



World Health Organization

HEALTH AS A POTENTIAL CONTRIBUTION TO PEACE

'Realities from the field: what has WHO learned in the 1990s'

“The role of physicians and other health workers in the preservation and promotion of peace is the most significant factor for the attainment of health for all” (World Health Assembly, Resolution 34.38, 1981)

Health initiatives may effectively reduce the levels of morbidity and mortality in the midst of wars and promote conflict prevention and a post-war reconciliation process, when a public health strategy combines with unhindered access to population in need.

Health initiatives may have a positive impact on peacebuilding, when they are based on wide perspective and strategic planning. This implies taking into consideration both short-term and medium/long-term concerns, addressing both basic needs and human rights, involving local capacities for change, and promoting international partnerships and networking.

On the contrary, when these conditions are not met and only short-term considerations are present, health initiatives have virtually no impact on peacebuilding. On some occasions, these initiatives may indirectly contribute to war economy.

1. HEALTH AS A BRIDGE FOR PEACE (HBP)

INTEGRATING PEACE-BUILDING STRATEGIES INTO HEALTH RELIEF AND HEALTH SECTOR DEVELOPMENT

As a WHO program, HBP was formally accepted by the 51st World Health Assembly in May 1998 as a feature of the 'Health for All in the 21st Century' Strategy. HBP, which term was coined by the Pan American Health Organization (PAHO) in the 1980s, is a multidimensional and dynamic concept aimed at providing a policy and planning framework to strengthen the returns of health sector investments in areas affected by conflict or undergoing a post-conflict transition. These returns cover a vast array of objectives going from the reduction of social violence to actual peacemaking. HBP integrates the delivery of health care with conflict management, social reconstruction, and sustainable community reconciliation.

DEVELOPING CONCEPTS AND STRATEGIES

After a consultative meeting held in Annecy in October 1997, EHA integrated in its plan of work the reflection on the relations between violence, conflict instability and public health, and mainstreamed HBP in its global strategies for disaster reduction and humanitarian action.

LEARNING LESSONS FROM THE FIELD EXPERIENCE

The HBP concept is supported by lessons from the field. In the last 10 years, WHO has carried out several field experiences, taking into consideration that each scenario poses different challenges and there cannot be simplistic recipes.

IMPROVING SKILLS OF HEALTH PERSONNEL

Field health personnel in conflict-prone or affected countries need new knowledge, attitudes and practice, as essential components of public health good practice, in order to seek out opportunities for peacebuilding. An *Active Learning Package* (background information on Human Rights and International Humanitarian Law, tools for conflict analysis and conflict resolution and negotiation) has

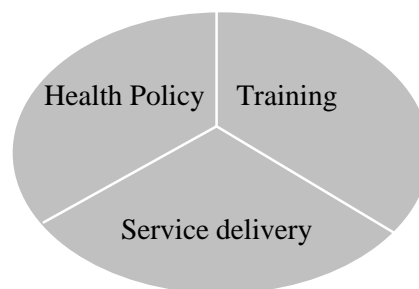
been tested in pilot settings – *Sri Lanka* and *Indonesia* – by WHO. At present, it is going through a process of revision.

NETWORKING AND ADVOCACY

Several partners such as organizations, institutions, and individuals of various backgrounds are involved in WHO/HBP initiatives, including networking and advocacy.

2. REVIEW OF PRACTICE

In general terms, going through WHO case studies (Angola, Mozambique, BiH, Croatia, FYR Macedonia, Sri Lanka, Indonesia, etc.) the essence of the experience can be summarized by the work done in a “technical space” where health personnel from different sides has been producing a joint effort in policy, training and service delivery initiatives.



HAITI (1991-1994)

Main partnership: local Government, local NGOs

Main outcome: the Health/Humanitarian Assistance Program (HAP), planned and implemented with the involvement of Haitian professionals of different backgrounds, contributed to the development and stabilization of the health sector. The HAP was based on a decentralized approach in which large role was given to locals.

