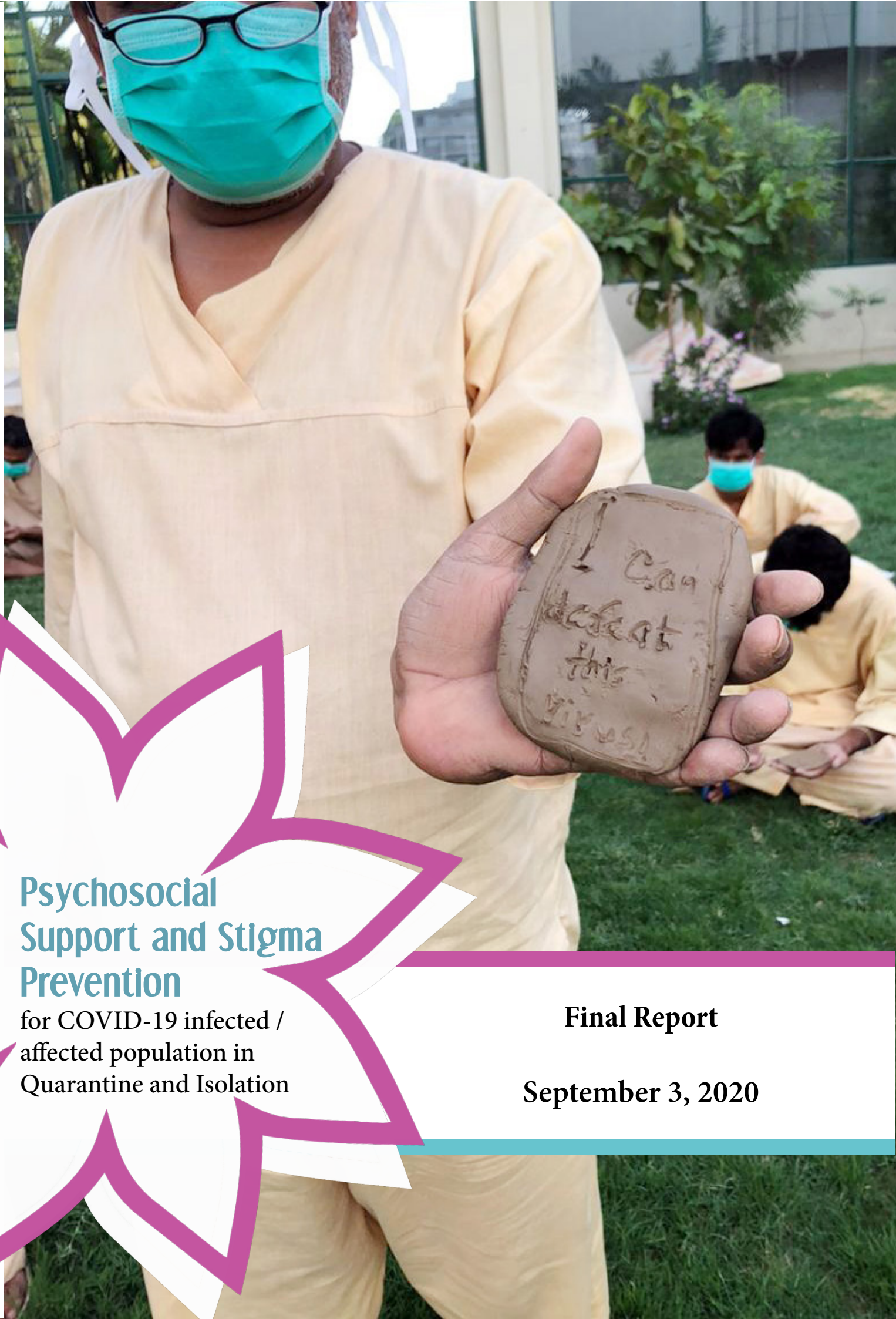

Psychosocial Support and Stigma Prevention

for COVID-19 infected / affected population in Quarantine and Isolation

Final Report

September 3, 2020

Psychosocial Support and Stigma Prevention for COVID-19 infected / affected population in Quarantine and Isolation

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Note from the Project Lead

Pakistan's government and its partners responded to the COVID-19 pandemic in line with the international strategy based on social distancing, screening, isolation / quarantine for infected people and wide-spread lockdowns. However, apart from risk of contagion, mental health emerged as a major stream impacting communities, health workers, and health program managers. Mental Health and Psychosocial Support and Stigma Prevention for COVID-19 infected / affected population in Quarantine and Isolation, conceptualized and operationalized predominately an arts-based methodology, and is the first of its kind in Pakistan. The intervention consisted of art-making sessions towards psychosocial support resource based counselling and a digital community outreach.

We are not only honored to have had an opportunity to contribute to COVID-19 pandemic response, rather we were able to demonstrate the effectiveness of using the arts in the context of a pandemic. We therefore hope to present this report to advocate for the use of arts as one of the strategy for mental health services and associated modalities and the long over-due institutionalization of mental health in Pakistan. We therefore suggest that this report be viewed as a learning document in addition to its reporting function. We hope that the case studies presented illustrate the "humanness" of this intervention and our target beneficiaries.

On behalf of my team, I take this opportunity to thank the UNICEF staff who supported us with timely feedback, suggestions and positive energy throughout the duration of the project. In particular, I would like to thank Dr. Jabeen Abbas and Emelia Allan. We are also grateful to the Social Welfare Department, EXPO Centre Isolation Facility team in Karachi and the local health authorities and above all, every single participant who shared with us their fears, deepest emotions and expectations.

We also showcase some of the art that has been produced in the process as a form of validating the lived experience of people. We hope you enjoy it.

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Centre for Arts-based
methodologies & Wellbeing


CPPD
COUNSELLING SCHOOL


PHC
GLOBAL
IMPROVING LIVES – Transforming
Health & Development


unicef

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List of Abbreviations

COVID-19	Corona Virus Disease 2019
CPPD	Centre for Personal & Professional Deveopment
CSO	Civil Society Organization
DG	Director General
DHO	District Health Office
DIY	Do It Yourself
DoH	Department of Health
EXA	Expressive Arts Therapy
EXPO	Exposition
HCA	Health Care Assistants
HCP	Health Care Providers
HDP	High Dependency Unit
IRC	International Rescue Committee
MHP	Mental Health Practitioners
MHPSS	Mental Health and PsychoSocial Support
MoH	Ministry of Health
NLP	Neuro-Linguistic Programming
PHC	Precision Health Consultants
PPE	Personal Protective Equipment
SARS	Severe Acute Respiratory Syndrome
SARS-CoV2	Severe Acute Respiratory Syndrome Coronavirus 2
SWD	Social Welfare Department
RNA	Rapid Needs Assessment
SOP	Standard Operating Procedures
PFA	Psychosocial First Aid
PSS	Psychosocial Social Support
PSSP	Psychosocial Support and Stigma Prevention
PTSD	Post-traumatic Stress Disorder
OPD	Outpatient Department
UNICEF	United Nations Children's Fund
WHO	World Health Organization

Executive Summary

The Pakistan government response to the current COVID-19 pandemic included implementation of partial lockdowns with complete closure of non-essential services, shops, restaurants and air travel. The pandemic, due to its multifaceted effect caused significant mental health issues including the fear of contagion, uncertainty of the situation and economic losses. All sectors of society are affected especially the infected and people taking care of them (families and especially children, health care providers and first-line responders). These cohorts were considered as target beneficiaries of the project. The intervention combined group art-making as psychosocial support combined with individual counselling sessions. The numerical targets agreed upon aimed at reaching 200 beneficiaries through art-workshops and a further 50 health care workers, 100 specialized counselling sessions, 1000 people reached through the digital campaign and 300 children reached through a cascading approach. A simultaneous media outreach focused of health promoting messages. Field activities were conducted from May to end of July focusing on three cities, Karachi, Hyderabad and Sukkur.

To kick-start the project, and as the first deliverable agreed upon, we conducted a Rapid Needs Assessment (RNA) prior to the initiation of the intervention. The RNA aimed to understand and include the voices of affected and infected populations in the design of the intervention. The RNA highlighted significant mental health problems, primarily due to stigma and discrimination of diagnosed and suspected population. Based on the RNA findings, and supported by the literature review, our intervention aimed at creating "safe spaces" where participants can express their emotions and share their experiences openly without fear of judgment in their groups. Art-making was combined with counselling sessions delivered by professional counsellors using the Humanistic Integrative approach.

The aim of the counselling sessions, similar to the art-making workshops was to focus on facilitating the clients to recognize their own personal strengths, creativity and choice in the here-and-now to be better able to cope with the crisis. Moreover, various techniques to manage anxiety and frustration and to control anger issues using Neuro-Linguistic Programming (NLP) was also integrated into the counselling sessions. A referral mechanism was set up to provide the HCA's at Expo Center with the names and contacts of 5 counsellors/therapists who are providing pro-bono counselling services after the project closed.

The multi-layered intervention incorporated elements of group coaching, individual support and experiential learning within the life-affirming pleasures of art-making. During the workshops, conducted both online and face-to face, the emotive experience of art-making was not only cathartic, rather the group dynamics allowed the participants to have a sense of community and support in this times of suffering. The temporary group formed therefore functioned as a resource. The sessions were designed not only to "de-stress", but also teach experientially basic coping strategies to apply, also post-workshop, to themselves, family and friends. The dynamic nature of the individual groups and various scenarios necessitated a flexible approach versus standardized workshops. In the three months of the intervention, through a total of 19 workshops, we covered 264 participants, of which 111 were men, 62 were women and 36 were children. In addition, we also conducted workshops with 55 health care providers and front-line workers. Workshops were conducted both online and face to face.

We initiated a digital campaign on creating and posting messages of hope and compassion using social media platforms (websites Instagram, Facebook, LinkedIn and WhatsApp). The main aim of our digital campaign was to generate a discussion on the stigmatization and how this may be prevented. The messages were specific

to COVID-19 prevention, coping strategies and sharing the experiences of quarantined individuals. We also created a blog that documented snippets from the intervention, not only as a form of sharing, rather also as case-studies to inspire others who are working on similar themes. Our intervention reached more than 65,603 individuals, of which 3,534 people engaged actively (sharing, liking and commenting). In addition, we developed and piloted a mental health coping mobile based application, named COPEit, that allows users to de-stress using mindfulness and arts-based activities. The application has been downloaded by 80+ individuals to date. Finally we recorded an video interview with a post-quarantine individual and created a short film as part of presenting the human face of the epidemic.

Participant feedback has been the mainstay of our intervention. We used the feedback to monitor and assess the relevance and impact of the intervention. In places where needed, we made adjustments and fine-tuned the workshops as well the counselling services to our client needs. The participants were engaged and enjoyed the sessions and realized the importance of catering to their own well-being as a form of social responsibility.

Major challenges in the implementation was to follow the physical distancing measures and the limitations of working online through zoom meetings or on-call discussions. Furthermore, as we discovered early on in the project, reaching out to women and children was a considerable issue as the quarantined population was largely males. To address the challenge, we conducted community workshops and engaged with Civil Society Organizations (CSOs) working in the front-line to help us organize workshops. We also worked closely with the Social Welfare Department by training four of their staff members to carry out a cascading approach with children in communities. A brief module was prepared for the trainees with notes of methodology and detailed art-activity plans. Through this approach 283 children were reached, consisting of 139 girls and 89 boys. In addition to this, 55 girls were reached by two teachers who conducted art activities suggested in the mental health app (COPE-it) with their (female) students.

Based on our experiences, we recommend that mental health coping and psychosocial support should aim to facilitate affected population in understanding the larger benefit of quarantine and aim at finding positive meaning from the experience. Art-making is an enjoyable, non-threatening and effective way to do just this.

Future programs should be resource-oriented to allow people to identify, organize and access internal and external resources to minimize the impact and cope as best as one is capable of. Staff involved in providing PSS must take steps to maintain their own wellbeing as responsible health care providers. Being the primary source of information, they must be provided updated information about the most recent developments and effectively communicate this to the quarantine population. The content of information for the population should be specific to culture, context, needs and the system's capacity. Finally, the pandemic has highlighted the significance of mental health and the importance of institutionalizing mental health services in the country.

Chapter One:

Introduction & Literature Review

This chapter presents the background to the project and literature review that was conducted before starting the intervention

1.1 Background

The outbreak of the Novel Coronavirus (SARS-CoV2) in December 2019 very rapidly progressed into a global pandemic. Countries across the seven continents were adversely affected and the number of human cases exceeding fifteen million and over 600,000 deaths. With no available vaccine and plenty of debate and research on effective therapy, the treatment is primarily symptomatic with measures to prevent the spread. The preventive measures include lockdowns, physical distancing and voluntary self-isolation. Whilst necessary, such measures and the disease itself, may have an adverse impact on mental health. In fact, literature from previous similar pandemics, show that such situations are likely to increase stress levels and have negative psychiatric effects. The impact is felt by the general public, sufferers of COVID-19, their families and friends especially women and children, persons with pre-existing mental health conditions including the elderly, and healthcare workers. This translates, on ground realities, as everyone.

In Pakistan the situation is no different with approximately 290,000 confirmed cases, almost 280,000 of whom have recovered and over 6000 deaths. The largest number of cases have been reported in Sindh where, as per government statistics, over 128,000 confirmed positive cases to date, nearly 2,400 deaths and over 4,000 active cases at the time of writing this report[1]. To control the spread of COVID-19, the government has implemented partial lockdowns with complete closure of non-essential services, shops, restaurants and air travel. Furthermore, in the initial response, the government issued directives for closure of OPDs and elective surgical services in all the Tertiary Care Hospitals, District Headquarters' Hospitals and Private Clinics[2]. Specific hospitals have been designated for screening and management of cases. Other measures included establishment of quarantine centres, testing facilities and public awareness regarding COVID-19[3]. Little previous experience of such a large shut-down globally, a lack of evidence-based information, constantly changing protocols as well as the lack of a vaccine or proven therapeutic guidelines, inevitably raised levels of anxiety, confusion and fear with direct effects on the mental health of all groups[4].

1.2 Literature Review

Quarantine and isolation is often an unpleasant experience due to the loss of freedom, uncertainty

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and boredom that may lead to more serious psychosocial effects[5] like emotional disturbance[6], depression[7], stress[8], low mood, irritability, insomnia[9], post-traumatic stress symptoms[10], anger[11], and emotional exhaustion[12]. These negative affects extend to those who are in close contact with those who are quarantined[13],[14]. Furthermore, studies have shown avoidance behaviors in others such as minimizing direct contact with patients, avoiding people who were coughing or sneezing and avoiding crowded and enclosed places, and public spaces in general for weeks following the quarantine period[15].

Children in particular have been affected with the most common diagnoses reported as acute stress disorder, adjustment disorder, grief, and post-traumatic stress disorder[16]. Literature from previous similar disasters also points towards increased rates of child abuse, neglect, and exploitation while children stay at home, and often unchecked due to social isolation[17]. In fact, one of the issues raised in literature specific to the closure of schools is the lack of access to school-based health services including mental[18].

Another important group that shows significant affects due to quarantine are health care providers and first responders[19] and may present with more severe symptoms of post-traumatic stress than

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members of the general public[20]. Major stressors during quarantine include duration of quarantine[21], a fear of infection both for themselves and others, in particular family members[22], and was of particular concern to pregnant women and those with young children[23]. Also documented is boredom, frustration, and a sense of isolation exacerbated by not being able to take part in usual day-to-day activities[24]. A real or perceived lack of supplies (e.g., food, water, clothes, or accommodation), being unable to get regular medical care and prescriptions[25], poor information from public health authorities and insufficient guidelines about actions to take and confusion about the purpose of quarantine are also mentioned[26]. All the above mentioned stressors may in fact carry on long after quarantine or isolation is over[27].

A rapid needs assessment in Pakistan conducted by IRC[28] reports a high level of stress in all groups (women, men, children and elders). Livelihoods and paying for rents, utilities and other expenses, inability to access education, disruption in routine activities, no socialization and fears of getting affected were documented to affect all population groups and in particular the elderly, people with disabilities and children. Access to health and the pressure of domestic work were amongst other key stress factors for women. Other factors quoted include the need to borrow money to make ends meet as well as increasing levels of domestic violence.

In addition to the above, stigma has been widely reported long after containment of the outbreak. The affected population reported being treated differently: avoiding them, withdrawing social invitations, and treating them with fear and suspicion[29]. This stigma can also come from family members and employers creating intra-household and workplace tension[30].

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Chapter Two:

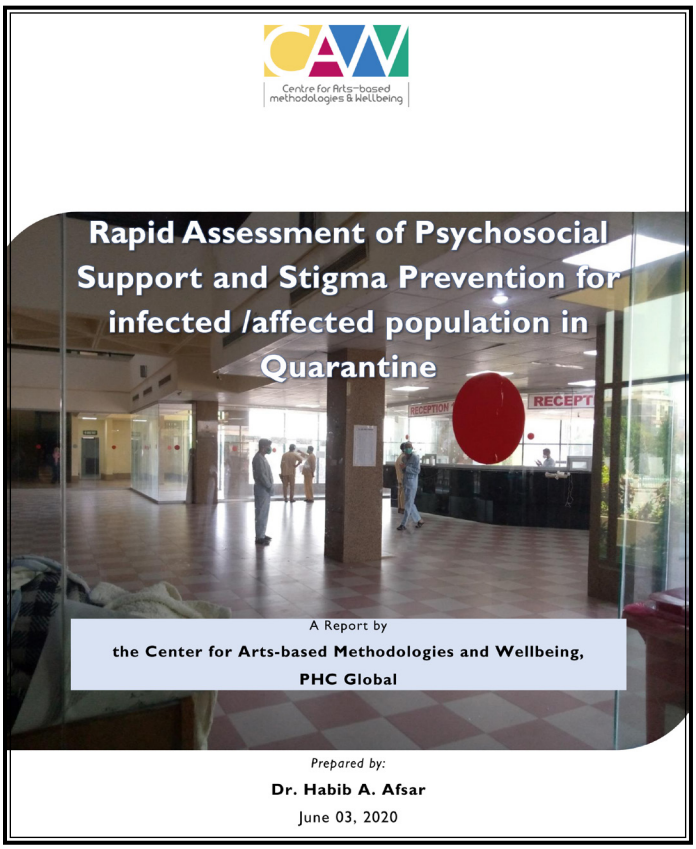
The Rapid Need Assessment (RNA)

This chapter presents the findings of the Rapid Needs Assessment conducted at the start of the project and that informed the specificities and finalization of intervention modalities.

2.1 The Rapid Needs Assessment (RNA)

In the first step towards our intervention design, we conducted a Rapid Needs Assessment (RNA). The objectives of the RNA were (1) to include the voices of infected and affected populations in designing and fine-tuning the intervention, (2) to contextualise the intervention and (3) to introduce the project to local stakeholders. The RNA focused on Karachi and was conducted between May 8 & 15, 2020. A convenience sampling using snowballing was used to interview respondents telephonically or face to face where possible following proper standard operating procedures (SOPs). Data collection included a literature search, key informant interviews with people having experience of quarantine (n=9), mental health service providers including first-line service providers in the city (n=9) and government representatives (n=4). The RNA also included one focus group with women in quarantine (n=5).

We continued interviewing people as and when the opportunity arose throughout the project to keep us updated and deepen the findings of the initial survey. Thus, in addition to the numbers quoted earlier, we interviewed a further six health care providers, three patients who tested positive for COVID, six community based workers and one recovering patient (severe case post-ventilator). While we make no claim to generalizability, we believe that our findings indicated trends that corroborated well with literature. It is worth noting that, while these further interviews gave us deeper insights into people lived experiences, they did not, in fact, add much new to what our initial analysis RNA suggested.



As part of the RNA we also conducted a mapping of psychosocial services in the three cities. This was done essentially through a google search as well as reaching out to providers identified for further information. As can be expected, the majority of services were located in Karachi, where we identified 35 providers in various areas related to mental health. Roughly 60% of these providers were verified by calling the numbers available and verbally confirming service provision. We suspect there may be a few small community-based services that we may have missed. In Hyderabad, we could identify only three providers while in Sukkur, none were actively present at the time of our research. Thus, an important finding, albeit not surprising, is the dearth of dedicated mental health services for the public in Pakistan, in both public and private sectors. Details of these service providers was included in the RNA report submitted earlier in the project.

2.2 Results of the RNA

The following sections present the summarized findings of the RNA.

