HIV and the Displaced: Deconstructing Policy Implementation in Tsunami Camps in Tamil Nadu

By

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> "There is an urgent need to incorporate the HIV/AIDS response into the overall emergency response. If not addressed, the impacts of HIV/AIDS will persist and expand beyond the crisis event itself, influencing the outcome of the response and shaping future prospects for rehabilitation and recovery."
>
> Inter-Agency Standing Committee, Guidelines for HIV/AIDS Interventions in Emergency Settings

> "This tsunami disaster has displaced over 1 million people…These people have been exposed to unique pressures, working constraints, living conditions and possible gender-based sexual violence, exploitation and abuse, all factors which may put them at increased risk of HIV."
>
> Dr Ulf Kristoffersson (Director of the UNAIDS Office on AIDS, Security and Humanitarian Response)

Introduction

The concept of HIV/AIDS interventions in emergency relief efforts is a relatively, and in some ways, a radically new idea that has increasingly become significant in the international policies and guidelines that govern the functioning of emergency response. Normative policy frameworks such as the Minimum Initial Service Package (MISP); the Inter-Agency Standing Committee's (IASC) 'Guidelines for HIV/AIDS Interventions in Emergency Setting'; and the Sphere Project's 'Humanitarian Charter and Minimum Standards in Disaster Response' offer strategies to mainstream HIV/AIDS into relief activities. The need to incorporate

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This work was adapted from the author's Master's thesis in Forced Migration, Oxford University
Refugee Watch, 32, December 2008

HIV/AIDS interventions in all emergency settings has been highlighted in particular, by the IASC guidelines. This 'need' becomes crucial in those settings where HIV prevalence rates are already high; and where displacement adds to pre-existing vulnerabilities so that the susceptibility of vulnerable groups to disease and sickness is amplified.

By evaluating the immediate Tsunami relief response in Tamil Nadu, this paper examines the manner in which these strategies are translated from normative models to actual ground practices. And in doing so, raises the challenges that prevent effective humanitarian policy governance.

The coastal districts of Tamil Nadu which suffered the onslaught of the tsunami provide a perfect scenario to test the applicability of integrating HIV/AIDS prevention and care interventions into international emergency action plans (In fact, the 2004 Tsunami provided the first occasion for the enactment of the IASC guidelines which propagate the introduction of HIV/AIDS interventions in emergency relief responses). Not only were the affected areas high HIV prevalent districts but also the existing discriminative social structure in which the affected population lived, made it mandatory almost to take a right and needs based approach such as the guidelines prescribe. This would have been the only way to ensure that those who were most in need of aid would be able to access it.

'Universalised prescriptions' however, often fail to take into account that their application does not occur in a void, but in a space in which multiple realities exist and in which knowledge and power produce unexpected outcomes (Long and Long 1992, cited in Marcussen and Bergendorff 2003). Hindsight has shown that both social equity and HIV/AIDS were areas in which the relief efforts had failed to deliver (the absence of HIV related data is indicative of the attention accorded to the subject). And though the links between HIV/AIDS and social exclusion may not be perceptible on the surface, a connection nevertheless has to be made, for which an understanding of local politics is required.

Health is powerfully affected by social position. Those placed on the peripheries of society are rendered disproportionately vulnerable to HIV transmission and HIV/AIDS mortality and morbidity. Using statistics of HIV prevalence in Northern Karnataka to help prove the point, one particular study which linked poverty to HIV/AIDS found considerable caste differentials in HIV prevalence, with the lowest castes having the highest prevalence rates (Bhargava 2005). Significantly, the study showed that women belonging to lowest castes had a significantly higher prevalence than others (Bhargava 2005). The double stigmatisation of caste and HIV/AIDS makes it doubly difficult for traditionally marginalised groups to voice their needs. It would have taken an extra effort to bring their needs to the table.

Participatory approaches to relief distribution are meant to do just that—to ensure full and equal participation of the community while also empowering its weaker members. However, 'participation' and

'empowerment' invariably end up as terminology which are 'nice-sounding' while remaining prescriptive; not understanding that the issue is not just about participation, but the extent of it. The emergency response to the Tsunami succumbed to the existing caste based divisions within Tamil society. Social diktats of discrimination prevented all sections of the population from accessing aid and healthcare benefits equally.

Policies such as those already mentioned, are important in guiding practice. However the ideals that they espouse often remain mired in the complexities of local situations. And ultimately, it is the manner in which policy is worded and framed that provides a key to analyse the practical aspects of the manner in which they are finally implemented. Power struggles occur at every level so that the question becomes at all levels of "who represents what to whom" (Gordenker and Weiss 1995:553), with preconceived ideas of needs and aid distribution hindering effective relief every step of the way. Using HIV/AIDS guidelines and the extent of their penetration into the disaster relief settings of the coastal districts of Tamil Nadu, this paper brings out the dichotomy between policy rhetoric and reality.

Background

The ocean wave that was triggered by an earthquake off the Sumatra coast, on the 26th of December 2004, became the cause of widespread death and destruction in India, affecting a total of 895 villages and causing 12, 500 deaths in the country (GOI Report 2005). The state of Tamil Nadu, which had been the most adversely affected, accounted for nearly 8,000 of these deaths. And of the 595 displacement camps that were set up in the country, 373 of these were in this state, housing approximately 0.28 million people (GOI Report 2005). The tsunami affected all thirteen of Tamil Nadu's coastal districts out of which Cuddalore, Nagapattinam and Kanyakumari suffered the most losses. The communities that were most distressed were those that lived along the coastline—the Meenavers and the Irulas who worked in the fisheries sector; as well as the Dalit community who in addition to working in the agricultural and informal sectors in the area, provided ancillary services to the Meenavers and the Irulas.

As part of the destruction wrecked upon Tamil Nadu's public infrastructure, the Tsunami severely impacted the health infrastructure of several districts. The poverty of these communities meant that their access to quality healthcare was already precarious, and as a result of the Tsunami, coverage by health services in certain locations is now even less secure. From a state government report, it appears that out of 414 totally damaged public buildings, 71 were those associated with health services (GoTN 2005). And although there are no details of the exact number of Primary Health Centres and Health Sub-Centres, two government hospitals were reported to be 'badly decimated'(GoTN 2005).

With increased pressure on existing health delivery systems, basic health services in the unaffected areas of the same districts have also been disturbed. As the preliminary damage and needs assessment report prepared by the United Nations (UN), Asian Development Bank (ADB) and World Bank noted

> The tsunami has damaged health-related infrastructure, including equipment and amenities, and disrupted routine health services in the affected areas. Moreover, with pressure on district health delivery systems increasing manifold, regular curative and preventive care in unaffected areas of the same districts has been disturbed (2005:55).

Since the mid-1990s, Tamil Nadu has had the highest HIV/AIDS prevalence rates in the country—the Tsunami affected districts in Tamil Nadu have been identified as high prevalence districts (UN et al. 2005). The 2003 prevalence rate, as estimated by the NACO was 0.75%, with 83.8% of Injecting Drug Users and 8.8% of commercial sex workers testing positive (NACO 2004). The state reported about 52,000 HIV cases in 2006, to the National AIDS Control Organisation (NACO), which was the largest number of reported cases in the country (NACO 2006).

There are at present no statistics that are indicative of the effect of the Tsunami upon HIV prevalence figures. However, this should be seen in the context of the long window period between infection and detection of the virus, especially since most people only get themselves tested after they begin to show symptoms of HIV opportunistic diseases.