ANGOLA (1994-1997)

Main partnership: United Nations Department of Humanitarian Affairs, local Government

Main outcomes:

- Humanitarian assistance during the demobilization process linked to the UN peacebuilding operation by the Lusaka peace protocol, and with mandate to WHO as health sector leading agency.
- Promotion of dialogue between health professionals of the two health systems with the adoption of national guidelines/protocols on priority health issues (sleeping sickness, malaria, TB); common simplified health information system (early warning system) and planning of in-service training and training modules.
- Joint revision of the criteria for assessment of disability of the soldiers of the two armies (5,000 from FAA and 11,000 from UNITA) and classification of UNITA soldiers by a joint commission.
- Incorporation of 1,513 demobilized military health personnel of UNITA into the National Health System.
- Definition of the tools and first implementation of the integration into the National Health System of the civilian health personnel working in the UNITA controlled areas.

MOZAMBIQUE (1989-95)

Partnership: local Government, Swiss Development Cooperation

Main outcomes:

- Definition of the post-war reconstruction strategy in advance to the peace agreement as a reference framework for the rehabilitation of the health system, giving the Minister of Health a high profile vis-à-vis the donors, and contributing to rapid and substantial improvements in accessibility and equity of health services.

- Survey carried out on RENAMO health personnel used to implement a comprehensive program to re-train RENAMO health workers and to re-integrate them within the National Health System, thus defusing political tensions and showing the Minister of Health willingness to proceed on the reconciliation path.
- Demobilization program that, through international NGOs, contributed to increase the accessibility to the basic health care for soldiers and their families resident in inaccessible areas.

CROATIA (Eastern Slavonia) (1996-1997)

Main partnership: United Nations Transitional Administration in Eastern Slavonia (UNTAES), Croatian Government, Serb leaders, local NGOs

Main outcomes:

- Facilitation of negotiations between the Croatian Ministry of Health and the Eastern Slavonia Serb leaders on public health issues through the Joint Implementation Committee for the health sector.
- Facilitation of cross-community contacts, through joint health workshops and seminars.
- Reintegration of health workers of minority groups into the Croatian health system.
- Health insurance and access to services for minorities.
- Joint working groups on technical issues such as health information, epidemiology, mental health, physical rehabilitation, health system administration and pharmaceuticals.
- Elaboration of a joint Health Information System.

BOSNIA AND HERZEGOVINA (1997-1998)

Main partnership: World Bank, DFID, local Government, local NGOs

Main outcomes:

- Elaboration of strategic plans for the health system reform, through joint meetings between the two Ministries of Health.
- Joint statement of Ministers of Health to the international community being the first public sector to adopt an inter-entity work plan.
- Regular contacts between health professionals of all communities, through the promotion of multiple cross-community technical conferences, workshops and seminars.
- Common policy and planning processes in various sub-sectors of the health system (e.g., Public Health, Pharmaceuticals).
- Formation of inter-entity associations (e.g., Inter-entity Physicians' Association).
- Countrywide health journals, public health networks and campaigns.
- Inter-entity advanced epidemiology workshops.
- HBP program broke the existing trend of operating separate health programs in each politically controlled area, thus enabling many NGOs to implement inter-ethnic programs.

CAUCASUS/RUSSIA (1998)

Main partnership: Italian Government, Rockefeller family, Organization for Security and Cooperation in Europe, international and local NGOs

Main outcome: Pool of health professionals (coming from Chechnya, Dagestan, Ingushetia, Ossetia, etc.) prepared to operate in conflict or conflict-prone areas, through HBP trainings in Pyatigorsk, Russia.