2.2.1. People with a history of quarantine/isolation:

All but two of the people interviewed had a history of travel. Of these, four had volunteered to be tested (prior to the full-blown COVID-19 response) because of a concern for their families. The subsequent quarantining of family members was not voluntary and reported as a particularly stressful event.

it was so humiliating and the whole Mohalla (neighborhood) was watching...they took my elderly parents.

It is interesting to note that all interviewees were of full praise for the service provision and staff at the centres. Our observations during the visit to the EXPO centre Isolation Field Unit validated the findings; the arrangements were well organized and supported by a team of passionate volunteers who were providing a high level of personal care, duly appreciated by all respondents:

the staff is wonderful…very kind and listen to us… may Allah keep them happy and healthy.

Nearly all the problems mentioned by the respondents had a mental health element including mental pressure (zehnee dubao) due to financial losses, uncertainty of their status and future, concern for the wellbeing of their family, sleeping problems, general anxiety and boredom. Uncertainty of status, test results and the future was mentioned by all of the respondents:

we did not get results for 20 days and there was fear if I have disease or not...this was terrible...no one tells us anything about it.

We focused part of our interviews to explore the experiences of interviewees with regards to stigma.

All my Mohalla (neighborhood) was scared off me when I went back home. When I went out for running they would be terrified... I ignored it...I tried to tell people not to worry but the fear was so much...so I gave up

This fear was also expressed by the immediate families:

The most painful thing I heard was my beloved uncle telling his wife not to cross in front of my door.

One correspondent told us of a hierarchy amongst the patients at the centre:

No one wants to come near the new arrivals because they are scared of them...but I do because I know how that feels.

Above the stigmatization from the others, all of our respondents mentioned the fact that they felt guilty for putting their families and communities at risk. One respondent mentioned that every time he calls someone and hears the corona health message on their phone, he feels fear, anxiety and guilt.

Social support, spirituality and professional counselling were mentioned as main coping strategies. We asked all participants what they had learned about themselves by passing through this experience. All mentioned that the challenge had shown them that they were "strong and tough" and that they "can deal with a lot" and are "useful for society".

One young mother responded:

I never knew I was such a strong woman.

Incidentally, this quote highlights the conceptual basis of our project vis-a-vis facilitating people to identify and mobilize their internal resources in this challenging situation.

2.2.2. Health Care Providers

Validating the findings from our interviews with quarantined individuals, all providers mentioned the issue of test results especially the uncertainty, timing of the results and a lack of confidence on test results.

Patients were often frustrated and short tempered leading to complains about "petty issues". Another area highlighted was a difficulty in communicating with families as all camera bearing devices are prohibited in the centre. A gender specific issue reported was that of harassment from the younger male patients. In response, the management provided a separate and secluded area for women to walk and get some fresh air without the unwanted attention of male patients. Several women reported harassment from their families as well:
One woman was accused by her husband to staying at the centre purposefully because he believed she did not want to come home to him.

With regards to their personal health, HCPs reported often being "constantly tired— exhausted", "sleep deprived, "craving human touch" and frustrated. Also mentioned was the difficulty of wearing PPEs (personal protective equipment) as a rather cumbersome procedure and really hot to wear. One respondent talked about the doubts that emerge every once in a while, more so on "tough days" (when a new batch arrives and needs to be registered).

Sometimes I wonder why I am here really…am I even useful?

The biggest coping strategy for the health providers was group support. In fact, their body language and references pointed towards a close group who supported each other.

I don't think I could survive without these guys (the team).. we take care of each other and support each other

In fact on being asked why he liked the work so much, one respondent replied:
I have my friends with me.. And I'm so tired after a shift that I just fall asleep…I am also getting valuable work experience.

2.2.3. Mental Health Practitioners

The mental health specialists we interviewed shared their views based on their experience and observations from their personal practices. They spoke of the need to cater to the feelings of isolation, anger, frustration, mistrust of government officials and boredom, and especially so in children. Three of them specifically pointed out the issue of domestic abuse as an area that needs more attention. They suggested to create activities that not only allow people to relax, rather also allow them to "find meaning in what is happening with them" for example through the use of survival stories as a way of catharsis and therapeutic sharing. In addition, all practitioners mentioned the challenges faced by themselves and that also included the effects of isolation due to self- quarantine, compassion fatigue and burnout.

The rapid needs assessment highlighted the prevalence and effects of mental health issues related to being quarantined above and beyond the general stressful conditions of the lock-down and its impact on all aspects of life: social, physical, financial and mental. The activity was therefore instrumental in determining the specificities of our intervention. The findings corroborated what we had already identified in our reports, the main points of which were as follows:

- People in quarantine are entitled to human dignity as is everyone else.
- They suffer significant mental health issues, many off which may be amenable to general counselling, while a proportion off them may require more specialized care .
- They need to be facilitated not only to find meaning in what they are experiencing, rather to find what is positive with regards to this challenge (and life in general).
- Expressing their emotions, thoughts fears and apprehensions, and telling their personal stories may be a valuable outlet for their mental health.

The report was also written as an academic paper which is being reviewed for publication in a peer reviewed journal.

Chapter Three:

The Intervention Modalities & Operationalization

This chapter presents the conceptual basis of the project and the individual intervention modalities that were subsequently utilized. These modalities include art-making workshops, triage counselling sessions, a media campaign and community outreach. Finally we describe the major challenges faced during implementation and how these were overcome.

3.1. Philosophical and Conceptual Basis

Based on the RNA and literature search, we felt that the most appropriate intervention would be to create safe spaces where our target beneficiaries could emote, express and share their fears and anxieties within the safety of a group, while those requiring more support were referred for counselling. We designed activities in such a way that would not only serve this function rather also teach basic culture specific coping skills. Our hope was that these coping skills would cascade down to the communities through the individuals taking part in the workshops. Above all, we designed all activities keeping in mind the concept of human dignity and at the same time, catering to the real concern of stigma and discrimination and furthered through a concentrated media effort.

Such an emotive experience, as afforded through art-making, is not only cathartic, rather the group dynamics allows for a sense of community and to understand that we are not alone in our suffering. The temporary group formed therefore becomes a resource as well. Furthermore, the sessions were designed not only to "de-stress", but also teach experientially some basic coping strategies that one can apply to themselves or friends and family. Thus this multi-layered intervention incorporated elements of group coaching, individual support and experiential learning within the life-affirming pleasures of art-making. Service-provision wise, it brought together group art-making sessions with individual counselling sessions for those who were most in need or expressed the desire thereof. The dynamic nature of the individual groups and other scenarios necessitated a flexible approach versus standardized workshops. This gave us tremendous insight on the use and practicality of certain activities and material use in the context. The workshops took place within a framework that was pre-determined as per our objectives. Due to the peculiar development of closure of facilities, we included CSOs and other front-line groups in the intervention with the specific outcomes of not only facilitating de-stressing events rather also creating a cascading affect vis-a-vis psychosocial support (PSS).

3.2. Operationalising a multi-model approach

In order to maximize impact and affect, we developed a multi-model approach, meaning to say that several modalities were used simultaneously. These are described in the following sections:

3.2.1. Art-making as a tool for Psychosocial Support

Any challenging situation or "problem" regardless of its scope, requires a deep understanding of multi-causal factors (read=context and connections) and a creative imagination to come up with appropriate solutions. The making of art is a powerful method to do just that and has served, since ancient times, as an integral means to perceive, respond to, and shape the world and herein lies the "healing" effects of the arts. It is essentially a "human" thing to do; to celebrate our humanity and our connection to the universe. From this perspective, (social) change, be it a community, organisation or at the personal level is only possible when people have a sense of connectedness, realise their own capacity to act, and see themselves as able to re-make the world in which they live. While the arts have always been used for the peculiar qualities mentioned above, recently it has seen a re-emergence in the mainstream with

substantial research, innovative programmes and more authorities understanding and advocating for arts-based methodologies. One of many examples being the recent World Health Organisation report on the evidence base for arts and health interventions that was launched in 2019. It references over 900 publications, including 200 reviews covering over 3,000 further studies advocating for the employment of arts-based methodologies[31].

The particular methodology for the art-making sessions we used is derived from the Expressive Arts Therapy (EXA) movement, where the phenomenological foundation, philosophical and theoretical base stresses that instead of giving "intrusive interpretations and overarching meaning-making, (therapists) maintain phenomenological attitude toward the subject matter by presenting the art-making as descriptive as possible "(Levine, 2015)[32]. This implies that images and other art work created are not analyzed for any psychological interpretations. Furthermore, the role of the artist is not to impose a pre-existing form upon senseless matter but to allow the material to find its own sense. In other words, it requires a 'letting-be' in order to take place. To do this, the artist must abandon any critical intention and become open or receptive to what is coming. The result is often a surprise. Such intuitive art-making allows for "risk taking", and, if conducted in a safe environment can be a truly liberating experience allowing for something "new" to emerge - a breaking of old habits or thought processes. It is an empowering experience.

Paolo Knill (2004)[33] gives a thorough overview of an important concept in EXA that is central to our methodology and that is a "low-skill/high sensitivity" approach. He describes that art which can touch and move us is not always the product of excellent skill, but rather something we might call sensitivity toward the art-making material and its qualities in relation to the environment (as manifested in space and time.) In other words, the activities that we asked of participants did not require a high level of technical skill and ability, though when coupled with a heightened sensitivity, the results, vis-a-vis the experience and the artistic outputs are impactful, and enable the freedom of expression that allows for individual experience and reflection to emerge. Thus the art-making workshops we conducted was very suited to populations who may never had any art experiences (and which was evident for a large number of our

31. http://www.euro.who.int/__data/assets/pdf_file/0015/413016/Intersectoral-action-between-the-arts-and-health-v2.pdf?ua=1
32. Stephen K Levine and Ellen Levine. Foundations of expressive arts therapy : theoretical and clinical perspectives. 1999. London: J.KIngsley Pulishers
33. Ellen Levine, Stephen K Levine and Paulo Knill. Principles and Practice of Expressive Arts Therapy: Toward a Therapeutic Aesthetics. October 2004. Publisher: Jessica Kingsley PublishersISBN: 9781846420320

participants, many off who claimed never to have used a crayon or color pencil). Another concept that is critical to the approach is the concept of Intermodal Decentering IDEC®. Watzlawick (1983) showed that centering or focusing on the problematic situation has a tendency to produce 'more of the same' and tends to worsen the situation. Knill (2005) further explains in the book, Principles and Practice of Expressive Arts Therapy that "by de-centering we move away from the narrow logic of thinking and acting that marks the helplessness around the "dead-end" situation in question". In real terms, this translates as the situation where the art-making may not have a seemingly direct connection to the problem at hand. This allows for the opening of surprising unpredictable unexpectedness. The de-centering also allows to participants to forget their worries for a while which in itself allows for respite and a form of de-stressing. Towards the end of a session a reflection, guided by the facilitator, relates the experience to the outputs in an effort to find closure.

3.2.2. Triage Resource-building Sessions (Counselling)

In order to cater to people who required professional counselling, we initiated counselling sessions as additional to the art-workshops. In all 100 counselling sessions were delivered, mostly to clients identified by Health Care Assistants (HCA) at the EXPO centre Isolation Facility in Karachi where art-making workshops were also conducted. This service was provided by a roster of 48 counsellors of Pakistani origin, many of who are senior and established professionals abroad. Our objective was to provide resource-building triage counselling sessions using the Humanistic Integrative approach. The Humanistic approach focuses on self-development, and see's all individuals as essentially good and capable of change. The aim of the sessions, similar to the art-making workshops was to focus on facilitating the clients to recognize their own personal strengths, creativity and choice in the here-and-now. This also included the spiritual aspiration of the human psyche; religion can be and is huge resource for majority of the country's population and various concepts from religions such as Islam were used as a source of comfort for many. Moreover, depending on the client in question, various techniques to manage anxiety and frustration and to control anger issues using Neuro-Linguistic Programming (NLP) was also integrated into the sessions.

We split this part of the intervention into 3 phases:
Phase-1 of the project was to conduct two-hours focus groups amongst the mental health community on how to best serve those quarantined; what techniques, skills and concepts to be used to further facilitate clients' emotional well-being and also to facilitate resource-building in terms of information, books, research etc. from the mental-health community. We had originally hoped to sign on 8-10 counsellors/therapists; the over-zealous response to our call, and the fact that almost all counsellors were fully booked led us to sign on 48 counsellors/therapists on board to offer triage counselling services to clients in quarantine centers in Sindh.

Phase-2 began with starting counselling services at Expo Centre, Karachi on 2 June, 2020. The CPPD team had multiple meetings with the HCA's in order to first understand how the Expo Centre was being run, the number of admissions and the issues the HCAs' were experiencing in terms of patients and their emotional states. Access to the Red Zone at Expo center was available 3 days a week; in the first week we piloted the project by completing 3 sessions a day for three days to glean the interest of those wanting counselling services. Despite a couple of connection and logistical issues, clients were keen to seek help. From the Client Tracker Information Sheet used by the counsellors/therapists, it is evident, that whilst unsure to start, they were extremely responsive to the sessions being

offered. We had to arrange a second phone to ensure that 2 sessions could take place at the same time as the HCA in the Red Zone were able to allot 3 hours a day, 3 days a week (which changed every week) towards Phase 2. The logistics of managing the session times available, the days that were available and matching the HCA schedule to client availability and therapist schedules was organized and coordinated between the HCA's and the CPPD Program Manager. An assessment criteria was derived in coordination with the HCA's with regards how to ascertain eligibility and suitability for counselling and is described later in this report.

Phase-3 was to provide psychosocial first aid (PFA) training at the EXPO Isolation facility for HCAs (volunteer medical students and young doctors) and which included stress-release techniques. This, as a response to interviews with 3 staff members who had expressed interest and also felt other staff members would be interested. The idea behind this was to provide a cascade approach i.e. to provide some form of stress release to reduce their own stress levels at work and also use these techniques on those quarantined. Counselling sessions were initiated in mid-June, 2020 and ended mid-July with the completion of the target of 100 counselling sessions.

3.2.3. Media Outreach

The digital campaign was initiated on 21st May 2020 and is still in progress. While mainstream media seems occupied with informing about death tolls and promoting mostly fear-based messages, we focused our strategy more on how to educate people through messages of hope and without creating panic. We also aimed to presenting a "human face" of the pandemic to counter the stigma and discrimination evident. To start with, we developed our personal ethical guidelines which included:

- Pictures/Videos of any individual were not posted without their consent.
- Faces for every person affected from COVID-19 were hidden/blurred.
- All messages / posts were strictly non-political and non-religious
- All content was shared with UNICEF in order to receive regular feedback.

Thus our social media strategy was based on creating and posting (1) messages of hope and compassion, (2) specific COVID-19 prevention messages, (3) coping strategies and (4) sharing the experiences of quarantined individuals. This all was complimented with a blog that documented snippets from the intervention, not only as a form of sharing, rather also as case-studies that may inspire others who are working on similar themes. Overall our focus has been to show the "human face" of affected people with the particular intention to generate a discussion on the stigmatization of this population as was observed widespread during our intervention. The platforms used included our Twitter, Facebook, and Instagram accounts as well as WhatsApp and our official internet websites. We also created a short film that presents the experience of a previously quarantined individual and is specifically aimed to generate a dialogue about the stigma associated with the disease.

3.2.4. Community Outreach

Despite the limited scope and duration of this project, we also reached out to community-based organizations active in front-line work. As with all front-line workers, this group is also highly affected by the stress and anxiety, and perhaps more so, because classically this group includes young highly-motivated individuals, who show a propensity to literally forget to take care of themselves in their devoted service and may also, occasionally, expose themselves to risk. Other than providing a space for these workers to de-stress, our emphasis was on promoting self-care, which includes mental health, with the simple albeit critical message that in order to promote the wellbeing

of our communities and clients, we need to be well ourselves. This simple message resonated well with all groups that we interacted with.

In particular, we utilized this approach to explore the effects of cascading, by training some outreach workers (essentially the Social Welfare Department) who further conducted art-sessions with groups of children.

The initial challenge to reach community was the lockdown and access to communities is why the digital platforms were thought of as an alternate means to access. Having said that, the major realization from this part of our intervention was the validity of using community based organizations to access infected and affected populations, as digital outreach, while a useful adjunct, may not be very affective by itself to do so in our particular context. Thus we feel that in the future, while digital mechanisms may be exploited, in Pakistan where access to internet and technologies is not too widespread, perhaps the best way to reach out to communities is still through community gate-keepers like CSOs.

3.3. Messages delivered

Over the project duration, our messages also got more defined. Ultimately, the various messages that we recommend are summarized as follows:

- Prolonged stress and anxiety affects many systems in the body and specifically depresses the immune system which is why it is important to de-stress regularly

- To strengthen the immune system we need to :
  - ✔ Eat well
  - ✔ Drinking lots of fluids / vitamins
  - ✔ Engage in some form of physical exercise
  - ✔ De-stress regularly (e.g. breath meditation)
  - ✔ Ensure family and community support (we are not alone)

- We can alter our body chemistry and physiology simply by creating positive emotions (we have control over our emotional responses).

- We need to show compassion towards people infected and affected by the virus - we are all in the same boat.

- There are lessons we can learn from this pandemic
  - ✔ health is central to well-being
  - ✔ health is a holistic concept (physical, mental social and spiritual)
  - ✔ our individual actions affect our communities and vice-versa (and the importance of maintaining recommended SOPs)
  - ✔ We are resilient and resourceful

3.4. Recommended DIY (Do it Yourself) coping strategies for PSS

The various coping strategies that we promoted included:

- Breath work and meditation/mindfulness

Breath work is an active meditation that involves guided breath, pulled in and out of the mouth for extended intervals. Coupled with mindfulness, which is the basic human ability to be fully present, aware of where we are and what we're doing, and not overly reactive or overwhelmed by what's going on around us, it can create a powerful physiological affect that is relaxing and de-stressing and provides several other physical, mental and emotional benefits.

- Art making and journaling

While art-making can be used generally for all the beneficial affects described in this report, journaling is one particular activity that generally involves the practice of keeping a diary or journal that explores

thoughts and feelings surrounding the events of your life. There are several different ways to do this. Journaling, as a stress management and self-exploration tool, works best when done consistently, but even occasional, sporadic journaling can be stress relieving when the practice is focused on gratitude or emotional processing.

- Gratefulness (count the blessings)
Recent evidence suggests that gratitude, as a practice, is a promising approach is to complement psychological counseling with evidence pointing towards the fact that people who consciously count their blessings tend to be happier and less depressed.

- Spiritual nourishment (remembrance and prayer)
It is known that prayer can lead to concrete results in mental health improvement and stress reduction. Prayer generates optimism, enriches interpersonal relationships and the quality of life. It allows us to connect to something greater then ourselves, and enable us to release control for the moment. All of these result into improved health. In our particular context, it is also very well accepted (and appreciated) by the cultural traditions and has shown to be a great resource.

- Positive thinking- reframing
Reframing is a technique used often in therapy to help create a different way of looking at a situation, person, or relationship by changing its meaning. Also referred to as cognitive reframing, it's a strategy therapists often used to help clients look at situations from a slightly different perspective. The essential idea behind reframing is that a person's point-of-view depends on the frame it is viewed in. When the frame is shifted, the meaning changes and thinking and behavior may change along with it.

- Tapping (qigong)
Tapping is a combination of Ancient Chinese Acupressure and Modern Psychology that works to physically alter your brain, energy system, and body all at once. The practice consists of tapping with your fingertips on specific meridian points while talking through traumatic memories and a wide range of emotions. Regardless of affects, as a group activity it can be an ice-breaker, a collective activity that refreshes and rejuvenates and, in our experience, inevitably generate smiles and giggles from participants.

3.5. Barriers and challenges in implementation

The project was conceptualized on the following core assumptions:

- The mental health of quarantined individuals is highly compromised leading for further health and social issues
- Catering to their mental needs will not only allow them to cope with the difficulty but also prepare them to re-enter society and be beneficial to the control of the academic as "informed allies"
- This population may be considered as highly accessible group to do in-depth health mobilisation work and identify key persons who may provide community support when they are finally released.

Of the three assumptions given above, it was the third assumption that did not live up to expectations except for in Karachi, where we had access to the quarantined population in the isolation facility at EXPO centre. In that sense it may be considered as the killer assumption, at least in the case of Hyderabad and Sukkur where all quarantine centres, while being officially open, did not house any people (in Sukkur the official quarantine centre at Labor Colony had only three to six individuals for most part of our project). Rather, most people testing positive are being home isolated. This means that we could not access them as a group in neither cities, nor work in-depth with any one group. The fact that a tremendous amount of fear as well as stigma associated with both the virus

and mental illness meant that people were not easy to access. Due to this we were forced to try out various other methods to access these populations and these are described in detail in a further section.
To start with, as our project caters to infected as well as affected people, we shifted our focus to the affected population, i.e. affected communities. Our gate-keepers were mostly civil society organizations (CSOs) and local leaders, and in particular, those who were involved in the COVID-19 response. We also emphasized on our social media outreach. In addition we experimented both with cold-calling potential clients and creating WhatsApp groups, both of which did not produce the desired results and were subsequently dropped. This is discussed in some detail later on.

