Psychosocial health and human rights: fair weather friends? Examining post-tsunami interventions in conflict-affected areas

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Multiple challenges are present in areas affected by both disaster and conflict. Support to psychosocial recovery and wellbeing is increasingly seen as a core component of responding to disasters and complex emergencies. We consider whether the increased attention and resources directed to psychosocial programs following the tsunami could assist in the promotion of human rights in the fragile settings of north-eastern Sri Lanka and Aceh in Indonesia. We identify ways in which the psychosocial and human rights agendas intersect and consider how progressive psychosocial health programming can assist in the promotion of human rights. We also highlight concerns and cautions arising from too explicit a connection in the absence of a safe environment. We conclude by presenting an emerging research agenda to more thoroughly explore the interface of these important areas of health and social policy response.

Introduction

The tsunami of 26 December 2004 affected 12 countries, eight of which experienced significant tragedy and disaster (these were Indonesia, Sri Lanka, India, Thailand, Maldives, Malaysia, Burma, Somalia: BBC 2005). Two areas most heavily affected by the post-earthquake wave have been embroiled in longstanding violent political conflicts: north-eastern Sri Lanka and Aceh, Indonesia. In areas affected by both disaster and conflict, multiple challenges are present.

Although violent conflict and the associated human rights abuses have a pervasive effect on mental health and psychosocial wellbeing, these services are rarely

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prioritised by governments or international agencies (Silove 2004). However, the recent tsunami shifted agendas and brought in its wake significant changes to health services, aid and development activities. Psychosocial[2] concerns received attention as donors and non-governmental organisations (NGOs) mobilised to respond to the widespread loss of lives and livelihoods.

The post-disaster period creates opportunities to bring mental and psychosocial health and human rights together in a mutually reinforcing way. Addressing key needs and rights will enhance mental health and psychosocial wellbeing, while ongoing attention to psychosocial health may also afford an opportunity to build awareness about human rights within affected communities. The synergy between promoting psychosocial health and protecting human rights is now central to the reconstruction of communities in the tsunami-affected areas.

In this paper we ask whether the increased attention and resources directed to psychosocial responses in the wake of the tsunami could assist in promoting human rights in the fractured settings of north-eastern Sri Lanka and Aceh. We discuss how psychosocial and mental health practice in disaster and conflict settings aligns with human rights agendas: we briefly examine traditional trauma-based approaches and present emerging models that emphasise social reconstruction and community support. We argue that the tsunami occurred at a time when mental health and psychosocial workers had been exploring human rights dimensions to their work, and new foci on rights to health and access to health care were opening out (WHO 2005a).

Against this background, questions arise as to how this relationship may further evolve. In north-eastern Sri Lanka and Aceh, an influx of resources (financial, material and human) and a commitment to psychosocial activities have occurred amid ongoing conflict and human rights violations. Mental health and psychosocial NGOs and professionals have offered services and solidarity, and

2 Mollica et al (2004, 2064), define psychosocial interventions as those that emphasise the 'dynamic relations between psychological effects (eg emotions, behaviours, and memory) and social effects (eg altered relations as a result of death, separation and family and community breakdown)'. In relation to complex emergencies, a psychosocial approach suggests three key areas are affected, 'human capacity (ie skills, knowledge and capabilities), social ecology (social connectedness and networks), and culture and values'.

many humanitarian and aid agencies are grafting counselling, psychosocial and healing dimensions onto their work portfolios.[3]

How might psychosocial programming support human rights work? What are the points of intersection for the two disciplines and where do the tensions lie? Will we see psychosocial health adopting an explicitly rights-based stance in these contested settings?

In an environment of urgent and competing health needs, linking psychosocial health with human rights work will not be simple. While human rights principles are widely accepted, their interpretation in different settings varies, and their promotion through policy and service delivery may be resisted by those anxious to get on with what they see as a technical job of relief and reconstruction.

Where psychosocial and mental health needs are great, services are often provided by external actors, notably NGOs, charities and faith-based organisations. Responsibility and obligations for human rights though, ultimately lie with governments (Gruskin and Tarantola 2001). Identifying where tensions between the disciplines may arise and thinking through how best to address these will be a valuable undertaking. To this end, we conclude with a research agenda which begins to explore these issues.

