

CERTI

Crisis and Transition Tool Kit

How Can Health Serve as a Bridge for Peace?

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Executive Summary

This document was prepared under contract with the USAID Bureau for Africa, Complex Emergency Response and Transition Initiative (CERTI). The CERTI project is composed of a large network of organizations seeking to establish broad-based consensus on best practices for providing public health services in advance of, during, and following complex humanitarian emergencies, with the aim of strengthening response capabilities of organizations involved in public health interventions during these critical periods. The purpose of this technical report is to examine the concept and practice of "Health as a Bridge for Peace" and how it is translated into an approach to providing health inputs before, during, or after crises.

In order to analyze Health as a Bridge for Peace (HBP) experiences retrospectively, four main methodologies have been utilized. First, we have attempted to analyze and synthesize available reports, books, studies, and proceedings from HBP meetings held over the past 15 years. Second, a review and comparative analysis of published and unpublished cases of specific HBP interventions was conducted. Third, individual semi-structured and unstructured interviews were conducted with key informants in order to verify findings from international meetings and case studies, identify gaps in knowledge, and determine practitioner and policy-makers' views on the utility of the HBP approach in contemporary Sub-Saharan Africa. Finally, intermediate and final drafts of this document have been peer-reviewed by a multidisciplinary team of health, conflict, and development experts.

Experiences to date have included successful, as well as unsuccessful HBP operations. The findings from research on HBP activities suggest that the presence of certain critical elements in any given conflict situation may increase the chances of a successful HBP operation. These elements include 1) political will of national governments; 2) support and facilitation of an international health organization, such as WHO; 3) investment of resources, including financial, material, and human; health personnel properly training in skills such as

conflict analysis, negotiation, and diplomacy; and 4) the implementation of HBP activities tailored to the specific contextual situation.

Health personnel are in the unique position to be able to leverage something universally important, irrespective of the details of any given conflict: the promise of good health. This makes the international health community a potentially powerful force in peace efforts throughout the world, and one that should be tapped further through expanded HBP initiatives and continued research, evaluation, and training activities.

Accordingly, the following strategies, skills, and tools as related to future HBP work in the context of contemporary Sub-Saharan Africa are recommended:

- Training programs for health personnel in skills relevant to peace building.
- Further evaluative research of HBP initiatives to date. Such continued research efforts should support further development of the theory behind Health as a Bridge for Peace.
- Commitment to health as a bridge for peace on the part of national governments, civil societies, international organizations, and the global health community.

Recommendations for next steps for the Health as a Bridge for Peace component of the CERTI project include: 1) Develop evaluation indicators and criteria, and 2) Capacity building and tools development. In the development of evaluation indicators and criteria, a situation analysis of 2 – 3 countries where health was used as a bridge for peace will be conducted in conjunction with USAID representatives. From this analysis protocols and indicators will be conceptualized.

This will lead to the second phase of activities, that of capacity building and tools development. This component will initially involve the conceptualization of a HBP Toolbox succinctly outlining options for training and tools development. This toolbox will consist of one-page fact sheets detailing impact evaluation indicators and criteria and outlining tools and

capacity building programs. Fact sheets describing tools and capacity building options will cover topics such as early warning systems, negotiation, conflict management, forecasting skills, risk communication, conflict communication, working with stakeholders, working with the media, problem resolution, institutional reconstruction, and crisis assessment. Fact sheets detailing training programs designed specifically for clinical personnel will include topics such as emergency preparedness, assessing and managing disaster/risk relief, managing for reduced loss, and conflict impact reduction.

Once the toolbox has been developed, we will craft an information-sharing strategy, which will allow the toolbox to serve as a stimulus in the cooperative development with local partners of in-depth training programs and tools tailored specifically to African populations. We believe that for training programs and tools to be relevant to the people of Sub-Saharan Africa, African input into their content and design is crucial on an on-going basis. The toolbox will also serve as an informational tool with which to elicit input from USAID Missions, NGOs, and civil societies. This will allow all partners the opportunity to analyze and provide feedback on the relevance and importance of each component within their community and/or country context. To facilitate this, information-sharing seminars will be organized in Washington along with one field trip to the region. Once this valuable input has been received, the development of training programs and tools may proceed in a way consistent with the real needs of the African nations served.

Acknowledgements

This document was prepared by a multidisciplinary team of researchers at The George Washington University Center for International Health (GWCIH) as part of the USAID Bureau for Africa's Complex Emergency Response and Transition Initiative (CERTI) project. The team worked under the general direction of Dr. Rosalia Rodriguez-Garcia, Professor and Chair of International Public Health and Director of the GWCIH.

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All facts and opinions expressed in this document are the responsibility of the authors alone and do not imply endorsement by the George Washington University or USAID.

I. Purpose of the Study

This document was prepared under contract with the USAID Bureau for Africa Complex Emergency Response and Transition Initiative (CERTI). The CERTI project is composed of a large network of organizations seeking to establish broad-based consensus on best practices for providing public health services during and following complex humanitarian emergencies, with the aim of strengthening the response capabilities of organizations involved in public health interventions during these critical periods.

The purpose of this technical report is to examine the concept of Health as a Bridge for Peace (HBP) and how it is translated into an approach to providing health inputs before, during, or after crises. The report provides an analysis of the approach, describes its historical evolution, and summarizes the current consensus regarding its manifestations and accomplishments. This report attempts to move the discussion on Health as a Bridge for Peace toward more practically defined strategies, skills, and tools. It highlights the possibility that health actions may provide an opportunity for promoting peace, but also recognizes its potential misuse. It seeks to a) expand the evidence-base by presenting an analysis of the role of health in the emergence, maintenance and transition out of conflict, b) lay out lessons learned from the experiences of other countries and regions worldwide that may be relevant to contemporary field realities in Africa, and c) identify specific actions to be undertaken to apply and adapt the lessons learned to CERTI's work in contemporary Sub-Saharan Africa. The overall goal is to provide guidance to USAID and CERTI partners and to inform future policy and programmatic actions designed to strengthen the capacity of health professionals, organizations, and donors to strategically employ this approach.

II. Study Design and Methods

In order to analyze Health as a Bridge for Peace experiences retrospectively, we have utilized four main methods. First, we have attempted to analyze and synthesize available reports, books, studies, and proceedings from HBP meetings held over the past 15 years. This allowed for an analysis of the state of the art and the elements of international consensus around the HBP approach. In addition, the literature review led to the identification of key questions and issues, which were explored in more depth through the case study analysis and key informant interviews.