In addition to the above challenges, the following are some of the major challenges and how we approached them. Despite the short duration of the project, we faced many barriers and challenges, many of which really had to do with the peculiar "novel" situation we all are facing. It is pertinent to mention that we took every challenge as a learning exercise.

3.5.1 The difficulties of working remotely

To start with, our office operations were greatly hindered, first by the imperatives of a lockdown, and later, a voluntary shutdown of our office due to concerns of contagion. Despite the limitations of not being able to sit at a table and discuss with peers, and the delays inherent in remote work, we made full use of zoom and WhatsApp and later opened our office premises on a voluntary basis.

Working online was also an issue, especially during the RNA for which we had to interview people. As such, interviewing on the phone makes it very difficult to create rapport, read body language and other cues that are important in qualitative interviewing.

Another difficulty we faced with regards to the peculiar situation was a heavy reliance on equipment and that included a screen, telephones and a stable internet connection. Furthermore, at EXPO centre we were totally dependent on the staff and their availability to help conduct the sessions (both counselling and art-making). This meant that our operational plans were totally dependent on them and often asked for a change of schedule and cancellations of planned activities.

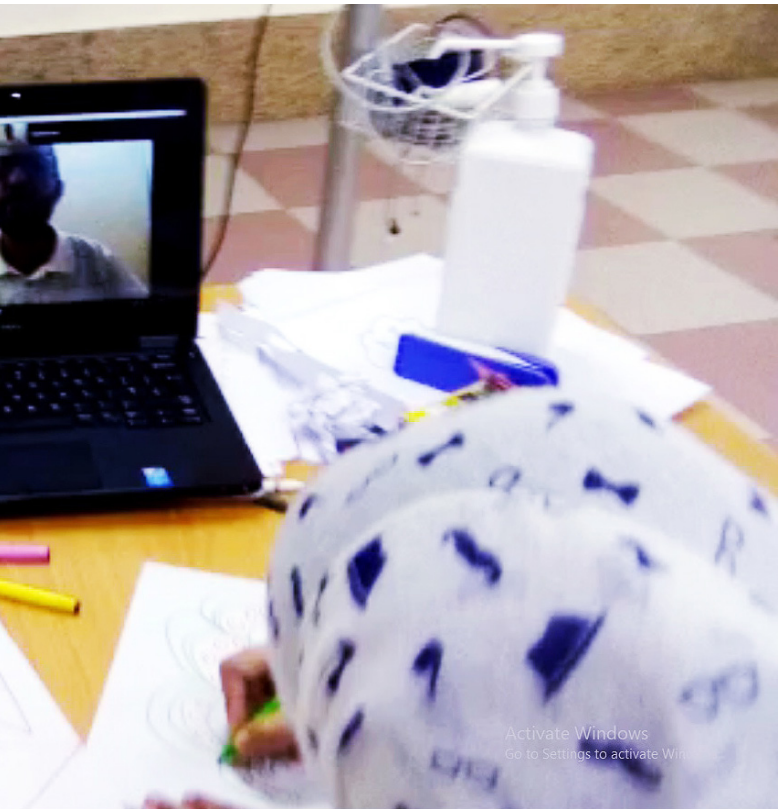
In one particular case, we came face to face with the difficulty of not being able to be on ground and monitor as usual in a project like this: We donated a screen and created a five-hour loop designed to create a relaxing environment for the patients admitted to the ICU in Liaqat Hospital, Hyderabad. The loop consisting of visuals and relaxing sounds with specific messages of hope that the doctors thought was necessary (especially with regards to avoid consuming "fake media" messages). The equipment was handed over to a senior HCP who was in-charge of the unit at the time. On a follow-up visit two weeks later, we learned that the particular HCP has been transferred and his colleagues could not answer to our queries

regarding the effectiveness of our intervention. In fact, we found out that the film was never played. We are in the process of trying to recover the hardware provided (a screen and a 64 MB USB device).

3.5.2 Digital versus face-to-face

The few art-workshops that we conducted online also brought to front the limitations in the types of activities, materials that could be used and depth of self-reflection, not to mention the difficulty of providing one-on-one guidance. Having said that, we were in fact surprised that the results were quite satisfactory, meaning to say that online workshops were reported as just as useful by participants as were face-to-face. Having said that, the limitations of conducting these workshops online included:

- A limitation of the type and scope of activities that is possible
- Difficult to read participants reactions and interact
- The dependence on a HCA to help assist
- The technical difficulties of setting up the systems (including network availability etc.)
- Difficulty to ensure that the whole group is involved
- Difficulty to provide one-on-one feedback and support



Noting the above, the staff at EXPO Centre Isolation Facility in Karachi explicitly requested that we provide face-to-face rather than online workshops.

Regarding the counselling sessions, we faced similar issues. Counselling is and has always been considered a service being provided face-to-face in a safe, confidential environment. Online counselling is relatively a new phenomenon, which has been around for the past ten years however, most clients prefer face-to-face sessions. Practically overnight, we have had to re-look at the ethical implications of working online with regards issues of confidentiality and regulatory guidelines, Internet and its connectivity issues etc. Moreover, the idea of working with clients online not being able to see their whole person, get a sense of their energy and persona during one single session was also a daunting prospect, particularly in this particular client group; the fear being that it may end up as more of a friendly or stilted chat rather than therapeutic work. We decided to use Whatsapp video call for counselling sessions (this decision coincided with the company WhatsApp improving and tightening their data encryption policies which is a necessary requirement to manage confidentiality requirements) as WhatsApp is widely used by a large number of the population from all types of income brackets and this proved to be extremely user-friendly. Moreover, we had not control over the quality of Internet available and WhatsApp video calls use the least bandwidth compared to other applications available. For awareness sessions and workshops, we used Zoom, as it was easier to share PowerPoint presentations with participants this way on a large screen at the Expo Centre. What we learnt was that intention and commitment play a pivotal role in forming that connection, that relationship with the client albeit for just one session; learning to adapt to using tools and techniques online did pose its challenges however, we managed to adapt and hold space for clients.

3.5.3. Difficulty of accessing children

Our hopes of this intervention being child-centered did not pan out as expected due to the difficulty of access, the main reason being that very few children presented at the Isolation facilities. Furthermore, the closure of schools meant that access through educational institutions was also not possible. This is reflected in the literal absence of children in the beneficiaries receiving counselling during the project. However, for the art-making workshops, we focused on reaching out through community based organizations and utilizing a cascading approach described earlier. In particular, the partnership with The Social Welfare Department, who have significant community outreach, allowed us to reach our targets with regards to children. With schools gradually re-opening, we envision working closely with educational institutions for service provision specifically for children.

3.5.4. The difficulties in accessing positive testing people in the communities

As mentioned earlier in this report, with the shut-down of quarantine centres and isolation facilities, much of the infected population is isolated at home. This was a major issue for us in which we tested out various ways to access people, specifically so in Hyderabad and Sukkur and that included:

- Cold calling from lists of infected people provided by the local health authorities.
- Creating WhatsApp groups for the same populations.
- Using social media platforms.

From our experience, we realized that the tremendous stigma attached to the disease, the perceived "harassment" of local officials towards suspected cases, and a general confusion and fear regarded to the subject were not conducive to such measures to reach out to people. In fact, the only success that we got here was to go through the usual gatekeepers vis-a-vis established and trusted CSOs.

3.5.5. Working with the local health authorities

All the officers we spoke to in the local health departments on initiation of the project were not only very receptive, rather they understood the need for the intervention. While a general letter was issued to the DG and DHOs to support UNICEF intervention through partners, the specific name of the partner was not mentioned. Subsequently, we suspended our work with the health departments until an official "letter of support" from the DG Health Office was acquired. This meant a loss of two weeks in field work. We did, continue with our community outreach as well as work at the EXPO centre during this time. It is worth mentioning that once this letter was acquired, the local health departments were very cooperative. In fact, our experiments to access people described in the above point (cold-calling and WhatsApp groups) were based on recommendations by the district health offices, both in Hyderabad and Sukkur.

It was obvious for us that the health departments were over-worked and stressed in the current pandemic. In such a situation, they understandably had limited time to entertain us regardless of their personal support. They were also totally absorbed in the screening and identification and may not have been in a position to entertain us. In Hyderabad, for example, where all the HCPs spoke of the need for PSS for their teams, none were able to organize a break from the routine work to allow for such an activity for their staff. As a result, we suggested that HCPs who were facilitating our work, participate in the workshops as well. This technique worked very well at EXPO centre and was much appreciated by both patients and staff working. However, we were unsuccessful in organizing workshops for government health care providers, the major reason being, and unavailability of staff to take time off from work.

3.5.6. High staff and patient turnover of staff and patients at Isolation facility

Unfortunately, post the Eid-al-Fitr break, the number of Covid-19 infections increased significantly around the country, with Sindh having the highest numbers and Karachi being the city with the highest numbers. The staff at Expo Centre and the HCAs' were deployed to start setting up a High Dependency Unit (HDU) to cope with the increase in Covid-19 infections. This also meant that the HCA who we had trained with regards the assessment criteria had to be shifted to the HDU and another HCA was given the task to continue our program in the Red Zone. We then provided training regarding the assessment criteria to the new HCA; the new HCA initially struggled to manage the assessment and scheduling and a further training was provided to her in this regard. Whilst we were not able to conduct the mental health first-aider training due to the Expo Center staff being busy with the rising numbers, we continued to stay in touch with the both HCA's throughout this time (the original one was by this time working in the HDU which was an extremely stressful environment). We developed a good working alliance and rapport with both and spoke to them on the phone at least 3 times a week, offering support, unofficial on the spot counselling, actively listening to them and the issues they were facing both emotionally and work-wise and provided solutions where necessary, empathy and encouragement. This in turn led to some unofficial mental health first-aider training which whilst this not originally how we envisioned it, led to these two HCA's sharing what they learnt with their colleagues and also them trying out some techniques with the patients such as breathing exercises, Mindfulness techniques etc.

To summarize, strategically speaking, in as much as this was a short-term service provision intervention, we focused not only on the delivery of psychosocial support, rather, we approached the process as an opportunity to test out the various methodologies that we applied for suitability and affect and that is discussed further on in this report.

3.5.7. Stigma associated with mental health

One significant challenge we faced was the negative association of the term "mental health". Coupled with the stigma associated with testing positive for COVID-19, this was a serious issue for us. In fact, one gentlemen, who wrote in to the WhatsApp group we initiated had this to say:

COVID-19 patients are not mentally ill. Therefore they are not supposed to be required mental health support. It is also pertinent to mention that after availing the required period of isolation then is there need of any support

We were therefore mindful of this association and avoided using the word mental health, rather, we promoted the work simply as an opportunity to do some enjoyable art-making in a group and that would help participants de-stress and cope better.

Chapter Four:

The Results

This chapter presents the results of the intervention as per the deliverables agreed upon.

4.1. The Art-making workshops/sessions

TARGET: 200 people (men, women, girls & boys) infected / affected with COVID-19 are provided with PSS and Psychological First Aid (PFA) directly and through cascaded approaches reach 300 more in quarantine centres (200 men, 100 women, 25 girls and 25 boys).

During the period May to July, we conducted art workshops with 264 infected and affected people in all three cities (Karachi, Hyderabad and Sukkur). This includes 111 men, 62 women, 24 boys and 12 girls, and 64 service providers (31 men and 33 women). Of these people (having attended the art-workshops), 15 men and 5 women availed the counselling sessions later on. A further 283 children were reached through cascading, bringing us to a grand total of 556 people who attended an art-making session. Details of the outputs of the cascading approach are presented in the section on cascading. We also have ample anecdotal evidence that suggests that this number may in fact be far greater as evidenced by the following quotes:

I cannot believe I did not get my children any colours till now… I will busy them lots of material to make art.
I will read stories to my children from now on
I think I can do any of the activities we did here with other people.. its really simple.
I learnt this [art marking workshop] from you and now I am practicing it with people in quarantine centre.

It is pertinent to mention that the workshops were not standardized, rather tailored for the specific group, space, resources available as well as the local context. Thus, the workshops ranged from simple de-stressing exercises for front-line workers and health care providers to more in-depth exploration with people in quarantine and other groups. Workshops were conducted both on-line (using zoom) and face-to-face. The materials used- clay, paper, crayons and text, were selected specifically for practicality and also for the particular affects envisioned. For example, clay, as a material, facilitates a calming and grounding tactile experience. Activities included drawing, sculpture, poetry and prose. In addition, all activities were curated within a mindfulness approach and breathing meditation was used as an anchor to start with and end all sessions. Music was used whenever the possibility arose. All the work was focused on expressing emotions as a way for catharsis, personal reflection and sharing; identifying internal resources and above all, as an opportunity to de-stress and do something enjoyable. The table below gives an overview of workshops and participants. Details of venues are provided in Annex 1.

Participants	N	Target
Total number of participants	264	200
No of men	111	-
No of women	62	-
Total number of children	36	-
Number of girls	12	-
Number of Boys	24	-
Number of front-line workers	55	50
Number of online sesions	7	-
Number of face-to face sessions	12	-
Total number of workshops conducted	20	-
No reached through cascading approach	283	300

Table 1: Participants of art-workshops (May to July 2020)

As we did not have access to the "red zone", we were heavily dependent on the health care assistants to

facilitate our work at the EXPO centre. We therefore had the opportunity to closely interact and understand their needs also. In fact they themselves were aware of this need and eager for support. However, due to the hectic schedule and inability to spare time, we devised a solution whereby the HCA assisting us would participate in the workshop. Through this approach we managed to provide PSS to 55 HCAs, the feedback from whom was just as encouraging. In the words of one HCA:

"All these art sessions I have attended and taken part have been one of an amazing experience as it has given new vision to me. I have always been fond of art as I love to draw and fill colors. But I haven't thought it can be sort of therapy, in a way that we can express our emotions. Creating art from music is thing I learn. Listening to music and let myself free to draw anything out of any colors and you are doing all these things subconsciously, this is best thing about it. You get involve so much in music and art that you forget about you have to go back to your stressful world. And when you returned to your world you are in much peace and confident. Also there was session in which we have to draw all things using dot or line in a particular box, that had given me wide angle to think. Only "Dots and line" together can come out so beautifully."

It is worth mentioning that in another related UNICEF project that is running simultaneously, we are currently providing PSS and capacity building to 150 health care workers from the MoH, Sindh*. While we did not include these numbers in this report for the obvious reasons, we did treat this second project as a continuation of this one, both operationally and content-wise. The advantage being that both projects fed into the other with regards to designing activities and catering to the specific needs expressed. In fact these Health care providers will be a resource and capacity for any future work with Health Department for institutionalizing MHPSS

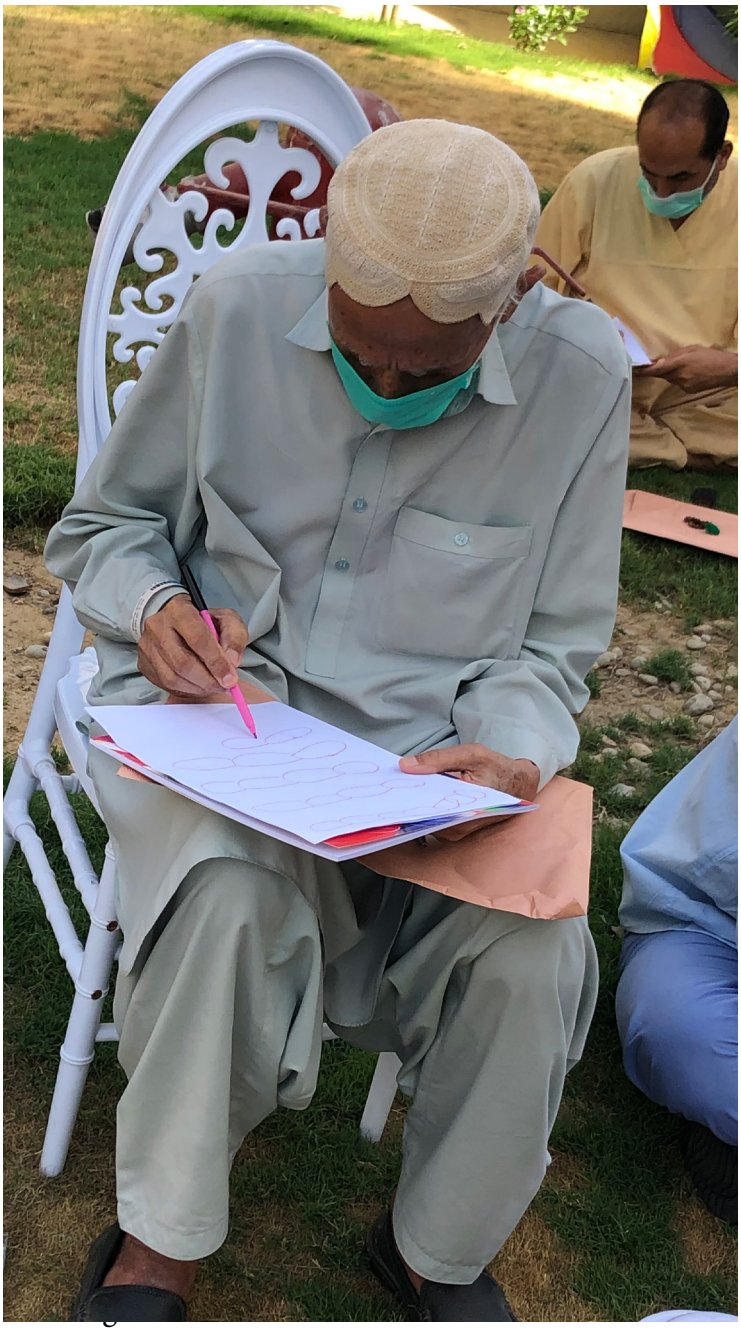
The workshops were received very well by all groups and providers and is supported by feedback from participants (both official and informal), personal observations and reports from our hosts. By and large, we observed that participants would not only be fully engaged in the activities, but also share their emotions with the groups. In fact, the group dynamics functioned as a safe supporting structure for individual participants to engage in. As we hoped, the workshops were perceived as a playful, non-threatening and relaxing experience wherein participants could emote, express and de-stress, while learning some basic coping skills that could be replicated easily with friends, family and colleagues.

4.1.1 Participant Feedback

Participant feedback has been the main method for us to monitor and evaluate our work and, more importantly, to make adjustments and fine tune the workshops as well the counselling services based on the feedbacks. Where it was not possible to get written feedback from every participant we took verbal feedback in the group at the end of the session. Feedback was essentially based on the following five questions:

- What did you enjoy most in the workshop?
- What difficulties did you face during the activities and how did you overcome them?
- What, if anything, surprised you?
- What message do you take home with you?
- Do you have any advice to make this workshop better?

By and large, the feedback was very promising. It seems that participants not only enjoyed the sessions but also realized the importance of catering to our well-being and in particular mental health. The following statements have been selected to give an overview of the types of responses we received.



4.1.1.1 What did you enjoy the most in the session

This question is specifically asked as a self-reflection that points towards areas that interest you most and that could point towards activities that not only work for you but also have a chance of being sustained.

By far the most common answer to this question was the "breathing meditation" which consisted of a simple awareness exercise (focus on your breath) and which we combined with drawing, body scans and other mindfulness activities. The popularity of this technique is perhaps the simplicity of instructions, the practicality (no need for special equipment or space) as well as the immediate affects- most people commented that they "felt" different after the breath work, the obvious effects of oxygenation, silencing the mind and closing the eyes for a bit.

The second most common reply was clay work. Working with the tactile properties of clay was not only found to be relaxing and de-stressing, rather the creation of something was sensed rightfully to be empowering. Furthermore, people enjoyed sharing their creations with the group.