FYR MACEDONIA AND BOSNIA AND HERZEGOVINA (1997-2001)

Main partnership: Decentralized cooperation entities (European and local municipalities), Ministries of Health and Social Affairs, NGOs and people associations

Main outcomes:

- Confidence-building through:
 1. Exchange activities promoting international links among professionals of different groups;
 2. Meetings between different ethnic groups on specific objectives (training, planning, visits to health services and free time spent together during twinning activities).
- Support to local NGOs, social cooperatives and citizens' associations strengthening civil society.
- Promotion of programs against the exclusion and discrimination of vulnerable groups increasing the acceptance of differences in sex, age, physical appearances, nationality, culture etc.

- Promotion of principles as equity, human rights, integration of vulnerable groups through different instruments such as magazines, books, cinema, theatre, and music.

SRI LANKA (1999-2000)

Main partnership: International Training Program for Conflict Management of *Scuola Sant'Anna di Pisa*

Main outcome: Piloting the Active Learning Package through HBP Training Workshops, both at national and regional level, in Colombo and Anuradhapura.

INDONESIA (2000-2001)

Main partnership: New Zealand Government, DFID, local Government, Universities

Main outcome: Pool of health professionals prepared to operate in conflict or conflict-prone areas, through HBP training in Yogyakarta and Ambon/Molukus. In particular, 28 of them, Muslim and Christian, improved their skills to operate in the 'religious' conflict in Molukus islands.

HUMANITARIAN CEASE-FIRES (1985-2001)

In different forms (Humanitarian Cease-fires, Days of Tranquility and Safe/Peace Corridors) temporary pauses in fighting have been often arranged in order to carry out important immunization campaigns (e.g. Global Polio Eradication Initiative) in the midst of wars in 19 countries since 1985 (Afghanistan, Angola, Bosnia, Chechnya/Russia, Democratic Republic of the Congo, El Salvador, Guinea-Bissau, Indonesia, Iraq, Lebanon, Mozambique, Philippines, Dominican Republic, Sierra Leone, Somalia, Sri Lanka, Sudan, Tajikistan, and Uganda). These initiatives, considered as a particular form of HBP, were possible through a series of partnerships amongst both international and national/local entities.

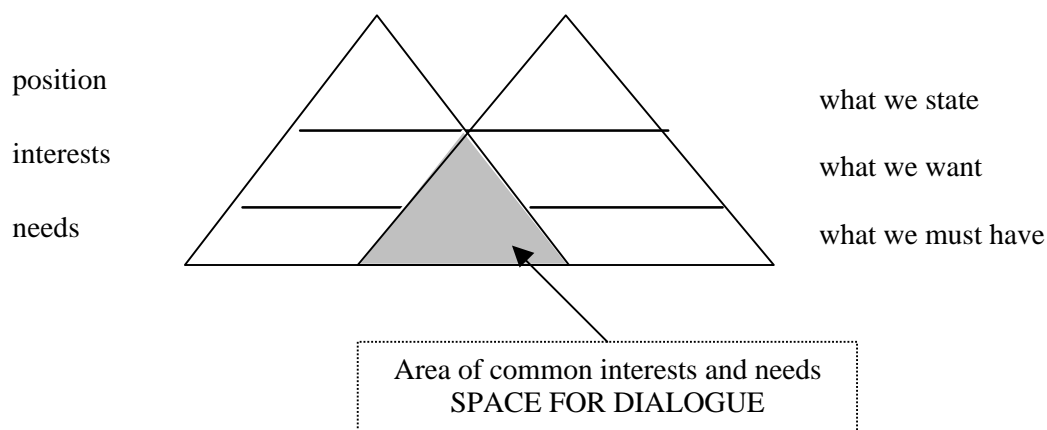
4. MECHANISMS OF THE NEGOTIATION PROCESS

People often negotiate by taking up a negotiating position. They then try to persuade the other person to agree with them or move towards their position. This often encourages power struggles and does not resolve the conflict.

To reduce the impact of power struggles, mediators can offer alternatives to positional negotiation. When we look below the surface we discover the interest, which their positions represent; the needs, which motivate their interests.

