

# Psychosocial and Ethical Response to Disasters: A SWOT Analysis of Post-Tsunami Disaster Management in Sri Lanka

**CHESMAL SIRIWARDHANA, SUWIN HEWAGE,  
RUWAN DESHABANDU, SISIRA SIRIBADDANA  
AND ATHULA SUMATHIPALA**

## Background

Disasters take place around the globe on a regular basis, creating challenges for various stakeholders responsible for managing the aftermath. Large-scale disasters bring about many challenges regarding human rights, research, ethics and social policies.

In this context, the authors aim to share the experience gained in the aftermath of 2004 tsunami tragedy in Sri Lanka, which engulfed several nations in the Asian region. This is especially relevant due to the paucity of evidence emerging from developing world on managing disaster aftermath.

Although the authors of this article were explicitly engaged in the field of mental health, the overall strategic approach described here went beyond mental health and involved academics, policymakers and practitioners. The approach was further aimed at incorporating seemingly diverse fields of work and experiences by the authors into a coherent focal point of mental health. These diverse fields such as dead body identification, ethics and medically unexplained symptoms had a direct relevance to mental health and disasters. These experiences can be equally relevant in the management of internally displaced people in post-conflict areas of Sri Lanka.

A vast number of organisations conducted valuable work in Sri Lanka after the tsunami. The work described here was conducted by the authors and their affiliated organisation in Sri Lanka; the Institute for Research and Development (IRD — [www.ird.lk](http://www.ird.lk)) with the partnership of Institute of Psychiatry (IoP), King's College London (KCL). IRD is a non-profit academic institution and a network of local and expatriate Sri Lankan academics working to achieve an overarching multi-disciplinary research culture in Sri Lanka.

On 26 December 2004, an earthquake with a magnitude of 9.3 on the Richter scale resulted in a catastrophic tsunami which affected 12 countries.<sup>1</sup> The human impact of the tsunami was enormous in terms of the families affected, displaced or dead. More than 175,000 people were killed. Almost two million people lost their homes. Indonesia, Sri Lanka, India and Thailand were the worst affected countries. There were around 40,000 deaths in Sri Lanka and thousands were displaced. Whole swathes of the coastal belt were destroyed, causing devastating damage to the economy and society. Mental health was recognised as one of the 17 main components in primary health-care as far back as 1980, but by 2004 Sri Lanka had a limited number of psychiatrists (around 40) for a population of around 20 million.<sup>2</sup> Mental health services are more or less based on institutional care and lack public health approach. At the time of the tsunami, common with most affected countries in the region, Sri Lanka did not have a mental health policy or a disaster management plan.<sup>3</sup>

These contradictions within Sri Lanka do not allow for generalisation of the Sri Lankan experience, although it can be safely said that there are important lessons to be learnt for other nations within the region and globally.

The immediate overall concerns among the team comprising the authors included provision of basic needs and alleviation of the immediate impact of human and material loss on the directly affected survivors, needs of children with or without surviving parents, basic need of dignified burial for the perished, sensationalised and traumatising nature of the media coverage and cultural intrusion and inappropriate “aid” rushing in. Also, pathologising immediate psychological reactions along with placing undue emphasis on PTSD at the expense of other long-term mental health consequences were another concern. Exploitation of vulnerable survivors for easy and cheap research along with potential tendency to neglect the psychological component of the health status of survivors in providing care was among other particular concerns.

The authors were involved in various activities providing psychosocial services to the affected population, and had the chance to carry out assessments and observations on the immediate prevailing situation. A Strengths,

Weaknesses, Opportunities and Threats (SWOT) analysis was subsequently carried out by the team of authors, utilising this information.

## **Methodology**

The SWOT analysis was carried out using information gathered by the authors in the tsunami aftermath period. The SWOT analysis method is generally used as a management and planning tool worldwide.<sup>4,5</sup> Also, it has been used in evaluating mental health and other health-related areas in the world.<sup>6,7</sup> In this article, SWOT methodology was used in the context of immediate post-tsunami Sri Lanka to analyse disaster management responses by various stakeholder agencies, both governmental and non-governmental. The SWOT analysis mainly focused on the psychosocial and ethical aspects of the disaster response.

## **Results**

Results from the SWOT analysis carried out by the authors are presented below.

### *Strengths*

The most significant strength can be attributed to strong social cohesion, evident among the surviving communities. Voluntary participation and contribution to the relief effort poured in from all corners of the country, from the public, political parties, local and international non-governmental organisations. Shelters for the displaced were provided at temples, schools and other places while stakeholder agencies were involved in restoring essential services within a few days. Social mobilisation was quick, efficient and entirely through the free will of people representing all social strata.