The following are some individual quotes from the feedback regarding what participants enjoyed the most:

- The breathing meditation
- Playing with the clay
- This is the first time I have used colors and it's wonderful. I want my children to do this
- The drawing meditation
- Drawing my name
- Meeting other people
- Making art during the meditation session
- To play with clay and try to "listen" to it
- I enjoyed the most when I shared my story with the group
- To look at my minds creation through the art and enjoying it
- Feeling the breath on the tip of my nostril as I breathed
- Describing what makes me special

4.1.1.2 What was difficult for you and how did you overcome this difficulty?

This question is specifically asked with the purpose of identifying our internal resources vis-a-vis how we deal with individual challenges. By far the most common response was the difficulty "not to think" while making the art. We must mention here that much of the art-making was intuitive, i.e. it was not planned for, rather the "artist" allowed for whatever needed to emerge. A "difficulty" is therefore a challenge that was successfully overcome, and hence the possibility to identify resources. A sample of responses are provided below.

When the trainer asked us to imagine the clay could talk [naming and voicing clay object] …. but slowly I got it.
Writing the things and story was so difficult and after many time I think, and I overcome it.
I remembered my divorce in 2016 which made me sad. Then I overcame this with writing the feelings.
The difficult is playing with mud (I don't like dirty hands) but I survived.
Talking in-front of everyone.
Logon sai baat karna lekin jab dost sunain tou ye mushkil asaan hojaati hai (it's easier to talk in public if the people are your friends).
The difficulties which I faced that I can't write words without thinking for long but I overcame from this when my friends motivated me.
I have social anxiety so I'm afraid to talk in public… I overcame it by ignoring my fear and just sharing like everyone else.
It was difficult to sit with a peaceful mind and not overthink...and meditation was helpful.
To write a poem- but I did write a poem!

4.1.1. 3. What surprised you?

A surprise is the unexpected, and a pleasant surprise is usually accompanied by a short inhale and a sense of wonder. In fact if there weren't any surprises, life would be quite boring- which is the same for learning something new.

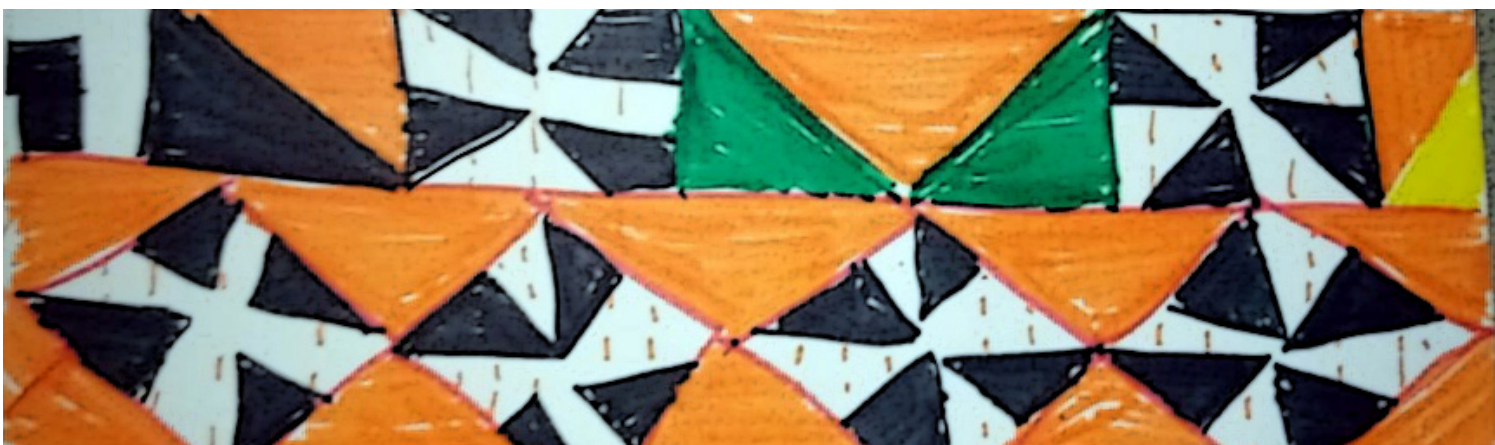
The thing that surprised most is that I was very depressed for some time. Just attended this session, now I feel very happy and good.
I was surprised that we have talent and can do everything we wish.
That I have such good memories from my childhood that make me happy when I think of it
When sir says to us for close your eyes and when I open my eyes so it surprised me very much (everything looked different).
The drawing can become a form of Zikar (remembrance).
That paper is such a wonderful material.
I wrote a poem.
The surprising thing how can you make yourself relax and calm by taking breath.
The feeling of the breath during inspiration and expiration.
It surprised me that we have lot of talented people around us.
It surprised me when the objects started to "talk"
Sometimes we don't even know how we ourselves are feeling…until we don't try to find out.
That I can control how I am feeling.
I can change my mood by sharing my worries with a trusted friend.
When I got the sms from Aseela (about the workshop), I thought something like [a session on] corona, but here is something new, how to enjoy yourself!

4.1.1.4. What message do you take home with you?

This question is specifically asked to enhance the chances of what a pleasant experience is usually, to something more substantial and which can affect our everyday lives. It is more a question to allow people to think of the applicability of what they have realized or learned to make a change in their daily lives.

If you are not happy, you cannot make others happy - so be happy and give happiness.
I got this message that I should work hard. I will become an artist.
The message which I will take to my home is besides taking a big decision to discuss with each other and find out the solution of it.
I can draw
Maine zameen kay sawalat logon tak pohanchai hai.
It is important to understand yourself first.
I take the message that life is very important- we must try to make it as pleasant as possible.
I can now provide some PSS to my family and colleagues using very simple practices.
I will make some "me time" for myself.
To simply listen to the other is better than giving advice.
I will read stories to my children from now on.
I will play with my imagination.

The "Art Gallery" at the end of this report is meant to showcase some of the art produced the project.



4.2. Triage counselling sessions

TARGET: 100 counselling sessions conducted for people requiring specialized services.

Based on our targets, we conducted 100 triage resource-building sessions. All data was collected and analyzed through a Client Tracker Information Sheet, is presented in annex 3. On reviewing the data on the Client Tracker, we see that 76.3% of the population was male and 23.7% was female. The table below illustrates further the gender demographic of clients.

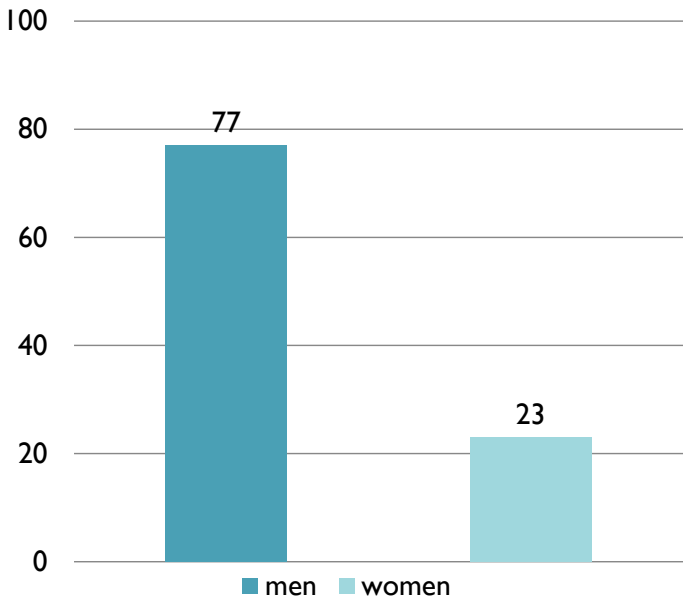


Figure1: Gender breakdown of counselled patients (number of clients versus gender)

Clearly more men were presenting at the Quarantine centers than women. This was discussed in the focus groups we conducted with our team. In fact in the datasets of patients that we received regularly, and shared in our weekly report, we see this gender gap even in the official Pakistan government statistics, and in fact is also similar to global statistics. Both sex and gender could have a role in explaining why men are not only more prone to the infection but seem to have worse outcomes of COVID-19 infection than women, including the fact that women immune systems may be more responsive than men[34]. In any case, no conclusive studies about the topic that we know of have been carried out as yet. Culturally, in Pakistan, particularly in the working and lower – middle to middle class demographic of the population, women are seen to need protection and kept at home, focusing more on housework and raising children. Moreover, concerns regarding a woman's safety and 'honor' and being in mixed-gender centers would hinder women from coming to such quarantine centers. In fact, both counsellors and the HCA's reported on the guilt felt by the few female patients that were admitted at the Expo Center, worry about their families who were at home, their children and who was looking after them etc.

The age brackets were spread quite evenly with 24.1% of the population between the ages of 20-29; 21.8% were 30-39 years of age; 27.6% were 40-49 years of age and 23% were 50-59 years. A small minority fit the 60-69 and 70-79 age bracket. The table below gives the age range of people counselled. Unfortunately, no children were referred. The main reason being a lack of children at the Isolation facility where most of our cases were referred from.

34 Klein SL, Flanagan KL. Sex differences in immune responses. Nature Reviews Immunology. 2016 Oct;16(10):626-638. DOI: 10.1038/nri.2016.90.

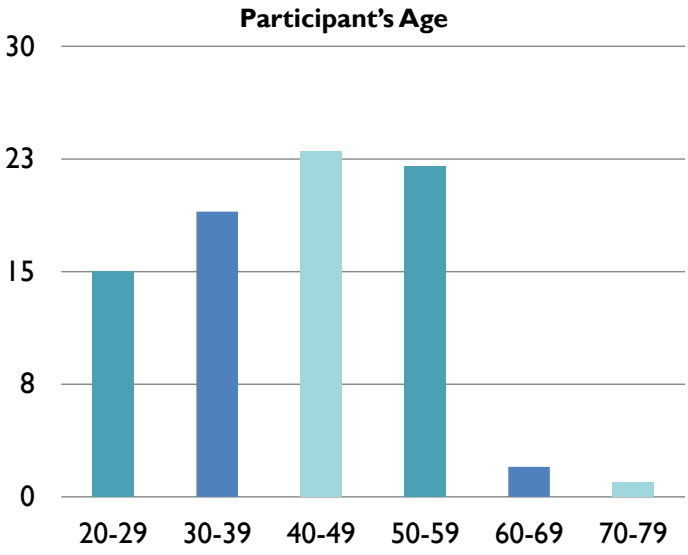


Figure2: Group breakdown of counselled patients (number of clients versus age group)

Initially, we had hoped to be able to conduct at least 50% of counselling sessions in quarantine centers in Hyderabad and Sukkur. However, due to closure of most centers, and difficulty to access infected populations as a consequence, this was not possible. In our search for the infected populations in these areas, we were however, able to provide counselling to two doctors from these areas.

Only 7.3% of the clients required more than one triage resource building session and 4.2% required 3 sessions; the majority of the clients felt safe, stable, held and grounded after a single resource building session. Whilst there is no replacement for long-term therapeutic work in terms of trauma, this information clearly evidences that a large part of this client base, built enough resources to sustain their emotional wellbeing through their time in quarantine. This is what we had hoped for when in the focus groups, we were deciding on the type of sessions that could prove the most beneficial with a more long-term impact.

In terms of psychological symptoms presented, the percentage of clients presenting with sadness and anxiety were similar, 14.3% and 15.3% respectively; Fear and denial were also similar; 12.2% of the client base respectively. 10.2% of the client population presented with restlessness & frustration. What we found most interesting was that 24.5% of the client population clung on to hope as their biggest resource. Anger was a common theme experienced by almost all clients. If we were to look at this information through the lens of Freeze/Fight/Flight trauma responses, denial would be considered a flight response as would anxiety; anger, fear and anxiety as more of a fight response and sadness and anxiety as more of a freeze (both sadness and anxiety can tend to paralyze people emotionally and keep them looping between the two emotions).

We had created a scale of (1-10) (with 1 being the lowest and 10 being the highest) in terms of how the client felt at the start of the session and the end of the session; 10% felt 3/10, 16% felt 6/10, and 22% felt that they were at a 7/10 at the start of the session.

After the counselling session, nearly 25% scored themselves as 8/10, 25% felt 9/10 and 6% felt 10/10 after the session. The following charts present these findings:

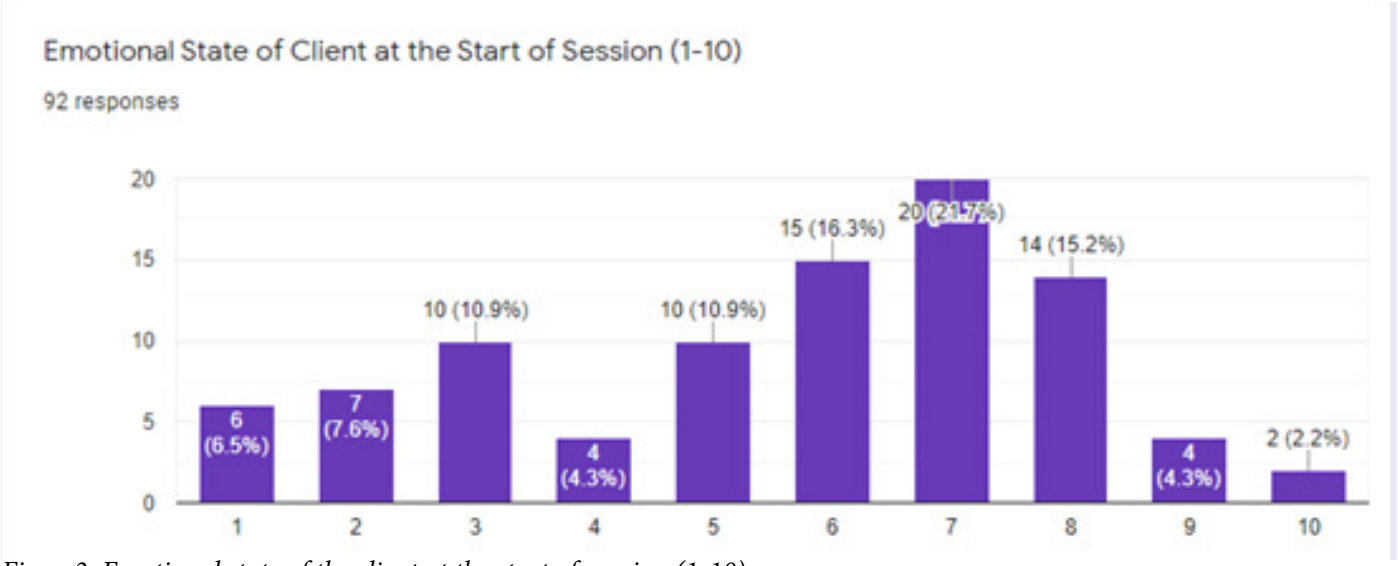


Figure3: Emotional state of the client at the start of session (1-10)

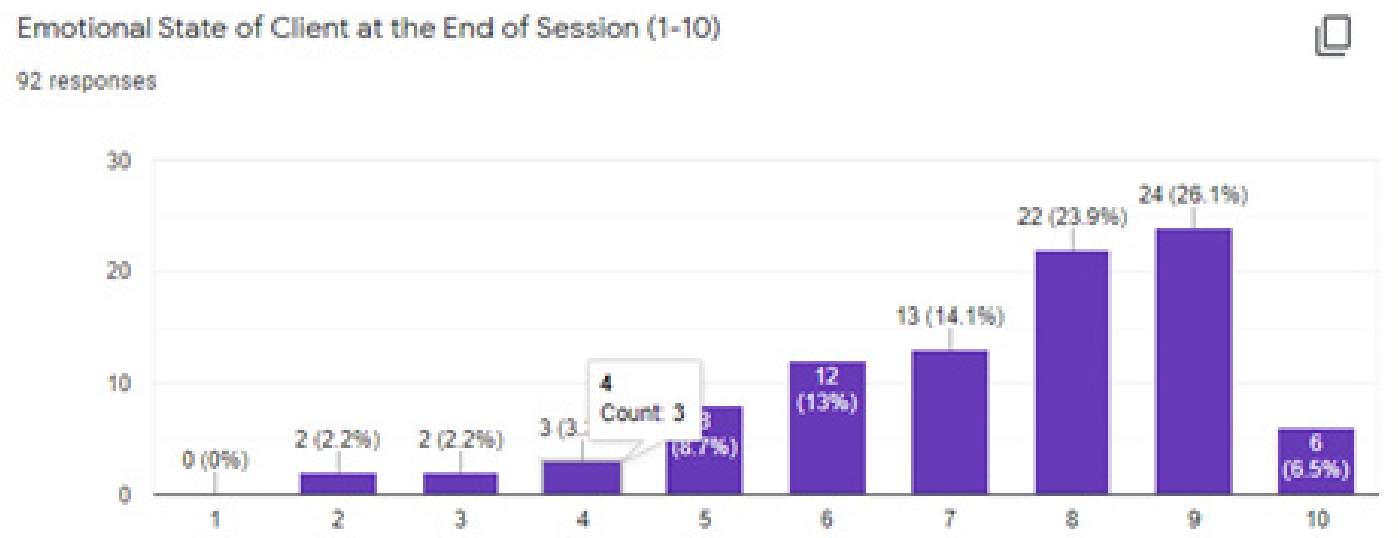


Figure4: Emotional state of the client at the end of session (1-10)

Recently, a new 4th trauma response is being spoken of in mental health communities around the world – Fawn. A fawn response is brought about by an attempt to avoid conflict and trauma by appeasing people; this was certainly noticed by some of the counsellors/ therapists and may explain the large number of 'hopeful' people. Similarly, if we are to look at the data collected in terms of how clients were feeling before and after the session on a scale of 1-10, 20-22% felt that they were at a 7/10 at the start of the session. This may be interpreted more as a fawn response as the comments from the counsellors/therapists say otherwise in terms of how they experienced the client, moreover, over 50% of the client base fell under the U Stress category (overwhelmed but functional) which again tends to point towards more of a 'fawn' response. It is important to note that culturally and spiritually in Pakistan, the practice of gratitude is practiced and at times enforced quite strongly and there is a lot of shame and distaste associated with 'being ungrateful'; some may even see it as a sin and something that may anger God.

Finally, keeping in mind population figures, we had hoped to be able to conduct at least 50% of counselling sessions in quarantine centers in Hyderabad and Sukkur. However, unfortunately due to circumstances discussed earlier vis-a-vis a closure of most centres, quick turnover and difficulty to access infected populations as a consequence, this was not possible. In our search for the infected populations in these areas, we were able to provide counselling to two doctors from these areas. All other clients were in Karachi at the time of the session.

A direct quote from Aliza Babar, the health care assistant at the EXPO centre facilitating these counselling sessions had this to say:

"In the beginning, patients were required a double negative (Covid-19 test result) for their discharge, but repeatedly their result used to come positive and they have to stay in the isolation center for like more then 40 days, away from family, jobless, without their smartphone. They had a lot of stress regarding how their family will be managing. Even I have witnessed patients getting dishearten so much that they wanted to attempt suicide or run away by breaking doors… these sessions have actually helped the patients a lot. They feel better. After sessions they used to smile and enjoy, I even witnessed a patient being so happy, that she started singing!"

She went onto saying that with regards patients, who were admitted whilst actively using drugs, counselling became a lifeline for them and they continue to stay on with those counsellors who are now offering them pro-bono sessions. She mentioned another female patient who had lost her husband to Covid-19, 2-3 days prior to being sent to a quarantine center who required 3 sessions and the change in her was remarkable. She also commended the counsellors for their patience in dealing with patient 'tantrums' and connectivity issues.