Second, utilizing secondary data we conducted a review and comparative analysis of published and unpublished cases of specific HBP interventions. Due to contract provisions in the CERTI project, the development of new case studies based on direct field observation was not possible. Instead, a systematic literature search was conducted of public health, social science, dissertation, and UN document databases. Additional resources were culled from documents retrieved through standard literature searches. Finally, additional HBP experiences were solicited through public health, humanitarian assistance and human rights practitioner networks. Individual case studies were developed and analyzed according to the standard methodology developed by Yin (1994). All case studies were constructed using a protocol, the domains of which were determined by the literature review. Cases were then compared based on the domains identified in the guide, and comparative lessons learned were drawn.

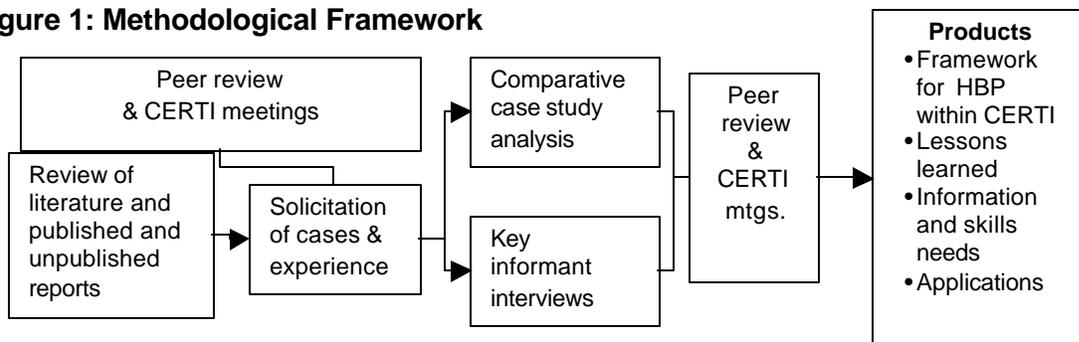
Third, individual semi-structured and unstructured interviews were conducted with key informants in order to verify findings from international meetings and case studies, identify gaps in knowledge, and determine practitioner and policy-makers' views on the utility of the HBP approach in contemporary Sub-Saharan Africa.

Finally, all case study protocols, key informant interview guides, conclusions drawn from the analysis of the literature, and intermediate and final drafts of this paper were peer-reviewed by a multidisciplinary team of health, conflict, and development experts. Results from these

analyses and interviews were then presented to the CERTI consortium to elicit their comments and suggestions. (See figure 1).

The four methods described above have been employed through a process of triangulation in order to increase the rigor of the study. Nevertheless, several important limitations should be acknowledged. Due to budget constraints, it was not possible to conduct original case studies based on contemporary experiences and utilizing a common format. For this reason, some aspects of cases may not be comparable, thereby limiting the generalizability of lessons learned. There is also the possibility of some publication bias since HBP activities have been underreported or undocumented. Documented cases may include only those that have been either successfully implemented or outright failures. We also expect that activities that are carried out by small, community-based NGOs are less likely to have been documented than those undertaken by larger donor agencies such as WHO. Any interpretation of lessons learned must therefore bear in mind these limitations.

Figure 1: Methodological Framework



III. Background

This section begins with working definitions of key terms. It then provides an analysis of the HBP construct, its historical evolution, and its relationship with the CERTI framework. Finally, an overview of HBP is presented as documented by numerous organizations, including the World Health Organization (WHO), Nongovernmental Organizations (NGOs), and the GW Center for International Health (GWCIH).

A. Working Definitions

Health as a Bridge for Peace is an approach to second track diplomacy originally undertaken in Central America in the 1980's and conceived of by the Pan American Health Organization (PAHO, 1985). The construct is based on the idea that shared concerns around fundamental health issues can provide an entry point in the process of negotiation because health issues transcend political, economic, social, and ethnic divisions among peoples and provide a nexus for dialogue at multiple levels (Guerra de Macedo, 1994).

In this document, Health as a Bridge for Peace actions refer to efforts by health-oriented organizations and/or health professionals that are consciously designed to *both* a) improve public health (e.g. surveillance and response, water/sanitation, nutrition, medical services, mental health, and others) *and* b) contribute to promoting peace and/or reducing conflict.

Box 1: Working Definitions: Health and Human Development

- **Health:** WHO defines health as “a complete state of mental, physical, and social well-being and not merely the absence of disease or disability” (WHO, 1978). Although some criticize this definition as being unattainable, it is used in this document to represent the ultimate goal of health and human development activities. Moreover, it is helpful in focusing interventions on health determinants beyond the strictly biomedical.
- **Human Development:** is defined by UNDP as the process of widening people’s choices and the level of well-being they achieve. The three essential choices for people are to lead a long and healthy life, to acquire knowledge, and to have access to resources needed for a decent standard of living. Other choices range from political, economic, and social freedoms and opportunities for being creative, productive, enjoying self-respect, and guaranteed human rights (UNDP, 1997). Put in another way, human development implies improving quality of life through expanding human and social capital, to better satisfy human needs for security/well-being, identity/valued relationships, and effective participation/justice (Davies, 2000).

Different types of Health as a Bridge for Peace efforts have been linked to peacemaking, peacekeeping, and peacebuilding initiatives. *Peacemaking* is the process of resolving the issues that led to conflict (Large, 1997). It is most closely associated with activities meant to stop fighting. Immunization cease-fires are an example of HBP peace-making efforts. *Peacekeeping* is the activity of preserving an agreed-upon peace and aiding parties in implementing peace agreements (Large, 1997). It is most closely associated with policing a cease-fire or deploying UN observers or troops in order to prevent a war from starting again once it has been stopped. HBP actions to aid in the demobilization of troops are often meant to contribute to peacekeeping efforts. *Peacebuilding* is an activity or set of activities meant to identify and build structures that will tend to strengthen or solidify peace (Large, 1997; Boutros-Ghali, 1992). Building on the Institute for Multi-track Diplomacy (1996), Large (1997) proposes several kinds of peacebuilding efforts relevant to the Health as a Bridge for Peace approach. See Box 2.