It has been anticipated that the increased social instability, poverty and vulnerability caused by the effects of the tsunami will heighten the risk of HIV transmission in the badly affected areas. In many locations, medical drugs and contraceptive supplies were lost and not replaced in the aftermath of the tsunami—the latter not being a high priority in relief kit distributions (Carbello et al. 2005; Padma 2005)). The shortages of clean injecting needles and of laboratory facilities to test for HIV contaminated blood are further aggravating factors (Toole and Waldman 1997). Facilities for testing and counselling as well as free anti retro-viral treatment are normally provided through the national program but with the disruption and destruction of healthcare facilities and equipment, these services have been affected. As Mehta notes

> Social services have been immensely affected with destruction of infrastructures and supplies and equipment...The tragic deaths of many doctors, nurses and health workers will have an impact on HIV/Aids prevention and care. (quoted in O'Connor and Holman 2005)

Policies Governing Relief Efforts

Under such extreme circumstances, victims of natural disasters have their rights and interests protected by a number of international human rights treaties and declarations, which although non-binding, serve as

guidelines to states and other relief actors in their approach towards displaced people. This section will draw out the normative frameworks and guidelines that supposedly provided the rationale to governmental and other humanitarian agencies in their efforts of providing relief to the tsunami-affected population of Tamil Nadu. The focus here will be on those policies that are drawn on the rubric of reproductive health, under which HIV/AIDS is categorised.

The Right to Health is a fundamental human right and is contained in several international treaties, one of the most relevant being the International Covenant on Economic, Social and Cultural Rights (ICESCR) which recognises 'the right of everyone to the highest standard of physical and mental health'[1]. Although the phrase "reproductive health" is not used, in the general comment on its implementation (ICESCR 2000), article 12(2)[2] is considered as creating a right to maternal and reproductive health and its related health services; as well as a right to prevention and treatment and control of diseases, in particular HIV/AIDS.

The Right to Health is contained in other conventions as well. Article 5e (IV) of the International Convention on All Forms of Racial Discrimination seeks to 'guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin…[to] the right to public health, medical care, social security and social services'; while the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) seeks to eliminate gender-based discrimination in access to health care. Article 12 (1) states

> States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

Most pertinent of all, are the Guiding Principles on Internal Displacement, which are recognised as being the most relevant guidelines that provide a direction to governmental, inter-governmental and non-governmental organisations in matters of internal displacement. Addressing the rights of Internally Displaced People (IDPs) to an adequate standard of living, Principle 18(2) states

> At the minimum, regardless of the circumstances, and without discrimination, competent authorities shall provide internally displaced persons with and ensure safe access to: (a) Essential food and potable water; (b) Basic shelter and housing; (c) Appropriate clothing; and (d) Essential medical services and sanitation.

Principle 18(3) goes on to stress 'special efforts should be made to ensure the full participation of women in the planning and distribution of these basic supplies'.

In a direct allusion to reproductive health, Principle 19(2) instructs

> 'Special attention should be paid to the health needs of women, including access to female health care providers and services, such as

> reproductive health care, as well as appropriate counselling for victims of sexual and other abuses'.

Moreover, 'special attention should also be given to the prevention of contagious and infectious diseases, including AIDS, among internally displaced persons' (Principle 19(3)).

Considerable efforts have been made to incorporate these guidelines into a standardised set of procedures that can be implemented in emergency and disaster situations. The Sphere Project—which was initiated in 1997 by a group of international humanitarian agencies—developed the Humanitarian Charter and Minimum Standards in Disaster Response to 'establish minimum standards in core areas of humanitarian assistance' and 'to enhance the accountability of the humanitarian system in disaster response' (Sphere 1997). The Sphere handbook is designed to be used in disaster response, including armed conflict, man-made as well as natural disasters. The standards apply to food, water, sanitation, health, HIV/AIDS and shelter and refer to the Minimum Initial Service Package as one of the minimum standards that need to be incorporated into a humanitarian response.

The concept of the Minimum Initial Service Package (MISP) is one of the strongest and most influential set of the most crucial reproductive health activities to be introduced in the early days of any emergency situation. In the immediate response to a disaster, it addresses HIV/AIDS prevention by providing for the availability of free condoms and ensuring that precautions are taken to safeguard medical equipment and blood supplies from infection. MISP activities also include planning for the provision of more comprehensive reproductive health services, as and when the situation permits.

Increasing concern over the need for introducing HIV interventions among displaced populations, led to the 2001 UN General Assembly declaration which recognised displaced and destabilised populations being at an increased risk of exposure to HIV and called on UN agencies and NGOs to integrate HIV prevention and care strategies into their own programme agendas. In what can be seen as a direct consequence, the IASC task force on HIV/AIDS produced a set of "Guidelines for HIV interventions in emergency settings" in 2003 to ensure that a minimum response to HIV/AIDS is incorporated into the emergency action plans of humanitarian agencies and governments in 'any emergency setting, regardless of whether the prevalence of HIV/AIDS is high or low' (IASC 2003:7). The guidelines and the accompanying matrix[3] emphasise that a 'multisectoral response during the early phase of an emergency…should be integrated into existing plans and the use of local resources should be encouraged' (IASC 2003). The IASC guidelines have been incorporated into the Tamil Nadu Tsunami Resource Centre's relief and recovery efforts.

Relief Operations on the Ground

In spite of the direction provided by the IASC and Sphere guidelines, relief efforts by non-governmental and governmental actors on the field had been riddled with problems from the word 'go'. One Asian human rights group described the relief efforts in India as 'pathetic', insisting that there existed

> …a lack of co-ordination between various agencies, aid mismanagement, caste discrimination in distribution of supplies, early shutting down of relief centres and a "meagre" quantity of relief being doled out to the thousands of survivors (Kumar 2005).

Problems of coordination between NGOs have been reported throughout the relief process and have resulted in many instances, in the duplication of services provided to survivors. Many organisations concentrated their activities on certain districts and/or on those worst affected—there were more than 450 registered NGOs working in Nagapattinam (Human Rights Centre 2005); and The NGO Coordination Centre in Nagapattinam focused entirely on the fishing villages with no attempts being made to assess the needs of those villages which were further inland and where agricultural lands had been destroyed.

Once the immediate relief phase had been declared over and different evaluation studies began to be conducted by different organisations and academic groups, it has been realised that there had been no strict adherence to the any of the guidelines. In fact as one report points out, it was the existing social structure with its proclivity of caste based discrimination that determined the manner in which relief and reconstruction activities were carried out; it determined the politics of inclusion and exclusion from gaining access to aid (Human Rights Centre 2005).

Post-tsunami relief assessments reports have time and again highlighted the various shortcomings of the aid delivery system in almost all affected countries. In one report

> Government and relief officials often failed to consult survivors and their communities about decisions regarding aid distribution, resettlement, and reconstruction aid. In some cases, these officials discredited or ignored the views and opinions of local communities. Donors and aid agencies often prioritised timely outcomes over deliberative processes that allowed for community participation and discussion (Human Rights Centre 2005).

Specific to India, another report that was the outcome of a high level meeting between the Government of India and international organisations like the UN, World Bank and the ADB noted

> a lack of understanding of the dynamics of social, cultural, economic inequalities and local conflicts of the affected coastal communities during post tsunami interventions…there was limited understanding of affected communities, their economy and livelihoods. This was reflected in inadequate representation of the affected

> communities…emphasis on visible damage and neglect of invisible ones (GoTN 2006)

Local government officials in many places failed to take into account the needs of the Dalits and Irulas, instead focusing on the more evident losses of the Meenavar community (Hedman 2005; Walls 2005). In some districts, non-dalit officials refused to register Dalits for emergency benefits and supplies, while those officials who were Dalits, refused to register their fellow caste members for fear of retribution from their higher caste superiors (Human Rights Centre 2005). Discrimination has been carried into the camps, with Dalits often being only unwillingly received in those camps which sheltered the Meenavar community (APWLD 2005). NGOs have reported meeting resistance from the Meenavars in their attempts to distribute relief materials to the lower castes. It took a Supreme Court hearing on Food Security in March 2005 for the government to sit up and take notice of the problems plaguing these communities (Walls 2005).

