

# Working Material

## 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"*

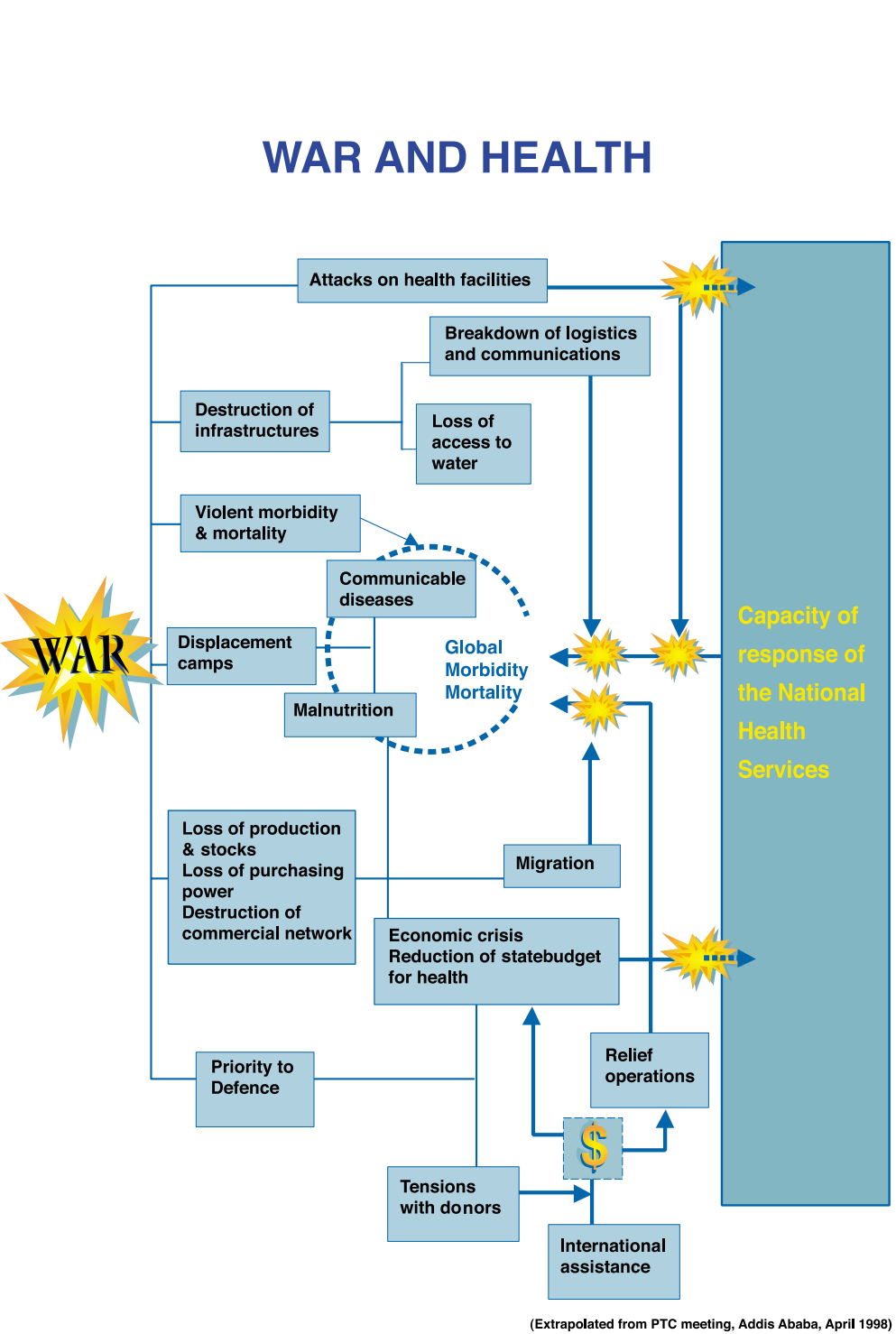
