

## Abstract

This paper describes the results of an investigation into how the December, 2004 tsunami and its aftermath affected the human rights of the survivors. Teams of researchers interviewed survivors, government officials, representatives of international and local non-governmental organisations, UN officials, the military, police, and other key informants in India, Sri Lanka, the Maldives, Indonesia, and Thailand. We also analysed newspaper articles, reports released by governments, UN agencies, NGOs, and private humanitarian aid groups, and we examined the laws and policies related to survivors' welfare in the affected countries. We found worsening of prior human rights violations, inequities in aid distribution, lack of accountability and impunity, poor coordination of aid, lack of community participation in reconstruction, including coastal redevelopment. Corruption and pre-existing conflict negatively impact humanitarian interventions. We make recommendations to international agencies, states, and local health service providers. A human rights framework offers significant protection to survivors and should play a critical role in disaster response. *Asia Pac J Public Health 2007; 19(Special Issue): 52–59.*

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# Human Rights and Mass Disaster: Lessons from the 2004 Tsunami<sup>1</sup>

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## Introduction

The tsunami of December, 2004 devastated thousands of communities along the coastline of the Indian Ocean killing more than 240,000 people. Tens of thousands went missing and are presumed dead, and more than a million people were displaced. Those most affected by the tsunami were the poor, including fisher folk, coastal workers with small retail or tourist businesses, workers in the tourism industry, migrants, and those who farmed close to coastal areas. The majority of those who died were women and children<sup>2</sup>.

While relatively greater attention has been paid to the plight of refugees protected under the Refugee Convention<sup>3</sup> and civilians affected by mass violence in armed conflict who are accorded special status under international humanitarian law<sup>4</sup> and the Geneva Conventions<sup>5</sup>, the international community has not addressed directly what mechanisms might apply when the human rights of those displaced by natural disaster are violated. In recent years, the United Nations has issued guidelines for the protection of internally displaced populations (IDPs), those who do not cross

international borders, whose protection and support must come from the state of which they are citizens<sup>6</sup>. The category of the internally displaced includes those who are forced to move from their homes due to "natural or human-made disasters." It is important to note that while refugees and civilians in armed conflict are guaranteed rights under international law, the IDPs fall under a set of guidelines that offer a standard of care but do not have the force of law at this point in time. Therefore, states are under no international legal obligation to care for their IDPs. Existing human rights norms provide some protection, but are not tailored to the specific vulnerabilities of IDPs, and therefore expose the displaced to deprivation of rights. In fact, when a state is in the throes of civil war or intrastate conflict, the state itself may displace vulnerable populations. Further, when a massive disaster strikes, the state simply may not have the resources to care for its people. Such was the situation in the months following the tsunami.

An additional international effort to assure that humanitarian aid will be delivered in an ethical manner has been developed by international humanitarian agencies in response to

concerns that no guidelines of this sort existed. The Sphere Project produced a Humanitarian Charter and Minimum Standards in Disaster Response for humanitarian assistance to “establish minimum standards in core areas of humanitarian assistance” and “improve the quality of assistance to people affected by disasters, and to enhance the accountability of the humanitarian system in disaster response”<sup>7</sup>. The standards, framed as rights, apply to food, water, sanitation, health, and shelter; the project also articulates technical indicators to monitor implementation of these guarantees. The goal is to promote voluntary compliance with these minimum standards among humanitarian agencies and states in order to provide those affected by disasters with access to a life with dignity. The guiding principles for internally displaced populations and the Sphere standards together provide benchmarks against which to measure the success of the tsunami relief and reconstruction efforts in fulfilling the basic human rights of survivors. One way that humanitarian interventions in the wake of mass disasters may be judged is by their success in promoting and protecting the rights of those who survive as measured by international instruments that protect the right to health such as the International Covenant on Economic, Cultural, and Social Rights<sup>8</sup>. A recent positive development has been that in the wake of the tsunami, the United Nations has developed operational guidelines for states and aid agencies to promote a rights-based approach to assistance to those displaced by natural disaster, in the absence of an international treaty<sup>9</sup>. The effectiveness of health-related interventions can be maximised by using a human rights analysis to evaluate their appropriateness.