Box 2: Conflict and Peace

- **Conflict** and disputes are found in all human and many nonhuman societies (Ross 1993a). The mere existence of conflict is not necessarily destructive, provided there are means for groups and individuals to peaceably resolve issues. Conflict becomes a problem when there are no structures, institutions or mechanisms for its peaceful resolution (Ross, 1993b). In this document the term “conflict” is used to describe any situation between individuals, communities, or political units where peaceful means of resolving differences have been abandoned or have not yet been fully utilized. Conflict avoidance can be a HBP activity. For example, acknowledging and addressing disparities in health and gaps in health services may serve to prevent/mitigate conflict based on perceived inequities and injustices.
- **Peace** has been defined as “the absence of war” and “more or less lasting suspension of violent modes of rivalry between political units” (Barash, 1991). Like the definition of health as simply the absence of disease, this definition does little to demonstrate what peace would look like or how one would work toward promoting it. Peace, as defined by Johan Galtung, is a state of society in which exploitation is minimized or eliminated altogether, and where there is neither overt violence nor structural violence that has the effect of denying people important rights such as economic opportunity, social and political equity, a sense of fulfillment and self-worth (Galtung in WHO, 1994). This definition of peace is congruent with the aims of human development and the means to achieve the WHO ideal of good health. However, the existence of disparities in health

Some HBP activities may be viewed as forms of *preventive diplomacy* that “encompasses health-related activities designed to help prevent disputes from arising or prevent them from escalating” (Macinko, et al, 1998: 98). It refers to “the use of diplomatic techniques to prevent disputes from arising, prevent them from escalating to armed conflict if they do arise, and if that fails, to prevent the armed conflict from spreading” (Boutros Boutros-Ghali, 1992).

Box 3: Types of Peacebuilding

- **Political peacebuilding**--agreements and political arrangements that provide the overall context within which to understand the relationships of the various parties and resources. It is about building a legal infrastructure that can address the political needs and manage the boundaries of a peace process. For example, HBP activities that seek to bring sides together to agree upon health policies and priorities are intended to contribute to political peacebuilding.
- **Structural peacebuilding**--activities that create structures (institutions, systems of behavior) to support the implementation of a peace culture. It is about building an economic, military and social infrastructure that provides concrete and realistic avenues through which a peace process might express itself. For example, HBP actions that seek to rehabilitate health services for all people from all sides of the conflict may be intended to contribute to structural peacebuilding.
- **Social peacebuilding**--relationships and the feelings, attitudes, beliefs, values and skills held between people, within individuals and among groups. It is about building a human infrastructure of people who are committed to engendering a new peaceful culture within the fabric of communal and inter-communal life. For example, HBP actions that seek to promote the reintegration of health workers from opposing sides within the same hospital or clinic may be considered social peacebuilding actions.

Source: Large (1997); Diamond and McDonald (1996).

B. Evolution of the Concept of HBP

After the original Central American conferences on HBP in the mid 1980s and the establishment of permanent regional summits in the Americas, the first comprehensive look at the complementary relationship between health workers and those involved in the promotion of peace was conducted at the World Health Organization (WHO) “Symposium of health, development, conflict resolution, and peace making” held in Copenhagen in June 1994 (Macinko, et al, 1998). Participants documented WHO actions in both arenas and provided an impetus for future actions including potential HBP projects. Case studies on activities in former Yugoslavia, Central America, and Cambodia were presented and prominent European conflict experts discussed the basic concepts of conflict resolution. The tone of the meeting was inspirational. The conference report was upbeat but largely uncritical of the HBP approach. The focus was on health-for-all and its implicit message of equity as one means to address conflict.

In April, 1996 a meeting entitled “Symposium on preventive diplomacy: The therapeutics of intervention” was held in New York. This meeting was sponsored by the United Nations (UN) and brought HBP activities to the attention of the mainstream diplomatic community. The meeting achieved an important goal in sensitizing the diplomatic community to the concept of HBP (WHO, 1997). It applied the medical diagnostic paradigm to the study of conflict and focussed primarily on preventive diplomacy actions, such as health actions designed to prevent instances of conflict from escalating.

In June, 1996, the Health and Development Forum organized by The George Washington University in Washington, DC, began the work of developing a conceptual framework aimed at sensitizing decision makers to the need for integrated approaches to

examining and promoting health, peace and human development. At the same time, the first meeting of the CERTI partners was convened to develop a framework for linking relief with development. In both fora, the concept of health was broadened from provision of health services to include the concepts of human development and human security whose absence may contribute to the origins of conflicts, and whose attainment can be seen as a means and an indicator of transition out of conflict.

- **Human Security** is "the sense that people are free from worries...about daily life. Human security is people-centered while being tuned to two different aspects: It means, first, safety from such chronic threats of hunger, disease and repression. And second, it means protection from sudden and hurtful disruption in the patterns of daily life – whether in homes, [on the] job or in communities" (UNDP 1994). Human security may in many cases be a pre-condition for the realization of good health and sustainable improvements in human development.

The CERTI project has proposed a working definition of human security as an underlying condition for sustainable human development. It results from the social, psychological, economic, and political aspects of human life that in times of acute crisis or chronic deprivation protect the survival of individuals, support individual and group capacities to attain minimally adequate standards of living, and promote constructive group attachment over time (Leaning and Arie, 2000).

On May 15, 1998, the WHO "Consultation on Health as a Bridge for Peace" in Geneva sought to insert Health as a Bridge for Peace into the WHO mission and defined a specific agenda for analyzing and utilizing HBP. The GW Center for International Health (GWCIH) developed the background paper for the event (GWCIH, 1997). Participants at the WHO

Consultative Meeting voiced concerns that the original definition of Health as a Bridge for Peace, stipulating that shared concerns around fundamental health issues can provide an entry point in the process of negotiation because health issues may transcend political, economic, social, and ethnic divisions among peoples, does not accurately reflect the reality of conflict in the post cold war era (WHO, 1997). Participants questioned whether concern for delivering health care should excuse health workers and organizations from the need to be more aware of the political realities in which they operate. Proponents of the HBP approach contend that health workers should do more than endeavoring to “do no harm,” and that they have a responsibility to seek out creative opportunities to promote peace. Participants endorsed this more strategic orientation to HBP, which is summarized in Box 4, below.

Box 4: Revised WHO Definition of HBP

"The Spirit of Health as a Bridge for Peace affirms commitment to Health For All and its Renewal. In achieving the primary goal of health for societies prone to and affected by war, we as health professionals recognize responsibilities to create opportunities for peace. For this we need new strategies, awareness, stance, skills, and partners."