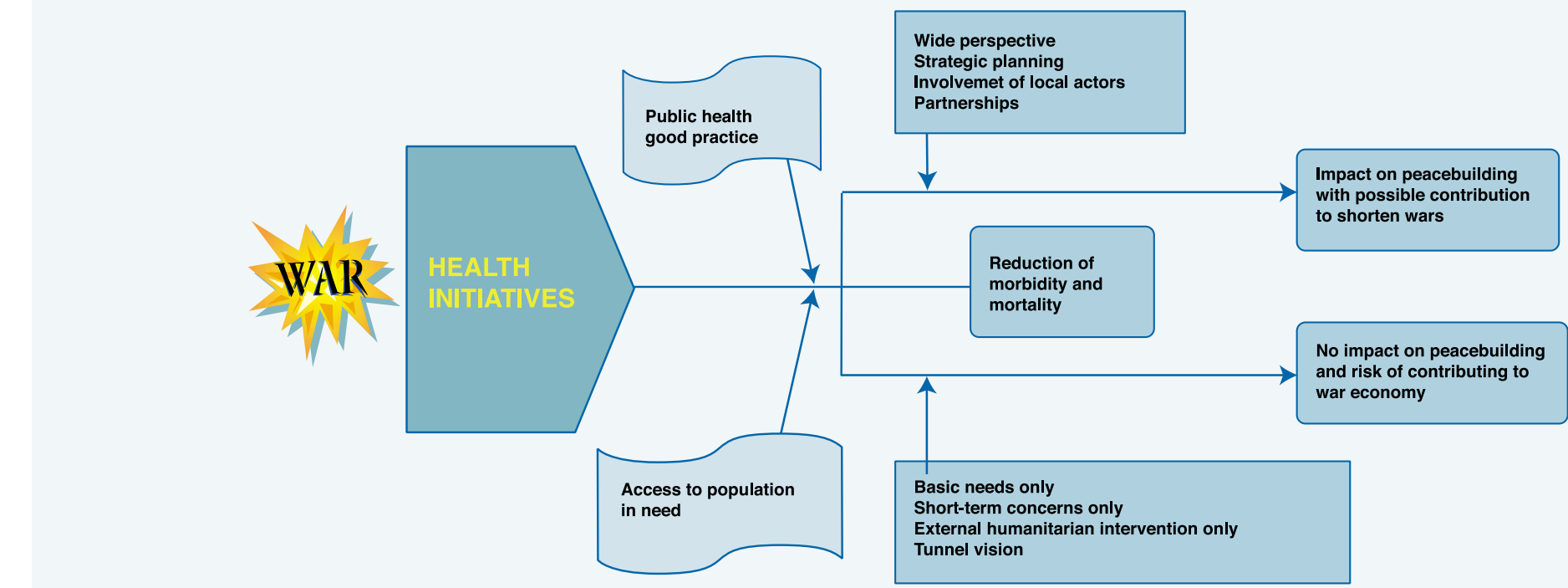
(World Health Assembly, Resolution 34.38, 1981)