Psychosocial and mental health interventions

Post-emergency interventions for psychosocial and mental health have, over the past two decades, been marked by ongoing debate and disagreement regarding key priorities, concepts and responses. More traditional, trauma-oriented programs were at their peak following the internal wars in the former Yugoslavia, which saw massive inflows of counselling and mental health teams into Bosnia and Kosovo (Summerfield 1999). Based on principles of individualised models of trauma, programming was underpinned by an assumption that the majority of those who experienced the conflict would require attention from mental health professionals. Interventions included the establishment of trauma centres; the rapid and often unco-ordinated training of counsellors; and a wide range of activities focused around one-off debriefing and counselling sessions for individuals or groups. A high level of dependency on

3 In Sri Lanka, for example, the United Nations Population Fund took the UN lead in developing the psychosocial response to the disaster. In Aceh, the International Council of Voluntary Agencies (ICVA) (2005) estimated the immediate tsunami response involved more than 2000 foreigners and thousands of Indonesians entering the region; as of July 2005, there were close to 600 different organisations operating in Aceh, around 260 of which were international NGOs (HIC, 2005), many engaging in some form of psychosocial activity.

external expertise resulted and international agencies planned, controlled and delivered services in parallel with established community and public health services.

There is a growing critique of these approaches (Bracken and Summerfield 1995; Silove 2004; Van Ommeren et al 2005a, 2005b). Conditions of durable security, if realised, will provide the best 'therapy', naturally reducing the levels of traumatic stress symptoms for most survivors. Short-term therapies, such as critical incident stress debriefing and its variants, that invoke memories of the trauma when persons are still in situations of threat may lead to a worsening of symptoms and to adverse consequences in some survivors. At the same time, a combination of factors (personal vulnerability, type and quantum of trauma, specific post-traumatic experiences) may prevent or retard recovery in a small percentage of survivors (Steel et al 2002; De Jong et al 2003) and these persons may require clinical interventions for post-traumatic stress disorder (PTSD), depression and other reactions. Specific trauma treatments requiring expertise and resources need to be reserved for the minority who are at risk of developing chronic and disabling conditions some time after exposure to trauma, rather than being applied indiscriminately to all survivors soon after a crisis. Instead of regarding the presence of PTSD symptoms (which are highly prevalent in acute humanitarian disasters and their aftermath) as requiring immediate individual intervention, such stress reactions should be regarded as an indicator of the need to establish conditions of genuine safety and security for the community as a whole.

Furthermore, many trauma-centred projects have reflected poor practice in aid and development more generally, with weak co-ordination among a range of actors, lack of accountability and limited engagement with local processes and institutions. Often dominated by expatriate experts, these projects appear technical, top-down and insensitive to developing local capacities and may be costly and unsustainable. They risk decontextualising population experiences and may downplay issues of social justice and disputes with the state and other powerful stakeholders.

Boyden (2004, xiv) has suggested that trauma-orientated models and the reliance on psychological and medical assessments, such as the use of symptom checklists, 'has the effect of both pathologising the survivors of conflict and individualising a phenomenon that is in fact profoundly political'.

It has become apparent that the rush to develop psychosocial services in conflict and disaster-affected settings risks doing harm and may inadvertently undermine some rights. Despite good intentions, those providing assistance transmit a particular set of cultural and other values. In emphasising efficiency, speed, competitiveness 'getting things done', core issues of participation, ownership, enhancing capacities and respect for local practices are often compromised.

Box 1: Psychosocial framework — emerging principles of good practice, post disaster/conflict

○ **Traumatic stress reactions are widespread but most often short-lived and self-limiting — a community level response which supports social reconstruction and mobilisation of local capacities for recovery is likely to be the most effective intervention. This should include:**

- Provision of simple, accurate information early and in an accessible manner about the disaster/emergency and associated relief efforts.
- Information on the typical response to trauma available in local languages, through different media and appropriate for varying levels of literacy.
- Support to reconnect families and kinship groups and mechanisms for registering and tracing missing persons.
- Facilitating religious and cultural grieving rituals; support communities to carry out appropriate burial practices; allowing for collective grieving and mourning.
- Identification and protection for vulnerable groups — 'persons facing extreme social risk'.
- Provision of food, safe shelter, water and access to medical care. Protection and support to women and girls, unaccompanied children, the elderly and people with disabilities, including those with mental illness.
- Resumption of normal community activity including re-establishing formal or informal schooling and providing appropriate recreational space and activities for children and adolescents; and encouraging community participation in meaningful activities such as rebuilding, organisation of relief efforts and food distribution.

○ **Widespread, psychological debriefing and one-off counselling should be discouraged.**

- Frontline workers should be encouraged to adopt principles of psychological first aid; meeting basic needs, providing protection from further harm and organising or re-establishing social supports and networks. Non-intrusive emotional support and empathetic listening is recommended, rather than debriefing and counselling.