With regard to aid distribution, several NGO groups pointed out that much of the aid bypassed women in favour of men—relief materials were often distributed only to male heads of households, female headed households were ignored. Compensation and relief packages were often delivered directly to the male heads of households, increasing women's dependency and susceptibility to exploitation

Since women were not allowed to join the fisher associations, they were excluded from the 'affected persons' lists; official attitudes added insult to injury when many women were turned away from receiving monetary compensation for their losses. Government officials in many areas refused to pay pensions to young widows (defined as those under the age of 45) as well as those widows who had a son. Furthermore, single women were also denied relief funds as by being single, they 'had not lost much' (Davis 2007; Krishnakumar 2005).

HIV/AIDS Intervention in Relief Efforts

In the wake of the destruction caused to the health infrastructure of the state, the government had arranged for medical teams to provide immediate preventive and curative treatment in the camps (UN et al. 2005). Great emphasis was laid on the control of vector borne diseases, water quality monitoring, and the establishment of a post-disaster surveillance system to ensure that there would be no major outbreaks of diseases (Wilder-Smith 2005).

With regard to HIV/AIDS, the damage and needs assessment report that was prepared by the Joint Assessment Mission in the immediate aftermath of the Tsunami, noted that the high HIV prevalence rate in the tsunami affected areas made prioritising needs assessment of provision of HIV/AIDS prevention and care programmes 'crucial'—especially since the 'loss of livelihood and clustering of population in temporary shelters increases the likelihood of transmission of HIV/AIDS' (UN et al. 2005).

Despite this, not many relief workers looked upon HIV/AIDS intervention as a necessity. A 2006 high consultation report by the Government of Tamil Nadu noted

> Organisations involved in relief did not understand the Sexual and Reproductive Health needs of the community...The medical camps also did not give specific importance to these issues in the initial stages of relief (GoTN 2006).

A study of the evaluation reports indicates that HIV/AIDS interventions were only later additions to the recovery process with a lesson learnt that HIV/AIDS programmes 'should be incorporated in all health projects from day one of recovery efforts' (GoTN 2006)[4] and with 'access to and services for marginalised populations still problematic' and recommendations for the inclusion of

> HIV risk and vulnerability in needs assessments as part of overall sexual health assessment…; interventions to restore livelihoods, services and to reduce vulnerability and risk…; [IASC] Guidelines and Matrix used to inform and inspire local planning and response, as well as capacity development (GoTN 2006).

HIV/AIDS programming is seen as a developmental issue and therefore out of the purview of relief and emergency medical aid which takes a more utilitarian approach of providing generalised services that can be adapted to the needs of the greater number of people (Ryan 2002); relief concentrates on providing medical aid to the injured and dying, and the prevention of epidemics[5]. Despite the efforts made by international policies—which promote mainstreaming to reconcile this perception, the tsunami experience "highlighted the gap between what is desirable and what actually happens in a crisis" (Kapila et al 2005: 372).

With particular reference to the failure of relief workers to incorporate policy guidelines in their activities, a WHO report noted

> The immediate use of the MISP would have helped to meet the reproductive health needs of women, coordinate the various health actors, and ensure the availabilities of essential supplies and equipment…There were no comprehensive HIV vulnerability or risk needs assessments conducted in any of the affected countries. Despite having been launched in 2003, the IASC Guidelines had not been used actively or integrated into emergency preparedness work, and they were not considered in the countries affected by the Tsunami until after the event (Sahu et al. 2005:434).

An HIV/AIDS intervention could have easily been incorporated into the tsunami relief efforts. An application of some of the mainstreaming principles of HIV/AIDS interventions in disaster situations would have enabled HIV/AIDS programmes to be integrated within every sectoral response. By way of an example, People Living with HIV/AIDS (PLHA) are at greater risk of sickness and disease in an emergency because of limited access to adequate and clean food and water supplies than are people with functioning immune systems (IASC 2003); malnourishment thus is a serious

concern for PLHA as it directly affects their ability to maintain their health. In any disaster situation, Sphere guidelines state

> food aid should be targeted to meet the needs of the most vulnerable in the community, without discrimination on the basis of gender, disability, religious or ethnic background, etc…However, attempts to target vulnerable groups should not add to any stigma already experienced by these groups. This may be a particular issue in populations with large number of people living with HIV/AIDS (2004: 169).

The Sphere Project further states that the minimum standards as set out in the handbook are 'what people affected by disasters have a *right* to expect from humanitarian assistance' (Sphere 2004). However, despite the best intentions of policy makers to have these rights implemented in a disaster response, the right to health, especially reproductive health, was neglected in the tsunami relief efforts. Inherent structural problems in Tamil society cannot be held responsible for the failure of these principles. A deeper analysis needs to be made into the policy making and implementation process itself.

Policy agendas for issues of international concern (such as HIV/AIDS and humanitarian aid) are set and implemented by actors from across the spectrum, who while differing in the scope of power they wield, work for the same purpose and goal of providing humanitarian assistance, and more often than not, in close collaboration with each other. Phrases such as the 'Global Governance of AIDS' (Soderholm 1997) and 'Global Emergency Governance' (Takeda and Helms 2006) are employed to connote the governance process by which guidelines for action are developed in the international system. Since the guidelines cannot be enforced by law, participation by NGOs is encouraged by policy makers in the policy making process to determine the practical applicability of their designs.

Contests of Power at International Policy Level

NGOs do not participate in policy formulating processes as independent agencies, but through networks and structures which represent their collective concerns in international and national decision-making processes. These NGO consortia work alongside UN bodies 'in formulating system-wide responses to specific emergencies and in determining priorities and aim to support the work carried out in the field' (UN A/53/170). Many inter-governmental organisations have, in an effort to create closer relationships with NGOs, created institutional linkages to international NGOs in the form of NGO advisory boards and committees (Duffield 2001; Martens 2006). For example, the IASC which is the UN's 'primary mechanism for facilitating interagency decision-making in response to complex emergencies and natural disasters' (IASC 2003) invites, in addition to its standing members, three NGO consortia—the Steering Committee for

Humanitarian Response (SCHR); Interaction; and the International Council of Voluntary Agencies (ICVA)—to participate in its activities on a permanent basis.

The ability of NGOs to significantly influence policy is however, circumscribed by the extent of authority "granted" to them. Despite the attempts to integrate civil society actors within the institutional framework of governmental and inter-governmental decision-making, the idea of the policy decisions that emerge from such processes as evenly reflecting the inputs of all members, is illusionary. NGOs are given a 'consultative status', so that it is state representatives who dominate policy[6]. They lack the status of Inter-Governmental Organisations (IGOs) and the legislative authority that only governments possess, so appearing to merely legitimate the decisions made by more powerful participants (Fisher 1997; Fowler 1997; Lewis and Opaku-Mensah 2006).

Contests of Power within NGO Networks

Within the NGO coalitions which lobby to influence power-holders at the highest level, representation is ambiguous, with fears that Northern "Super" NGOs, because of their control over funding, are able to dominate NGO networks and push forward their own agenda, even when most policies are aimed towards efforts in the South (Fisher 1997). For example, the SCHR which is one of the most influential NGO networks at the UN—it played an instrumental role in drawing up the Sphere Project's Humanitarian Charter and Minimum Standards in Disaster Response—is made of an alliance of nine of the largest international NGOs (Martens 2006).