### *Weaknesses*

The main identifiable weakness lay in the evident lack of preparedness for a large-scale disaster, including the lack of a disaster management policy or a national mental health policy to provide guidance. In the SWOT analysis, these weaknesses were identified in relation to existing frameworks and mechanisms for disaster management, albeit in a limited capacity. Immediately after the tsunami, numerous international non-governmental organisations arrived in

Sri Lanka. But a lot of their efforts were duplicative due to a lack of proper coordination. The effectiveness of their activities was again limited due to a lack of knowledge about local language, culture, health infrastructure and epidemiology.<sup>8</sup> This created various barriers, especially notable in the care of patients with psychiatric symptoms, for whom diagnosis and treatment is mainly dependent on effective, culturally competent history taking.<sup>9</sup>

Another weakness or a problem identified is the application of non-appropriate interventions on surviving populations. One example is vaccinating survivors for cholera where the threat was minimal for cholera and distribution of anti-malarial prophylaxis when the coastal strip was designated as non-endemic. Distributed medications in many instances had expired, and many were unfamiliar commercially-labelled medicine while many other donations were of an inappropriate and unusable nature (these included winter jackets, stiletto shoes, winter tents, thong underwear for women and Viagra tablets).<sup>10</sup> Although there were clear signs that people were coping amidst disaster, it appeared that inappropriate psychological and social support was imposed, rather than offered. Continuous relief packages offered to survivors belonging mainly to fishing communities led to the development of a “culture of dependency” among them, reducing productivity and the rehabilitation process.

Others included society-related issues, such as the myth of corpses leading to epidemics which created pressure on the government to dispose dead bodies rapidly and against cultural norms, taking away the basic right of a dignified burial. In Sri Lanka, burial rituals are usually elaborate, prolonged affairs that last around a week, with a strong religious component involved. The predominantly Buddhist country has religion entwined deeply with every aspect of human life course, and performing established burial rituals are believed to help a person along his or her onward journey in life after death and reincarnation.<sup>11</sup> The pressure to dispose dead bodies in hastily dug mass graves prevented the surviving relatives of tsunami victims from having the chance to perform these burial rituals and would have had a potentially strong psychological impact upon them. As both locals and foreigners (mainly tourists from Europe and other western countries) were buried together in these mass graves, the foreign governments faced a problem in identifying their nationals as requested by the relatives. As a solution to this, a number of western governments trying to identify their nationals requested the reopening of these mass graves, which was against cultural norms, and the DNA techniques used to identify foreign nationals were neither available nor offered to the locals.<sup>12</sup>

In the midst of all this, electronic media repeatedly telecast emotionally charged scenes of people being washed away and bodies floating around,

without a regard for the subsequent psychological impact on the rest of the country's population.

### *Opportunities*

In spite of the lack of preparedness, there was potentially a large number of stakeholder organisations (governmental and non-governmental) responding well to a disaster situation, although in a fragmented and uncoordinated way. Human resources were readily and abundantly available. There was a strong social mobilisation, and social support networks were actively engaged in relief work.

In the long-term aftermath of the tsunami, "windows of opportunity" were presented to develop policies, guidelines and action-plans to effectively manage any large-scale disasters that the country may face in the future.<sup>13</sup> A national mental health policy, national disaster management policy and disaster victim identification plans along with developing ethical guidelines took place in the long-term aftermath, which are discussed later in this article.

### *Threats*

For a country where the education and health services were provided free-of-charge by the government and had a strong public health system and related infrastructure, the biggest threat was the potential of undermining these services. Although this system was damaged in the affected areas, government structures were fully functional in other areas of the country. In certain instances, non-governmental agencies assumed that these structures were defunct and tried to overrule existing systems, threatening the overall balance of support structures.

The lack of understanding about the need for a comprehensive public health approach in providing mental healthcare complicated the issue of service provision. Tensions arose from the failure to recognise the complementary nature of different models to address psychological issues. Some stakeholders rigidly argued for the psychosocial model which called for counselling each and every person; others were adamant on the medical model where services were to be provided in hospitals and clinics. Another threat was the potential exploitation of vulnerable survivors by unscrupulous researchers.