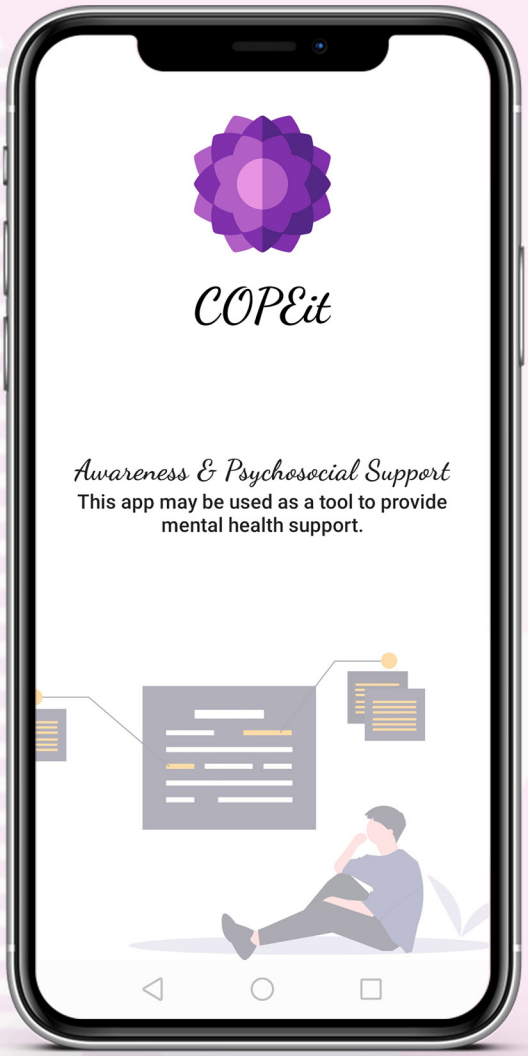
4.2.1. Establishing a referral network

We originally aimed at establishing a network of 5-10 trained therapists/counsellors who could later be part of a referral network after the project was over. Early on, we realized that the relatively few counsellors in Karachi were fully booked. To cater to this problem we reached out to our small and rather over-worked mental health community about this project and surprised by the overwhelming response, which ultimately led to the creation of a cadre of 48 counsellors/therapists. They were all keen to offer their services and in fact were already thinking of ideas on how to give back to the community; they were extremely grateful for the opportunity being provided. We have tried to provide an opportunity to most counsellors/therapists on the team to provide sessions and the ones who could not further facilitated the process by giving clinical supervision to the therapists/counsellors, providing the team with advice and guidance, resources etc. Moreover, as our counselling sessions have ended at the Expo Centre on Sunday, 19th July 2020, we have provided the HCA's at Expo Center with the names and contact of 5 counsellors/therapists who are willing to provide pro-bono counselling services if the need arises. The number of patients being discharged is increasing rapidly and the HCAs' informed us that the Expo Center may well be closing down in the coming weeks after Eid-al-Adha.

COPEit

Breathing
Deep breathing is one of the best ways to lower stress in the body.

Meditations
helps in metabolism, lowers blood pressure, and improves heart rate, breathing, and brain waves.



Art Tasks
expressing through art can help people with depression, anxiety, or cancer, too.

Healing Nature
Being in nature, or even viewing scenes of nature, reduces anger, fear, and stress and increases pleasant feelings.

helping you maintain peace & harmony

This app has been created specifically to allow you to de-stress when you get the time - and we do need to make time for ourselves!

Take all the precautions you can and don't worry about things you can't control... work with what you can.

Download now from:

ANDROID APP ON Google play

Download on the App Store

4.3. Media Outreach campaign

TARGET: 1,000 community members, mothers, fathers, caregivers, religious leaders, key community influencers reached in communities affected by COVID-19 with psychosocial support and stigma prevention messages using innovative technology (mobile app).

DDespite using inorganic reach i.e. unpaid advertising, we managed to reach out to over 65,000 individuals at the time of writing this report. Of these, over 3,500 people engaged actively in some way (sharing, liking and forwarding).

On the whole, we noticed that posts addressing the personal arena (e.g. with regards to supporting each other with domestic work) were more popular than those that tackled technical aspects (e.g. hand washing). This can be understood considering that the majority of messages on social media are related to the technical aspects of contagion prevention. The most popular posts by far were messages that contained images of our workshops, perhaps due to the curiosity of people regarding people testing positive with COVID as well as the allure of an image. While we preferred messages created by the UN and other government agencies, we also created our own content keeping in mind the objectives of our intervention. Ultimately, we were very conscience of presenting these people not as diseased or victims, rather, we were eager to share an image normalizing this cohort and presenting the human picture of this pandemic. See next page for some of the messages that were posted.

In addition to the above, we created, and pilot tested a mental health coping app called COPEit-19, that was placed on google store and is now available for downloading. This process was greatly hampered by the current stringent review protocols of google in which anything related to COVID19 required government approvals. In order to circumvent this, we reapplied as a non-COVID intervention. In fact, the app has general applications not at all specific to COVID and has been designed more like a game. The app is available in English, Urdu as well as Sindhi languages and has been downloaded by 80+ users till date. The initial reviews we receive have been promising.

We also produced a short film that presents the experience of a COVID-19 survivor who spent three weeks at a quarantine centre. This clip is specifically intended to show a "human face" and greater a discussion about the stigmatization of infected and recovered people.

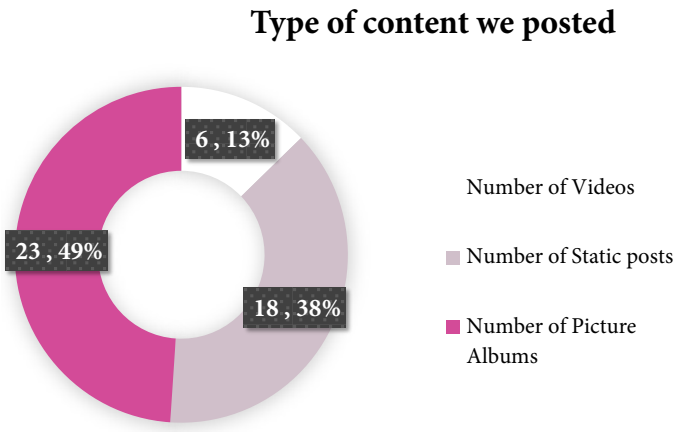


Figure5: Breakdown of the type of content posted on social media

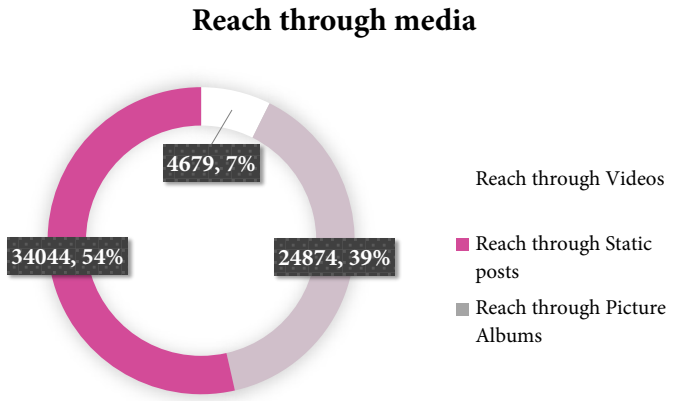


Figure6: Breakdown of the reach through type of content psoted

4.4. A Cascading approach

As part of our initial proposal we had envisioned working in-depth with a few groups of quarantined people who would subsequently reach out to others through a cascading approach. Unfortunately, due to circumstances vis-a-vis a closure of most centres, quick turnover and difficulty to access infected populations, we could not pursue this plan. We then focused on community based workers to achieve this aim by training four members of the Social Welfare Department for providing psychosocial support through art-making. These individuals replicated the activities with groups of children in communities. To assist them, we developed a small manual with a proposed methodology and step by step instructions to conduct selected art activities with children in the communities. In all 228 children (139 girls and 89 boys) were reached through this approach. Feedback from the participants, aged 9 to 18 years, shows that not only did the children enjoy the art-making, rather they saw the value of the art as a coping strategy.

I started feeling anxious and angry most of the time (after schools closed)… Doing this activity really made me comfortable and I felt that I have spent time with my self, drawing the thing which I like.

I was feeling angry, I wasn't allowed to go out like it used to be but I have put my anger in this drawing and I think I would like to continue this activity.

I really feel that I am more energetic after doing this activity.

The facilitator (staff of the SWD in this instance) reported:

The activities were little difficult to comprehend for children as how the ART will help them to deal with their stresses. However, they really enjoyed participating in the sessions as after the sessions the sense of calm to the body and positive impact on their minds were visible. They had the opportunity to draw their thought about their surroundings, their self and their emotional state and they clearly find it really interesting and showed their excitements while doing the activities. Putting their emotions into drawing and making things through clay really gave children a safe outlet to vent their negative emotions through an engaging and enjoyable activity and it accelerates their coping with the situation.

#	Area	District	No. of Sessions	Participants	
				Girls	Boys
1	North Karachi	Central	1	20	10
2	Korangi crossing	Korangi	1	1	14
3	Ibrahim Hydri	Malir	2	53	25
4	Mehran Town	Korangi	2	39	21
5	Safoora Chowrangi	East	1	14	1
6	Makh-doom Bilawal	Malir	1	7	8
7	Shanti Nagar	East	1	5	10
	Total No. of Participants			**139**	**89**
	Grand Total				**228**

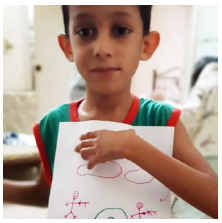
Table2: Details of cascading activities conducted with children (in collaboration with the Social Welfare Department, Sindh)

35 https://www.artsbasedmethodologies.org/post/a-love-affair-with-my-shoe










Apart from this, two people, both teachers, conducted one of the exercises they learned with their (female) staff and students (n=55)[35]. Both these participants shared the art work produced and their experiences thereof and have subsequently requested for more workshops that will follow (after the current project is over).

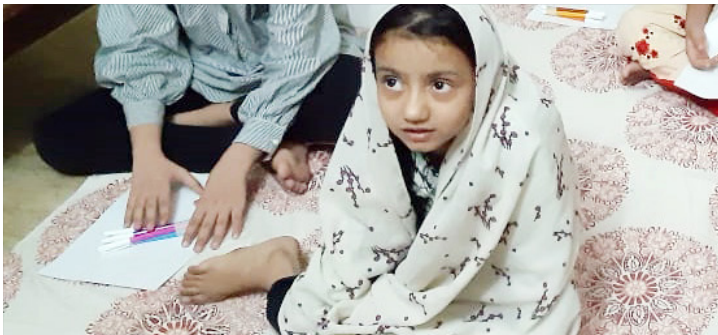
Finally, we encouraged all people we catered to during the intervention to use the skills we taught them with their peers and families. We have sufficient anecdotal evidence that suggests that a cascading affect vis-a-vis the simple PSS skills we promoted was created and continues as is evidenced from the following feedback participants

I shall be doing these exercises with my little sister.

I read the story I wrote yesterday to my children…they loved it… I will be doing more art with them and buy them some colors.

Breathing is such an easy way to calm down and relax…I want to tell all my friends about it.

last night I did the breathing exercise before I went to bed…it really works. I will be doing this regularly.

Chapter Five:

Discussion & Recommendations

This chapter presents a discussion of the findings in context to the intervention and our short and longer term recommendations based on our experience.

5.1. An overall view of the project

The current COVID-19 pandemic has seen entire cities effectively placed under mass lock-downs, while all others have been asked to self-isolate at home or in state run facilities. Pakistan has followed the global response with an initial 23,557 beds made available for quarantined people all over the country coupled with a screening and testing programme. Due to the large numbers of positive tests, a relatively small number of symptomatic people and the impracticability of housing large numbers in the quarantine centres, we saw the closure of many of these centres and the focus shifting to home isolation. While this may have decreased the effects of isolation to some degree, whereby infected people are being taken care of by their families, our experience has shown, that regardless of where people are isolated, there is a significant increase in stress and anxiety related to the disease, and a real problem of stigma and discrimination.

While there is little doubt that the pandemic has increased mental health issues, it must be noted that Pakistan suffers a considerable burden of mental health disease (6% prevalence of' depression, 1.5% schizophrenia, 1 to 2% epilepsy and 1% from Alzheimer's disease)[36] which includes substance abuse and suicide. Thus we believe that the pandemic has not only contributed to the burden, rather, more importantly, it has brought to forefront a serious public health concern vis-a-vis mental health. And the strong association between poor mental health and decreasing immunity is critical in the outcomes of the pandemic with regards to mortality.

Furthermore, access to management may be a significant problem with a low number of qualified mental health professionals. For example, the number of psychiatrists in Pakistan is very low at roughly 300[37]. It is little surprise then that the existing number of psychiatrists are insufficient to cater to the mental health need of the country. With regards to the three cities we looked at, it was only Karachi that had a significant number of professionals providing PSS and that included trained counsellors. Having said that, literally all counsellors in the city were fully booked during our search for counsellors to hire in this project. Finally, the average charge of a one-hour session is Rs.3000 per session which may be much too high for many people.

A lack of understanding of the concept of counselling was evident not only in the attitudes of clients, rather also health providers. In fact, when the management changed at the EXPO centre, the new management had to be literally convinced of the benefits of counselling through a series of awareness raising workshops (one both for men and women). It goes without saying then, that perhaps the first step would be to create awareness of the need, use and expected outcomes of counselling and other mental health interventions prior or simultaneous to offering them.

The art-making workshops, on the other hand, did

36 Gadit AA, Vahidy AA Mental health morbidity pattern in Pakistan. JCPSP., 199, 9:362-5.

37 A. A. Gadit . Editorial, State of Mental Health in Pakistan (Department of Psychiatry, Hamdard University, Karachi.) July 2001, Volume 51, Issue 7

not create any such issues, and perhaps because we did not associate them with mental health directly - rather we promoted the activity as a de-stressing and relaxing exercise that had positive benefits for mental health as well. Furthermore, art-making as an activity may be more fun and less threatening as compared to talking to a stranger (counsellor). Also to note, is that while many people we came in contact with could not read or write, everyone can draw. In fact, for most of our participants as they reported in their feedbacks, the art activities reminded them of their childhood and created a playful mood. Subsequent referrals from the art-making sessions for counselling sessions shows that the two interventions together worked very well in combination.

Finally, the difficulty in accessing children in this intervention, regardless of the reasons that have been discussed earlier, point towards the need to develop projects that cater specifically to the group (versus including them with adults and other target groups as was the case in this intervention).

5.2. A note on the gender perspective

Worthwhile to mention is the gender specific issues we came across during the project implementation. To start with, there was a wide gender gap with regards to not only people at isolation facilities but in the general public as well. While many reasons have appeared in literature, it seems that by and large women and children have not been affected as badly as men, where it seems that the age range above 50 was most affected. Regardless of the reasons, for our project, this meant considerable difficulty in accessing women or children.

Furthermore, we collected a lot of anecdotal evidence regarding gender-specific issues. For one, there were several reports of female harassment at the hands of male patients at the EXPO centre. The few women that we did access at the isolation facility spoke of the difficulties their families faced due to their absence and specifically separation from their children. Two women at the EXPO Isolation Facility also reported that their husbands suspected that they were at the isolation facility on purpose simply to stay away from home. Finally, women specifically mentioned the added burden and stress to supervise their children for online homework. This theme showed up repeatedly in our conversations throughout the project.

5.3. Recommendations:

Social effects are the shared experiences caused by disruptive events and consequent death, separation, sense of loss and feeling of helplessness. The term psychosocial refers to the close relationship between the individual and the collective aspects of any social entity. Psychosocial support can be adapted in particular situations to respond to the psychological and physical needs of the people concerned, by helping them to accept the situation and cope with it. Psychosocial support is thus an integral part of any emergency response. It helps individuals and communities to heal the psychological wounds and rebuild social structures after an emergency or a critical event. Most importantly, it can help change people into active survivors rather than passive victims, and this was the basis of our intervention.

Early and adequate psychosocial support can:

- prevent distress and suffering developing into something more severe
- help people cope better and become reconciled to everyday life
- help beneficiaries to resume their normal lives
- meet community-identified needs

Based on our experiences, we recommend that mental health coping and psychosocial support should aim to facilitate affected population in understanding the

larger benefit of social distancing and appropriate isolation and aim at finding positive meaning from the experience. Thus we need resource-oriented strategies, which is any strategy that allows people to identify and access their internal and external resources in order to cope with a challenging situation. The approach allows for creating personal agency, i.e. empowerment. Such approaches are not only affective in the short run, rather they may allow for longer term externalities. Art-making is an enjoyable, non-threatening and effective way to do just this and helps not only to recover but can have larger impact by participants adopting the methods to work around their own problems. The dynamics of a, however, pandemic need an evolving design/approach to interventions (for example there were more than 400 quarantined people in Sukkur but by the time we started field operations, there were none).

The cornerstone of such work relies on the expression of emotions, thoughts, fears and apprehensions in a "safe" environment. By safe, we mean a space where participants feels unthreatened, un-judged and comfortable enough to want to share. In addition interventions must include some life skills that they can adapt, if they wish, to improve their mental health status after they have been cleared for discharge. This is even more important when we consider the real issue of the stigma and discrimination being faced by infected and quarantined people, and one that they will continue to face when they re-enter their communities. This implies that any mental health support for affected population is warranted beyond their recovery from the infection and must be coupled with a continued community education programme geared towards de-stigmatizing these populations.

Therefore, with regards to a continuation of this support and other similar interventions, our short to mid- term recommendations include the following:

5.3.1. General recommendations:

- Do not view people as victims and avoid language that victimizes.
- To consider the notion of human dignity in all interventions.
- Generate and disseminate the "human face" of the pandemic- i.e. the stories of ordinary people without sensationalizing them.
- Sensitization of police and other departments involved in the screening, testing and isolation facilities.

While people are in isolation or quarantine:

- Clear and concise information on what to expect, the most recent updates on the disease and SOPs.
- Providing avenues for expression and processing emotions related to the isolation
- Avoiding an over-exposure to news related to the Pandemic.
- Providing structured activities and facilitating people to create a structured schedule for the duration of isolation (e.g. especially relevant for children who need a structure that includes meals, play, studies and, most importantly, sleep on time)
- Ensuring communication with families and support systems.

5.3.2. Recommendations for PSS staff

- Keep yourself informed of the latest developments as well as local resources and referral systems
- Your wellbeing in your responsibility- take care of yourself
- Offering a listening ear, support and solace and being open to the immediate practical needs of those affected; Often it is enough for people only to "be heard"- listen!
- Promote natural recovery and the use of natural sources of help
- Offering factual and up-to-date information about the event; Consider the use of art-making and journaling as a form of expression, catharsis and reflection
- Identify those affected who need acute psychological help;
- Refer and treat, as necessary, those affected who

need acute psychological help.
- Mobilizing social support from their own social surroundings;
- Facilitating reuniting with people close to them and keeping families together;
- Reassuring those affected who display normal stress reactions

5.3.3. Recommendations for MHPSS programme developers:

The underlying goals/principles of first psychosocial aftercare should be based on (1) that the psychosocial care is aimed at psychologically healthy people who have a common reaction from a shocking experience and (2) that the main point of the psychosocial care is to mobilize the social support systems for the victims in order to enhance the psychological coping with the traumatic experiences.

To keep an eye out and recruit if possible, individuals who may be "natural helpers" or "peer counsellors" with other groups.

To define and propose procedures addressed to psychologists and non-psychologists to enhance their preparedness to handle psychological effects on people.

Training of PSS providers should prepare workers to provide those emergency responses identified as priorities in assessments of needs. Training content must be specific to culture, context, needs and capacities of each situation, and cannot be transferred automatically from one scenario to another. Essential teaching may be organized through brief orientation and training seminars followed by ongoing support and supervision.

It is pertinent to mention here that Psychological First Aid can be done by any one and training communities on PSA is a valid disaster risk reduction strategy.

Workers in emergency settings spend many hours under pressure and within difficult security constraints. As the biggest stressor of the staff members is an insufficient managerial and organizational support.

It is necessary to support and to mitigate the possible psychosocial consequences of work in crisis situations with regards to service providers.

Utilize community leaders' and gate-keepers prior knowledge of affected communities and the resilience and vulnerabilities of people.

Working with groups rather than individuals and focusing on strengthening networks in the community so that a much larger number of people can be helped.

The well-being of young children depends to a large extent on their family and community situations. Programmes should support the care of young children by their families and other caregivers and avoid separating young children from primary care-givers.

With schools gradually re-opening, the easiest way to access school-aged children is literally through the school institutions. To access out of school children, CSOs may be involved.

Also critical is bringing onboard the government health officials and other relevant departments as early as possible for smooth operations of interventions. Ideally, such an involvement at proposal development phase, for example, would not only provide valuable real-time inputs but also enhance the chances of ownership.

Finally the Health care providers we worked with will be a resource and capacity for any future work with Health Department for institutionalizing MHPSS.

5.3.4. Hiring and training of counsellors

Counsellors/therapists in this country are inundated with client work; even the trainee counsellors/therapists during their clinical training practice end up with full practices. An average counsellor anywhere else in the world would work with membership to a regulatory body and indemnity insurance. There is no concept of indemnity insurance in Pakistan, nor is there an active local governing body. This is an expensive profession to qualify and work in (allowing only a certain segment of the population to train) as they continuously need to continue our own Continuing Professional Development with further training. Most counsellors/therapists work on a sliding scale where it is recommended that they offer low cost counselling to at least 10-20% of their client

base. Unlike other countries, they work without any government funding or insurance-backed schemes; working with 2 low-cost clients out of 20 is hardly going to make a dent in a country like Pakistan, which is rife with trauma, and Complex PTSD. Add the stigma that is still linked to counselling as well as the misconception that we should provide this work for free or at a cheaper rate as all we do is 'talk' to the client, it is no wonder that they are overworked, under-paid and underappreciated. Having said that, counsellors may provide the backbone of any MHPSS programme to be instituted and is an investment that will pay in the future.