Establishing institutional links between Southern NGOs (SNGOs) and Northern NGOs (NNGOs) or International NGOs (INGOs) is seen as improving the legitimacy and effectiveness of all concerned but smaller NGOs run the risk of being co-opted into the network in their effort to secure the partnership—which brings with it credibility and increased funding opportunities (Foreman 1999). "Partnerships" in this sense, lose their meaning, as NGO networks become 'little more than a patron-client relationship, one of vertical rather than horizontal ties… [which] can undermine the potential for important horizon relationships' (Smillie 1995:193-194)[7]

In such unequal relationships then, local understanding and knowledge are often 'marginalised' (Hendrie 1997), to be applied only if they assist implementation. Smaller SNGOs that work within the community find it difficult to share their indigenous knowledge and understanding with their "superior" Northern partners who design policy practices with the intention of them being uniformly applicable as a blueprint in all emergency situations. But using these practices as "universalised formulae" is problematic because the logic with which they were articulated does not take into account the local context which impedes their proper application—they usually regard

affected populations as aggregate units with common characteristics and needs, rather than as different social sub-groups within the larger community (Hendrie 1997).

Tsunami relief aid was initially directed to those living by the sea, to those who had suffered the most losses in terms of human lives and property damage. Compensation was paid on the basis of the loss of lives and livelihood assets. The Meenaver by virtue of their proximity to the coastline had suffered the most material setbacks from the tsunami and therefore, they received the most attention. They were identified by aid workers at that time, as being the only community which was in dire need of assistance. The needs of the secondarily affected communities were initially ignored in the immediate response (GoTN 2006).

However, as Amick et al. point out, 'poverty is not measured by absolute level of deprivation but by people's comparative position' (1992:345). While being the most visibly affected group, the Meenaver were not the most marginalised coastal social group so that the impact of the tsunami on the marginalised would have been equal or greater in proportion to their pre-existing vulnerabilities. The Dalits who were mostly settled inland, worked as landless agricultural labourers and had comparatively, lost fewer valuables in absolute terms. Thus in terms of the above mentioned criteria, they were considered to have suffered little and were not seen as a priority (UN 2006).

INGOs have to realise that relief work does not occur in a political vacuum. Decision makers have to take into account the socio-political subtleties that shape the context in which a programme is going to be launched. The wrong kind of assistance to displace persons can worsen their situation, 'Inappropriate development…may not necessarily be better than none at all' (Gordenker and Weiss 1995:555). Indigenous agencies or those organisations which have already established their presence in the affected area are in the best position to conduct relief activities; external agencies should intervene with the intention to support local initiatives and responses. This is important because many relief organisations, being unfamiliar with local realities, concentrate on providing aid to the most visible of needs and groups but which may not be the neediest or most vulnerable (Anderson and Woodrow 1998; Gordenker and Weiss 1995; Hulme and Edwards 1997).

Contests for Funding

With increased donor funding, NGOs are known to be drawn away from protecting the interests of their constituencies and instead be drawn closer to donor interests. NGOs become "donor driven" in their policies because in the 'alms bazaar' (Smillie 1995) of NGO funding, securing aid becomes more of a 'hierarchical contest' (Epstein and Gang 2006) creating rivalries among local organisations. In their bid to secure funding, Northern values and understanding are accepted without protest, even when agencies

working at the ground level are aware of their deeper incompatibility. This is because aid is more likely to be distributed to the most efficient aid-seeker rather than the most deserving so that 'as NGOs get closer to donors they become more like donors' (Hulme and Edwards 1997:8).

Moreover, to ensure the 'proper' utilisation of funds by their partners, it is common practice to have donor members on the governing body of the NGO, to monitor and regulate financial and project planning. Such "tied funding" however can severely frustrate an organisation's efforts to meet the needs of the community—especially in terms of HIV/AIDS intervention, when a successful intervention may have to go beyond straightforward HIV/AIDS prevention programme, and address the deeper societal issues such as gender inequity.

Noting how earmarked tsunami donations did not always highlight the community's needs, the WHO in a special report observed

> Policy-makers must make it easier for operational managers to deliver the assistance to the affected population more successfully. This requires a certain degree of autonomy and flexibility that must be provided…for projects that require priority attention. "Tied funding" restricts such need-based deployments of aid in an efficient manner. (Procacci et al. 2005: 409)

HIV/AIDS, in marked contrast to emergency relief, remains heavily under-funded. For example, while Canada has been celebrated as being most generous in its tsunami relief efforts, its pledge to the Global Fund for AIDS is below than what is deemed adequate by the Equitible Contribution Framework (Christie et al 2007). There is a hesitancy to support HIV/AIDS programmes because of their controversial nature due to the moral judgement attached to the spread of the virus.

Similarly, reproductive health interventions with their provisions for emergency contraception and condom distribution are controversial for some relief organisations who see such provisions as encouraging "immoral" or "promiscuous" behavior—in 1996, the Vatican withheld its annual symbolic contribution to UNICEF for its involvement in the Refugee Reproductive Health Initiative (Cohen 1998; Girard and Waldman 2000).

Furthermore, funding is usually given for those relief projects which will have immediate, visible, concrete results. To regulate project development, funding policies may specify the projects for which funds may be employed. For example, while certain sectors, including food received prompt attention and have been overfunded, health requirements in the UN Flash Appeal received only half of the sum requested. Investing in HIV/AIDS intervention in tsunami relief, as opposed to investing in food programmes or the construction of houses, will take more time to have a substantial impact on the affected community. Aware of the hesitancy of donors to support long drawn out projects, relief organisations too tend to stay away from such sectors.

In fact, due to a growing trend since the early 1990s, of aid being directed more towards relief that development on account of the former's

greater visibility in terms of funding priorities—In 1991, the European commission provided three times more to NGOs for food, emergencies and refugees that it did for development—many organisations use disaster appeals or the 'pornography of disaster' (Smillie 1995:117) to establish donor relationships.

Contests of Power within the Beneficiary Population

There are certain inherent pitfalls that agencies need to look out for when implementing projects in actual practice. When organisations began to distribute relief material in the immediate post-tsunami period, officials relied on the list of tsunami affected persons which were prepared for them by the fishermen associations, based on the assumption that the lists would have included *all* members of the community who had been affected by the tsunami. But 'community' it should be remembered, can be used as a definition of both inclusion and exclusion, dependent on a person's compatibility to the defined local identity (Cleaver 1999). Since dalits and women are not allowed to join these associations, they were excluded from the lists and the associated benefits (Revathi et al. 2005 ; UNTRS 2006).

A lack of analysis of the socio-political power structures of the community at the situation assessment and project development phase will only lead to the "artificial definition of target groups along primarily technical or geographical lines whose members may not share a common perception of collective problems and possible solutions" (Stiefal and Wolfe 1994:231). The human rights violations that have been highlighted in different reports, should not be treated as isolated incidents but should be seen as symptomatic of 'deeper pathologies of power' (Farmer 2003) which determine inclusion, exclusion and subordination.

Organisations, before engaging with the targeted population, would do well to consider the different vulnerabilities that affect people and should mull upon the following questions—are community representatives really representative? How can vulnerable, discriminated groups be brought into the consultative process? And, if included, will they be accepted by the majority group as having valid claims? (Indra 1989; Procacci et al. 2005) Most pertinent of all, how can relief workers reconcile cultural sensibilities (healthcare providers, when introducing HIV prevention concepts have to take into consideration cultural sensitivities so as to avoid offending the moral and cultural values of participants) with the more disturbing aspects of cultural norms (caste discrimination in India, FGM in some African countries)?