Ample evidence of such instances of inappropriate interventions advocated by professionals (mainly from western countries) has been documented.<sup>14</sup> Also, case studies have been presented as evidence of vulnerable survivors being

exploited by both local and foreign research teams in the aftermath of the tsunami.<sup>15</sup>

## **Discussion**

Although Sri Lanka was ill-prepared to face a natural disaster of such magnitude as the tsunami, the existing strengths had enabled a commendable amount of work to be conducted during the immediate and long-term aftermath. However, there was an urgent need for a coordinated multi-sectoral approach to attend to the immediate needs of the survivors which would have had a positive impact on their psychological status. While recognising the importance of such psychosocial work as giving immediate priority to deal with the normal trauma reaction, there was a need for developing mental health services to manage medium and long-term mental health consequences of the tsunami among the Sri Lankan population.

An evidence-based approach was advocated, aiming to build on the strengths of existing services (health, education, social services, national child protection authority, etc.) and people, enhancing their coping strategies. Consequently, a call for multi-disciplinary, culturally sensitive, locally appropriate, primary care based public health approach was raised. The aim of such a call was to effectively deal with the situation at hand and to use the tsunami as a window of opportunity for future service development. To propagate these ideas, usage of mass media positively along with networking and coordinating the fragmented initiatives were essential. Challenging the opportunistic exploitation of survivors was considered a key responsibility.

Within the first 24 hours of the tsunami, the government established a Centre for National Operations (CNO) to coordinate both national and international relief operations as a temporary crisis intervention centre. The CNO provided the essential interface between concerned government ministries, local authorities, the military, and the international community.<sup>16</sup> AS was invited to lead the psychosocial desk at the CNO while SH, SS and RD were involved in its work. All possible steps were taken to involve government departments, professional colleges, individual professionals, the World Health Organization (WHO), international and local non-governmental organisations and expatriate groups in relief and rehabilitation efforts.

Public health and the primary care approach to mental health issues advocated following the tsunami was resisted by some clinicians. With other stakeholders, IRD lobbied the Ministry of Health to develop a mental health policy along the public health and primary care principles. WHO took the lead role

to facilitate and to ensure formulating a national mental health policy with substantial contribution from all possible stake holders in the country. WHO commends and recognises the fact that “Sri Lanka collectively achieved some strategically important steps such as developing the agenda for mental health as opposed to psychiatry and bringing in public health perspective and multi-disciplinary perspective to the fore” as a major achievement.<sup>8</sup>

Medicalisation of normal distress and assuming western models of illness and healing in other cultural settings are criticised by some.<sup>17</sup> Others consider denial of the importance of traumatic stress a profound error, and a denial of preventable suffering.<sup>18</sup> However, there is a wider agreement that single one-off compulsory debriefing of victims of trauma is harmful.<sup>19</sup> WHO believes that the threat posed by post-traumatic stress disorder is overstated and focus should be on the recognition and treatment of common mental disorders.<sup>20</sup> This is supported by the fact that prevalence of PTSD in the areas affected by the tsunami was not found to be significantly higher than that of unaffected areas in a national mental health survey conducted island wide in Sri Lanka.<sup>21</sup> Most acute mental health problems during the immediate aftermath of a disaster are best managed without medication, with psychosocial interventions.<sup>20</sup>

In a disaster, information should be disseminated according to principles of risk communication. It is advisable to widely disseminate uncomplicated, reassuring, empathic information on normal stress reactions to the community, emphasising natural recovery.<sup>8</sup> Brief non-sensationalistic press releases, radio programmes, posters and leaflets are valuable to reassure the public. Focus of public education should be primarily on normal reactions, because widespread suggestion of psychopathology during this phase (and approximately the first four weeks after) may potentially lead to unintentional harm.<sup>19</sup>

Efforts were taken to disseminate correct information and to challenge fallacies on the role of counselling in the immediate aftermath of trauma.<sup>22</sup> Use and abuse of media after the tsunami and its effects on the public were discussed in various platforms and included media professionals.

Identifying possible ways to convey the natural psychological reactions that occur following a disaster and normalising it was a challenge. It was important to contrast this from potential long-term mental ill health that only affects a minority.<sup>23</sup>

A campaign titled “Children First — Even in Disasters” was launched to prevent the marginalisation of children’s needs amidst the turmoil. Children were encouraged to express their emotions by drawing, while early reopening of schools was advocated, especially those that were used as temporary shelters for survivors. UNICEF supplemented these efforts by distributing kits with

school uniforms, books and shoes to all children affected. These actions contributed to the process of “normalisation” of children’s lives affected by the tsunami.