Source: WHO (1997)

The WHO Consultative Meeting also focussed on a number of other important questions, which are briefly discussed below:

1. *What is the role of health professionals in promoting peace?* Participants found the role of the health professional to be unique due to the strength of the health profession and feelings of solidarity among its members worldwide. In addition, there is a perceived impartiality of health professionals. They have an intimate relation with individuals and communities, and can have opportunities that may open doors for other sectors. Other strengths of health professionals in working for peace include the personal attributes of health providers, professional skills and know-how in rebuilding the health sector, and the potential ability to act as brokers for peace.

At the same time the idea of the sanctity of the health and medical professions was

questioned. For if health professionals are supposed to hold the sanctity of human life above all else, how do we explain the actions of some who incite ethnic rivalry, who condone ethnic cleansing and participate in genocide? While the cases reviewed at the meeting illustrated the potential of health professionals to contribute in a unique way to promoting peace, participants also recognized that the assumption that health is always an overriding ethical imperative for all health professionals or within all societies is questionable. Participants identified critical activities for health professionals in fulfilling their responsibilities towards peace promotion, which are detailed in Box 5, below.

Box 5: The Potential Role of Health Professionals in Peace Promotion

- Collecting data to address the health effects and inequities resulting from or exacerbated by conflicts and violence, and bringing about policy changes;
- Providing a framework for conflict reduction and context-based health and peace interventions;
- Identifying threats to larger populations that might lie beyond the strictly biological;
- Providing evidence on ways in which health interventions promote reconciliation and peace (WHO, 1997).

2. *The role of international organizations, especially WHO, within a war or conflict situation.* Participants acknowledged that any organization working within a war or conflict situation is working within a political context. Consequently it can have an impact on the political dynamics of that conflict, and runs a potential risk when trying to promote peace.

Participants also identified a number of potential roles that international agencies such as WHO could play in the peace process. They include:

- The potential to act as a facilitator, or a catalyst to bring all sides together;
- The potential to contribute to the development of health and peace infrastructure; and
- The potential to take the lead in coordinating civil society through public health and medical associations, institutes of higher learning, and other sectors (WHO, 1997).

They concluded that conflict analysis skills and best practices should be documented and disseminated to enable health professionals to take into account such risks in the design and implementation of HBP interventions.

3. *The importance of health data.* At all stages of conflict, data, especially health data, have the potential to move public opinion and can instigate political change. Some examples include the success of the international campaign to ban land mines, and the contribution of the International Physicians to Prevent Nuclear War in the ratification of the atmospheric test ban treaty. Health professionals can influence policy by activating the data-to-policy link. This includes conducting studies of "strategic epidemiology," making cases for policy change based on health data, and developing constituencies both from the grassroots to the level of decision-makers (WHO, 1997). Box 6 describes the Demographic and Health Surveys (DHS), which is a particularly relevant data collection vehicle in post-conflict environments (Mock, 2000).

Box 6: The Demographic and Health Surveys Program (DHS)

The Demographic and Health Surveys Program (DHS), funded by the United States Agency for International Development (USAID), is the most important cross-nationally comparable data collection vehicle available for health, population, and nutrition (HPN) programming in the African region. Though originally designed for relatively stable populations, it has been found to be a particularly useful programming tool in post-conflict environments. DHS is designed to produce cross-national comparability of data, which is critical in the post-conflict context where coordinated data collection between two or more countries is needed to develop cross-border strategies and programs. Cross-national data are also important for policy research related to the demographic and health effects of conflicts. Though experience in the application of the DHS program in countries affected by conflict is limited, DHS is seen as a potentially important tool due to its extensive coverage and methodologic standardization (Mock, 2000).

4. *Is health itself really neutral?* Participants questioned the assumption that health is by its very nature neutral. Cases presented suggested that health and health actions, especially in situations of conflict, are not always viewed as neutral or value-free. Health assets can be manipulated by political leaders to further their own interests. Nevertheless, health providers

and organizations can try to be impartial. At the very least, they should not contribute to or exacerbate conflict. Experiences also show that even though health may be as politically charged as other sectors or concerns, the act of technical cooperation in health and among health professionals has the potential to facilitate certain aspects of the peace process. In some instances, health can bring together conflicting sides and serve as a bridge for peace (WHO, 1997).

5. Stakeholders. Three basic categories of stakeholders emerged from the analysis: Top-level leadership consisting of political decision-makers, business leaders, the diplomatic community, member states, and donors; middle range leaders, including ethnic or religious leaders, prominent members of the health professions, and academic community, and staff of international organizations; and grassroots organizations (WHO, 1997).

Participants described different types of actions corresponding to the different categories of stakeholders. To influence top-level leaders, international agreements, accords, and visible leadership are necessary. At times, a grassroots movement may also trigger high-level leaders to recognize an issue (such as land mines). Three other elements seem to be essential in mobilizing the power of health as a bridge for peace: resources, political will, and the media. One strategy for mobilizing support for HBP initiatives is to strengthen the data-to-policy link through the use of the media, which may be especially important in influencing public opinion especially (WHO, 1997).

In 1999 the GWCIH established the Health Diplomacy Institute to serve as a think tank for putting into practice health as a bridge for peace as a key to conflict resolution and development.

Table 1: Major Symposia on Health as a Bridge for Peace

| Date | Meeting | Major outcomes |
|--|--|---|
| March 16, 1984 San Jose, Costa Rica | PAHO/Contadora Group “Priority Health Needs in Central America and Panama | •First Health as a Bridge for Peace Initiative launched |

| | | |
|-------------------------------|--|---|
| June 3, 1994 Copenhagen | WHO "Symposium of health, development, conflict resolution, and peace-making" | <ul style="list-style-type: none"> •First comprehensive look at complementarity between health and peace professions •Documented WHO Actions and provided impetus for future actions |
| April 23-24, 1996 New York | CIHC/UN/EHA "Symposium on preventive diplomacy: The therapeutics of intervention" | <ul style="list-style-type: none"> •Brought HBP activities into the mainstream of diplomatic community •Sensitized diplomatic community to Health as a Bridge for Peace |
| June, 1996 Washington, DC | <ul style="list-style-type: none"> •CERTI Consultative Group Meeting/ Linking Relief with Development •GW Health and Development Forum | <ul style="list-style-type: none"> •Begin development of conceptual framework •Sensitize decision-makers to the need for integrated approaches |
| May 15, 1998 Geneva | WHO "Consultation on Health as a Bridge for Peace" (with GWCIH) | <ul style="list-style-type: none"> •Effort to insert Health as a Bridge for Peace into WHO's mission •Defined a specific agenda for analyzing and utilizing HBP |
| 1999 to present | GW Health Diplomacy Institute | <ul style="list-style-type: none"> •Reinforce and put into practice health negotiation, problem-solving, conflict management, ethics, and media utilization for improved conflict mitigation and human development |

Source: Adapted from GWCIH, 1997.