When we start digging beneath the surface for interests and needs, we often discover, as the diagram above indicates, that there are some needs and interests which are common to both parties.

Interests are what people want and what gives them pleasure. Interests are always potentially negotiable. Needs tend to be things that are crucial to the person and if they do not have them, it causes them pain. Needs are, by definition, not negotiable.



5. LESSONS LEARNT

- When there is an underlying genuine thrust towards peace and reconciliation, Health can play a role as catalyst in the peace process.
- Health and humanitarian assistance can be explicitly linked to peacebuilding processes.
- Neutrality and impartiality cannot represent a deviation from the principle that health assistance should be delivered proportionally to the needs.
- An effective contribution to the sustainability of peace can be ensured by addressing the root causes of conflict.
- Humanitarian assistance cannot ignore the situation of human rights.
- Development and emergency assistance must not be separated.
- Lack of comprehensive and locally-owned strategy can generate inconsistent, short-lived and even counterproductive outcomes.
- It is essential to shift from vertical to horizontal technical programming in order to involve people in reconciliation process.
- Different Partnerships - public/non-profit, central/peripheral, and international/national - are crucial elements for effective peacebuilding.
- Coordination facilitates a common understanding of respective roles/responsibilities.
- Complex emergencies call for new expertise from humanitarian workers.
- Decentralized cooperation/twinning/social partnerships among local communities is a tool to promote human development and peace.
- Training activities can involve professionals from different conflict groups.

APPLY A WIDER PUBLIC HEALTH VISION

In emergency as well as in development, WHO bases its activities on evidence and guidelines against unhealthy behaviors. Discouraging use of smoking and alcohol, maintaining basic hygiene, ensuring water and food safety; promoting healthy eating; physical activity and the use of public transportation are some of the commitment of WHO towards promoting healthy behaviors and discouraging unhealthy ones.

However, how to consider behaviors that encourage social polarization and practices of discrimination, racism and violence? Such behaviors are spreading, as witnessed by increasing episodes of xenophobia in several countries. Applying a wider vision of public health implies starting from the undeniable evidence that these behaviors provided the social and cultural basis of several wars and complex emergencies, being that war is often the major cause of mortality and morbidity in several countries. Working in similar contexts implies a confrontation with these issues, and WHO has the responsibility to assist public health workers in finding appropriate strategies and programs to tackle them.

6. RECOMMENDATIONS

Before the conflict flares	- develop health programs promoting the democratic stability, peace-building and conflict prevention.
During open conflict	- health initiatives can continue to identify the scope for supporting development processes.
In fragile transitional phase	- health sector can promote a concerted effort to help overcome the enduring trauma, encourage reconciliation, and help prevent renewed outbreaks of violent conflict.
After the conflict	- health sector has opportunities for reforms to change past systems and structures, which may have contributed to economic and social inequities and conflict.

MORE SPECIFICALLY:

- Elaborate strategic planning based on a broad political understanding of the conflict (addressing its root causes), a wide public health approach, a comprehensive perspective of victims and political actors, and a full consideration of Human Rights issues.
- Involve local capacities for change.

- Create partnerships, with a strong presence of local civil society organizations.
- Promote coherence of objectives and strategies and coordination.
- Prevent side effects of humanitarian programs, which can foster dependency of beneficiaries on external aid.
- Develop training for lead staff in war-prone regions.
- Affirm the primacy of field experience (bottom-up, instead of top-down approach) in the definition, (re)adjustment and evaluation of HBP strategies.

7. CONCLUSION

Nevertheless, the most effective way to promote a sustainable long-term peace is to be committed to social justice. For WHO as well as for other health institutions, the natural and most consistent way of such a commitment is to advocate for equity. Nothing new. But beside the rhetoric declarations – what is needed is real. Effective influence on the health policy of the reform processes that many countries in the world are undertaking.