The horror of the tsunami challenged the capacities of governments, non-governmental organisations, the international humanitarian community, and health professionals to deliver services that would meet the needs of those who had lost every-

thing. It was an opportunity to examine closely the linkages between health and human rights. As Jonathan Mann observed<sup>10</sup>, “the promotion and protection of human rights and the promotion and protection of health are fundamentally linked.” Along with the provision of clean water, shelter, food, and sanitation and attending to the emotional needs of the survivors, ensuring respect for human dignity and protection from those who would seize the opportunity to violate the rights of the most vulnerable becomes a critical aspect of the aid effort.

Soon after the tsunami, scattered reports appeared that women and children were at risk to become victims of human trafficking for the sex industry, placed in forced labour or indentured servitude. While there was little evidence that this had occurred, international agencies raised the alarm<sup>11</sup>. The Human Rights Center at the University of California, Berkeley and the East-West Center in Honolulu, Hawaii collaborated to examine this question and further, to investigate whether human rights violations were taking place in the affected states.

While the literature on disaster management has developed in the past few years<sup>12-15</sup>, most recently spurred by threats of bioterrorism, the framework of human rights has received little attention in the arena of natural disasters. Yet, the effects of Hurricanes Mitch and Katrina, the earthquakes in Gujarat, Pakistan, Iran and Turkey, and the catastrophe of the tsunami immediately raise questions to which human rights treaties and international law might provide answers. We know from consideration of past disasters that the most vulnerable populations (the poor, the excluded, those at the margins of society) are the most affected. The poor often live in areas which are subject to greater risk e.g. in the *favelas* of Brazil, in the townships of South Africa, and in the squatter camps that surround the new megacities of Africa; thus geography and poverty play a role in who is most affected by natural disaster. In these

same areas, access to health care is limited and endemic disease weakens communities. We know too that if these disasters occur in the context of war or violence that a community in which there is little infrastructure or in which food security has been compromised will be at significantly greater risk. Further, if there is an ongoing war or mass violence or where torture, disappearances or extrajudicial executions have occurred, large segments of the population may already be displaced and living in precarious situations.

South Asia has undergone massive change in the last twenty-five years. The so-called “tiger” economies have catapulted once poor countries into the global marketplace, yet the wealth is unevenly distributed. While many have grown rich, many others toil for little pay; some make their living as they have for generations – from the sea or agriculture – with no resources set aside for bad times. Marginalised populations facing discriminatory practices because of ethnicity or religion or because they are refugees or are otherwise poor are exploited by employers and by governments as well. Despite the fact that many of these states have signed international human rights treaties<sup>16</sup>, pledging to promote human dignity and to uphold important protections for all of their citizenry, in practice, these protections may be a charade. Where this is the case, a natural disaster will worsen the predicament of those whose rights are poorly supported.

## Methods

Shortly after the devastating tidal wave, multilateral and nongovernmental international organizations began to raise questions about how the basic rights and human dignity of tsunami survivors were being compromised by corruption, discriminatory practices based on gender, ethnicity or caste, forced displacement and by inconsistent responses by aid workers<sup>17</sup>. In March and April 2005, with

these considerations in mind, in collaboration with researchers in five countries that were severely affected by the tsunami - India, Indonesia, the Maldives, Sri Lanka, and Thailand - we carried out an interview survey of a representative sample of survivors and key informants in order to evaluate the effects of the tsunami on the human rights of those who were affected. This was designed primarily as an ethnographic study to include interviews, group meetings, document analysis, and observation in affected areas<sup>18</sup>.

The objectives of the study are as follows:

1. to assess the nature and extent of pre-existing human rights problems and their impact on vulnerable groups prior to the tsunami;
2. to investigate violations of human rights in the post-tsunami period;
3. to examine the response of governments and aid agencies to reports of human rights abuses; and
4. to identify human rights violations that may develop or persist during the reconstruction phase.