○ **Emphasis should be placed on fostering 'culturally-appropriate mechanisms for overcoming traumatic losses', recognising the resilience of communities and reinforcing local capacities for recovery (Silove 2004, 93).**

- Provision of resources and support to indigenous recovery systems (religious, spiritual, cultural).
- Where external agencies have established psychosocial programs, early transfer of leadership and decision-making to local communities should take place.

○ **Psychosocial and mental health care should be provided through established primary health and community health care services rather than through vertical programs and specialised trauma-focused services.**

○ **Clinical services should target those most in need, whose psychosocial problems are 'of such a nature as to compromise their capacity to survive in a chaotic environment'.**

- Assessment should focus on functional capacity rather than on establishing a definitive diagnosis.

○ **Those with pre-existing psychiatric illnesses are at particular risk.**

- Avoid the sudden, harmful discontinuation of medication.
- Prioritise support to carers.
- Interventions should assist shift from custodial institutional care to community-based, family-focused services.

○ **Programming should be flexible.**

- Interventions should be responsive to changing needs: acute phase may concentrate on meeting basic needs and preventing further harm, while medium to longer-term will likely see the emergence of persistent chronic reactions in a minority of people, requiring greater clinical support and follow-up.

○ **Awareness of, and respect for, history, culture and traditions and an understanding of how these influence social behaviour is necessary.**

○ **Non-discrimination and equality in access should be emphasised, with a particular focus on gender, age and other factors which may influence vulnerability in such situations, either in isolation or in combination.**

An alternative approach suggests that effective *social reconstruction* is probably the most powerful engine for broader individual and societal psychosocial recovery.

Policy makers and practitioners are coming closer to agreeing the core principles that should guide post-disaster and conflict-relevant interventions. Box 1 presents an emerging framework drawing, in particular, on four recent source documents (Sphere Project 2004; Silove 2004; Mollica et al 2004; Van Ommeren et al 2005a). This framework highlights the need to work with communities, to build and enhance local capacities, to think medium and long term, and to see post-conflict interventions as an opportunity for reform and not simply reconstruction. In this respect it echoes other debates about the opportunities to enhance equity and pursue reforms in the aftermath of conflict (Shuey et al 2002).

Psychosocial programming and human rights: complementarities and shared agendas?

Key issues encountered in the course of emergency preparedness, response and post-impact phases call for actions falling under international human rights obligations of the two governments concerned: see Table 1. While Sri Lanka is party to all five treaties that are the most relevant to this discussion, Indonesia is party to all but two of these It has not ratified or signed the International Covenant on Civil and Political Rights (ICCPR) or the International Covenant on Economic, Social and Cultural Rights (ICESCR): see Table 2. However, the treaties Indonesia has ratified impose obligations towards minorities, women and children which encompass most of the obligations stemming from the two treaties it has not ratified.

In this section we present some of the ways in which psychosocial and mental health interventions complement human rights principles.

Table 1 — Issues encountered in emergency preparedness and response and relevant international human rights treaties

Issues faced by the community	Treaty (and specific article) relevant to the issue*	Measure to be considered
• Lack of information about potential/ real impacts of disaster and sources of support • Inability to assemble, associate or participate in public	• **ICCPR 19:** Freedom to seek, receive and impart information • **ICCPR 21 and 22:** Peaceful assembly and association • **CRC 15:** Child's rights to freedom of association and peaceful assembly • **ICCPR 25:** Participation in public affairs • **CEDAW 7:** Women's equal participation in political and public life and in NGOs	• Provision of information • Participation of all, in particular women and children, in disaster preparedness, response and reconstruction

Issues faced by the community	Treaty (and specific article) relevant to the issue*	Measure to be considered
policy or program development	• **CEDAW 14:** Participation of rural women in development, public life and NGOs • **CRC 12:** Child's right to express their views • **CRC 13:** Child's freedom to seek, receive and impart information • **CRC 17:** Child's access to information	
• Lack of access to basic survival means: health, food, shelter, water, security and services • Loss of employment and means of survival	• **ICCPR 6:** Right to life • **CRC 6:** The inherent right of every child to life, survival and development • **ICPPR 9:** Right to liberty and security • **IESCR 6:** Right to work and gain a living • **IESCR 11:** Right to an adequate standard of living • **IESCR 12:** Right to the highest attainable standard of physical and mental health • **CRC 24:** The right of the child to the highest attainable standard of health • **CEDAW 12:** Equal access to services • **CEDAW 14:** Right of rural women to enjoy adequate living conditions • **CRC 3**: The best interests of the child shall be a primary consideration • **CRC 20:** Special protection • **CRC 21:** Child's adoption • **CRC 27:** Right of the child to an adequate standard of living • **CRC 32:** Right of the child to be protected against economic exploitation • **CRC 34:** Right of the child to be protected against sexual exploitation and abuse • **Convention Relating to the Status of Refugees:** In particular on Rationing (art 20), Housing (art 21), Public education (art 22) and Public Relief (23)	• Provision of food, shelter and access to medical care and other health services • Equal access to services • Attention to the needs of women, children and vulnerable populations such as refugees
• Disrupted families	• **ICCPR 17:** Right to be protected against arbitrary interference with privacy, family, home, etcetera • **ICCPR 23:** Protection of family • **IESCR 10:** Assistance to the family	• Protection of the family • Efforts to reconnect family members during and after disaster