#### HEALTH INITIATIVES' OUTCOMES IN WARS

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.



#### THE POLITICAL SPECTRUM OF HUMANITARIAN WORKERS VIS-À-VIS TRADITIONAL PRINCIPLES

PRINCIPLES	ENGAGEMENT WITH POLITICAL AUTHORITIES	NEUTRALITY	IMPARTIALITY	CONSENT
ENGAGEMENT WITH POLITICAL AUTHORITIES	Avoid public confrontation	Advocate controversial public policy		
NEUTRALITY	Avoid taking sides	Take the side of selected victims		
IMPARTIALITY	Deliver aid using proportionality and non-discrimination	Skew the balance of resource mobilization according to real needs		
CONSENT	Pursue a <i>condicio sine qua non</i>	Override sovereignty as necessary		

- #### LESSONS LEARNT
- When there is an underlying genuine commitment towards peace and reconciliation, Health can play a role as catalyst in the peace process.
  - 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 and health sector 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 as well as other activities focussing on common needs and interest can involve professionals from different conflict groups.

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## HEALTH AS A BRIDGE FOR PEACE (HBP)

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

As a WHO programme, HBP started in August 1997 and 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 Organisation (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, WHO Department of Emergency and Humanitarian Action (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 organisations, institutions, and individuals of various backgrounds are involved in WHO/HBP initiatives, including networking and advocacy.