C. The Link Between Health as a Bridge for Peace and CERTI Approaches

The Complex Emergency Response and Transition Initiative (CERTI) is an international and interagency program initiated in 1996 by the USAID Bureau for Africa in support of one of its Strategic Objective, known as Programs for Preventing, Mitigating and Transitioning out of Crisis. The purpose of this initiative is to form a link between relief and development strategies.

CERTI has two major objectives:

- To establish broad-based international consensus on best practices before, during, and following complex emergencies (CEs); and
- To strengthen the capacity of various implementing organizations which provide public health interventions in crisis and post-crisis contexts.

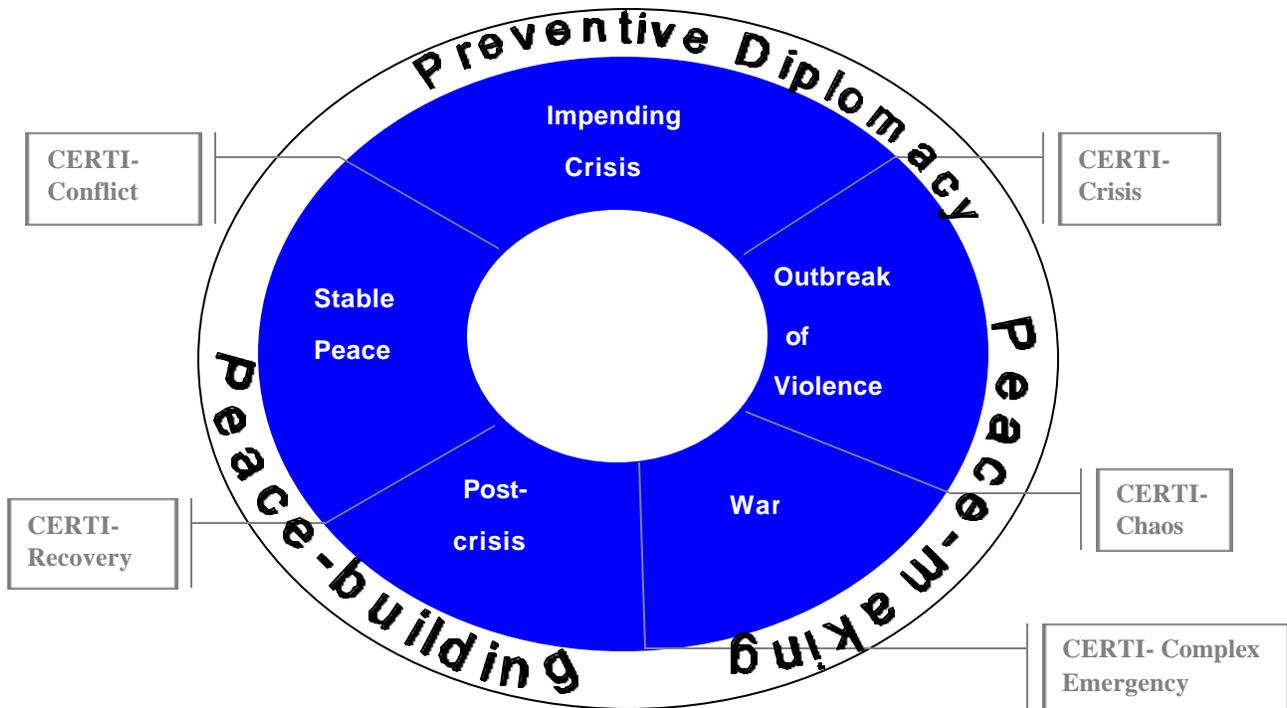
The CERTI approach is congruent with the HBP approach in several areas, which are discussed below:

1. Stages of Conflict

The CERTI framework identifies phases of conflict that call for different programming approaches. Four principal strategies have been developed to enhance the transition from conflict to sustainable development: 1) investment of development resources to address the causes of conflict such as inequity (gaps and disparities) and the lack of a foundation for civil society; 2) development of early warning and conflict resolution/management strategies; 3) strengthening relief response to ensure professionalism and interventions that are supportive to rather than competitive with long term development goals; and 4) design and support of effective programs that facilitate the peace process while addressing the special developmental needs of populations emerging from the trauma and devastation of war (CERTI, 1999).

The HBP approach is compatible with the CERTI conception of conflict analysis. Figure 2 shows the main stages of conflict as conceptualized by the CERTI approach: conflict, crisis, chaos, complex emergency and recovery. These stages are indicated by the text boxes. Each CERTI stage corresponds with the HBP stage depicted inside the circle: Impending crisis, outbreak of violence, war, post-crisis, and stable peace. Furthermore, like the CERTI approach, HBP suggests that different actions are appropriate at different stages of conflict. The case studies analyzed in Section V. provide a critical assessment of the types of HBP actions that have been initiated at different stages of the conflict.

Figure 2: Congruence of CERTI and HBP Stages of Conflict and Action



Source: adapted from Macinko, et al., 1998.

It is important to note, however, that one of the key issues in analyzing a conflict is to determine when exactly the conflict is over. For relief agencies, the end of a crisis means an end to much of their work and a transition to development work. Macrae (1995) suggests several indicators that may signal the end of a conflict: 1) signing of a formal peace agreement; 2) a political transition such as elections or negotiated power transfer; 3) increased levels of security; 4) perception among national and international actors that there is an opportunity for peace and recovery. However, As Van der Heijden (1997) points out, single characteristics may be misleading. He points to Ethiopia and Uganda as cases where peace developed

without formal peace accords, and to Angola where the first UN-brokered peace accord and election were the start of the next phase of war. Moreover, different actors in a conflict may feel they are at different stages. For this reason, the stages of conflict approach can be used as a heuristic device, but must be analyzed within the context of each conflict.

2. Multiple Units of Analysis and Action

The CERTI approach recognizes that crises have both sub-regional and highly location-specific manifestations. For this reason, the nation-state may no longer be the most effective analytical unit for programming purposes. Rather strategic actions that can be implemented through cross-border programs affecting subregions may be most appropriate. Within a country, programs that are flexible and decentralized enough to permit the delivery of interventions across the relief/development spectrum may be more likely to succeed (CERTI, 1999).