Issues faced by the community	Treaty (and specific article) relevant to the issue*	Measure to be considered
	• **CRC 9:** Child should not be separated from family (except when in the best interest of the child) • **CRC 16:** Child's right to be protected against arbitrary or unlawful interference with privacy, family, home, etcetera	• Efforts to protect children against illicit and unjustified displacement
• Restriction of movement within and from/to the disaster area	• **ICCPR 12:** Right to free movement within the territory of a State except when restrictions are provided by law, are necessary to protect national security, public order, public health, etcetera) • **CRC 11:** Protection against the illicit transfer and non-return of children abroad	• Allowed free movement unless restrictions are found necessary for the protection of national security, public order or public health, and legitimised through a due process
• Lack of sensitivity or objections to religious, cultural and traditional practices	• **ICCPR 18 and 27:** (ethnic, religious or linguistic minorities) • **CRC 14:** Child's freedom of thought, conscience and religion • **CRC 30:** Right of the child to enjoy his or her own culture, practice own religion and use own language	• Attention to religious beliefs and cultural traditions as well as language during the preparedness, response and rehabilitation phases of natural disasters
• High vulnerability of women, children, people who suffer from inequality and discrimination, including people with mental illnesses or disabilities and incarcerated or institutionalised populations	• **ICCPR 3:** Equality of men and women • **IESCR 3:** Equal rights for men and women • **ICCPR 26:** Non-discrimination • **ICCPR 24:** Special protection of children • Protection of persons with mental illness or disability • **ICCPR 7:** Right to be protected from cruel, inhuman or degrading treatment, etcetera • **ICCPR 10:** Human treatment of persons deprived of their liberty • **IESCR 10(2) and (3):** Special protection of mothers and children • **ICCPR 24:** Special protection of children • **CEDAW 2 to 16:** On the adoption by state parties of measures to be taken towards the elimination of discrimination • **CRC 2:** Non-discrimination against children	• Protection of vulnerable groups • Respect for principles of equality and non-discrimination during all phases of disaster preparedness and management • Prevention of inhuman or degrading treatment to which institutionalised population may be particularly exposed

Issues faced by the community	Treaty (and specific article) relevant to the issue*	Measure to be considered
	• **CRC 23:** Special protection of children with mental and other disabilities • **CERD 5:** Enjoyment of rights regardless of race, colour or national or ethnic origin	
• Disruption of education and unequal access	• **IESCR 13:** Right to education • **CEDAW 10:** Equal rights in the field of education. • **CRC 28 and 29:** Right of the child to education	• Resumption of schooling • Attention to equality and non-discrimination in access to education
• Lack of recreational activities and opportunities for children	• **CEDAW 13:** Equal right to participate in recreational activities • **CRC 31:** Right of the child to engage in cultural, artistic, recreational and leisure activity	• Equality in recreational opportunities for men and women • Creation of recreational space for children
• Lack of community participation in the planning and implementation of emergency response	• **ICCPR 25:** On participation in public affairs • **CEDAW 7:** On participation in political and public life • **CEDAW 14:** Participation of rural women in development, public life and NGOs	• Encourage community participation in relief and reconstruction efforts
• International co-operation needed to prepare for and respond to disasters, including in the rehabilitation and reconstruction phases	• **IESCR 2:** International assistance and co-operation	• Obligation by all state parties to engage in international co-operation to the maximum of their available resources

***The following international human rights treaties are referred to in this table:**
ICCPR: International Covenant on Civil and Political Rights
IESCR: International Covenant on Economic, Social and Cultural Rights
CEDAW: Convention on the Elimination of All Forms of Discrimination Against Women
CRC: Convention on the Rights of the Child
CERD: International Convention on the Elimination of All Forms of Racial Discrimination

Table 2: Status of ratification of international human rights treaties by Indonesia and Sri Lanka, 2005