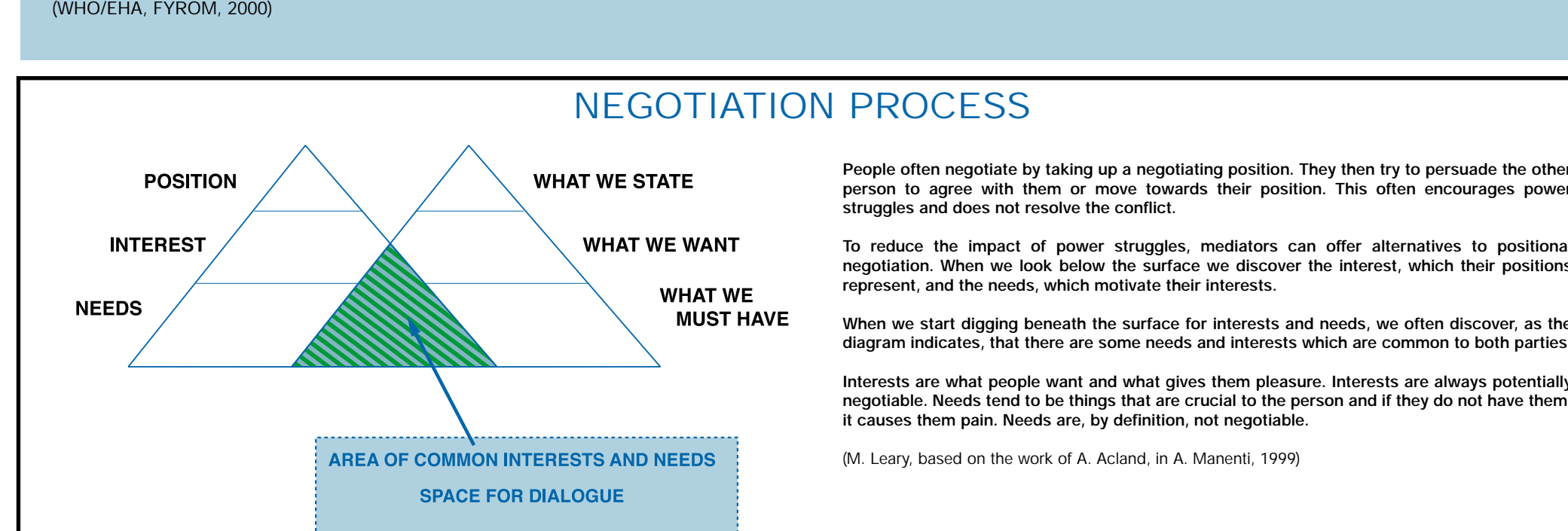
## REVIEW OF PRACTICE

- #### HAITI (1991-1994)
- Main partnership: local Government, local NGOs  
 Main outcome: the Health/Humanitarian Assistance Programme (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 (1989-1995)
- Main 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 programme 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 programme that, through international NGOs, contributed to increase the accessibility to the basic health care for soldiers and their families resident in inaccessible areas.
- #### 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-ethnic work plan.  
 • Regular contacts between health professionals of different 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-ethnic associations (e.g. Inter-ethnic Physicians' Association).  
 • Countrywide health journals, public health networks and campaigns.  
 • HBP program broke the existing trend of operating separate health programmes in each politically controlled area, thus enabling many NGOs to implement inter-ethnic programmes.
- #### SRI LANKA (1999-2000)
- Main partnership: International Training Programme 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.
- #### FYR MACEDONIA (2000-2001) AND BOSNIA AND HERZEGOVINA (1997-1999)
- Main partnership: Decentralized cooperation entities (European and local municipalities), Ministries of Health and Social Affairs, NGOs and people associations, Italian Cooperation  
 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 exercise, 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 programmes against the exclusion and discrimination of vulnerable groups increasing the acceptance of differences.  
 • Promotion of principles as equity, human rights, integration of vulnerable groups through different instruments such as magazines, books, cinema, theatre, and music.
- #### 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 trainings 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.
- #### 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.
- #### 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.
- #### HUMANITARIAN CEASE-FIRES (1985-2001)
- In different forms (Humanitarian Cease-fires, Days of Tranquillity 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.

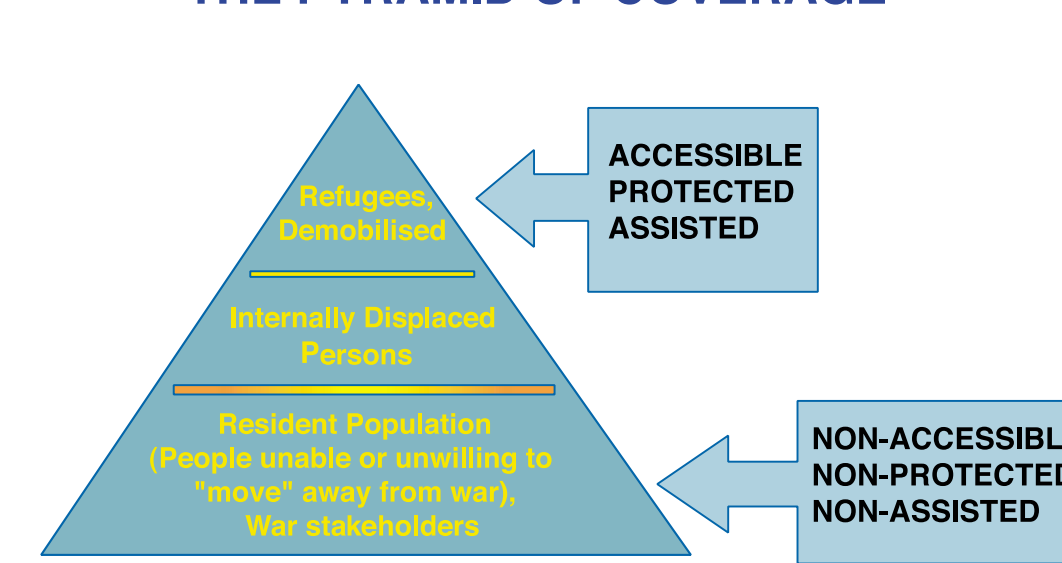
## APPLY A WIDER PUBLIC HEALTH VISION

In emergency as well as in development, WHO bases its activities on evidence and guidelines against unhealthy behaviours. 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 commitments of WHO towards promoting healthy behaviours and discouraging unhealthy ones.