Researchers used a semi-structured questionnaire to gather the data. The questionnaire and procedures were approved by the Institutional Review Board of the University of California, Berkeley. Ethical concerns that might arise in such a study emerge from the possibility of placing respondents at risk for retaliation. We asked respondents about discrimination in humanitarian assistance, human rights violations, corruption, trafficking, child abduction, and forced labour. We addressed human rights violations prior to the tsunami as well. Interviews of survivors were anonymous. Key informants had the option of anonymity and if they were public figures, they were aware of what was acceptable to say.

We asked similar questions in all five countries. In some cases, survivors were interviewed in a group setting, particularly in shelters or tem-

porary housing camps for displaced people. It proved difficult at times to interview one or two people since they would be joined quickly by anywhere up to 40 survivors, all of whom wanted to express opinions. We identified key informants – defined as individuals directly responsible for developing or implementing policies or practices that affected post-tsunami relief – through contacts with researchers, international, and local organisations. These informants included representatives of government aid or other agencies, police, army officers, UN disaster relief personnel, and representatives of non-governmental human rights and aid organisations. In India, we surveyed individuals living along the coast of Tamil Nadu, the worst hit state, and in the districts of Cuddalore, Nagapattinam, Kanyakumari and Kancheepuram. In Sri Lanka, we interviewed in three provinces, North-eastern (Batticaloa and Ampara), Southern (Galle and Matara), and Western (Colombo). In the Republic of the Maldives, research was done in Male', Hulhumale', and Guraidhoo. In Thailand, interviewers worked in eighteen communities on the coasts of the Andaman Sea and the Gulf of Thailand. Finally, in Indonesia, field research was undertaken in nine refugee areas, Banda Aceh, Aceh Besar, Sigli, Bireuen, Pidie, Lloksuemawe, Aceh Utara (all in Aceh), Medan and Deli Serdang (in North Sumatra). In sum, the population that we sampled came from areas where massive damage and displacement had occurred.

Researchers also consulted archival documents; including newspaper

articles, and reports on the conditions and experiences of tsunami survivors, as well as laws, policies, and guidelines issued by national governments and international organisations.

## Results

While the five countries differ widely in wealth and resources, their histories and cultures, forms of government, and exposure to on-going conflict, we found six themes that were common to all the affected countries<sup>19</sup>. These commonalities reveal significant gaps in disaster preparedness, the downside of international assistance, ignorance of the international standards that govern the protection of displaced populations, and of great concern, from the perspective of this study, we learned of a range of human rights violations to which governments responded very poorly.

### *Gender violence and health*

While there were few reports of actual rape in displaced persons camps in Sri Lanka, both our research and that of non-governmental organisations revealed that women were at risk. Survivors and key informants reported incidents of attempted molestation and coercion especially by camp leaders. Women were being groped and touched in the dark, and the lack of privacy for women and girls was especially problematic in Muslim camps. For example, distribution of underwear and panties was carried out in public with embarrassing comments, sanitary napkins were kept under control of male camp leaders and distributed in amounts that forced women to return repeatedly (this also was reported in the Maldives and Indonesia). The lack of attention to reproductive needs and contraceptives was problematic in situations where men insisted on sex. Further, there was little attention in the early months to the special needs of pregnant or lactating women (who had lost children) or the needs of elderly women with special nutritional or health needs. These incidents not only

**Table 1. Sources of data**

Country	# Key Informants	# Survivors
India	16	58
Maldives	22	15
Sri Lanka	22	92 (includes groups)
Thailand	34	32
Indonesia	41	27
TOTAL	135	224

compromised the basic human dignity of the women but also exposed them to STD infections including HIV, unwanted pregnancies, pregnancy complications, rape and molestation and other gender-related risks to their well-being.

### ***Lack of government attention posed health risks***

#### ***A Thai relief worker reported:***

“To the casual visitor it might look as if the government has done a good job here, but in reality, it hasn’t. It is like the pachee roy naa (cilantro) that we Thais put on top of what might be a so-so meal to make it look and smell good. The camp was built to last three months, but residents were recently told that they will have to stay here at least a year... We have no 24-hour health staff or a surveillance system to treat infectious diseases. We often have no milk powder or supplemental food for children... recently the soup kitchen was closed”.