The HBP approach has been applied within countries (e.g. Angola), across borders (e.g. Croatia), and within regions (e.g. Central America) and is congruent with the CERTI approach. HBP recognizes the concerted efforts of individual health providers and organizations and attempts to link them through networks to each other and to higher levels of authority (GWCIH, 1997). HBP has been practiced in one form or another by the United Nations system, as well as by bilateral agencies, international NGOs, civil society organizations, and local communities.

One approach, known as decentralized cooperation (DC), engages actors at multiple levels and has been utilized in the former Yugoslavia. Decentralized cooperation may be relevant to the CERTI environment and is described in greater depth in subsequent sections of this document. Box 6 provides a summary of the DC approach.

Box 7: Decentralized Cooperation

“Decentralized cooperation refers to systematic links between local communities in donor countries and local communities in countries that need support. The objective of these links is to create and/or consolidate long-term cultural, technical and economic partnerships between local communities as a tool to promote human development and peace... Decentralized cooperation can better use its potential when it is an integral part of a multilateral program with a specific role...such as coordination of activities and technical assistance ensuring an orientation in line with national priorities, reform trends and international standards.”

-Manenti, 1999: 7.

3. A multidisciplinary approach to understanding the causes of and possible solutions to conflict.

The CERTI framework for intervention acknowledges the strategic role of development investments, improved early warning and preparedness, professional development and training, improved policies and programming, and networking and coordination (CERTI, 1999). The framework incorporates the actions of donors; international NGOs; PVOs; the military; and indigenous, regional, and local institutions, and underscores the relationship between poor investments in human development and the development or perpetuation of conflict. It recognizes the critical role of public health in preventing as well as responding to complex emergencies worldwide and in leveraging the developmental potential of African countries (CERTI, 1999).

The GW Center for International Health, in collaboration with WHO, has developed a conceptual framework for guiding research and action in the area of Health as a Bridge for Peace. The conceptual framework (see Figure 3) seeks to contribute to a better understanding of specific conflict situations and their health impacts. It represents a holistic view of the health to peace concept, including its environmental, health, political, economic, social, gender, and human development dimensions. These dimensions are described in more detail below.

First, the physical environment and gender are shown as overarching dimensions of the framework. All health actions take place within a particular physical environment, the characteristics of which may contribute to or hinder efforts to provide humanitarian assistance, reduce conflict, and promote health. Gender is also important, especially when looking at differences between conflict perpetrators and victims.

Second, the economic situation of a nation, especially in terms of unemployment, economic instability, and inequitable distribution of wealth, may create or exacerbate conflict. Inequity and poverty can lead to the creation of vulnerable groups unable to participate fully in the development process, thus creating a situation for continued or future conflict situations. In turn, conflict ultimately affects a nation's economic development, resulting in lost investment, deterioration of trade, and long-term damage to the economy as a whole. As the economy deteriorates, funding for public health services also dwindle, leading to breakdowns in disease surveillance and vector control, inadequate primary and preventive health care, deterioration of water and sanitation services, and ultimately a higher level of morbidity and increased economic costs. Due to a greater burden of disease in a society, lower productivity may be seen, and in many cases extend to post-conflict generations.

Third, social factors such as poverty, poor housing, the breakdown of community structures, and poor educational opportunities place people in survival situations of increasing marginalization and hopelessness. These factors may promote aggressive behavior and exacerbate conflict, leading to the emergence or strengthening of a culture of violence, which favors force as a means to resolve frustrations and disagreements.

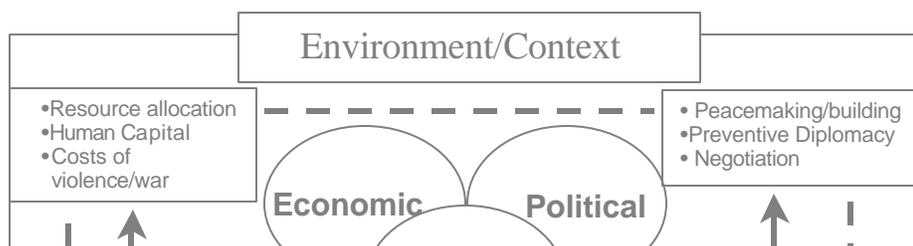
Fourth, lack of political participation and government accountability, coupled with social and economic disparities can lead to increased prevalence of conflict and violence. Obstacles to the establishment of democratic forms of government occur when, in attempting to contain

violence, governments favor one group over another, silence opposition, or allow police and security forces to infringe on basic human rights.

Finally, conflict takes a heavy toll on human development. Besides the economic, political, and social dimensions mentioned above, violations of human rights and the persistence of unresolved conflict can lead to a devaluation of life and a lessening of mutual respect on the part of both the authorities and civil populations. Children and youth raised in such hostile environments may come to understand these attitudes as normal.

In summary, the framework does not endorse a particular theory of conflict. Instead, it allows both researchers and practitioners to address certain key aspects that may lead to conflict. Health is seen as central as a bridge for peace, utilizing epidemiologically-based public health tools for conflict prevention, surveillance, and evaluation. This approach facilitates comparisons among conflict situations; provides a means to address multiple dimensions of conflict; and allows for a common framework, which may be adapted to examine individual countries or particular conflicts. By combining political, economic, social, health, and human aspects, the conceptual framework can guide the process of identifying, characterizing, and evaluating past and current HBP initiatives and aid in the design of future activities. (Rodriguez-Garcia, et al., 1998). The HBP approach as depicted here allows for a multidisciplinary analysis of the causes of conflict, and points to sectors, stakeholders, and institutional features that need to be addressed in the context of post-conflict rehabilitation.

Figure 3: GWCIH Health as a Bridge for Peace Framework



- Education/training
- Social networks
- Participation
- Gender

4. Concern with human security

The United Nations 1994 *Human Development Report* defines human security as "the sense that people are free from worries, not merely from the dread of a cataclysmic world event but primarily about daily life. Human security is people-centered while being tuned to two different aspects: It means, first, safety from such chronic threats of hunger, disease and repression. And second, it means protection from sudden and hurtful disruption in the patterns of daily life – whether in homes, in job or in communities." (UNDP, 1994).