5.3.5 Long term recommendations

As for long term recommendations, we acknowledge that it is time for mental health to take a central place in health service delivery, not only with regards to the Pandemic in present times, but also to deal with the repercussions of the global preventive strategies and lockdowns and its effect on literally all aspects of our private and public lives.

Such a MHPSS programme will require significant work that includes visioning, capacity building and planning with the government, albeit, with the inclusion of non-governmental and community stakeholders. A bottom-up, collaborative effort will enhance the chances of success in establishing any such intervention. Arts-based methodologies may be a very valuable tool to not only develop a context-specific programme, rather allow for creative thinking, ownership, and most importantly, achieve a consensus between stakeholders.

Finally, we have demonstrated that capacity building of critical staff in art-based methodologies, in both government and the civil society sector is a viable and effective method of reaching out to the communities. As a last note, the major outcome/impact that we hope for in this relatively short intervention is reflected in a quote from a respondent who speaks of finding strength in adversity, and this is ideally what any intervention, and especially so having to do with mental health should include- to facilitate people to identify and utilize their internal and external resources to not only deal and cope with the challenging situation they are in, but rather learn from the experience.

I passed a difficult experience, 30 days in a room, so I'm tough... yes I found out I am very strong and tough.

Case Studies

Case 1: Clay Work

In this particular session at the EXPO Center Isolation facility in Karachi, we made use of clay as the material for art-making. As a material, clay is comforting and tends to ground people. It is a very malleable material which allows for it to be easily shaped. Many people have joyful experiences of playing with mud as children, so it allows for positive memories to emerge. Above all, the metaphorical value of earth as mother is well known in almost all cultures in the world and triggers a peculiar calming and nourishing experience.

We started with a breathing meditation with the clay in our hands, sensitizing ourselves to the body, the environment and the art material. Participants had their eyes closed. This in itself can be a very calming experience. After they had "become friends" with the clay, participants were asked to open their eyes and observe what was there and continue to shape their clay. Finally, participants "gave a voice to the voiceless" by imagining what the clay would say if it could speak. Of the many strange and beautiful objects that were born, is the one shown in the picture. It is small Corona virus- something that we all fear is sitting in my hand where I can touch it, feel it, shape it and talk to it. Imagine the power of holding in your hand the invisible fear that you hold in your body. They virus spoke to this participant and said:

I am so small but see how I have conquered the whole world - and you are stronger then I am!

For this particular participant the art-making allowed him to (1) forget his worries for the hour and do something calming (2) create something that is an empowering feeling in itself, (3) give him a sense of control over his fear (the virus) and (4) realize in the process that he was a strong man and capable of facing the challenge. Our work is really to facilitate a "safe space" where people can express and emote, and indulge in play- and the art talks.

Case Studies

Case 2: Health Care Provider

Aliza Babar is a volunteer health care assistant working tirelessly with a fantastic team of motivated selfless young professionals taking care of people at the EXPO Isolation Facility in Karachi. Without her, our work cannot be done. She has been assisting us in the "red zone", where we do not have access to. And she has been taking part herself in the activities and giving us regular feedback about the sessions. This is what she had to say about one particular session:

The session was really helpful. Patient Y who is always in a bad mood suddenly was in a happy mood after the session. The other patient who gave a lot of input and made the drawing "corona bye bye - I miss my husband" - was very emotional after the session and spoke to me for 20 minutes and shared her story. She cried and was very grateful and asked for the counsellor to contact her as she.

At the end of the intervention we asked Aliza to share her overall impressions of the work she had witnessed:

All these art sessions I have attended and taken part have been one of an amazing experience as it has given new vision to me. I have always been fond of art as I love to draw and fill colors. But I haven't thought it can be sort of therapy, in a way that we can express our emotions. Creating art from music is thing I learn. Listening to music and let yourself free to draw anything out of any colors and you are doing all these things subconsciously, this is best thing about it. You get involve so much in music and art that you forget about you have to go back to your stressful world. And when you returned to your world you are in much peace and confident. Also there was session in which we have to draw all things using dot or line in a particular box that had given me wide angle to think. Only "Dots and line" together can come out so beautifully.

After all this what I have started is, for all those wonderful or amazing moments I have spent in red zone, which I cannot capture of course, I have started to sketch them, to save it as life time memory. ART, this only three alphabet word has much broader meaning then it appears to be. It is beautiful world of its own.

~ Aliza Babar

Case Studies

Case 3: Workshop with men

As an inspiration for the art activity, we used two Arabic words for their metaphorical value- Jamal (meaning beauty) and Jalal (meaning majesty), both words well known as the "Names of Allah". Incidentally both words are common names for boys in Pakistan (with corresponding feminine forms).

After a short breathing meditation, we started by considering the razor wire fence that separated the facilitator from the participants as a metaphor for Jalal. Participants talked about how it was something not so beautiful and scary while at the same time was useful and beneficial- in fact necessary for its purpose.

We started by drawing the outlines of this wire by closely observing the shape and curves. After this initial drawing, participants were asked to make it beautiful (Jamal) by using colors in any way that they wished. After 20 minutes of coloring, the drawing was concluded and participants asked to write a letter to Jamal. The drawings and letters were then shared voluntarily with the whole group.

Session was concluded with a short talk on identifying internal resources and the following tips for positive mental health were reiterated:

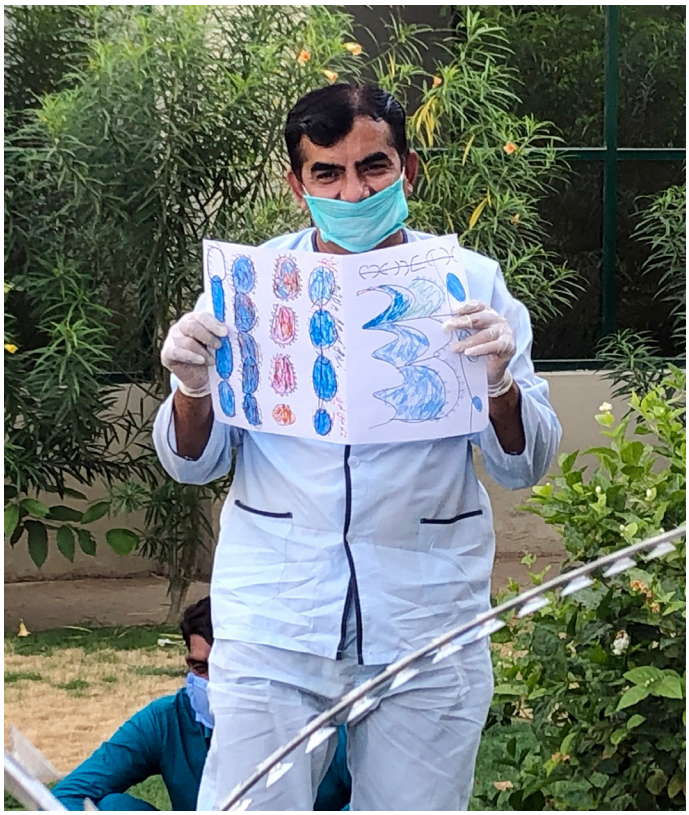
- Breathing awareness and mindfulness
- Art (drawing and writing) as a form of free expression and specifically catharsis

Feedback:

It was a very relaxing session.

I never thought of drawing in this way...I feel very calm and good.

Next time I want to draw whatever I feel like.



Case Studies

Case 4: Children in the community

We were invited to a village in Sukkur to make art with the kids of an extended family living in the same premises (hence no social distancing). Because of the extreme heat, we started at sunset, when the 52 degrees (yes that's true!) came down to a "bearable" 43. The instructions were simply to copy the patterns that the kids liked best in the traditional patchwork blankets, "ralli", that we sat on, and to create new patterns out of them. Of-course the power went off as soon as it got dark and yet the kids kept on drawing. We observed them for some time, confused, wondering why no one complained. Perhaps they had better eyesight's than we did. Perhaps these simple village kids were just happy to draw. Or then it never occurred to them that they could complain. However, it was, I envied the focused concentration of the children was rather enviable. Soon it was too dark so we used our mobile phones to create light and they continued the drawing for an hour. At the end we spoke about patterns and colors and the use of arts to be creative and deal with difficult emotions. In the end the children were encouraged to make cards and present their drawings as presents for a friend or family member.

In the written feedback that we received, the children really appreciated the session. As one child wrote:

I didn't know that drawing is so much fun. The next time I am angry, I will not fight but make a drawing instead!

Annex 1:

Details of art-making workshops held (May to July 2020)

Date	Location	type	n= men	n= women	n=children	n= HC workers
20.5	KHI (expo)	Live	17			2
21.5	KHI (expo)	Live		5	1	2
22.5	PHCG	Online	5	6		11
1.6	KHI (expo)	Online				2
1.6	KHI (expo)	Online			3	2
1.6	KHI (expo)	Online		7	3	1
3.6	KHI (expo)	Online	25			1
7.6	KHI (expo)	Live		4	3	6
7.6	KHI (expo)	Live		7		2
9.6	KHI (expo)	Live	13			3
15.6	HYD (uni)	Online	25	8		
16.6	Sukkhar (village)	Live	1		24	
17.6	Sukhar (school)	Live	3	5		
17.6	Sukkhar (school)	Live		4		
25.6	KHI (FFP)	Live				10
27.6	KHI (expo)	Live		8		3
30.6	KHI (comm volunteers)	Live			2	17
11.7	PHCG	Online	6	6		
17.7	KHI (expo)	Live	14			2
29.7	KHI (SWD)	Live	2	2		
Subtotal			111	62	36	64
Subtotal			**273**			
16.8-21.8	Cascading approach @ 11 sessions - with SWD				228 (139 girls + 89 boys)	
	Other Cascading	Live			55	
Sub total			**283**			
Grand total			**556**			

* In addition to this number we have, to-date, conducted PSS training and support for 84 front-line government health care providers (doctors, nurses, paramedic staff and screening teams) in a simultaneously running UNICEF funded project. This number has not been counted in our deliverables for the obvious reason despite it being objective and content-wise the same as this project.

Annex 2:

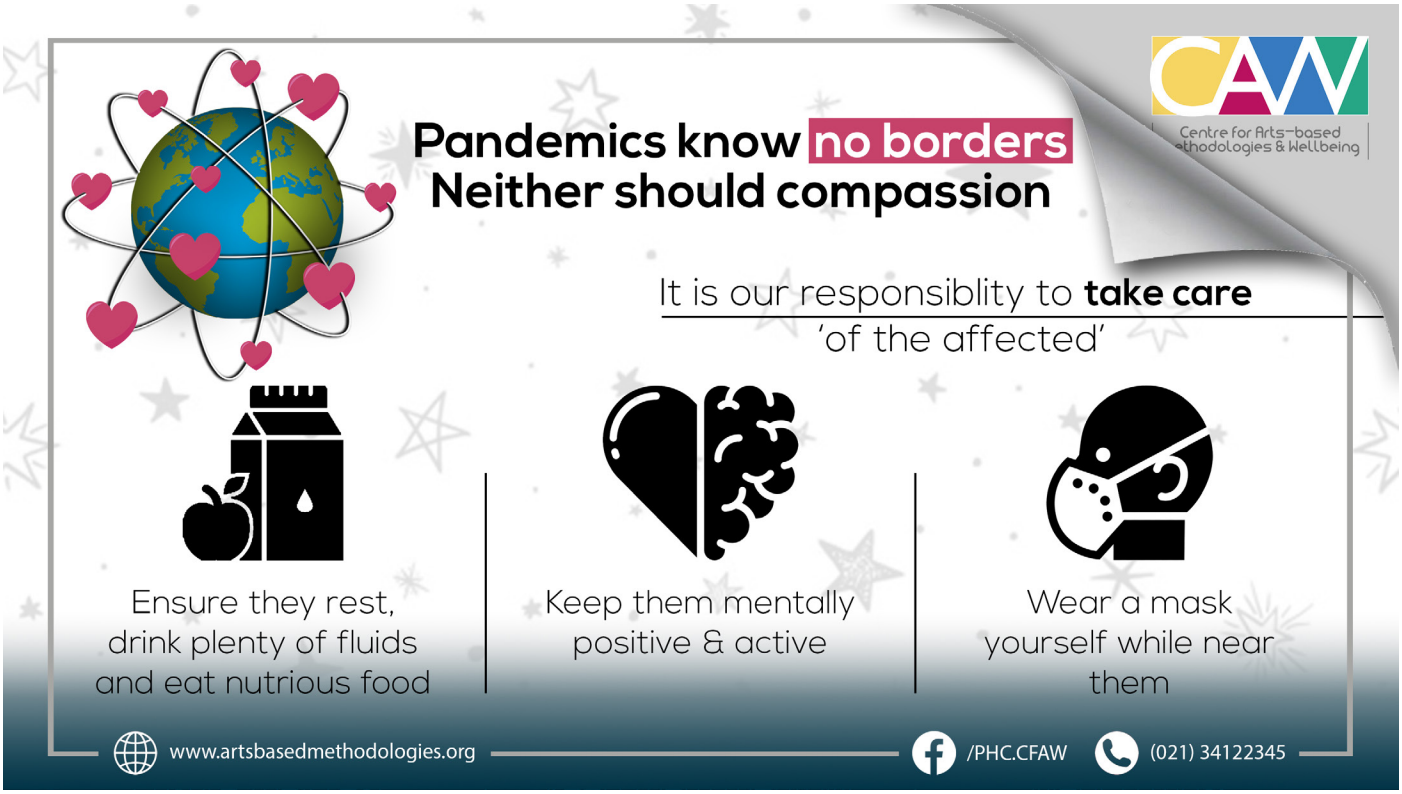
The Client Tracker Information Sheet and Analyses (The raw data has been shared in the Report for Deliverable 3)

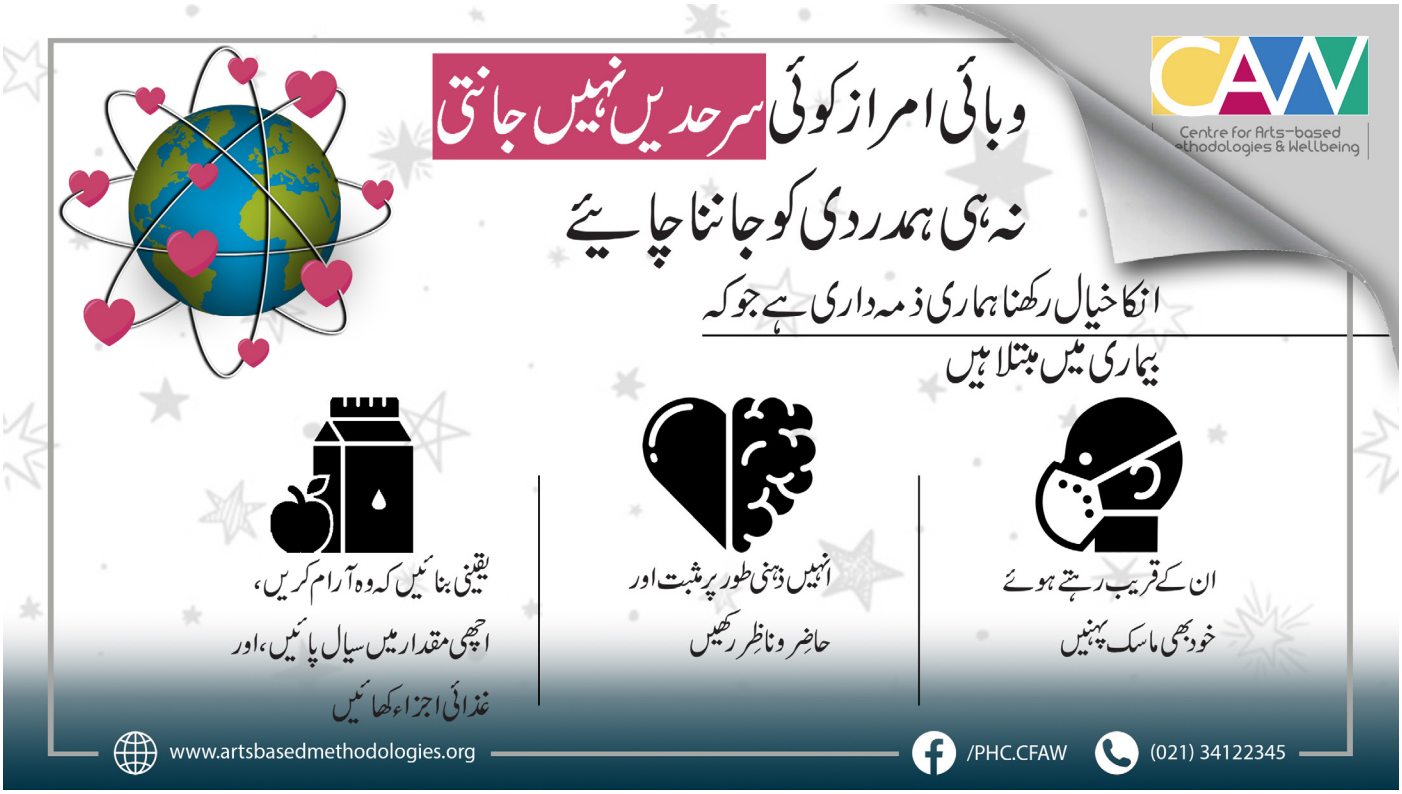
Tracking Clients of Psychosocial services