	ICCPR	ICESCR	CEDAW	CRC	CERD
Indonesia			R	R	R
Sri Lanka	R	R	R	R	R

R = Ratified

ICCPR: International Covenant on Civil and Political Rights
ICESCR: International Covenant on Economic, Social and Cultural Rights
CEDAW: Convention on the Elimination of All Forms of Discrimination Against Women
CRC: Convention on the Rights of the Child
CERD: International Convention on the Elimination of All Forms of Racial Discrimination

Identifying and responding to individuals at risk

Providing early support and information and ensuring that services are accessible to all affected members is central to psychosocial recovery and aligns with human rights principles of equality. Working with frontline workers (teachers, health care workers, police) to assist them to provide psychological first aid, and to assess when additional mental health services are required, is a crucial activity in the acute phase. Involving women and children in the planning and delivery of services is also important, and helps ensure appropriateness and protection while reinforcing the right to participate in, and influence, service delivery, something not well promoted in most complex emergency settings (Palmer and Zwi 1998; Fustukian and Zwi 2001; Sphere Project 2004).

Among the most vulnerable in any emergency are those with pre-existing mental illnesses (Silove et al 2000). Psychosocial and mental health interventions offer opportunities to assess and provide care, facilitate ongoing provision of medications where required and monitor mental health facilities. Incarceration should be carefully assessed, especially in settings where psychiatric labels and institutionalisation may be used to restrict the rights of those who oppose government policies.

In the longer term, the aid and support provided in the wake of the tsunami offer an opportunity to integrate psychosocial and mental health concerns into community health services' core responsibilities in environments where this was not previously the case. Through the provision of training, mentoring and supervision to health providers and other frontline workers, rights-sensitive approaches could be emphasised, protecting the rights of those with mental illness and highlighting approaches to treatment that promote dignity and respect.

Identifying and responding to groups at risk

Psychosocial workers in Sri Lanka recognised early the value of community-level needs assessments to establish who was providing what services.[4] Needs assessments also have the potential to reveal uneven distributions of resources and services; in some cases they expose inequitable patterns of broader health (and other) resource allocation. Such assessments may act as powerful indicators of neglected communities and marginalised groups within communities.

In the context of the tsunami, psychosocial workers had an opportunity to raise awareness of the needs of displaced people, and the risks to rights present among those uprooted from normal family and community support systems (Gallappatti 2005). This includes particular attention to the rights of women and girls who may be especially vulnerable to sexual and gender-based violence during displacement (Carballo, Hernandez and Welle 2005; UNHCR 2003). This vulnerability arises, in part, from dependency on a range of service providers and personnel for meeting basic needs and assuring protection.

Participation of affected communities in decisions related to resettlement and rehabilitation is especially critical in areas where community division and conflict is already commonplace. In advocating for access to basic information and local participation in decision-making, psychosocial workers can pose critical questions: What is to happen with the land occupied by many poor people on the coastal fringe? Who will determine the bylaws that dictate where people are to live and to what services they gain access? What legal and other protections exist for those who have lost all they had — including the title to their property, their personal documents and related insurances? How will resettlement plans impact on the rights of other populations who should not be deprived through efforts to resettle and 'privilege' directly affected groups or accommodate new economic and development opportunities?

Recognising resilience and supporting participation

Psychosocial recovery following disaster will be influenced by pre-disaster coping skills, social networks, psychosocial wellbeing and the resilience of affected individuals, groups and institutions (Carballo, Heal and Hernandez 2005). An approach that prioritises community resilience and agency, and builds and enhances local capacity, serves the agendas of both psychosocial health and human rights movements.

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4 See notes from the Psychosocial Needs Assessment Working Group Meeting held at the CHA on 27 January 2005: <www.humanitarian-srilanka.org/Pages/PS_Tsunami/Needs%20Assessment%20Working%20 Group%20Update%20-%2027th%20Jan.pdf>.

Collective grief, community healing and the development of local responses to recovery from loss must be supported rather than an emphasis on western counselling and individually focused strategies. Early participation of grassroots organisations and community leaders in decisions concerning relief and aid empowers communities and encourages local control of activity: 'Disaster–affected communities must be the architects of their own psycho-social recovery' (Silove and Zwi 2005). New frameworks for psychosocial interventions demonstrate a shift in understanding of 'participation' from a basic involvement in projects towards engagement in the planning and processes that shape policies, reflecting a more rights-oriented approach to participation.