A diabetic woman in a fishing village reported that she had not gone to the hospital because she recently had been denied health as she was born at home and thus had no birth certificate to prove her Thai citizenship. Seriously injured during the tsunami, she was now bedridden; her right leg had turned gangrenous, and without immediate care, would require amputation. Her husband had received 4,000 baht from the local government administration to fix his boat but that was insufficient to cover repair. They had to borrow an additional 10,000 Baht to buy analgesics and other medications.

### ***Exacerbation of prior human rights violations***

Examples of these were the instrumental use of aid delivery to control perceived threats to internal security, lack of migrant protection, lack of trust in government based on prior abuses, corruption threatening property rights, and gender violence. In some cases, humanitarian aid agencies ignored prior human rights violations and unwittingly, became

collaborators with the abusing parties.

Prior conflict interfered with aid delivery and protection of the displaced. In Indonesia, the military in Aceh demanded that IDP’s be housed in barracks controlled by the army. Adult males were most vulnerable to accusations of being part of the Free Aceh movement with the possibility of dire consequences. In Sri Lanka, the decades long war between the government and the Tamil Tiger movement interfered with humanitarian relief and there were reports of aid being sidetracked and used as propaganda. In Tamil Tiger controlled areas, there were reports of IDP’s in camps having little freedom. Tragically, the abduction of children to serve as soldiers continued after the tsunami, compounding the fears of those displaced. In India, on-going discrimination against the lowest castes resulted in little attention being paid to their needs while in Thailand, Burmese migrant workers who did not die as a result of the tsunami went into hiding for fear of being arrested; the bodies of their co-workers went unclaimed. In the Maldives, the human rights violations that have characterised the government of President Gayoom for twenty-seven years resulted in the exclusion of IDP’s from any significant input into the reconstruction process. Reports of women being abused either directly by men or indirectly by agencies ignoring their unique needs demonstrated a complete disregard for gender equity in protection.

### ***Inequities in aid distribution***

There were multiple causes for our finding of maldistribution of aid including, the withholding of aid from certain ethnic, religious, or discriminated subgroups such as castes, inequities based on political influence, bureaucratic inefficiencies, and exclusion of specific groups based on government definitions of victimhood.

In Sri Lanka, reconstruction funds favoured the south coast over the east, attributed by the survivors to the fact

that the Prime Minister maintained a home in the south; aid agencies appeared to assist one village but not the next – decisions that puzzled the villagers and led to resentment; corruption seemed to have a major influence on how government aid was apportioned in the Maldives and Sri Lanka. Thai government offered free medical care to foreigners but excluded Burmese migrants. In Indonesia and Sri Lanka, aid in conflict areas was profoundly influenced by either the military or rebels and in India, the Dalit who assisted the fishermen but who lived away from the coast received no assistance.

### ***Impunity and lack of accountability***

Human rights vulnerabilities were insufficiently addressed due to the lack of state action in responding to tsunami victims, lack of independent redress mechanisms, lack of political will to investigate abuses, and lack of reporting of human rights violations by humanitarian aid agencies.

Government accountability was lacking in all the countries that we studied. Further, humanitarian aid agencies hesitated to report human rights violations for fear that the governments would prevent them from continuing their work. Further, some NGO’s acted unethically in building inappropriate housing, and in neglecting to establish follow-up programmes. Survivors had no access to mechanisms through which to address their complaints against the state or private groups.

### ***Poor coordination of relief aid***

Relief efforts of multiple institutions and organisations were not harmonised due to a lack of coordination among humanitarian and aid agencies, different levels of government, competing agendas, and lack of NGO accountability. The tsunami elicited an outpouring of funds and an influx of humanitarian aid agencies. Some of the aid agencies were the large UN agencies, many were smaller but reputable groups, and some appeared

out of nowhere offering assistance but with their own agendas such as proselytising or securing funds for their own use. Housing was built without government consultation or even consultation with the local community. In some cases this led to construction on flood plains that would become inhabitable. One agency might provide water tanks that were never filled. Central offices a world away made decisions that did not meet the needs of the people. And mistrust of government by local NGO's led to their acting on their own and resisting government oversight – all of which led to processes of reconstruction that were less than efficient and would lead to a need to revisit prior programmes.