The concept of 'culture' in the community development discourse is extremely problematic. In societies where rigid culturally prescribed norms prevent women from owning a voice of their own, it might prove difficult for them to raise their specific concerns and fears, especially when men are present (Indra 1989; Williamson 2004). Traditionally, in Tamil society, women are an under-privileged group—treated as "second-class citizens"

with little control over decision making—they are not allowed to assume leadership positions in the *panchayat*; and have little access to resources and benefits—they are ineligible to join the Fishworkers Society because of which they cannot receive off-season relief, subsidised loans, insurance coverage, or calamity compensation (Krishnakumar 2005). Referring to the harsh living conditions that these women face, a recent newspaper article cited an unpublished 2003 study by the Madras School of Social Work, about women in these coastal villages being ten times more prone to disease attacks than those living inland.

Structural inequalities threaten women's health and increase their vulnerability to HIV/AIDS. Basic supplies such as condoms and sanitary towels had not been provided in the tsunami relief kits. Both of these are essential components of relief kits. Furthermore, the heightened vulnerability of women who survived the tsunami is of special concern especially in the camps, where the security of women remains fragile. Despite the great emphasis laid on ensuring women's security and particular needs in camp designs and layout by the Sphere handbook, women still faced problems. Ten days after the disaster, UNFPA was already reporting incidences of sexual exploitation and rape (Lalasz 2005). In some camps, toilets and bathing facilities were constructed one kilometre away from the camp site; in others, separate facilities were not provided. At the temporary shelters set up in Karaikkal, T.R.Pattinam and Vadakattalai, women were obliged to bathe only at night (APWLD 2005). Reports of increasing alcoholism among men, who would frequently drink and play near the bathrooms (APWLD 2005; Human Rights Centre 2005), heightened threats to women's security.

The lack of sensitivity of women's needs and the absence of women in the general consultation process with NGOs and other governmental agencies at all levels of policy designing and programming in the post-tsunami phase, severely limited the effectiveness of the relief programmes. Recognising that women must be seen as 'valuable partners' and not 'vulnerable victims', a post-relief tsunami assessment report suggested that health interventions in a disaster situation must include the following programmes minimum service packages for reproductive health; maternal and child health services; and actions to prevent transmission of sexually transmitted diseases and the human immunodeficiency virus (HIV) (Kapila et al. 2005).

Socially excluded groups such as the Dalits and Irulas are similarly not expected to participate in village activities nor protest against the traditional discriminatory treatment meted out to them. To ensure that SCs/STs are able to access the special welfare benefits granted to them by law, members of these groups are issued with caste identity certificates. Without these vital documents they are unable to obtain certain types of aid, secure employment and obtain subsidised health care (Stover 2005). The loss of these identity cards in the Tsunami, prevented many from gaining access to government benefits and compensations. Unlike the more

politically active Dalit community, many Irulas until recently, did not possess these government-issued certificates of their ST status (UNTRS 2006). In Cuddalore, it took a special initiative by the district collector to re-issue these certificates. This issue becomes even more pressing when, because of discrimination, special camps had to be opened for Dalits and Irulas. The loss of identity cards would have prevented many from gaining access to these special relief camps.

If Dalits and Irulas could not even get adequate coverage of their more elementary needs (shelter, food etc), then what chances would they have for successfully expressing more 'sophisticated' needs of HIV prevention and care provisions? Furthermore, because of the stigma and discrimination attached to sexual health issues such as STIs (Sexually Transmitted Infections) and HIV/AIDS, even PLWHA may not have been willing to raise their specific concerns—especially their life-saving needs for ARV drugs to be included in medical relief measures—for fear of having their rights violated. The problem would have been compounded for the already stigmatised SC/STs who would run the risk of being outcast from their already peripheral position.

As an USAID report notes 'stigma has been found to be more challenging for groups that have a pre-existing stigma' (2004:5) so that for Dalits infected for the HIV virus, the issue would be one of double stigmatisation. Adding a gendered perspective would compound the problem of stigma further for dalit women as 'lower-caste women who test positive for HIV are likely to experience more stigma than lower-caste HIV-positive men' (USAID 2004:5).

In accordance to such traditional patterns of power, relief workers should be aware that those individuals who do end up participating in project activities may be members of the local elite (Laverack and Wallerstein 2001)—in the Tamil coastal communities, the Meenaver occupy this position. There is a marked tendency among elite groups to represent their interests as community needs; subordinate groups, out of a fear of retribution, often have no choice but comply, thus making 'communal needs' appear as a democratically agreed upon consensus. Moreover, the competition to secure relief material created tensions between community factions. Organisations such as Human Rights Watch noted that local leaders when expressing community needs, had a tendency to direct assistance towards members of their own caste, thereby excluding other groups from aid (Sharma 2005; Walls 2005).

Apart from the imposition of self interests and values as community interests and values; dominant groups take great pains to ensure that their power—and any related symbol of it—do not get displaced. The equal distribution of relief materials, would probably have been understood by many Meenaver as placing them on par with Dalits and Irulas. The acquisition of these new symbols of wealth and power, is often internalised as conscious attempts to compete with community elite, to challenge the traditional power structure (Platteau and Abraham 2002).

To counter these problems, aid agencies often leave it to the different groups to 'elect' their leaders in the hope that this will bring about a more equitable representation (Sphere 2004: 169). But without understanding that the issue isn't simply of participation but the extent of participation, subordinate groups are usually acquiesced into electing traditional leaders as representatives, thus bringing into focus the legitimacy of such representatives.

This failure to understand the subtle 'elite capture' of the communal decision making process is indicative of the double standards that organisations (both governmental and non-governmental) follow—pushing for an ideology of 'empowerment' and 'community participation' at the policy making table; and reverting to traditional practices of selective vertical interventions with the result being that projects remain technocratic in their approach.

The Importance of Mainstreaming HIV/AIDS Response in the Tsunami Response

To ensure their successful implementation, almost all the above mentioned policies and guidelines stress on mainstreaming HIV/AIDS prevention and care into existing relief programmes. Instead of the development of separate HIV projects in the camps, HIV/AIDS programmes should be built upon pre-existing programmes. The IASC guidelines state

> Effective implementation will rely on strong collaboration between international agencies, local authorities and local groups and NGOs who are instrumental in reaching vulnerable populations (2003:11)

Mainstreaming HIV/AIDS interventions in humanitarian responses would mean then, reconceptualising sectoral strategies so that HIV programming can be incorporated at all levels of policy making and analysis (Elsey and Kutengule 2002). Adapting such an approach to HIV/AIDS intervention implies the improvement of programming to include not just high-risk groups who have traditionally been the principal beneficiaries but the greater community as well; and also to ensure that HIV strategies are well integrated into existing communal structures so that they can be adjusted to adapt to altering communal values and situations. Humanitarian organisations in this context, must ensure that PLHA be included and actively benefit from their activities as well as adapting their activities to the local circumstances so that vulnerability is reduced. However, 'HIV/AIDS Mainstreaming' has often been reduced to policies that simply attach a HIV component into already existing projects; few sectoral approaches understand the less obvious complexities that link HIV/AIDS to a wider developmental programme.

Mainstreaming HIV/AIDS intervention activities into other relief efforts is just as important as it is to address social equity in HIV/AIDS intervention (and other relief) activities—the two are intertwined; because as several scholars have noted, improved healthcare does not guarantee

improvement in health status; there is a link between social marginality and ill-health (Evans et al 2001; Marmot 2005; Ruger 2004).