Respect for local processes and principles of progressive realisation

Deep appreciation of the particular context — history, traditions, culture, nature and role of conflict — takes time to develop, and unless an agency has prior involvement in the area, relationships will be slow to establish.[5] Building trust is increasingly recognised as important: in essence 'trust matters to health systems' (Gilson 2003; 2005). In relationships between state and citizenry, providers and users of services, and between external agencies and local partners, and especially in situations of disaster, conflict and post-conflict, trust matters (Zwi and Grove 2005). Expatriates may come with their own systems and perceive local ones as inefficient. The smaller-scale activities of local organisations may be overlooked and involvement in decision-making undermined (Mylle 2005; Galappatti 2005) — the International Council of Voluntary Agencies (ICVA 2005) cites the example of interagency co-ordination meetings being conducted in English and without local translation. Furthermore, external NGOs often seek change at a pace that few societies can comfortably absorb. Women's human rights have taken generations to promote in established democracies, but are being fast-tracked in post-disaster situations where impediments are numerous. Finding strategies which can take account of local constraints and limitations, which can identify respectful ways to overcome these, and which retain a sensitivity and commitment to promoting rights, remains an important challenge.

The principle of progressive realisation, that one should seek iterative improvements and achievement, is as applicable to the right to health as it is to most other rights. Short-term interventions prompted by time-constrained donor funding do little to assist the recovery of individuals, nor are they able to support sustainable community change. Frameworks sensitive to need, pace and culture may contribute to the development of achievable national mental health strategies based on local priorities.

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5 ICVA (2005) estimates that around 300 international NGOs responded to the disaster in Aceh, only a handful of which had any prior experience in the area.

How closely will the psychosocial sector align itself with human rights concerns in Aceh and Sri Lanka?

The tsunami has presented opportunities to strengthen the capacity of community health services and to address prior weaknesses within existing mental health services. In Sri Lanka, substantial effort went into producing a national plan around psychosocial responses,[6] and the Centre for National Operations, the co-ordinating agency during the emergency, established a 'desk' to deal with psychosocial issues. In Aceh, frontline mental health workers reported an out-of-date system heavily reliant on poor quality hospitalisation with limited attention to community services and perspectives. Following the tsunami, the World Health Organization (WHO) set out policy guidelines for mental health services and systems (WHO 2005b). With psychosocial health firmly on the agenda, international organisations in particular have been presented with a unique and significant opportunity to access populations that had been otherwise closed to outsiders and to actively promote a human rights agenda in settings where this has been especially difficult: see Box 2 and Box 3.[7]

Box 2: Human rights in Aceh

Human rights groups registered grave concern regarding rights abuses in Aceh, especially following the announcement of a military emergency in 2003. They consistently and unsuccessfully called on Indonesia to open Aceh to independent human rights workers, journalists and observers. Abuses and violations by the Indonesian military and police had been reported to include 'extra-judicial executions; rape and other crimes of sexual violence against women; torture and ill-treatment; and arbitrary detention'. At the same time, reports of abuses carried out by GAM (Gerakan Aceh Merdeka, or Free Aceh Movement) have included the taking of hostages and the use of child soldiers. The authorities have also accused GAM of carrying out unlawful killings.[8]

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6 Ministry of Health (Sri Lanka), Department of Mental Health Services, *National Plan of Action for the Management and Delivery of Psychosocial and Mental Health Services for People Affected by the Tsunami Disaster,* 10 January 2005; and Ministry of Health (Sri Lanka), *Policy on Psychosocial and Mental Health Issues Related to the Tsunami Disaster in Sri Lanka,* 19 January 2005.

7 Since submission, the following valuable report has been released: Human Rights Center, University of California Berkeley (2005) *After the Tsunami: Human Rights of Vulnerable Populations*. The report includes chapters on Indonesia and Sri Lanka. Available at <www.hrcberkeley.org/afterthetsunami/>.

8 Since the writing of this paper, the Indonesian Government and GAM have signed a peace treaty (on 15 August 2005) to resolve their longstanding conflict.

Following the tsunami, there were concerns that displaced populations had not been provided with adequate information or alternatives regarding relocation, that military intimidation in IDP (Internally Displaced Peoples) camps had gone unchecked and that distribution of aid and relief had been biased in terms of who benefits.

(Amnesty International 2005; Human Rights Watch 2005; Human Rights Watch 2004)

Box 3: Human rights in Sri Lanka

A two-decade long war being waged in the north and east of Sri Lanka between the LTTE (Liberation Tigers of Tamil Eelam) and government forces has been the source of ongoing human rights violations. Political killings, police torture and harassment and recruitment of child soldiers were among the main concerns reported in the Human Rights Watch's World Report 2005. Following the tsunami, human rights groups have become increasingly concerned with issues of protection for women and children, access to housing and compensation and the growing frustrations with the lack of systematic mechanisms for community participation.