The CERTI project has asserted that "human security" should be an outcome of relief-to-development activities. Though the HBP approach does not explicitly address human security, it does place human development as the objective of its actions and a measure of its success. Moreover, some measure of human security may be seen as a necessary, but not sufficient, condition for the realization of human development and for sustainable improvements in population health status. For this reason, the framework depicted in Figure 3 includes elements of human security along with the general concept of human development, which may be viewed as analytical approaches to defining problems as well as outcome measures.

5. Adaptations to the HBP framework

Several adaptations are needed to make the HBP approach more relevant to CERTI. First, the HBP approach should focus on the stages of conflict most relevant to CERTI – Chaos, complex humanitarian emergency, and most importantly, recovery. For this reason, the majority of experiences reviewed here will focus less on the prevention side (although several important prevention initiatives will be reviewed) and more on the conflict and post-conflict stages. Second, the HBP approach has, by and large, focused on the actions of international organizations, most notably, the World Health organization (WHO). However, in order to be relevant to CERTI it must incorporate the actions of multiple parties including local and international NGOs and civil society, the military, and bilateral and multilateral donors. Third, the focus should be on Africa. Although several important HBP activities have taken place in Africa (Angola, Uganda, Mozambique) the majority have taken place in other regions. When reviewing the lessons from other regional experiences in HBP, it will be important to take into account the applicability of the approach and the lessons derived from it within the context of Sub-Saharan Africa. Finally, the original HBP projects took place in a vastly different international political context- that of the cold war. In order to be most relevant to CERTI, lessons should be learned from experiences in Rwanda, Democratic Republic of Congo, and the former Yugoslavia, for example, in order to place the HBP approach within the context of contemporary political realities.

D. The Challenges of HBP in Today's Global Environment

The fall of the Berlin Wall spelled the end of the bi-polar world. However, rather than having the effect of reducing the number of conflicts worldwide, there has been an acceleration in the number of conflicts, which have affected more people around the world than ever before. Indeed, from 1990 to 1995, over seventy states were involved in 93 wars, killing at least 5.5

million people, three-quarters of whom were civilians, including nearly one million children (Smith, 1997). However, mortality data represent only part of the situation. Mortality estimates should be supplemented with data on injuries and trauma as well as economic, social and political erosion within and among countries as a result of wars and other less overt manifestations of conflict. Additionally, the majority of impacts are seen within the world's poorest countries or within the poorest, most neglected populations within countries, exacerbating already critical situations. An example can be seen in East Timor, which has the lowest development level among all 27 provinces of Indonesia, even 25 years after it was incorporated into the country. Given the widespread mortality and morbidity resulting from conflict and its obvious impact on health; development programs; and economic, social, and political security, it is not surprising that the health community has found it imperative to understand and explore the relationship between conflict and health.

Health has also been recognized as a security issue. The Institute of Medicine (1992) underscored the important link between economic and human development needs in developing countries and the risk of newly emerging infectious diseases that could affect the U.S. population while traveling abroad and at home. Jack Chow (1996) also discusses the potential of infectious diseases, such as AIDS, for disrupting political and economic security in the developing world, and highlighted the fact that even our responses to such humanitarian emergencies may be manipulated for political ends, further exacerbating potential security threats.

The Center for Strategic and international Studies (CSIS) identified three main areas where health intersects with security, namely failing states and instability, assistance during "humanitarian warfare," and terrorist use of biological weapons (CSIS, 2000).

1) *Failing States and Instability* CSIS identified failing economies and lower levels of humanitarian assistance as leading to reductions in public health services in many developing

countries. As a result, some governments have lost popular support and have been replaced by societal factions competing each other to protect their own well-being. This competition often turns violent, leading in some instances to the collapse of national health infrastructures.

2. *Humanitarian warfare* This term refers to the growing tendency of civil combatants to manipulate food and medical supplies in efforts to gain advantage over adversaries. This often results in forced displacement or mass expulsions of groups, creating new political factors to be resolved. The “safe havens” and refugee camps created for meeting the needs of displaced populations can both overwhelm the capability of relief services and create an additional factor to be manipulated by warring factions.

3. *Biological Weapons* The use of biological weapons (BW) involves the deliberate spread of disease, either by state entities in the context of a conflict situation, or by non-state entities seeking to inflict a high level of casualties on an unsuspecting population. CSIS outlined several international findings in this regard, including:

- the surprising size and scope of Iraq’s BW program;
- the existence of an offensive BW program in Russia, in violation of the 1972 Biological and Toxic Weapons Convention (BWC), of which Russia was a signatory nation;
- an attempt by the cult responsible for the 1995 poison gas attack in the Tokyo subway to develop BW;
- interest in acquiring BW by an increasing number of countries.

Material and technology that can be used to make BW also have legitimate commercial or medical uses. As developing countries demand more sharing of technology to combat disease, the question of how to manage the global diffusion of “dual-use” material will become a major political issue (CSIS, 2000).

As illustrated in the preceding discussion, the intersections of health and international security are, and will continue to be, important issues for policymakers. In the future, it will

become increasingly important for policymakers to develop an approach to dealing with these questions in the most effective way possible. To do this, three key questions must be addressed:

- What are the key intersections of health and security at the state and international levels?
- What are the critical dimensions of the health/security interface?
- What policy challenges does the interaction of health and security create and what multi-sectoral approaches will most effectively deal with this relationship? (CSIS, 2000)

These topics are discussed below.

1. New Approaches to post-conflict mitigation and negotiation tactics

In an attempt to address such questions, the World Bank has advanced the concept of post-conflict development, which represents a new type of development that bridges relief and reconstruction. Post-conflict development entails detailed analysis of the conflict situation in order to address the structural causes of the conflict, the demands of different interest groups, and concern for human security. It promotes collaborative efforts among development agencies and relief and emergency organizations and local ownership of post-conflict development initiatives. Accordingly, some countries have reduced their national military spending, using the funds instead to strengthen social and civil institutions. However, these funding reallocations have required increased attention by national governments on issues such as demilitarization, demobilization, and the reintegration of ex-combatants into society (World Bank, 1998).

