaluation was made of the current situation in this respect in the countries participating in the above Project. To this end, meetings for consultation were held in Guatemala, Nicaragua, El Salvador and Honduras. The main

strengths and weaknesses identified, which were common to most countries, are summarized below.

Strengths or requirements for the Plan's implementation to be feasible:

It is important to draw attention to the efforts made by the disasters units of the mental health programmes in ministries of health to improve response capacity in the mental health sphere. A number of strong points were identified; they include:

- Availability of some specialized professionals (psychiatrists and psychologists) with training in risk management. Health workers showed themselves to be motivated by and sensitive to the issues raised by disasters.
- Universities have shown an interest in contributing to training for mental health during disasters.
- There are inter-institutional agreements bearing on training of human resources.
- In most countries, mental health resources and services have in one way or another been decentralized to the local level. A number of PHC mental health units have been set up in general hospitals.
- Earlier diagnoses have been carried out and have identified needs in the fields of prevention and of psychosocial care.
- Institutional structures responsible for disaster prevention and response have been strengthened in recent years.
- The mental health programmes of ministries of health are acquainted with the topic and are willing to incorporate the topic of disasters and emergencies into their work.
- Various agencies which have disaster response plans are incorporating the topic of mental health.
- Community organization has gained in strength. Existing local structures may serve to increase awareness of the topic.
- Documentation of experience in providing mental health care during disasters is available. Health personnel have started to draw on the lessons learned in the wake of hurricane Mitch.
- Some countries possess a background in and experience of work in the field of mental health, particularly with populations who were affected by armed conflicts.
- In most countries in the region legislation concerning intervention in the field of risk management is in force.
- Support is available from international organizations for specific actions.

Weaknesses or critical variables:

Clearly, in all countries, the health sector has enhanced its response capacity, nevertheless, a number of crucial aspects should be singled out:

- Although all ministries of health possess disaster offices, they still need to be strengthened to enable them to assume leadership of the sector.
- Questions relating to mental health during disasters have not yet been given due priority by the public sector in most countries. The mental health component has not been regularly and effectively incorporated into programmes for primary health care during emergencies.

- Disaster planning has been restricted to institutional, rather than sectoral plans.
- There is a lack of common strategies and complementarity among institutions to facilitate decision-taking and action.
- Such coordination mechanism as exist among public and private institutions and universities, as well as among those providing health services, NGOS and other agencies involved in mental health care are unsatisfactory.
- Mechanisms for evaluation and follow-up in the different spheres of action are limited.
- Decentralization of responsibilities to towns or health regions was not preceded by training to develop local disaster-management capacity.
- The actions for which each level is responsible have not been properly determined (regional, national and local).
- Weakness of strategies and plans to provide the population and institutions' staff with training on how to prevent and mitigate the psychosocial consequences of disasters. Training in countries has been provided on an ad-hoc rather than a systematic or regular basis.
- The legislation and norms applicable in each country to disasters have not been sufficiently publicized.
- The population is poorly informed about psychosocial issues.
- Subregional mechanisms for coordination between the ministries of health of the member countries of RESSCAD are weak.
- Although all countries have legal instruments that set for the legal foundations for developing emergency activities in response to disasters, they need to be integrated within a systems approach that enhances the health sector.

IV. VISION

The Central American health sector will have strengthened its capacity to make preparations for and adequately to respond to disasters by incorporating the mental health element and including joint subregional actions.

V. MISSION

By strengthening its institutions and coordination mechanisms, the health sector in the Central American countries will unite its efforts in order to improve the response in the field of mental health during disasters.

VI. OBJECTIVES

General Objective:

To reduce vulnerability and mitigate the psychological and social repercussions of disasters among the population of the RESSCAD member countries.

Specific Objectives:

1. To identify and set up coordination mechanisms and technical cooperation actions among the member countries of RESSCAD in order to enhance the mental health response capacity during disasters.
2. To build up the institutional capacity of disaster units and mental health programmes within the ministries of health.

3. To introduce and develop the mental health component into health care during disasters.

VII. Strategies:

1. Consistency among programmes in the health sector.
2. A comprehensive approach to health, focusing on Primary Health Care and including promotion of mental health and ad-hoc preventive measures.
3. Development of human resources.
4. An approach based on vulnerability and risk.
5. Preference for methodologies that rely on group work
6. An ad-hoc approach to children and use of child-child and child-adult strategies. Games, sports and other forms of expression are fundamental tools for the rehabilitation and full development of children and adolescents
7. A human-rights based approach.
8. An approach based on ethnic, linguistic, cultural and religious considerations.
9. An approach based on gender equity.
10. Interdisciplinary and multi-sector coordination to foster involvement of governmental and nongovernmental organizations.
11. Flexibility and adjustment to local circumstances.
12. Development of monitoring and evaluation skills.