#### ***Low public confidence in coastal redevelopment***

There was a lack of clarity among survivors in coastal areas regarding the conditions under which the coastal areas would be rebuilt. Officials responded to the environmental damage with nontransparent policy recommendations that appear to marginalise or even disenfranchise the poor. An important response to the tsunami by the governments of India, Indonesia, Sri Lanka and India was to support the creation of “buffer zones” along the beach areas of these countries. However, there was little consultation about the size of these zones and little transparency in how the government reached its decisions. Some governments offered financial incentives to move inland but provided no assistance if the homes were rebuilt within the zone. In the Maldives, the so-called “safe island” plan to move people to new islands that had safeguards against flooding leaves little choice to those who would prefer not to move. Land rights became a contentious issue for those who relied for decades on legal custom to occupy their homes. In Thailand, the lack of legal title exposed these survivors to rapacious developers. These planning decisions threatened the livelihoods of those

who depend on their proximity to the sea such as fishers and those who support the fishing industry.

#### ***Lack of community participation***

In all the countries, survivors had little to no input into any of the planning that was taking place in the capital cities far from the destruction.

Community participation rarely took place when decisions were made about reconstruction and rebuilding programmes. In some cases, decision-makers discredited or ignored the views and opinions of local communities. Many survivors perceived the government as aloof and non-responsive. Donors and aid agencies often prioritised timely outcomes over deliberative processes that allowed for community participation and discussion. Some agencies deliberately excluded certain groups because they were viewed as only serving “their own.” The UN Guiding Principles on Internal Displacement state: “Special efforts should be made to ensure the full participation of IDP's in the planning and management of their return or resettlement and reintegration.” This process of exclusion has led to poor planning, disaffected survivors and great resentment of government.

#### **Discussion**

Our findings illustrate that a human rights framework can offer a useful analysis of the processes of reconstruction that follow mass disaster. Pragmatically, what does this mean? While Gostin and Mann<sup>20</sup> have proposed a strategy for assessing the human rights implications for health policies, the evaluation becomes more acute in situations of mass disaster. Several assumptions underlie this approach; first, human rights are interrelated and indivisible. They cannot be separated from effective disaster response. Health professionals must move away from focusing solely on the direct physical and psychological consequences of the disaster to recognising that lack

of identity papers has consequences for health access; that maldistribution in aid that emerges from ethnic or caste discrimination has implications for access to food and shelter, and that government corruption disturbs supply lines especially to the most vulnerable. The second assumption is that health professionals have both the expertise and the obligation to assess health risks broadly and to advocate for attention to these other factors that inhibit assistance. The third assumption is that during the aftermath of disaster, multiple organisations (local and national, government, multi-lateral, and international non-governmental) will offer assistance. The challenge is to coordinate and to develop a strategy that reflects the differing realities of the country in question. Human rights violations – discrimination, denial of access to health care, sexual violence or abuse – have implications for the health and well-being of survivors. Whether it be a history of civil conflict, violence towards women, the rebuilding of homes in flood zones, abduction of children, or corruption and aid inequities, these violations impinge significantly on how well the displaced populations will do both in the short and long-term. In this regard, the reluctance of humanitarian organisations in Aceh to insist on secure housing for women IDPs, away from military barracks, contributed to the vulnerability of the population aid groups sought to assist.

