



“To silence the deafening silence”: Survivor’s needs and experiences of the impact of disaster radio for their recovery after a natural disaster



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ABSTRACT

In the aftermath of the Haiyan typhoon, disaster radio was used to spread information and music to the affected population. The study described survivors' experiences of being in the immediate aftermath of a natural disaster and the impact disaster radio made on recovery from the perspective of the individuals affected. Twenty eight survivors were interviewed in focus groups and individual interviews analyzed with phenomenological-hermeneutic method. *Being in disaster mode* included physical and psychosocial dimensions of being in the immediate aftermath of the disaster. Several needs among the survivors were expressed. Disaster radio contributed to recovery by providing facts and information that helped the survivor to understand and adapt. The music played contributed to emotional endurance and reduced feelings of loneliness. To re-establish social contacts, other interventions are needed. Disaster radio is a positive contribution to the promotion of survivors' recovery after disasters involving a large number of affected people and severely damaged infrastructure. Further studies on the use and impact of disaster radio are needed.

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1. Introduction

Disasters are one of the major causes of deaths and massive suffering among human beings around the world (World Health Organization and International Council of Nurses, 2009). There are several descriptions of health in disasters. In this study, a biopsychosocial approach was used. The biopsychosocial model describes health as a state of physical, mental and social well-being (Engel, 1981, 1992). Engel stated that in order to understand the health effects, all these dimensions must be taken into consideration. Health consequences of disasters should therefore be seen in a wide perspective, including biological, psychological and social dimensions (Katz, 2012).

Typhoons cause physical traumatic injuries (Doocy et al., 2013), shortage of food and fresh water, and severe damage to the infra-

structure, including medical facilities (PAHO/WHO, 2000). In addition, disasters might cause a range of psychosocial harms compromising stress reactions, disturbance of social relations and economic consequences, as well as psychopathologies such as post-traumatic stress syndrome (PTSD), depression and anxiety (Bartels and van Royen, 2011; Bonanno et al., 2010).

The concepts of recovery and resilience will be of importance in this paper. In this study, recovery is defined as “something which aims to ease physical and psychological difficulties for individuals, families and communities, as well as building and supporting social and psychosocial well-being” (Mooney et al., 2011, p. 27). In a psychological dimension, recovery means a process where the individual first experiences moderate to severe levels of stress-related symptoms, which do interfere with the ability of normal function, but over time the person returns to normal levels of functioning (Bonanno et al., 2010). A traditional metaphoric description of resilience is to “bounce back” after a displacement. Psychological resilience means the capacity to maintain relatively stable, healthy levels of psychological and physical functioning after a highly disruptive event (Bonanno, 2004). Resilience is the most common

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outcome following a potential traumatic event, accompanied by recovery (Bonanno et al., 2011).

After the Haiyan (locally called Yolanda) supertyphoon that hit the Philippines on the 8th of November 2013, about 4 million people were displaced, 28,000 were injured and about 7,000 died (The International Disaster Database, 2014; UNOCHA, 2013). In Tacloban, the capital of the region of Eastern Visayas, normally with about 250,000 residents and in the aftermath of the typhoon housing about half a million people (UNOCHA, 2013), the typhoon caused severe damage. There was an almost complete loss of electricity, mass communication systems including radio and TV stations, internet, mobile phone signal and official services for several weeks after the typhoon (Austin and Baily, 2014). In the immediate aftermath of the typhoon, disaster radio was used to disseminate information and music in the area (Hugelius et al., 2015). Disaster radio means a radio station operating in a disaster-affected area transmitting specific disaster-related information, either by temporary technical solutions or by ordinary means. The disaster radio, in this area performed by the Non-Governmental Organisation First Response Radio as part of the requested international disaster response, was on air from day five after the typhoon. Officials and relief organizations were offered to broadcast information via the radio. Solar cell driven radio transmitters were distributed free of costs, and broadcasts were played through loudspeakers at official places such as evacuation centers and hospitals.