VIII. METHODOLOGY

The Plan was developed using a participative methodology. The disaster unit coordinators, the heads of mental health programmes in the ministries of health, authorities in the sector and other players contributed their ideas and experience.

The steps in the development of the plan were as follows:

1. A consultant visited several countries (Honduras, Guatemala, El Salvador and Nicaragua) to update the information available with regard to mental health during disasters.
2. A document setting out the main findings of the visit was drawn up.
3. A workshop was held in Guatemala to present the document and discuss the proposal for a “Guide to drawing up national plans for mental health during disasters” which was subsequently approved by the experts participating in the workshop.
4. The Guide was submitted to countries together with a recommendation that they organize national workshops, which were sponsored by PAHO.
5. Organization of national workshops, determination of commitments to monitor the process and definition of criteria and contributions to the Subregional Master Plan.
6. Preparation of an initial draft of the Master Plan using the criteria derived from the national workshops.
7. Central American workshop to discuss and approve the Master Plan (Managua, July 2004).
8. Preparation of the final version of the Plan (Panama, August 2004).

IX. FOLLOW-UP AND EVALUATION

1. Dissemination of the Plan in the countries of the subregion.
2. Systematic verification and evaluation of completion of actions.
3. Annual presentation to RESSCAD of the progress made by the Plan through the report of the country responsible for coordinating the Subregional Plan for Reducing the Vulnerability of the Health Sector.

Follow-up and periodic reports, at the country level, will be the responsibility of the respective mental health programmes, with the assistance of the disasters units and of PAHO.

X. PLAN OF ACTION

Line of action No. 1: Strengthening mechanisms for coordination and technical cooperation among countries, with the assistance of PAHO

Activities / Tasks	Responsibility	Dates for completion
<p>Design, exchange of experience and technical documentation:</p> <ul style="list-style-type: none"> • Development of working instruments, tools and indicators in the MH field suitable for validation and use by the countries of the subregion. <ul style="list-style-type: none"> - DANA-MH and guide to the incorporation of MH into local/ municipal emergency plans (2004) - Training modules and guide to mental health care in shelters (2005). • Selection, on a country-by-country basis, of worthwhile documents and experience for the development of a process of exchange, with the assistance of PAHO's local offices. • Selection of documents for publication at the subregional level. <p>*DANA: Damage analysis and needs assessment</p>	<p>-Technical units and officials in the ministries of health, with the assistance of PAHO/WHO.</p>	<p>2004 - 2005</p> <p>December 2004</p> <p>2005</p> <p>2004-2005</p> <p>2005</p>
<p>Cooperation over training processes:</p> <ul style="list-style-type: none"> • Selection, in each country, of specialists with a sound knowledge of the topic and capable of joining a working group to perfect training processes. • Organization of a subregional workshop with this group to exchange experience, prepare topics and documents and to formulate training strategies, methodologies and content for each level. • Organization of a validation workshop for the proposed documentation, and of technically sophisticated aids capable 	<p>-Technical units and officials in the ministries of health, with the assistance of PAHO/WHO.</p>	<p>December 2004</p> <p>First half of 2005</p> <p>Second half of 2005</p>

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<p>of being used by countries (interactive CDs , video tapes, books, etc).</p>		
<p>Inter-country cooperation projects:</p> <ul style="list-style-type: none"> • Selection of topics by countries, in accordance with needs and experience garnered. • Definition of mechanisms and project planning (bilateral, multilateral, TCC etc.). 	<p>-Technical units and officials in the ministries of health, with the assistance of PAHO/WHO.</p>	<p>January - March 2005 2005</p>
<p>Recruitment and constitution of a specialized subregional group for action during disasters:</p> <ul style="list-style-type: none"> • Selection in each country, with the assistance of PAHO, of experts capable of constituting a task force to act during disasters wherever they may occur. • Organization of a subregional workshop to train this team and standardize criteria for action. 	<p>-Technical units and officials in the ministries of health, with the assistance of PAHO/WHO.</p>	<p>December 2004 First half 2005</p>

Line of action No. 2: Strengthening technical units dealing with Risk Management and Mental health in countries' ministries of health.