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

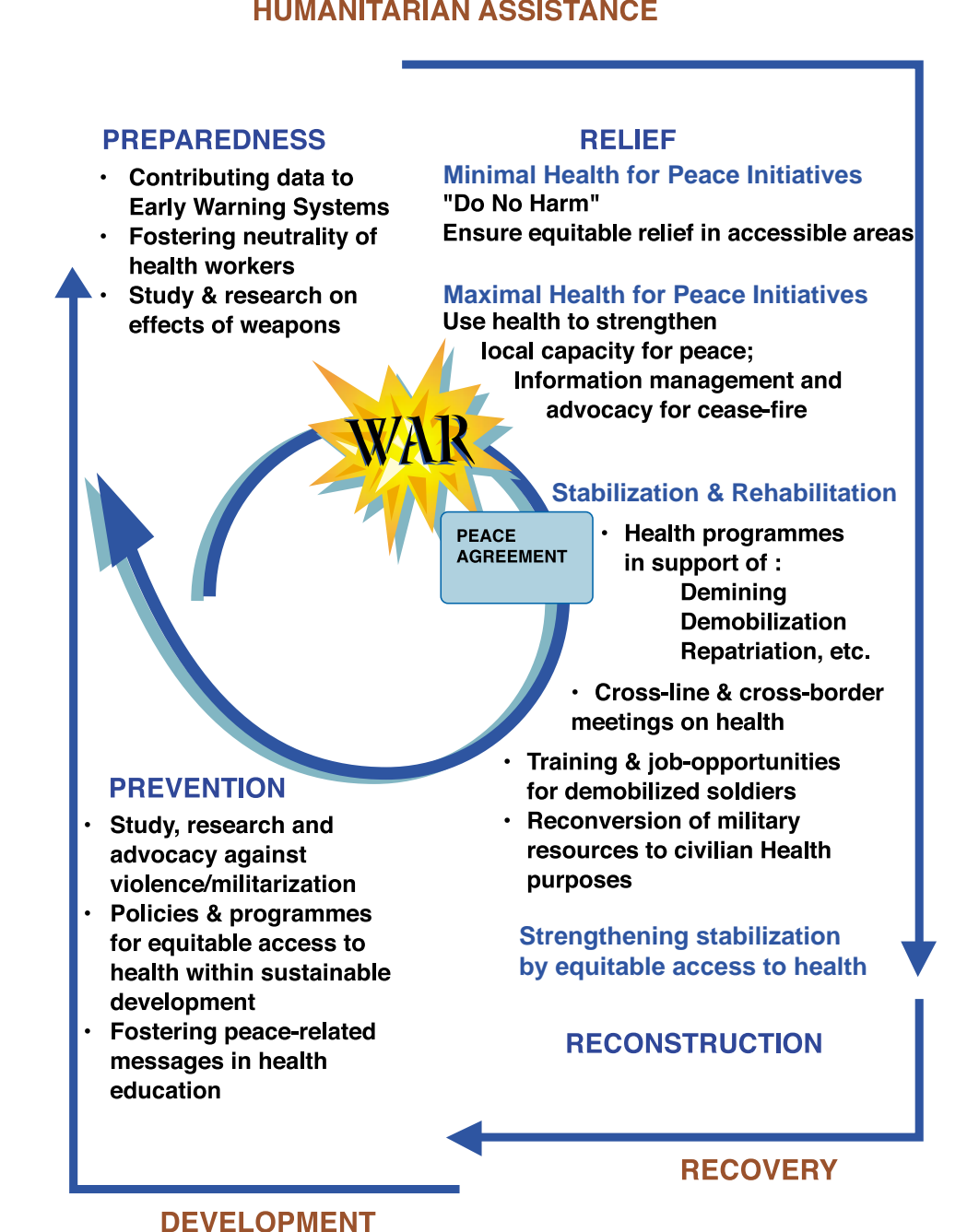


## THE PYRAMID OF COVERAGE



Humanitarian interventions may be a successful vehicle for peace when their operational activities involve all population, that is all political actors.

## HEALTH FOR PEACE OVERVIEW



## RECOMMENDATIONS

- Before the conflict flares** develop health programs promoting the democratic stability, peacebuilding 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.
  - Prevent side effects of humanitarian programs, which can foster dependency of beneficiaries on external aid.
  - Involve local capacities for change.
  - Create partnerships, with a strong presence of local civil society organizations.
  - Promote coordination and coherence of objectives and strategies.
  - Develop HBP 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.



WORLD HEALTH ORGANIZATION (WHO)  
EMERGENCY AND HUMANITARIAN ACTION (EHA)