(Asian Forum for Human Rights and Development 2005)

Psychosocial workers often reinforce human rights through their everyday practices. Consciously adopting a human rights approach, however, may broaden the scope and range of interventions pursued. Where human rights receive low priority and abuses have gone unchallenged, drawing on other sectors in the post-disaster recovery efforts may provide additional mechanisms and momentum to advance these issues. Practitioners working in tsunami and conflict-affected areas will be confronted with restrictions and violations of rights. In developing an appropriate response, a high level of sensitivity to the local context, including risks and opportunities to intervene, will be needed**.** Where practitioners detect significant abuses of rights, they will be faced with decisions about whether and possibly how to document and report these. If workers consider that speaking out themselves will prejudice other valuable activities, they may assist the media to publicise such insights.

Encouragement for mental health workers to adopt a rights-sensitive approach, and to view some of their core activities through a human rights lens, could result in widening attention for individual and collective rights. Doing so will challenge any illusions of 'neutrality' that psychosocial workers may have associated with their work. At an individual level, this will include examining the interface between services and individuals and assessing who gains access to what, how needs are met

and how rights are protected. At a collective level, engagement with social, economic and cultural rights is indicated. In instances where the mental wellbeing of minority groups is being undermined by systematic discrimination, workers are faced with a choice: respond with individual-level interventions or articulate the needs and rights of these groups at a population level. Similarly, where access to basic psychosocial and mental health services is lacking, NGOs may mobilise additional resources and expertise to meet this need. Service providers should not only fill the gap in service provision, but acknowledge that the lack of services may reflect underlying structural inequities in resource allocation, thus invoking advocacy as part of an engaged response.

Psychosocial and mental health workers may be in a position to draw explicit links between mental health and other rights that require attention. Restrictions or neglect of rights to shelter, education or information may impact negatively on the psychosocial recovery of populations under stress. All rights should be considered systematically for their impact on health and psychosocial practitioners may be perceived as legitimate advocates for this.

The process through which the psychosocial field seeks to provide support and promote change in the wake of the tsunami may reveal a traditional point of disjuncture between public health practice and human rights. In conflicted areas especially, strategic choices must be made in terms of relationships with the state. Human rights work, in particular its emphasis on accountability, often directly confronts the state. Yamin (2004) notes that a willingness to openly criticise, to expose abuse, to draw attention to discrepancies between stated laws and practice, means that 'the relationship between human rights groups and the state in almost every country in the world can be described as ambivalent, at best'. The new public health promotes an engagement with rights and advocacy (Beaglehole et al 2004; Macfarlane et al 2000) alongside usual public health approaches to working with government to focus on service provision and sustainability. 'The dissident role of human rights organisations' (Yamin 2004) may set workers in opposition to the government, potentially placing individuals, agencies and communities at risk where local authorities feel they are being threatened or undermined. Slim (2001, 8) reminds us that 'the moment one uses rights-talk, one becomes explicit in a demand for responsible politics and justice'.

Proceed with caution?

New approaches to psychosocial health programming in disaster and conflict have demonstrated greater sensitivity to human rights. However, further change may be indicated, including shifts from needs to rights, and from notions of assistance to

notions of obligation. They will require deeper reflection on issues of sustainability and accountability and the manner in which psychosocial health should confront or conform with state health systems.

And while resolving these philosophical tensions will be important, engagement with human rights in conflicted settings clearly carries significant risks at an implementation level. Psychosocial programs will want to carefully consider the consequences of waving a human rights banner in contested environments such as those in Aceh and Sri Lanka. They face the possibility that workers will be denied access, that the state will clam up and clamp down, and that programs will be cut and communities left without adequate psychosocial services.

Inaction has its own consequences, less easily articulated but no less real. Failing to take up these opportunities may affect individual client-provider relationships; after experiences of war and torture, establishing trust may require an indication of solidarity by the provider in relation to client experience (Behnia 2004). In contested environments, psychosocial programs, like any aid and development effort, must consider whether and how their interaction with local authorities or other key organisations supports a history of control or exclusion. The willingness of the international community to align with government plans for rehabilitation and reconstruction in Aceh is seen by some as undermining the aspirations for greater autonomy and freedom in this area (ICVA 2005). The delivery of health services, like the distribution of any other scarce resource, is subject to political and value-based considerations (Macrae 2001).