Material deprivation as well as social deprivation not only excludes people from accessing health services but because of their marginality[8] restricts them from participating in the processes of decision-making that affect their well-being (Fowler 1997). Constraints on their agency to act in their own best interests—due to poverty and/or their low position in the traditional social hierarchy—renders people living in chronically marginalised situations more susceptible to sickness than those people who are able to exercise some degree of control over their lives(Ecks and Sax 2005; Wallerstein 1993).

Thus, any enduring action that is undertaken to investigate the susceptibility of certain populations to sickness and disease will have to necessarily have to go beyond its focus on health and also redress the wider social and economic determinants of health. As Kottow points out.

> If susceptibility is a state of destitution, of actual harm being compounded with the predisposition to additional harm, it should become apparent that the most aggravating component of susceptibility is the inability to untangle the vicious circle of destitution (2003: 467**)**

Thus, to implement a HIV intervention which would be effective in the relief distribution phase, an environment conducive to such policy would have to be created both at local and supra-local levels. Existing laws and policy guidelines (both national and international) regarding equity and discrimination have to be stressed upon and efforts to ensure compliance by actors in the field to these policies, would have to be undertaken. At the immediate local level, HIV programming needs have to be institutionalised and made a core component of all aid and relief programme structures.

The challenge of mainstreaming HIV/AIDS into relief activities thus has to begin by the conscious inclusion of HIV/AIDS policies into an organisation's day-to-day practice. Mainstreaming is not concerned with completely changing an organisation's core functions and responsibilities, but with viewing them from a different perspective (Oxfam 2007). The UNAIDS Working Definition of Mainstreaming AIDS into development work is more illuminating Mainstreaming AIDS is a process that enables development actors to address the causes and effects of AIDS in an effective and sustained manner, both through their usual work and within their workplace (UNAIDS 2004).

The Practical Problems of Mainstreaming

In the immediate relief and reconstruction phase of a disaster, organisations working in the field have to achieve rapid and visible results in a short space of time. Aware of the constraints in the traditional social structure, most international organisations avoid political issues completely and focus mainly instead, on the technical implementation of a project.

These technocratic 'top-down' approaches continue to be effected without any real participation, so that "ownership is created through listening to an inaudible rendition of problems, and an illegible rendering of solutions" (Cornwall and Brock 2005: 13). In fact, as the World Bank reports, inadequate participation has been one of five major reasons why aid projects—including HIV prevention and care programmes—have been ineffective (Stiefal and Wolfe 1994).

As a result of not ensuring equitable inputs from all members of the community, projects such as those aimed at needs assessment lose their rationale from the very beginning and organisations generally revert back to beneficiary approach. The issue however isn't to just identify relief needs because 'relief efforts directed at "getting things back to normal" will do just that and no more' (Anderson and Woodrow 1998:2); those needs have to be met in a way that will contribute to long-term development.

In this respect, due to the failure to consult with marginalised groups and the non-inclusion of the more 'invisible' needs of the displaced groups, can the relief workers who were working on the field be equated with local power-holders who render participation—and through it, the mainstreaming of HIV activities into other relief measures—ineffective?

An answer could be found in the practice of aid organisations who—in an effort to demonstrate their compliance of the 'empowerment/participation' strategy— operate through 'development brokers' or institutional organisers (usually members of local community based or grass root organisations) who work alongside the community with the intention of ensuring equal involvement by all members in the project (Platteau and Abraham 2002).

Unfortunately, using such formal organisations over informal social structures to realise project goals, does not always guarantee equity or success. This is because traditional informal structures usually enjoy greater authority than formal organisations[9] and also because local developers are used merely to implement different stages of the project without being guided by its rationale. For example, the focus of relief workers in the immediate tsunami relief phase was so concentrated upon providing for the immediate medical needs of the people, that many donor agencies later expressed their frustration that there had been an 'excessive focus on curative health care' and not enough on 'public health interventions in peripheral areas' (Procacci et al. 2005).

Conceptual confusion over terms and definitions, and the political and social implications of their translation at the lower levels is one of the reasons why policies are not converted to practice. Traditional linear approaches to relief operations divide disaster recovery—as in the tsunami recovery strategy—into different phases of 'immediate relief', 'rehabilitation', and 'development' with different subsets of activities for each phase. However, as Brandt points out, while each phase is associated with its own specific strategies, the classification of activities into different phases is often arbitrary (Brandt 1997). Due to being a long term, hidden problem,

HIV/AIDS interventions in the context of emergencies seem a "luxury"; a secondary "add-on" to medical services, if it doesn't detract from 'essential' relief provisions especially when there are problems in accessing other more basic services (Williamson 2004). Mainstreaming HIV interventions (both short and long-term) into other relief activities that are in turn geared for sustainable development, is part of the effort to de-isolate emergencies from their socio-political, economic context. As Peter Piot (Executive Director of UNAIDS) puts it, 'AIDS demands that we do business differently; Not only do we need to do more and do it better, We must transform our personal and institutional responses'. (Peter Piot, cited in IASC 2003)

Conclusion

The tsunami relief process brought to light the disjunction between what is considered to be relief operations and what is considered to be development work; the two are seen as being diametrically opposite to each other in their methodology. As Buchanan–Smith (1990) points out, relief, driven by a sense of exigency, follows a top-down approach which is reliant on a narrow range of indicators. Development on the other hand, is based on a bottom-up, community participatory approach (cited in Williamson 2004). This proves to be extremely relevant when studying HIV/AIDS interventions in disaster settings such as the tsunami affected areas in Tamil Nadu, with its high HIV infection levels.

Many organisations that work in both disaster relief and development programming, often use different sets of principles and modes of thinking to govern their work. As a result, opportunities are lost to learn both from past experience on how to introduce projects into the community, as well as harnessing relief work to reinforce development activities, once resumed. The high flown language of policy serves merely as rhetoric so that on the ground, the traditional approaches to distributing relief continue. This paper has analysed the manner in which normative HIV/AIDS guidelines such as the MISP and the IASC guidelines for HIV intervention in emergency settings, are applied to disaster situations and in so doing has brought out the problems which afflicts the transformation of policy into practice.

The process by which international policies are deconstructed into local practice is not a straightforward, linear process. Multiple realities exist so that aid agencies have to contest power struggles at every level of the process. They have to contend with larger, stronger, more visible INGOs for political space at the policy making table; they also have to battle each other to secure project funding in an insecure donor environment. On the field, they have to ensure that power contests between different beneficiary groups do not sideline one group for the other.

The need for an HIV/AIDS intervention wasn't a very conspicuous one in the immediate relief phase. However, in light of the prevalent HIV/AIDS levels in the state and the existence of several ongoing

HIV/AIDS projects both by the government and other NGOs, a concentrated effort should have been made to mainstream HIV/AIDS into general relief measures.

The very lack of information and statistical data regarding HIV/AIDS in the immediate tsunami reports can be used to gauge the invisibility of the subject. Moreover, the absence of such records implies the inherent difficulty in uncovering such data for when living conditions are deemed precarious, HIV/AIDS appears to be just one more killer disease among others (Bourdier 1997:16). Furthermore, raising HIV concerns is problematic even in ordinary circumstances, in a society where a lot of stigma is attached to the subject. In a emergency situation, discretion and delicacy would have been needed in eliciting the HIV needs of people, especially of PLHA who fear that public knowledge of their seropositive status might render them social outcast, worse still, be excommunicated from their caste. This problem is magnified for Dalits and Irulas who on account of their caste, already are stigmatised. From a gender perspective, women who were from the SC/ST community then, would find it near impossible to express their needs.