Crisis communication is seen today as an integrated part of disaster response, and good communication with the public is considered as essential to reduce mortality and psychological impacts in crises (Inter-Agency Standing Committee, 2013; Longstaff and Yang, 2008). Disaster radio has the advantage to function as a transmitter of information also in severely affected disaster areas and is therefore a potential way of reaching a large number of affected people, although research on the use and health outcomes of disaster radio in a health recovery perspective after natural disasters is limited (Bradley et al., 2014).

The aim of this study was to describe survivors' experiences of being in the immediate aftermath of a natural disaster and the impact disaster radio made on recovery from the perspectives of the individuals affected.

2. Method

A qualitative study using a phenomenological hermeneutical method (Lindseth and Norberg, 2004) was conducted. The method aims to understand the essential meanings in lived experiences as expressed by the persons interviewed and by interpretations of texts (Lindseth and Norberg, 2004).

2.1. Participants

A purposeful sampling method (Coyne, 1997) was used and 28 survivors were interviewed (see Table 1) about five months after the typhoon. To participate, the survivor should be 18 years or older and must have listened to disaster radio in the immediate aftermath of the typhoon. Participants were recruited by official announcements at a nursing school and an evacuation center in a severely affected area where disaster radio had been broadcast. Participation was voluntary and oral and written study information was given and a letter of consent was signed prior to the interviews. All persons who volunteered to participate were included in the study. Of all participants, 14 persons had a connection to the nursing school either as a student or as a member of staff. None of them had been professionally engaged in the disaster response. Participants could choose from being part of a focus group interview or an individual interview.

None of the participants had suffered serious injuries or illness as a direct result of the typhoon. Some had lost family members or friends and all had experienced either damage to or a complete destruction of their homes. At the time of the interviews, eight persons still lived in temporary shelters. Vulnerable groups were represented by elderly people and low income beneficiaries (Philippine Council for Health Research and Development, 2006).

2.2. Data collection procedures

The interviews were performed at a nursing school, in an evacuation center or at workplaces, as preferred by the participant (see Table 1). All interviews were conducted by the first author (KH), along with a local assistant who could also act as an interpreter when needed. The primary language used was English. Interpretations were needed for specific words or sentences in two of the individual interviews. A semi-structured interview guide (see Fig. 1) was used. The interviews were tape-recorded. Immediately after the interviews, the first author wrote field notes arising from the interviews (Lindseth and Norberg, 2004).

2.3. Data analysis

All interviews were analyzed together; no distinction was made between focus group interviews and individual interviews. The interviews were transcribed verbatim by the first author and thereafter analyzed using phenomenological hermeneutic methodology (Lindseth and Norberg, 2004). First, a naïve understanding (Lindseth and Norberg, 2004) was reached and formulated from several readings of the whole text and the field notes. Thereafter, a structural analysis (Lindseth and Norberg, 2004) was performed where

Table 1
Descriptions of all 28 informants: gender age, place of interview, individual or focus groups interview, and lengths of each interview.

Type of interview	Participants (gender and approx. age)	Interview time	Place of interview
Focus group 1	3 men, 4 women, 20–60 years	55 min	School
Focus group 2	1 man, 5 women, 20–25 years	60 min	School
Focus group 3	4 women, 50 years	72 min	Evacuation center
Focus group 4	3 men, 1 women, 20–70 years	20 min	Evacuation center
Individual interview 1	1 man, 40 years	12 min	School
Individual interview 2	1 men, 50 years	35 min	Evacuation center
Individual interview 3	1 woman, 50 years	45 min	At workplace
Individual interview 4	1 woman, 85 years	125 min	At workplace
Individual interview 5	1 woman, 35 years	22 min	At workplace
Individual interview 6	1 men, 55 years	45 min	At workplace
Individual interview 7	1 woman, 40 years	18 min	At workplace
Total	28 persons	509 min	

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