Identification of dead bodies as well as providing a dignified burial are crucial in alleviating long-term psychological issues for the surviving population and also to manage legal consequences. Hence, a comprehensive forensic service with modern genetic capabilities as part of the disaster response is a must. Comprehensive psychosocial interventions after a disaster should include dead body management.<sup>12</sup>

The author’s strategic work spanned from awareness-raising and advocacy to establishing a national policy on the management of dead bodies. Representations made to a Select Committee of Parliament recommending steps to minimise the damages from natural disasters contained a policy on dead body management.<sup>16</sup> These policies were also included in the National Policy on Disaster Management, formulated by the Ministry of Disaster Management. Recommendations to the parliamentary committee by authors included the following:

- Efficient grassroots structures and networks that can be mobilised with short notice, which are essential to execute disaster management processes;
- Capacity-building for comprehensive forensic services with genetic capabilities;
- Well-coordinated and rehearsed “National plan of action for the management of psychosocial and mental health services for people affected by a disaster”;
- Research and development should be one of the most important ingredients of future disaster management. Advance planning is crucial;
- A central ethics committee dedicated to disasters should be in place to ensure highest standards in research and to prevent exploitation of survivors; and
- The media is an important stakeholder and should be involved at all stages in responsible information dissemination.

AS chaired a technical advisory committee at the Ministry of Disaster management on setting up a disaster victim identification (DVI) programme. Other authors contributed in drafting a policy document in DVI and establishing four rudimentary centres around the country.

Medically Unexplained Symptoms (MUS) is a common occurrence after disasters regardless of the culture or the country.<sup>24</sup> Research conducted by AS spanning 15 years including epidemiological work and two randomised controlled trials using cognitive behaviour therapy (CBT) for MUS were converted



into practice by training primary care doctors using a manual.<sup>25,26</sup> This was funded by the WHO and supported by the Ministry of Health. This is an example of how the tsunami was used as a window of opportunity to translate research into evidence-based practice. This training package on MUS was implemented in Pakistan and China, in 2005 and 2008, after devastating earthquakes occurred in the two countries.

Inter Agency Standing Committee (IASC — spearheaded by WHO) guidelines on mental health and psychosocial support in emergency settings have been incorporated in this training package and have recommended it as a post-disaster intervention.<sup>27</sup>

The tsunami was followed by a huge influx of foreign organisations and individuals offering humanitarian aid, including counselling to Sri Lankan survivors. Many international academics were interested in undertaking research in the post-tsunami period, and an international dialogue was organised under the theme of “ethics of research in post disaster situations” by IRD.<sup>28</sup>

When research is combined with humanitarian aid and clinical care, there can be undue inducement for participation in vulnerable populations. Researchers may “rush” to collect data, without adequate planning and under the guise of “need assessments”, complicating an already complex situation. Although research can and often includes routine clinical care as a component in the developed country settings, this is not common in developing countries. Therefore, research participants, especially in the developing world, should be explicitly informed that clinical care given together with research that they are asked to participate in, is/can be only limited to the specific research and is not routine.

Otherwise, survivors are at risk of being exploited for research disguised as clinical care (therapeutic misconception). In the tsunami aftermath, this had actually taken place in various forms.<sup>14,15</sup> Therefore, policy and guidelines had to be established to prevent unethical data collection and exploitation of the tsunami survivors. IRD launched a campaign under the title “prevent re-traumatisation of the traumatised” with collaborations from local, regional and international professionals.<sup>28</sup>

The lack of an efficient and central ethical framework, specifically to deal with disaster-related human subject research, created space for foreign academics to perform unethical “Parachute Research”, because it is easy and cheap in developing countries such as Sri Lanka. Establishing a Central Ethics Committee under the Ministry of Health was accepted in principle but failed to materialise. However, establishment of an ethics committee at the National Institute of Education was achieved.

The authors, along with other collaborators from the South Asian region, took a lead role in formulating the “Working Group on Disaster Research Ethics” (WGDRE) to formulate a draft statement on disaster research ethics from a developing world perspective. This draft statement has been published and has been widely disseminated among professionals for input.<sup>29</sup>

## Conclusion

The information, ideas and analyses presented in this article are seemingly diverse when advocating psychosocial and ethical disaster response. However, these diverse issues congregate in one crucial focal point, which is providing effective and ethical response, including psychosocial management in a post-disaster situation.

While research and development is one of the most important ingredients of future disaster management, advocacy is also crucial, particularly during the disillusion phase of the post-disaster period. A strong effort is needed to ensure that the carefully formulated national plans and policies are implemented in a timely and efficient way, without compromises.

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## Authors' Contributions

AS proposed the initial conceptual framework for the Paper. AS, SS, SH, RD and CS were involved in the writing and editing the manuscript. AS prepared the first draft and SS, SH and CS wrote the second draft. CS and AS edited the final version.

## Competing Interests

The authors declare that they have no competing interests.

## Notes

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