As the tsunami recovery process has moved from relief and reconstruction to rehabilitation and development, HIV/AIDS is increasingly becoming an issue of concern. A successful HIV/AIDS intervention depends on the groundwork already laid and had such an intervention been made at the juncture prescribed by the guidelines, it would have contributed in its turn, to the success of the already existent programmes in the state. However, the vacuum created by the inability of relief actors to link HIV/AIDS to developmental and simultaneously, relief programmes has meant that previous efforts have been washed away by the tsunami and its consequent relief efforts; so that organisations that were working in this area will have to pick up the pieces and start afresh.

Notes

[1] Article 12 (1) of the ICESCR

[2] Article 12 (2**)** states: The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: […]

(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness

[3] The IASC Matrix offers guidance on how to manage a minimum HIV/AIDS response according to specific phases of the emergency: emergency preparedness, minimum response and comprehensive response.

[4] See also UN 2005; UN 2006

[5] See for example, Connolly et al. 2004; Toole and Waldman 1997; Wilder-Smith 2005

[6] Article 18 of the ECOSOC Resolution 1996/31 draws a clear distinction between participation and consultation. This distinction 'is fundamental and the arrangements for consultation should not be such as to accord to non-governmental organizations the same rights of participation as are accorded to States not members of the Council and to the specialized agencies brought into relationship with the United Nations'

[7] See also Katz 2006

[8] Marginality implies a clear set of power relations between different groups. It is a relational concept—persons can be made marginal spatially or socially only in relation to those who remain at the 'centre' (Ecks and Sax 2005)

[9] This was exemplified in Tamil Nadu where the traditional caste based authority structures (for example the fishermen's associations) were able to sideline the democratically elected *panchayats* from controlling aid distribution

Bibliography

Amick, Levine, Tarbo, and Walsh (1995) *Society and Health*, Oxford: Oxford University Press

Anderson, M. and Woodrow, P (1998) *Rising from the Ashes: Development Strategies in Times of Disasters*, London : IT Publications, 1998

Asia Pacific Forum on Women, Law and Development (2005) *Why are Women More Vulnerable During Disasters? Violations of Women's Human Rights in the Tsunami Aftermath*, APWLD. Available from http://www.apwld.org/pdf/tsunami_report_Oct2005.pdf

Asian Development Bank United Nations and World Bank (2005) *India Post Tsunami Recovery Program Preliminary Damage and Needs Assessment*, Joint Assessment Mission

Bhargava, P.K. (2005) "Poverty Linked HIV/AIDS as Determinants of Mortality: Evidence from a Community Based Study in Karnataka, India", Paper delivered at the *CICRED Seminar on Mortality as Both a Determinant and a Consequence of Poverty and Hunger*, Thiruvananthapuram, India, February 23-25, 2005

Bourdier, F. (1997) *Of Research and Action: Contribution of Non Governmental Organizations and Social Scientists in the Fight against the HIV/AIDS Epidemic in India*, Pondicherry, French Institute of Pondicherry

Brandt, D (1997) '*Relief as Development, but Development as Relief?*', World Vision International. Available from http://www.jha.ac/articles/a024.htm

Carballo, M., Hernandez, K.S. and Welle, E.(2005) '*Impact of the Tsunami on Reproductive Health*', Journal of The Royal Society of Medicine, 98 (9), 400-403

Christie, T., Asrat, G., Jiwani, B., Maddix, T. and Montaner, J. (2007) '*Exploring Disparities Between Global HIV/AIDS Funding and Recent Tsunami Relief Efforts: An Ethical Analysis*', Developing World Bioethics 7(1), 1–7

Cohen, S.A. (1998) '*The Reproductive Health Needs Of Refugees: Emerging Consensus Attracts Predictable Controversy*', Guttmacher Rep Public Policy, 1(5), 10-12

Cornwall, A. and Brock, K (2005) '*Beyond Buzzwords: "Poverty Reduction", "Participation" and "Empowerment" in Development Policy*', Overarching Concerns Programme Paper Number 10 United Nations Research Institute for Social Development

Davis, K. (2007) '*Gender Perspective in Disaster Preparedness*', Sangamam 15, 4-6 Tamil Nadu Tsunami Resource Centre

Duffield, M. (2001) *Global Governance and the New Wars*, London, Zed Books

Ecks, S. and Sax, W. (2005) *'New Perspectives on Health in South Asia'*, Anthropology and Medicine 12(3), 199–210
Elsey, H., Tolhurst R.and S. Theobald (2005) *'Mainstreaming HIV/AIDS in Development Sectors: Have We Learnt the Lessons from Gender Mainstreaming?'*, AIDS Care, 17(8), 988 – 998
Epstein, G. and Gang, I. (2006) *'Contests, NGOs, and Decentralizing Aid'*, Review of Development Economics, 10(2), 285–296
Evans, Whitehead, and Diderichsen (2001) *Challenging Inequities in Health: From Ethics to Action*, Oxford, Oxford University Press
Farmer, P. (2003) *Pathologies of Power: Health, Human Rights, and the New War on the Poor* , London : University of California Press
Fisher, W. F. (1997) *'Doing Good? The Politics and Antipolitics of NGO Practices'*, Annual Review of Anthropology 26, 439-464
Foreman, K. (1999) *'Evolving Global Structures and the Challenges Facing International Relief and Development Organizations'*, Nonprofit and Voluntary Sector Quarterly 28, 178-197
Fowler, A (1997) *Striking a Balance: A Guide to Enhancing the Effectiveness of Non-Governmental Organisations in International Development*, London, Earthscan Publications Ltd
Girard, F. and Waldman, W. (2000) '*Ensuring the Reproductive Rights of Refugees and Internally Displaced Persons: Legal and Policy Issues',* International Family Planning Perspectives, 26(4), *67-173*
Gordenker, L and Weiss, T (1995), *'NGO Participation in the International Policy Process'*, Third World Quarterly, 16 (3), 543 – 556
Government of India (2005) *Tsunami—A Report to the People*, New Delhi, GOI
Government of Tamil Nadu (2005) *Tsunami: Impact and Damage*, Chennai
Government of Tamil Nadu (2006) *Taking Stock of Tsunami Recovery in Tamil Nadu, India--Report on a High Level Consultation in all sectors of Tsunami Recovery*, Chennai
Hedman, E.L (2005) *'The Politics of the Tsunami Response'*, Forced Migration Review, Special Issue, 4-6
Hendrie, B. (1997) *'Knowledge and Power: A Critique of an International Relief Operation'*, Disasters 21 (1), 57–76
Hulme, D and Edwards, M. (1997) *NGOs, States and Donors: too close for comfort?*, [Basingstoke] : Macmillan Press
Human Rights Center (2005) *After The Tsunami--Human Rights of Vulnerable Populations*, Honolulu, Human Rights Center, Berkeley
Indra, D. (1989) '*Ethnic Human Rights and Feminist Theory: Gender Implications for Refugee Studies and Practice*', Journal of Refugee Studies 2(2), 221-242
Inter-Agency Standing Committee (2003) *Guidelines for HIV/AIDS Interventions in Emergency Settings*, IASC
Kapila, M., McGarry, N., Emerson, E., Fink, S., Doran, R., Rejto, K. and Profili, M (2005)--*Health Aspects of the Tsunami Disaster in Asia,* Prehospital and Disaster Medicine 20(6), 368-378
Katz, H. (2006) '*Gramsci, Hegemony, and Global Civil Society Networks'*, Voluntas 17, 333–348
Kottow, M.H. (2003*) 'The Vulnerable and the Susceptible'*, Bioethics 17, 5-6
Krishnakumar, A. (2005) In *Chennai, Women's Vulnerability Exposed by Tsunami*, Chennai, Population Reference Bureau
Kumar, P (2005) 'India Blasted over tsunami Aid', *The Australian*, January 11

Lalasz, R (2005) *The Indian Ocean Tsunami: Special Challenges for Women Survivors*, Population Reference Bureau. Available from http://www.prb.org/Articles/2005/TheIndianOceanTsunamiSpecialChallengesforWomenSurvivors.aspx?p=1

Laverack, G. and Wallerstein, N. (2001) *'Measuring community mpowerment: a fresh look at organizational domains',* Health Promotion International 16(2), 179-185

Lewis, D. and Opoku-Mensah, P (2006) '*Moving Forward Research Agendas on International NGOs: Theory, Agency and Context*', Journal of International Development 18, 665–675

Marcussen, H. and Bergendorff, S. (2003) *'The Mythology of Aid: Catchwords, Empty Phrases and Tautological Reasoning'*, Forum for Development Studies, 2 (3), 302 – 324.