Activities / Tasks	Responsibility	Date for completion / Follow-up mechanism
<p>Assistance, at the central level to help countries to update, perfect and incorporate new knowledge:</p> <ul style="list-style-type: none"> • Help to develop mental health and Disasters teams in the ministries through cooperation among countries and training activities supported by PAHO. • Subregional workshop with the management teams (MH and Disasters) of the ministries of health. 	<p>-Technical units and officials in the ministries of health, with the assistance of PAHO/WHO.</p>	<p>2005 / in accordance with a timetable drawn up in good time.</p> <p>Second half 2005</p>
<p>Review of the existing legal framework in countries, to draw up the relevant proposals.</p>	<p>-Technical units and officials in the ministries of health, with the assistance of PAHO/WHO.</p>	<p>2005 / in accordance with a timetable drawn up in good time.</p>
<p>Drawing the attention of political and media players to the topic of MH during disasters and promotion of national information campaigns involving:</p> <ul style="list-style-type: none"> • The creation of a subregional working group; • Development of material and exchange of experience among countries (with the assistance of PAHO). 	<p>-Technical units and officials in the ministries of health, with the assistance of PAHO/WHO.</p>	<p>2005</p>

Line of action No. 3: Development of the mental health component in national plans for health care during disasters and emergencies.

Activities / Tasks	Responsibility	Date for completion / Follow-up mechanism
Follow up of the implementation of the national sectoral plans for MH during disasters, with technical cooperation from PAHO.	-Technical units and officials in the ministries of health, with the assistance of PAHO/WHO.	As from October 2004
Selection in each country, of the departments or towns in which the Plan is to be implemented on a pilot basis at the local level. <ul style="list-style-type: none"> • Selection of sites by agreement among national players. • Implementation of the local Plan • Subregional workshop for the presentation of experience on completion of the local projects' first year of activity. 	-Technical units and officials in the ministries of health, with the assistance of PAHO/WHO.	December 2004 2005 First half 2006

ANNEX 1

RECOMMENDATIONS FOR THE FORMULATION OF NATIONAL PLANS FOR MENTAL HEALTH DURING DISASTERS

This plan, which is the result of the workshops organized and experience garnered, makes general recommendations to enable countries to develop their national plans, focusing especially on expected outcomes and general lines of action:

Expected outcome	Proposed lines of action
<p>R. 1. Capacity rapidly to conduct a preliminary mental health diagnosis during an emergency (damage assessment and psychosocial needs analysis).</p>	<p>A mental health situation analysis must be available (MHSA) in territories and/or countries, to serve as a basis for and to permit more efficient damage assessment and analysis of the psychosocial needs; it must be carried out in the immediate aftermath of the disaster. The main features of a rapid diagnosis include:</p> <ul style="list-style-type: none"> • General, social and demographic evaluation of the population • Damage assessment and needs analysis • Evaluation of health services • Determination of priorities and target groups for immediate action. <p>Include the mental health component in the situation room analyses.</p>
<p>R. 2. Availability of mental health care for survivors and members of the response teams, with a suitable and effective model for intervention during crises</p> <ul style="list-style-type: none"> • Non-specialized care • Direct specialized clinical care for cases with more complex disorders • Priority for care for risk groups 	<p>National inventory of specialized human resources, of the coverage they provide and of the existing support network. The mental health resources available for mobilization during disasters and emergencies should be evaluated, together with the distribution of specialized and / or trained staff. Psychosocial care (for individuals and groups) by non-specialized staff (primary-health-care workers, community health promoters, schoolteachers, first aiders, voluntary and humanitarian assistance staff) is a cornerstone of this activity. It entails the organization, support and supervision of the work of non-specialized staff and the implementation of on-site emergency training plans alongside interventions.</p> <p>Provision of direct specialized clinical care for persons with more complex mental disorders, implying the organization of services at the different levels (mobile teams or teams temporarily assigned to selected sites, mental health units or services in different institutions (governmental and nongovernmental organizations), primary health care mental health services, psychiatric hospital or psychiatric department of a general hospital.</p>

	<p>Preference for group and community care strategies rather than individual care</p> <p>Definition or updating of mechanisms for referral and counter-referral of cases).</p> <p>Priority for comprehensive care for highly vulnerable risk groups: Identification of specific highly vulnerable groups Care for deeply affected groups Care for women and the elderly Care for children and adolescents. Care for displaced persons, especially those living in shelters or refugees.</p> <p>Design and implementation of measures to provide psychosocial care and self care for members of response teams.</p>
<p>R. 3. Members of the response teams, PHC staff and community health workers trained on psychosocial issues.</p>	<p>Ensuring the availability of support- and teaching tools and books. Distribution of publications on mental health.</p> <p>Refreshing the skills of and training health personnel, community leaders and workers while circumstances are normal. The most important target groups for training are primary health-care workers, staff responsible for the management of shelters and refuges, volunteers, first aiders and humanitarian assistance staff, teachers, community leaders and health promoters.</p> <p>Continuity and follow-up of the training process. Make provision for on-the-spot training during emergencies if required by circumstances.</p>
<p>R. 4. Implementation of health promotion and education activities, with a focus on groups of children and adolescents and in schools. Participation of community organizations in educational activities.</p>	<p>Ensure easily understandable educational material is available, graded by age group and level of vulnerability</p> <p>Group awareness-raising educational activities during emergencies, involving</p> <ul style="list-style-type: none"> • groups and families deeply affected by the disaster • Evacuees and shelter dwellers.