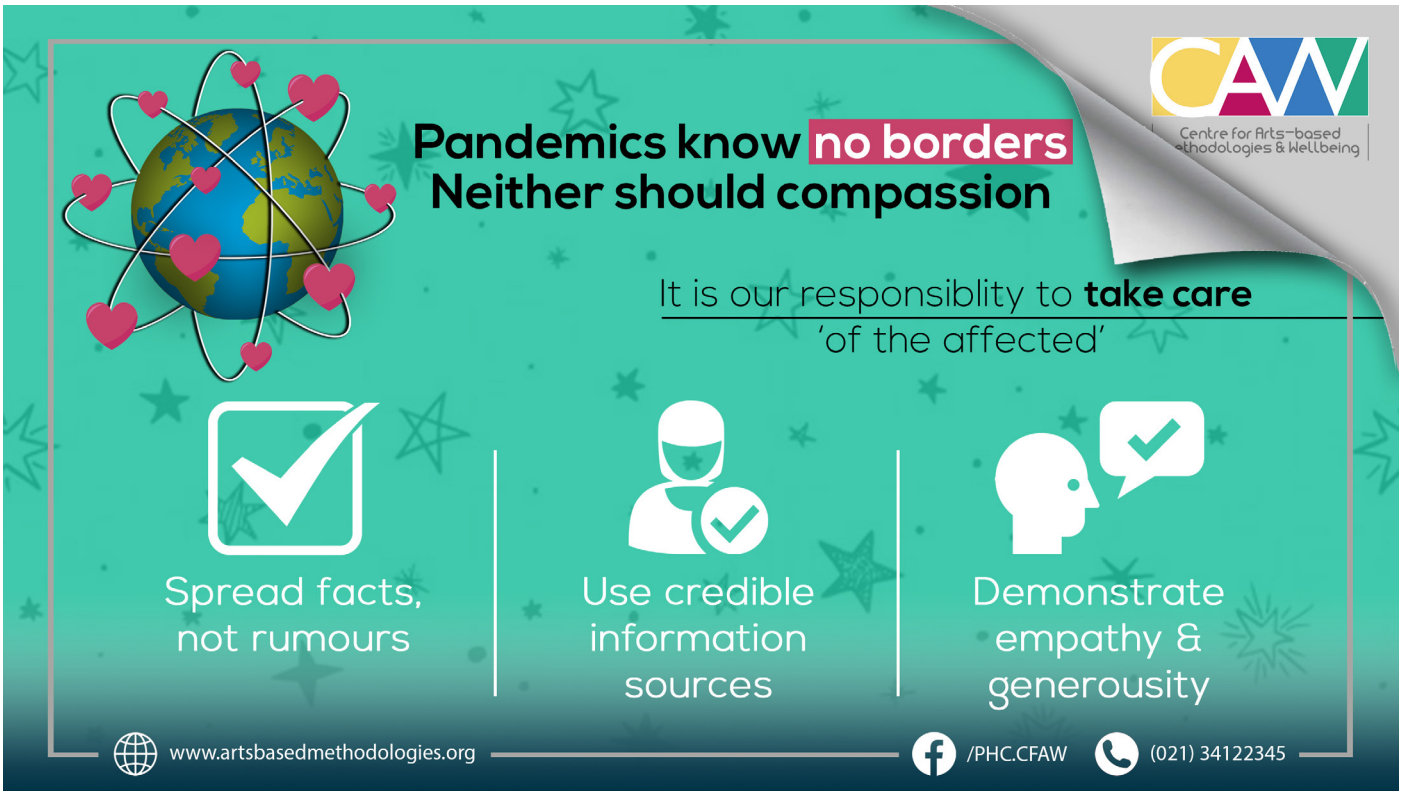
Karachi Sindh

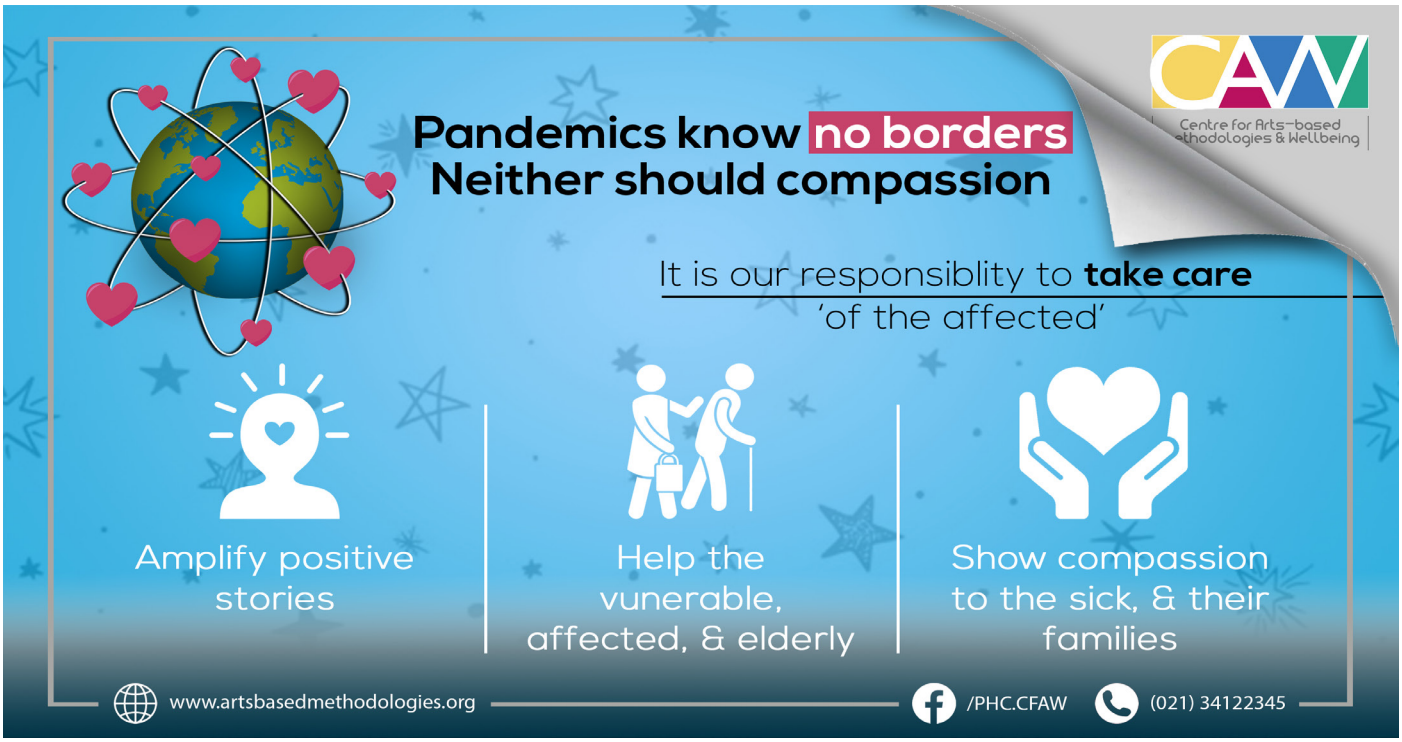
No		Name of Facility:	Name of Service Provider	Reference # of Client	Emotional State of Client at the Start of Session (1-10)	Date visited/called (dd-mm-yy)	Session Number	Age of Client	Gender: M/F
1		expo centre	Psychologist (Tasleem)	Azeem	anxious (7)	6 Sep 20	1	44	Male
2		Expo Centre	Trained counseller (Irum Ali)	Shahida	Distress (6)		1		Female
3		Expo Center	Trained counseller, Javeria Khuhro	Shahida (the pervious session had many connectivity issues)	Distress (6)	11.06.20	1	30	Female
4		Expo Center	Trained counseller, Gohar Alam	Mukhtyar	Distress (6)		1		Male
5		Expo Center	Trained counseller Amber Jatoi Hashmi.	Amjad	Slightly restless.4	11.06.20	1		Male
6		Expo Center	Nida Khan	Nida	3 - Restless, but optimistic	June 13th 2020	1	24	Female
7		Expo center	Sadaf Mulji	Anwar	Work tension and uncertainty about the future	June 13th	1	52	Male
8		Expo Cetrer	Atia Naqvi	Sakina	hopelessness, grief, distress	June 13th	1	57	Female
9		Expo Center	Bina Yusuf	Usman	Helpless, distressed (6-7)	June 13th 2020	1		Male
10		Expo Center	Samar Khandwala	Shamsuddin		13th June 2020	1		Male
11		Expo Center	Khadija Zahid	M. Shamsuddin	Withdrawn (4)	13/06/2020	1	60	Male
12		Expo Center	Ayesha Mubashir	Saleem	Little overwhelmed but hopeful	June 15th	1	38	Male
13		Expo Center	Zainab Tufail Arbab	Kamran	hopeless, fearful, guilty	June 15th	1	24	Male
14		Expo Center	Urooj Mazhar	Shahzad	10 - Lively, sorted, in control, clearheaded	June 15th	1	34	Male
15		Expo center	Sukaina Faizi	Ghulam Mustafa	Distress 6	June 15th	1	27	Male
16		expo Centre	Khola Zaman	Munsib Ali	Distress 9	June 15th	1	24	Male
17		Expo Center	Anum Lakhani	Shabana	5 (self-stated); lively but anxious	June 15th	1	48	Female
18		expo center	Tabassum Alvi	Minhas	positive	17th June	1	52	male
18		Expo Center	Gohar Alam	Mukhtyar	Distres..8	June 13	2		Male
19		Expo Center	Huma Aftab	Tariq	Distress 6	June 17	1	55	Male
20		Expo Center	Momina Rizwan	Wahid	Distress 3	17 6 2020	1	55	Male
21		Expo Center	Munir Bhatti	Imdad	Distress 6	17 06 2020	1		Male
		Expo Center	Munir Bhatti	Rizwan	Avoidance behavior	17 06 2020	1	49	Male
23		Expo Center	Expo Center	Nida	5 - mild distress, anxiety	June 17th 2020	2	24	Female

Annex 3:
Static Messages from our Media Outreach campaign





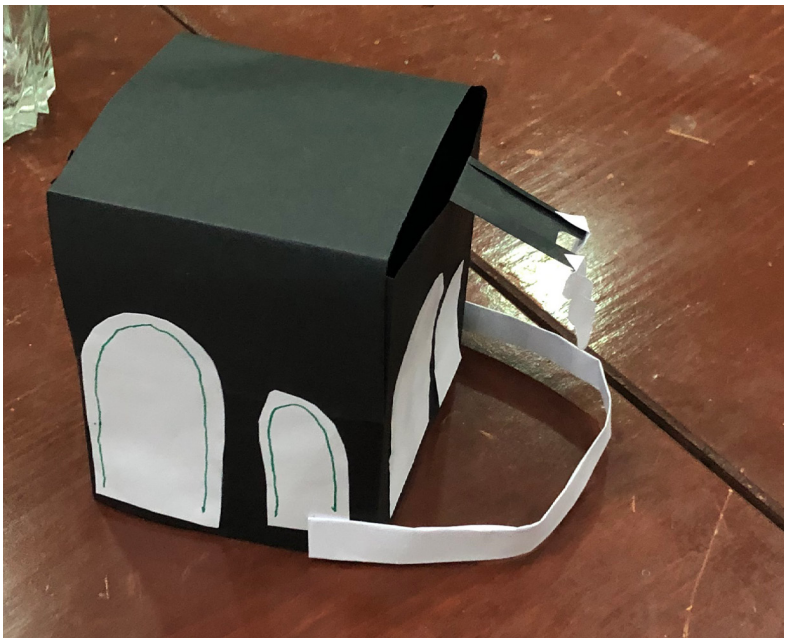

Pandemics know no borders
Neither should compassion
It is our responsiblity to take care
'of the affected'
Spread facts, not rumours
Use credible information sources
Demonstrate empathy & generousity
www.artsbasedmethodologies.org
/PHC.CFAW
(021) 34122345

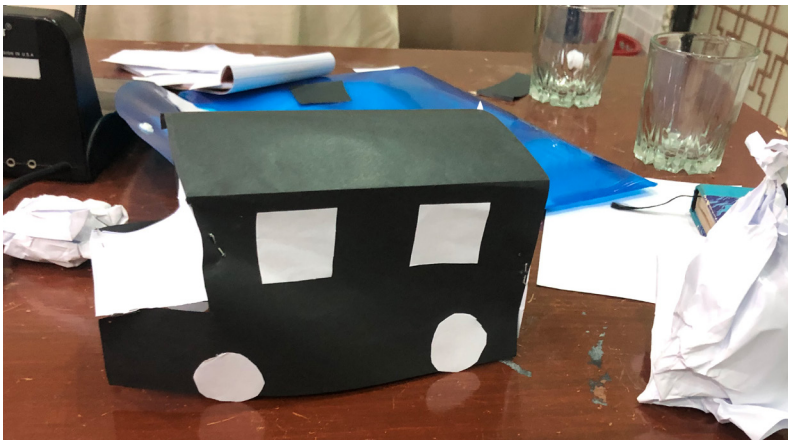

Pandemics know no borders
Neither should compassion
It is our responsiblity to take care
'of the affected'
Amplify positive stories
Help the vunerable, affected, & elderly
Show compassion to the sick, & their families
www.artsbasedmethodologies.org
/PHC.CFAW
(021) 34122345

Picture Galleries

Black & White

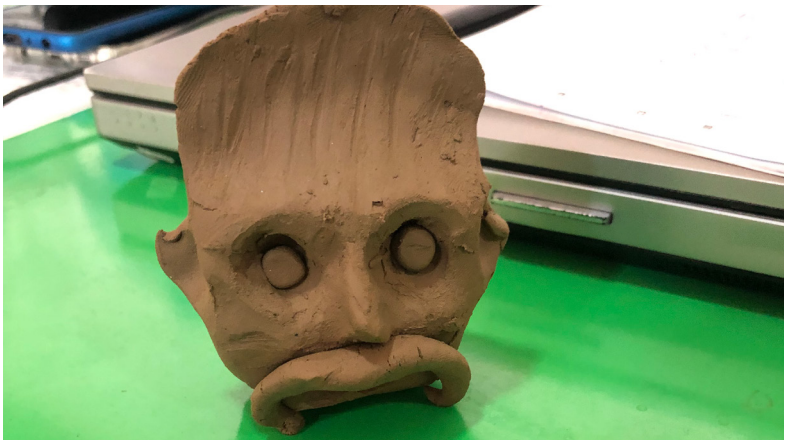
Generally considered as opposites, black and white paper is used together to create something beautiful, and that is the beauty of diversity.





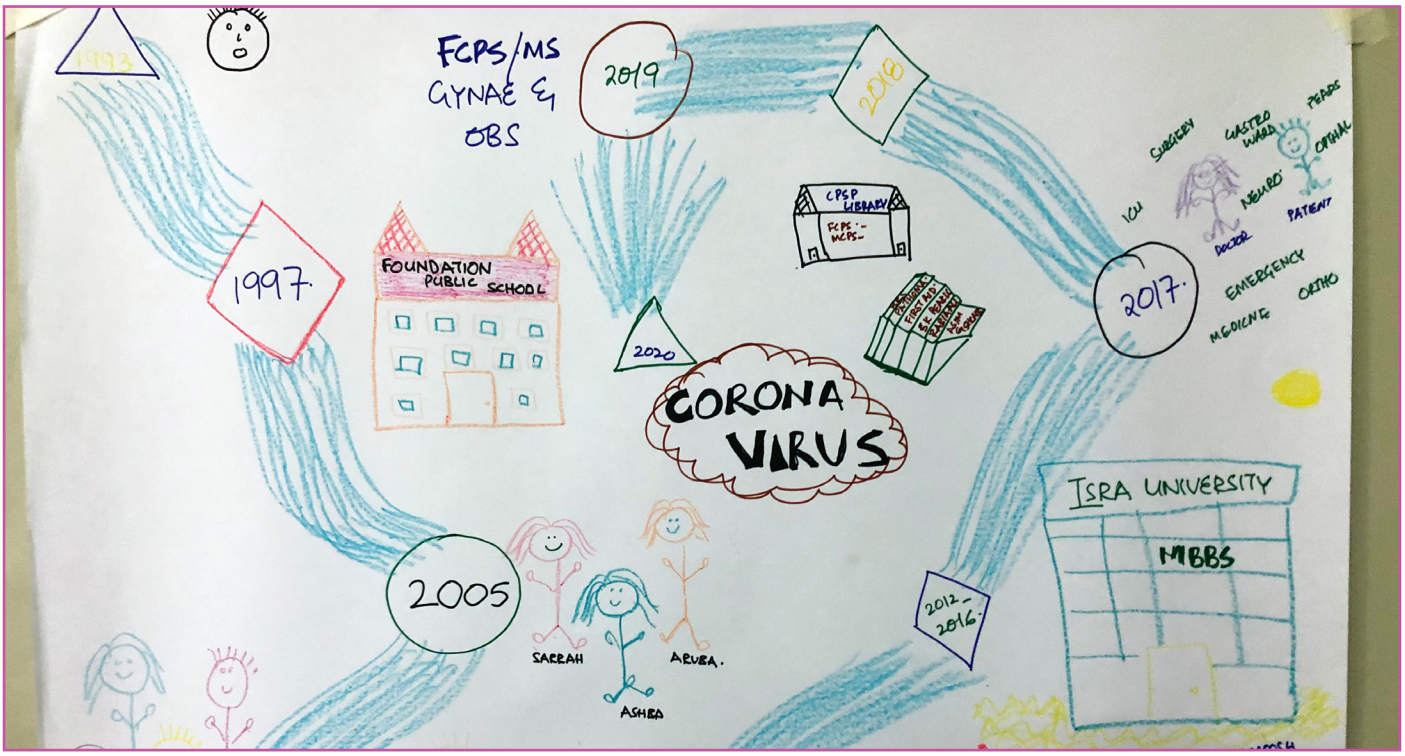
Clay work

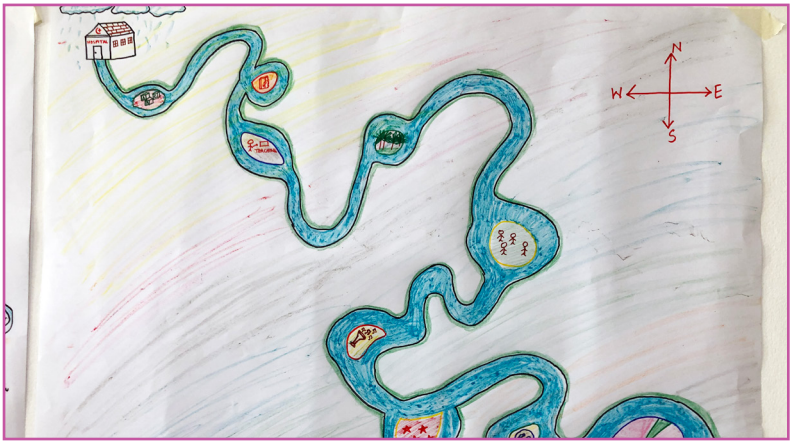
The material qualities of clay render it a calming and grounding art material- the perfect de-stress. We meditate with the clay in our hands for some time and open our eyes to what arrives. The pieces are named and then given “a voice”. The clay objects thighs produced always have some comforting words to give its creator.

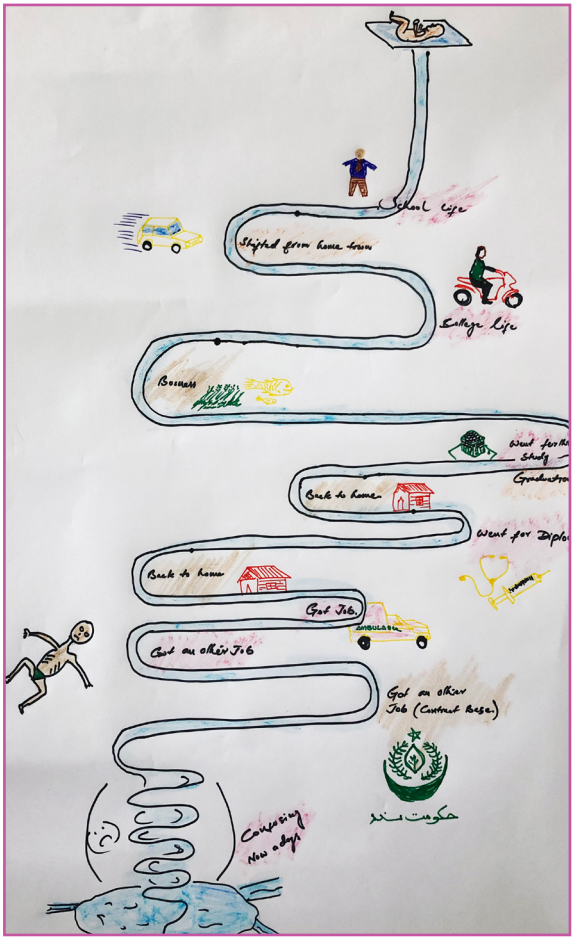


The River of Life

Using the metaphor of a river, we create a drawing in this activity as a reflection on our lives. In the "bigger picture", all challenges, tragedies and tribulations somehow make sense. Nothing lasts forever.