Marmot M. (2005) '*Social determinants of health inequalities*', Lancet 365: 1099–1104

Martens, K. (2006) '*NGOs in the United Nations System: Evaluating Theoretical Approaches'*, Journal of International Development 18, 691-700

National AIDS Control Organisation (2004) Observed *HIV Prevalence levels State wise: 1998 – 2004*. Available from http://www.nacoonline.org/facts_statewise.htm

National AIDS Control Organisation (2006) *Overview*(online). Available from http://www.nacoonline.org/about.htm

O'Connor, C. and Holman, R. (2005) '*AIDS Care Dealt Major Blow in tsunami hit Regions'*, Positive Nation, 109. Available from http://www.positivenation.co.uk/issue109/regulars/worldnews/wnews109.htm

Oxfam (2007) *Humanitarian Programmes and HIV and AIDS*, Oxfam

Padma, T.V (2005) 'Tsunami Aid Spending Draws Fire over Public Health', Nature Medicine 11, 237

Platteau, J.P and Abraham, A. (2002) *'Participatory Development in the Presence of Endogenous Community Imperfections'*, Journal of Development Studies, 39(2), 104 – 136

Procacci, P.; Mookerjee, A; German, T.; O'Dwyer, M.; Eppel, G. (2005) *WHO Panel 2.4: Funding Policies and Practices,* in Prehospital and Disaster Medicine 20 (6), 408-412

Revathi, Niruj, Deepu and Clifton (2005) *Relief and Rehabilitation of Tsunami-Affected Persons in Tamil Nadu and Pondicherry*, Tsunami Recovery Network. Available from http://www.reliefweb.int/library/documents/2005/trn-tsunami-24Jun.pdf

Ruger, J.P. (2004) 'Ethics of the Social Determinants of Health', The Lancet, 364(9439), 1092-1097

Ryan, J.M. (2002) Conflict and Catastrophe Medicine—a Practical Guide, London : Springer.

Sahu, S.; Musani, A.; Schaller, J.; Pairojukl, S.; Senanayake, M; Brenny,P.; Rosati,M.; Dekkak, H. (2005) *WHO Panel 2.10: Reproductive, Mental, and Child Health,* Prehospital and Disaster Medicine 20 (6), 432-436

Sharma, A. (2005) 'The Politics of Aid –Post-Tsunami Reconstruction and Conflicts in India', 19-23 in John, M. and Illerhues, J. (ed) *A New Dynamic For Peace? Post Tsunami Reconstruction and its Impact on Conflict Resolution*, Friedrich-Ebert-Stiftung

Smillie, I. (1995) *The alms bazaar : Altruism Under Fire - Non-Profit Organizations and International Development*, London, Intermediate Technology Publications

Söderholm, P. (1997) *Global governance of AIDS: Partnerships with Civil Society*, Lund, Lund University Press

Sphere Project (2004) *Humanitarian Charter and Minimum Standards in Disaster Response.* Available from http://www.sphereproject.org

Stiefal, M. and Wolfe, M (1994) *A Voice for the Excluded-- Popular Participation in Development: Utopia or Necessity?* London : Zed Books in association with the United Nations Research Institute for Social Development (UNRISD)
Stover, E. (2005) *After the Tsunami --'Protecting the Human Rights of Vulnerable Populations'*, International and Area Studies 2(1)
Takeda, M. and Helms, M. (2006) "Bureaucracy, meet Catastrophe": Analysis of the Tsunami Disaster Relief Efforts and their Implications for Global Emergency Governance, The International Journal of Public Sector Management 19 (2) 204-218
Toole M, Waldman RJ (1997) *"Public Health Aspects of Complex Emergencies and Refugee Situations',* American Review of Pub Health 18, 283-312
UNAIDS (2004) Support to Mainstreaming AIDS in Development: Secretariat Strategy Note and Action Framework 2004-2005
United Nations (1998) *Report of the Secretary-General--Arrangements and Practices for the Interaction of Non-Governmental Organizations in all Activities of the United Nations System*, A/53/170
United Nations Team for Tsunami Recovery Support (2005) *Tsunami One Year After—A Joint UN Report*, United Nations
United Nations Team for Tsunami Recovery Support (2006) *Building Back Better: How the Tsunami changed the lives of Irula communities in Cuddalore District*, Tamil Nadu, United Nations
United Nations Team for Tsunami Recovery Support (2006) *Quaterly Report—Tsunami Recovery, A Joint UN Report*, India
United Nations, the World Bank and the Asian Development Bank (2006) *Tsunami—India – Two Years After,* United Nations
USAID (2004) *Big Issues In Brief Scaling up responses to HIV/AIDS--Stigma and HIV/AIDS*—A Pervasive Issue, USAID
Wallerstein, N. (1993) *'Empowerment and health: The theory and Practice of Community Change'*, Community Development Journal, 28 (3), 218-27
Walls, M (2005) *Review of Tsunami Recovery*, London, Tsunami Recovery Network
Wilder-Smith, A. (2005) *'Tsunami in South Asia: What is the Risk of Post-Disaster Infectious Disease Outbreaks?'*, Annals Academy of Medicine 34(10), 625-631
Williamson, K. (2004) *'AIDS, Gender and the Refugee Protection Framework'*, RSC Working Paper No. 19, Refugee Studies Centre, University of Oxford

Acronyms

ADB	Asian Development Bank
APWLD	Asia Pacific Forum on Women, Law and Development
AIDS	Acquired Immune Deficiency Syndrome
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
ECOSOC	Economic and Social Council
GoI	Government of India
GoTN	Government of Tamil Nadu
HIV	Human Immunodeficiency Virus
HRC	Human Rights Centre
IASC	Inter-Agency Standing Committee
ICESCR	International Covenant on Economic, Social and Cultural Rights

ICVA	International Council of Voluntary Agencies
IDP	Internally Displaced Person
IDU	Injecting Drug User
INGO	International Non-Governmental Organisation
JAM	Joint Assessment Mission
MISP	Minimum Initial Service Package
NACO	National AIDS Control Organisation
NGO	Non-Governmental Organisation
NNGO	Northern Non-Governmental Organisation
PLHA	People Living with HIV/AIDS
SC	Scheduled Caste
SCHR	Steering Committee for Humanitarian Response
SNGO	Southern Non-Governmental Organisation
ST	Scheduled Tribe
TNSACS	Tamil Nadu State AIDS Control Society
UN	United Nations
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNTRS	United Nations Team for Tsunami Recovery Support
WHO	World Health Organisation