The duplication of similar problems that emerged in the United States following Hurricane Katrina reveals that it is not only a country's resources that determine the efficacy of humanitarian assistance but also, the lack of coordination, pre-existing vulnerabilities, opportunistic developers and other manifestations of power imbalances bedevil even wealthiest of countries. As in the tsunami-affected countries, ignorance of international human rights norms as described in the UN guidelines for the internally displaced revealed the lack of attention to lessons that are

learned from international disasters. A human rights framework can be used to identify priorities and strategies for public health diagnosis and intervention by expanding the health lens to examine more closely the larger political, social and environmental dynamics that may impinge on humanitarian intervention. A human rights analysis then involves the following steps:

1. An analysis of the pre-existing patterns of human rights violations in the affected country with particular attention to vulnerable groups (women, children, the elderly, minorities, refugees).
2. An analysis of the international treaties that the state has signed and ratified and which bind its government to act under international law. It is important that health-related humanitarian interventions be based upon the rights accorded to survivors under international law and accepted guidelines such as the UN Guiding Principles on Internal Displacement and the newly-adopted UN Operational Guidelines on human rights and natural disasters.
3. On-going advocacy by health professionals at both the national and international levels particularly those on the ground as the inequities and human rights violations become apparent. Working through the UN, the World Health Organization, the ICRC as well as through such health agencies as the International Organization for Migration and Médecins Sans Frontières, along with human rights advocacy organisations such as Amnesty International, Human Rights Watch, Physicians for Human Rights, and humanitarian agencies such as Save the Children, Oxfam or CARE in a coordinated fashion becomes an essential element of health interventions. The goals of advocacy are two-fold: first, in

the acute situation, to assure equitable and unimpeded distribution of aid, and second, to promote health rights as a legacy in the rehabilitation and reconstruction phase of the disaster response.

4. On-going monitoring of programmes to assure that the goals developed by central or regional offices are implemented in the field and coordinated both with other aid agencies and with government health planning. Such monitoring should include monitoring of human rights violations.
5. Health professionals should encourage the use of epidemiologic survey tools to maximise the knowledge base that emerges from anecdotal data gathering. It is especially important to assess disaster effects subsequent to a tragedy like the tsunami at a regional level. Epidemiology can also contribute to a better understanding of human rights violations and their relationship to health effects.

### Limitations

This study has some limitations. The qualitative design is limited by questions of selection bias, language constraints, time constraints, on-going conflict, class and ethnic suspicion. We have suggested that a more comprehensive geographic multistage cluster sample survey would be an important next step; however, there has been little interest from international agencies in pursuing a regional approach.

In each of the countries that we studied, there were significant human rights problems that antedated the tsunami. Many of these are entrenched in a culture of corruption and impunity (all the countries) or have been mired in violence and war (Sri Lanka and Indonesia). We are aware that changes in these areas are incremental and at times, agonizingly slow. It is indeed

difficult to assess whether increased international access to Aceh as a result of the tsunami led to the peace agreement or whether changes within Indonesia itself would have led to the same end-point. Certainly, our reports indicated that the military in Aceh actively interfered with aid distribution and that even now, problems persist in rehabilitation although the peace agreement has mitigated military involvement<sup>21</sup>. Events have worsened in Sri Lanka, no changes have occurred in the Maldives. Progress continues in India but human rights violations remain<sup>22</sup>. However, the human rights commissions of these countries remain active in assessing the tsunami's impact<sup>23</sup>. Finally, a recent report from Actionaid indicates that as of January, 2006, the human rights concerns continue to influence the process of reconstruction across the region<sup>24</sup>. The findings of this report suggest that on-going vigilance is critical if the rights of the survivors are to be assured.

We therefore make the following recommendations with the recognition that the promotion and protection of human rights is a state obligation under international law:

1. UN agencies and NGOs should take into account the prior human rights context of the particular country in their aid and reconstruction policies and programs.
2. States should increase accountability and transparency of public and private aid providers.
3. State agencies should strengthen coordination with UN and NGOs during the reconstruction phase of the tsunami catastrophe.
4. States, international agencies, and local aid organisations should improve community participation in reconstruction planning and implementation.
5. Particular attention must be paid to those affected by ongoing armed conflicts.

With respect to health professionals, we suggest the following:

1. Those engaged in international relief work should familiarise themselves with those elements of international human rights law that impact the health and well-being of survivors.
2. That health professionals work with established government, human rights agencies and the United Nations to assure that care delivery be minimally affected by prior human rights violations especially in the context of civil war and that access is open and unimpeded.
3. That health professionals utilise their expertise to leave a legacy of sustainable health benefits to affected communities.

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