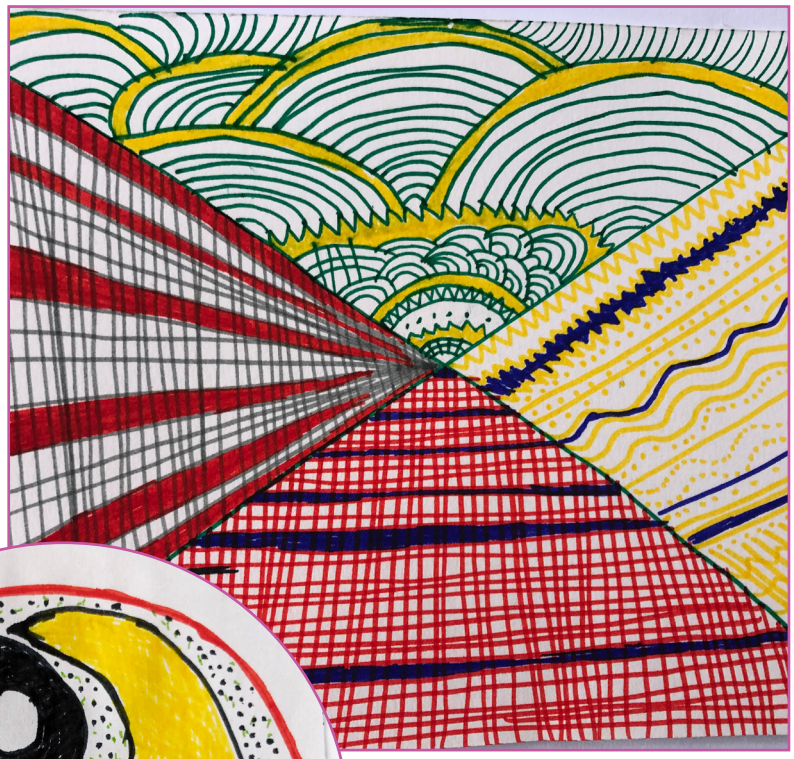


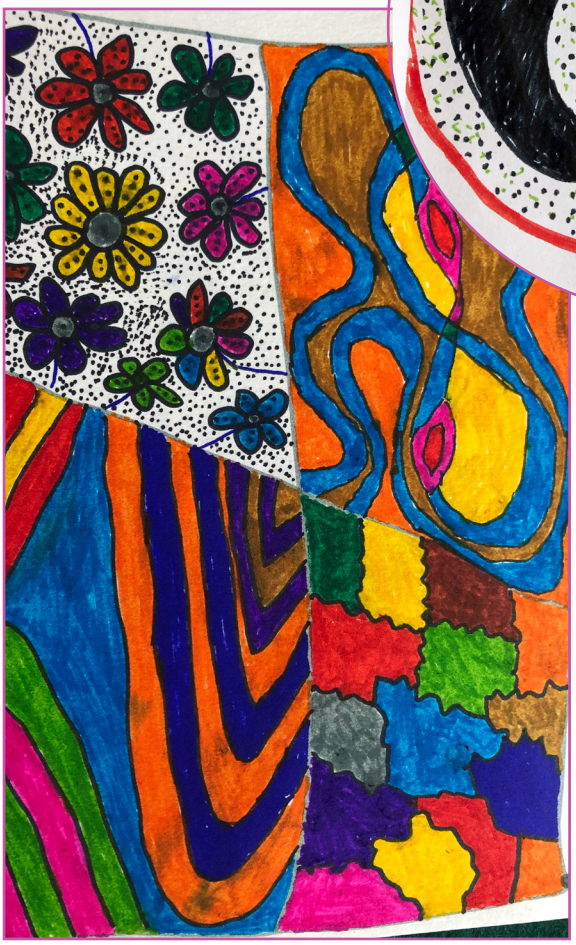


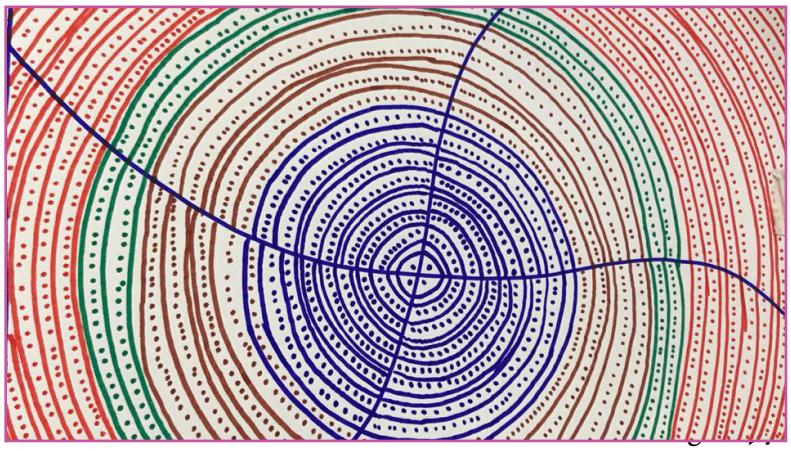


Zendoodles

Combining doodling with breath meditation, we create these wonderful and colourful pieces representing the infinite and repeating patterns we see in nature.

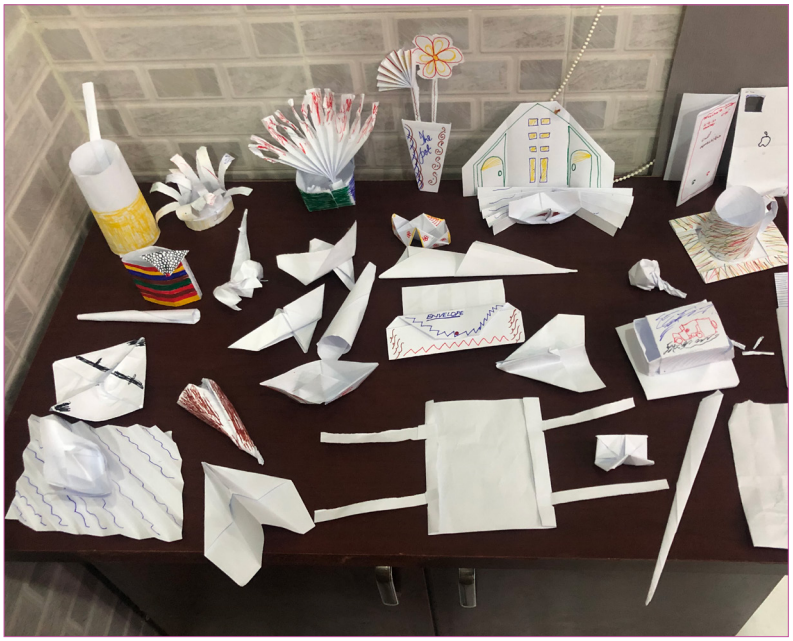


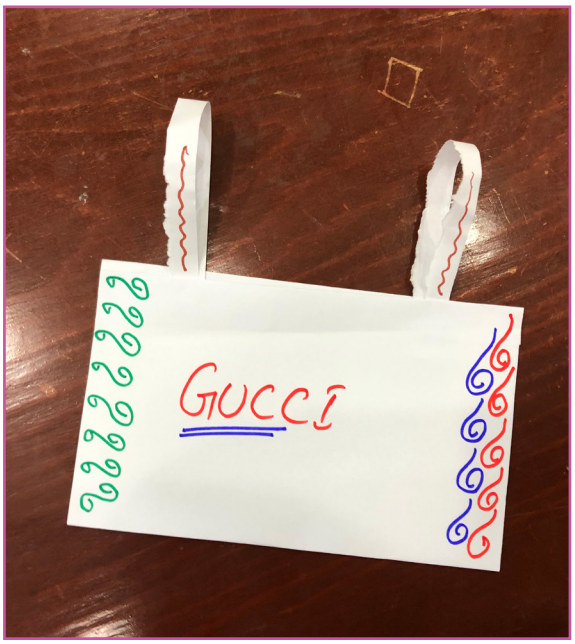


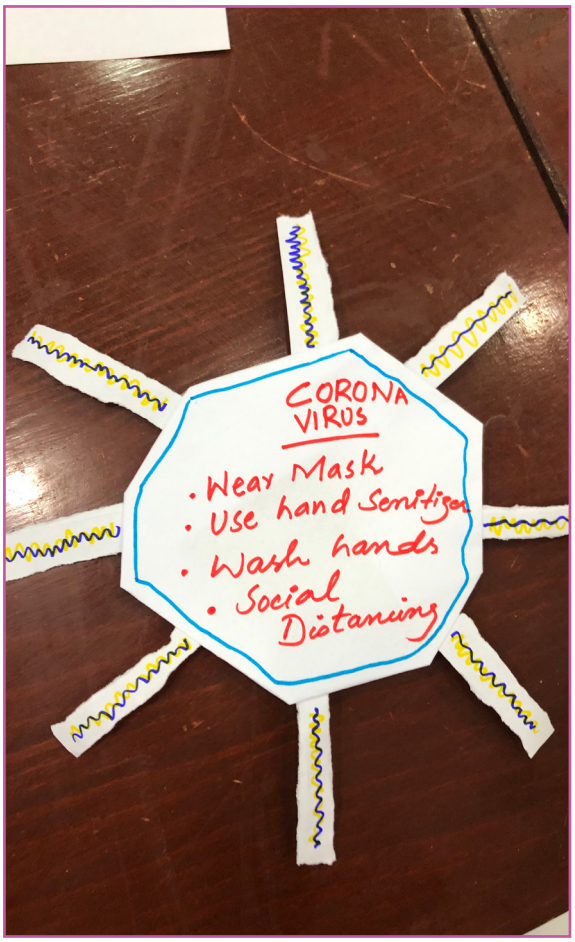


Paper

Often ignored because of its simplicity, paper is a highly versatile material to create form. Just one piece of paper is folded, cut and glued to create something. And we remind ourselves that every paper we use is really a tree cut down.

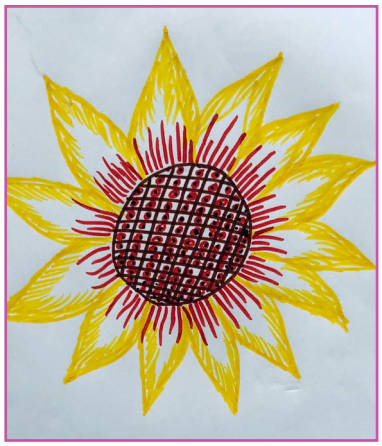


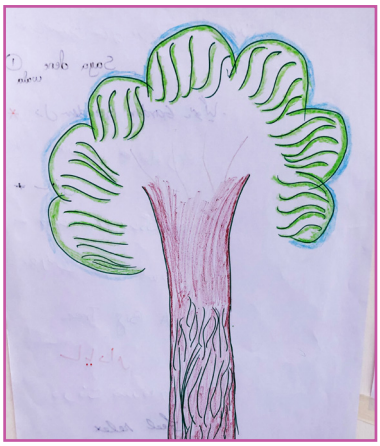




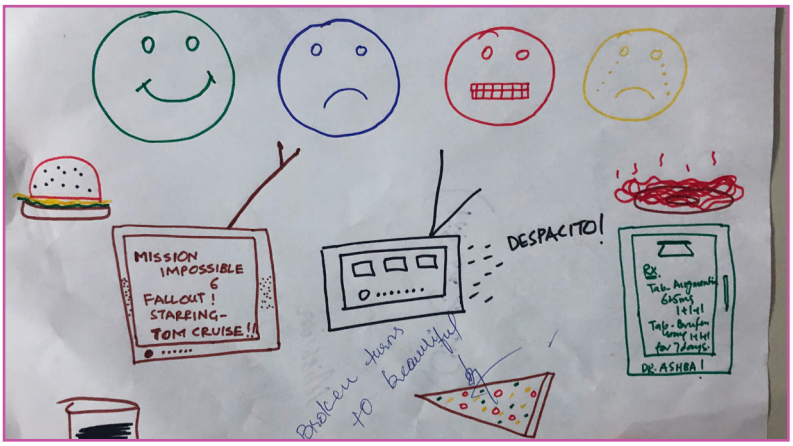
Draw my name

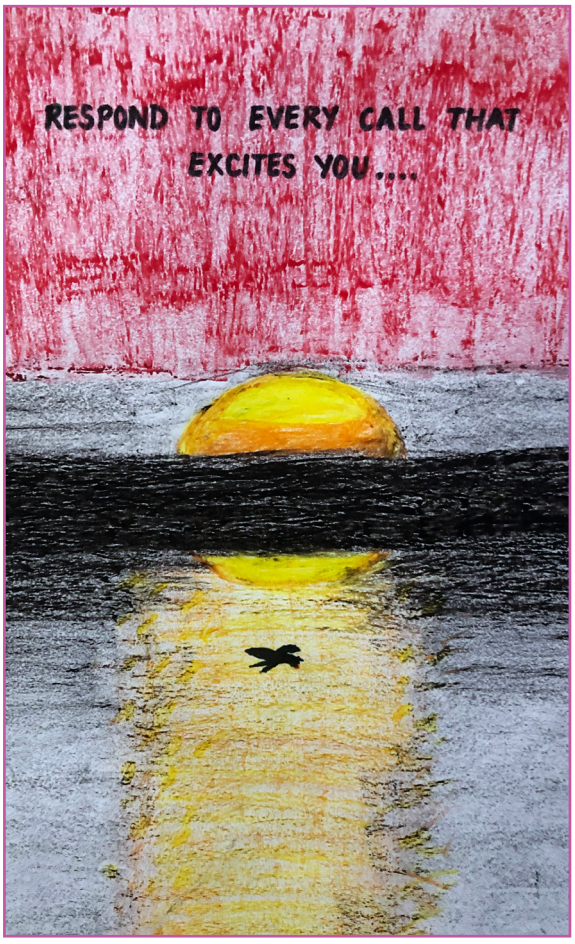
An abstraction of our names, in the form of a drawing, allows for an expansion and exploration of our identity. The poems that follow are shared in a group and help us realise our uniqueness in the multitudes



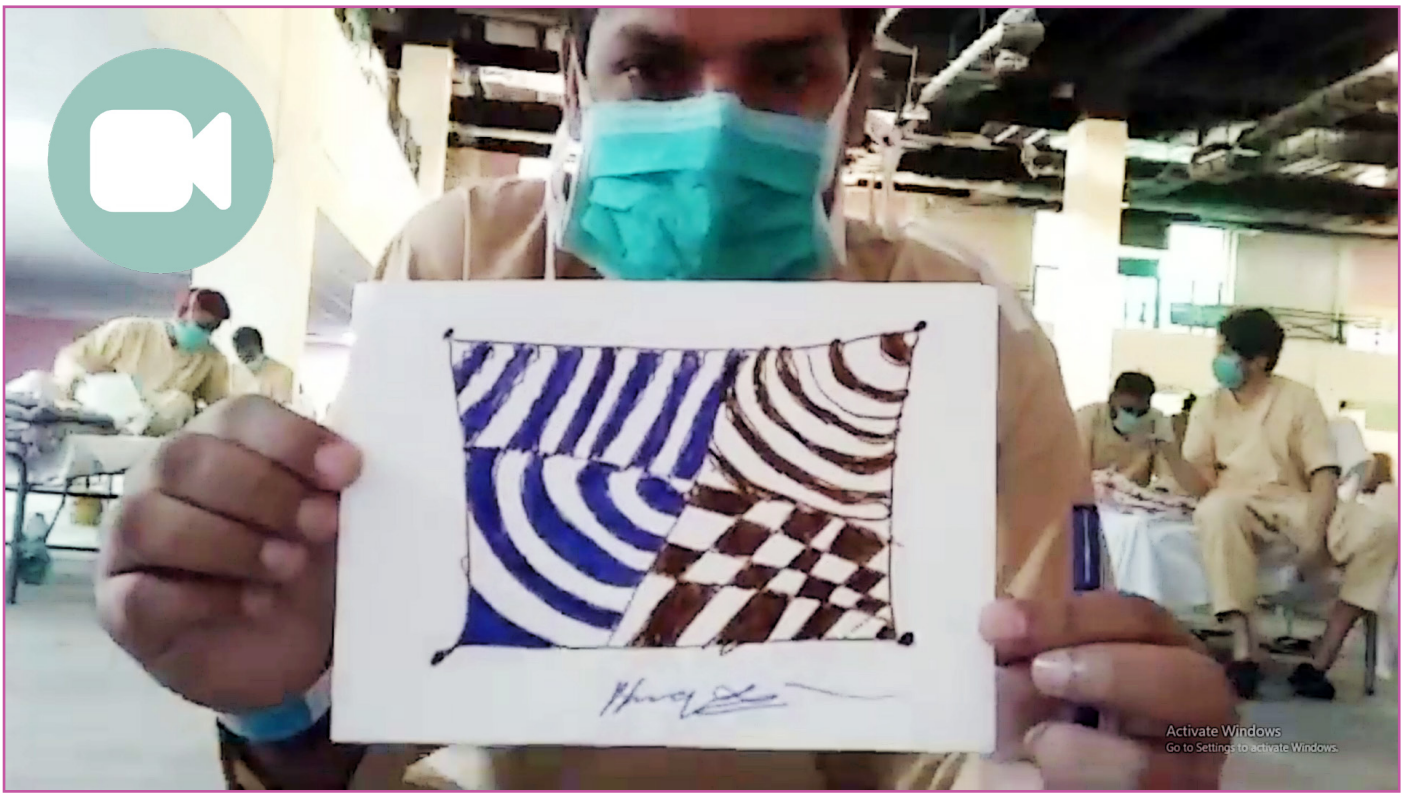


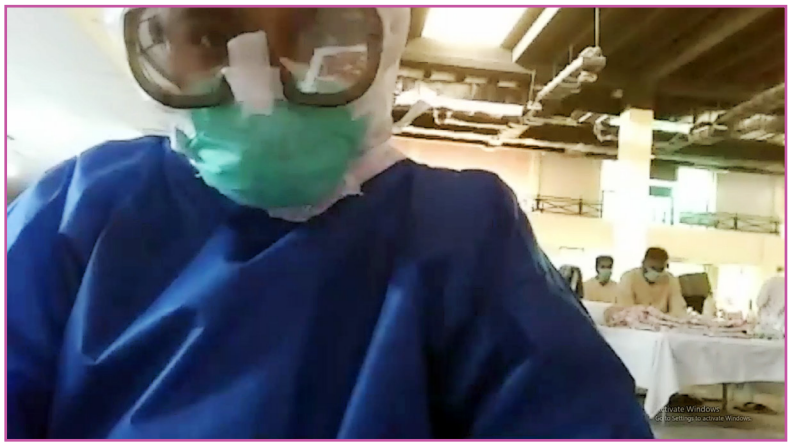
Miscellaneous

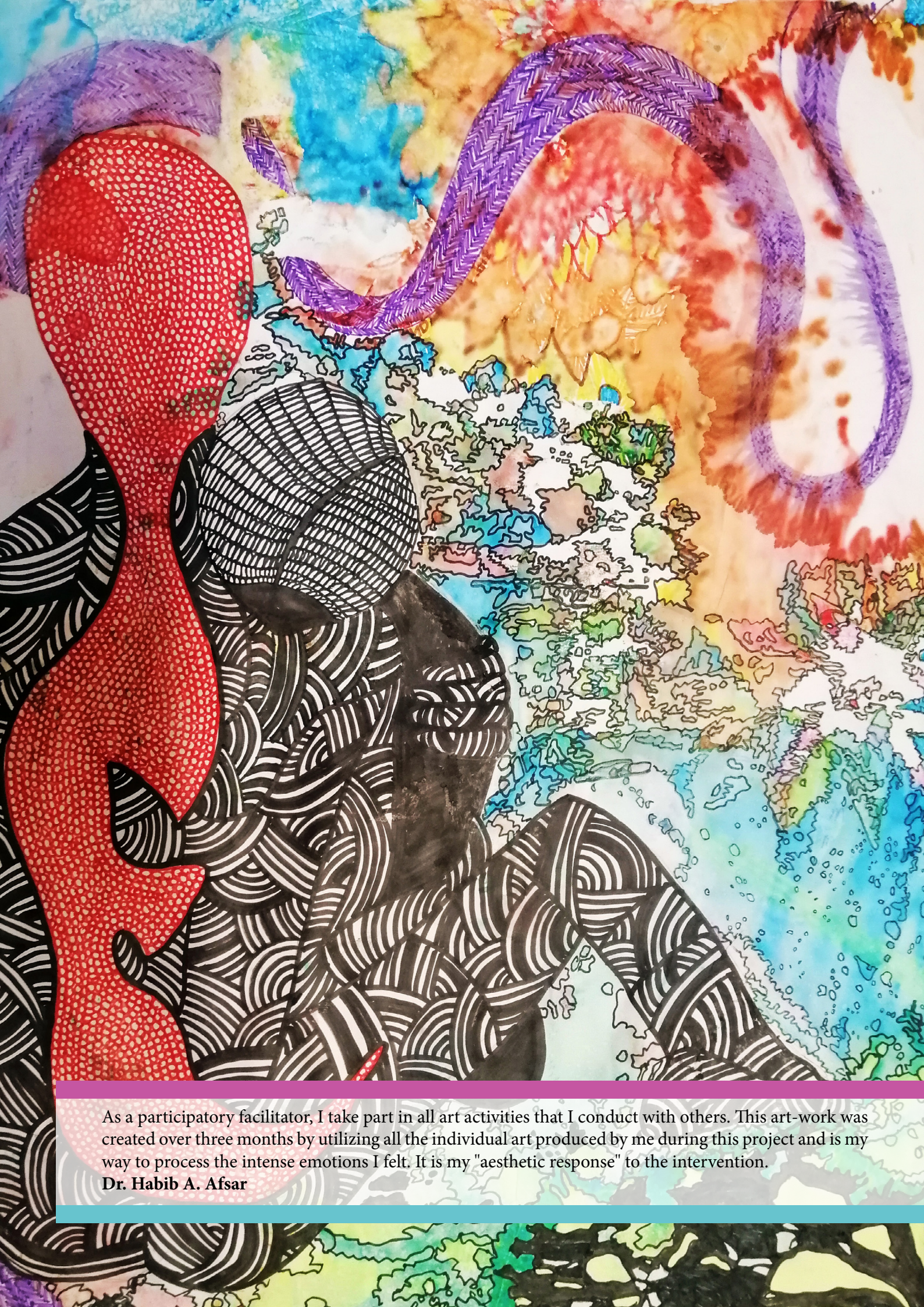




Process







As a participatory facilitator, I take part in all art activities that I conduct with others. This art-work was created over three months by utilizing all the individual art produced by me during this project and is my way to process the intense emotions I felt. It is my "aesthetic response" to the intervention.

Dr. Habib A. Afsar

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Please feel free to reach out in case of any query

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