A reluctance to confront broad concerns with rights will limit the extent to which psychosocial programs can meet their own standards for good practice. Support for communities, participation and empowerment are fundamentally political — MacFarlane (2000, 89) has suggested that 'positioning of humanitarian agencies outside or above politics may prove self-defeating'. The positioning of humanitarian agencies in relation to the politics of the moment is an issue of ongoing debate (Weiss and Collins 1996; Macrae 2001; Duffield 2001; Collinson 2002). If governments are not pressured and called to account on human rights issues at this time, important opportunities to advance rights may be lost. Aceh, for example, has only since the tsunami opened access to a wide range of international and national NGOs, allowing monitoring of government and opposition behaviour, and the ability to assess abuses and examine health needs. Many see the mere presence of international agencies as critical to their current and future protection and security (De Jong et al 2005).

Emerging research agenda

There is a need for more and better research in this area. NGOs, UN agencies and government bodies are rightly preoccupied with the business of rehabilitation and reconstruction, of supporting those who were affected by the tsunami, delivering much needed psychosocial services and working to protect and promote human rights in fragile settings. Documenting post-tsunami experiences, monitoring the impacts of new policies and programming and weighing the risks and benefits of aligning with human rights work is necessary to improved disaster and conflict response.

In-depth case studies analysis undertaken in north-eastern Sri Lanka and Aceh to examine government and NGO-led psychosocial interventions will be illuminating. These contexts vary substantially and are very likely to require different approaches to psychosocial interventions and human rights.

Case studies would need to consider the psychosocial principles for better practice (see Box 1 on pp 75–76), the human rights context and the interface of these domains. Box 4 identifies some of the relevant research questions.

Box 4: Research questions

Situation analysis

- What questions were raised in the immediate post-disaster phase about psychosocial health and human rights protection? Who raised these issues and why?
- What have we learned about identifying and supporting those in most need?

Policy and program development

- How central are the principles of human rights and the inclusion of dignity, trust and equity in psychosocial and mental health policy, programming and service delivery?
- How do experiences of psychosocial programming in Sri Lanka compare with those of Aceh?
- To what extent is recognition of the conflict explicit within program development?
- To what extent do any of the psychosocial interventions promote peace-building and a broader set of rights?
- Do new initiatives provide any space for the stories of those affected, of vulnerability and resilience, to be heard and shared?

Implementation and monitoring

- What objectives (direct or indirect) do those working on psychosocial issues identify with respect to reinforcing or promoting human rights in their work?
- To what extent and how do individuals and organisations working on psychosocial issues link with human rights organisations?
- Do psychosocial programs have any links with justice, media and other civil society projects?
- Are there any situations where psychosocial workers and the human rights communities have clashed? Where, when, why and how were these resolved?

As findings emerge from empirical work, it will be important to engage key stakeholders from both the psychosocial health and human rights fields to reflect on these and to begin to define what a rights-focused approach to psychosocial and mental health programming post-tsunami might look like. This would facilitate discussion on what psychosocial workers would need to know about human rights before working in conflicted environments, and what human rights workers would need to learn about good psychosocial practice. Encouraging debate around the merits and risks of working more closely together and identifying potential barriers to promoting human rights in psychosocial and mental health policy would be valuable. Suggestions are needed for how to resolve tensions that exist within and between the two disciplines. Developing a set of indicators to employ in evaluating the rights-sensitivity of psychosocial and mental health interventions will be an important task. These should allow ongoing monitoring of psychosocial and mental health program performance to assess their complementarities and differences.

Conclusion

Good psychosocial interventions have the potential to embody and reinforce human rights. However, in an acute emergency, exacerbated by conflict, identifying and consolidating the links between psychosocial and human rights work is unlikely to be straightforward. In some settings it may attract repressive state action, thus undermining the provision of key services.

The right to health is often reaffirmed in times of dramatic loss and destruction. Promoting the right to health, however, requires better understanding of the types and forms of discrimination that contribute to, or compound, ill-health, and identification of those most at risk of marginalisation within the health system (Hunt 2003). While there is much overlap between the goals of psychosocial health and human rights, their approaches to change differ fundamentally, and these differences will need to be reconciled if a closer working relationship is to be forged. For psychosocial programming and mental health work, we argue that incorporating a rights-focused

approach to planning and delivery of programs has multiple benefits and that failing to do so is likely to have negative consequences. The tsunami presents a challenge to both these communities of practice: to enhance their complementarities and support for one another, and in so doing to promote psychosocial wellbeing, healing and rights in the aftermath of disasters, despite ongoing conflicts and instability.

Postscript

The authors have recently secured an ARC Discovery Grant to examine the development of psychosocial and mental health policy and services in conflict and disaster affected countries. They will be studying developments in Sri Lanka, East Timor and the Solomon Islands.

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