	<ul style="list-style-type: none"> • Children and adolescents. • Women's groups. • Other organized community groups. <p>Devote special attention to working with groups of children and youth, through schools, shelters and the community and using dynamic expression techniques and play. Emphasize child-child activities and training for teachers.</p> <p>Develop the potential of adolescents as potential actors, leaders, social outreach workers and organizers during the different moments of the intervention.</p> <p>Actions in support of community organization, social participation and self-help. Identifying community organizations and leaders.</p> <ul style="list-style-type: none"> • Encouraging and organizing the population to help themselves and each other. • Encouraging the population to take part in planning and implementing actions during emergencies.
<p>R. 5. The health sector advises and supports social communication activities.</p>	<p>Advising the authorities on how to set up a coherent and efficient social communication system.</p> <p>Informing key political players.</p> <p>Making use of the legal instruments available in each country to define a truthful, reliable, sincere and focused information policy for situations involving risks and disasters.</p> <p>Drawing the attention of the media to the importance of a responsible communications policy on the topic of mental health during disasters and emergencies.</p> <p>Informing and motivating direct service providers in respect of psychosocial issues</p> <p>Helping to design messages to the population, at the different levels</p>

	<p>Dispelling and managing rumours.</p> <p>Evaluating the response by the population in order responsively to organize (appropriate) immediate social communication activities.</p> <p>Organizing, during times of risk, campaigns in the community (e.g. during the rainy season or hurricanes, etc.).</p>
<p>R. 6. Inter-agency coordinating mechanism operating at the different levels to develop the mental health plan.</p>	<p>Definition of inter- and intra-institutional and intersectoral coordination mechanisms.</p> <p>Identifying and strengthening organizations and institutions operating in the mental health field.</p> <p>Definition and enhancement of cooperation mechanisms and establishment of networks.</p> <p>Enhancing the Ministry of Health's stewardship in this field.</p> <p>Commitment by organizations to implementing and following up plans. Periodic assessment meetings for different national players.</p> <p>Exchange and systematization of experience.</p>

Other recommendations:

1. Define the functions, tasks and responsibilities of the participating programmes or technical units (MH and disasters).
2. Circumscribe actions, within the plan, in terms of the time or phase of the emergency: (preparation, critical phase, or emergency proper, post-crisis period and recovery)
3. Define clear follow-up and supervisory mechanisms
4. Set up an information system to evaluate the ongoing process
5. Determine actions to ensure continuity and sustainability

ANNEX 2

GLOSSARY OF TERMS

Mental Health: is a state of well-being in which the individual is able to function within the family and group, to work productively and deal with adversities. It is not merely the absence of symptoms or of emotional distress.

Psychosocial: a very broad term which designates as a whole those individual and societal factors which together form a human being's life experience. In practice, it has on some occasions been used as a synonym for mental health and on others as a distinct term to describe the normal and not merely pathological responses of a human being. In this document, we use it to refer to the social and mental aspects of persons who form part of a system.

Threat: A factor which is external to the subject or system exposed to it and which represents the potential occurrence of a harmful event of natural or human origin.

Vulnerability: A factor which is internal to a subject, object or system exposed to a threat and which corresponds to its inherent liability to suffer harm.

Risk: Risk is the outcome of the threat and results from vulnerability. It is the likelihood of an event exceeding a specific level of harm (to society, to health, to the environment or to the economy).

Prevention: Activities whose purpose is to avert an event or to provide protection from disasters by controlling the effects of natural or other phenomena.

Mitigation: Reduction of the impact.

Preparations: Activities undertaken before a disaster and intended to strengthen response capacity.

Initial response team: Personnel who intervene immediately when a disaster occurs; it comprises a broad variety of workers, such as volunteers, firemen, first aiders, rescue workers, humanitarian assistance workers, workers from local organizations, community leaders, the police, the armed forces, primary health care workers, etc.

Technical units: These are the administrative units or teams in the ministries of health which are responsible for a specific topic. In this document, the term refers to those entities currently operating at the central level of the corresponding ministries and which deal with mental health and emergencies.