Scholars at the London School of Hygiene and Tropical Medicine have also written about the concept of “post-conflict rehabilitation.” They have agreed that opportunities may be gained in garnering political support for negotiated peace settlements by addressing the direct and indirect effects of war on health and health systems. Like the counterparts at the World Bank, the proponents of the post-conflict rehabilitation concept focus on the transition from relief to rehabilitation to long-term development and argue that cooperation is often necessary among

development agencies and relief organizations as well as national political leaders. However, they also acknowledge that such cooperation may be difficult in situations where there exist serious questions of legitimacy of the government in power. In such circumstances, international aid is increasingly delivered outside of government structures, by international and non-governmental organizations, allowing donor governments to avoid endorsing political entities that were party to conflict situations (Lanjouw, et al., 1999).

The mission of the Department for International Development (DFID) of the Government of the United Kingdom has expanded on these ideas. Its policy is to examine the conditions that have led to conflict, assess strategies for reducing violence, and build lasting peace. The DFID seeks to fulfill this mandate by building political and social infrastructures that enable meaningful representation of different interest groups, promoting human rights, and resolving disputes and grievances without recourse to violence. In addition, the DFID has begun a process of integrating conflict reduction objectives into its development programs, placing emphasis on fostering economic growth that benefits all sections of society and ethical trade conditions which are fair to all countries. In so doing, macro-economic policies become key in addressing underlying causes of conflict, namely social inequality and poverty (DFID, 1999) .

The DFID approach complements HBP strategies by utilizing similar values and strategies on a much broader macro-level. For example, while supporting capacity-building activities of local disaster response entities, the DFID advocates for strengthening international networks such as the United Nations and the Red Cross. And, while health is not specifically mentioned in its policy document, concepts related to health security, such as human rights and more general “humanitarian needs” are emphasized. Importance is placed on diminishing barriers imposed by strict adherence to national sovereignty, focusing instead on international collaboration and cooperation among poor and rich nations alike, conflict resolution and peacebuilding, and peacekeeping operations in order to build mutual confidence (DFID, 1999).

This new type of development approach, while still in its infancy, reflects the growing importance of the basic philosophy behind using health as a bridge to peace. It underscores the importance of brokering peace by rebuilding social and civic structures, among which the health system is especially critical to fostering long-term stability and recovery. Like the HBP perspective, the emphasis is on viewing a conflict situation from a holistic perspective, including its political, social, economic, and human development dimensions, in the design of appropriate long-range development strategies, while addressing the root causes of conflict. Health is seen as crucial for peace-building. Conflict-affected nations are often among the most health deprived, with the poorest and most vulnerable populations least likely to be able to access health services (Lanjouw, et al., 1999). In the absence of health security, countries risk renewed unrest and a return to conflict or violence.

2. Relationship Between HBP and Conflict Mitigation and Negotiation Tactics

As discussed above, there is a clear link between approaches such as Health as a Bridge for Peace and post-conflict development. There are also similarities between these approaches and contemporary conflict mitigation/negotiation strategies, which include the use of persuasion, bargaining, arbitration, and threats (Brams, 1990). Conflict negotiation requires planning and strategic thinking. In order to plan effectively, a negotiating party must: a) understand the nature of the conflict; b) specify goals and objectives; c) clarify the process for managing the negotiation process, which includes identifying the issues for negotiation, prioritizing issues, developing desirable packages among the important issues, and establishing an agenda; and d) understand the opponent, including the opponent's current resources and needs and the history of the opponent's bargaining behavior (Lewicki and Letterer, 1985).

A bargaining situation may be distributive in nature, whereby the goals of one party and the attainment of those goals are in fundamental and direct conflict with the goals of the other party. This type of bargaining situation may be characterized as a win-lose situation. On the other

hand, in integrative bargaining, the goals of the parties are not mutually exclusive. One side attaining its goals does not preclude the other from doing so as well, making possible a win-win situation (Lewicki and Letterer, 1985).

The relationship between Health as a Bridge for Peace approaches and contemporary conflict negotiation strategies may be seen in both the planning elements necessary for successful negotiation and the integrative bargaining approach. As described in Peters (1996), careful planning of a Health to Peace initiative is crucial to its success. Further, an integrative bargaining process that involves the identification of common problems and goals and mutually-benefiting strategies for problem resolution, allows the health sector along with all sides of a conflict situation to move towards common ground and to begin to build trust and working relationships. Such relationships may help lay the groundwork for more permanent peace agreements.

A full understanding of conflict and strategies for negotiation/mitigation by health personnel is critical in identifying appropriate opportunities for negotiations between warring parties. As noted earlier, health can be a powerful tool in bridging the gap between conflicting parties because health problems often must be addressed in a timely manner to avoid catastrophic situations. Irrespective of the nature of the conflict, health issues will most likely affect all parties, particularly outbreaks of epidemics such as cholera, malaria, dengue, tuberculosis, and other infectious diseases. Microbes neither take sides nor identify an adversary. Therefore, health becomes a priority for all parties in conflict and a concerted action will be more effective than isolated and unilateral efforts.

Despite the role that health can play in resolving conflict, health personnel are not traditionally provided with training in conflict and conflict resolution. There is a need, then, to train health personnel, in particular those working in conflict areas, in conflict management and negotiation. Such training programs must include information about basic tenets of conflict and

negotiation. The newly acquired skills can then be used to identify opportunities for bringing parties together to discuss common problems and facilitate appropriate interactions. By seizing such opportunities, health may be used as a springboard for dealing with issues that go beyond health, towards broader conflict resolution.

IV. Overview of HBP Experiences Worldwide

In order to make sense of the varied HBP experiences undertaken over the past 15 years, a comprehensive literature search was conducted of documents describing, analyzing, and evaluating different HBP initiatives in different countries. Public health and international affairs databases were searched and the bibliographies of retrieved documents were culled for additional references. Note, this search was very narrow in scope: it sought only relevant experiences where health was used (or misused) to promote peace. In total, 56 documents were retrieved and reviewed. Results of the literature search are summarized in table 2 below.

Table 2: Results of Literature Search

| Terms | Limits | Hits | After inspection of titles | After inspection of abstracts | Number retrieved |
|--|---|------|---|-------------------------------|------------------|
| <i>Database 1: Pubmed</i> | | | | | |
| Health AND Peace OR "dispute resolution" | Both words in Title and/or abstract, any year | 184 | 68 | 17 | 15 |
| <i>Database 2: PAIS international</i> | | | | | |
| Health AND Peace OR "dispute resolution" | Both words in Title and/or abstract, any year | 14 | 6 (after discarding duplicates) | 3 | 3 |
| <i>Database 3: Dissertation abstracts international</i> | | | | | |
| Health AND Peace | Both words in abstract, any year | 103 | 5 | 3 | 1 |
| Culling selected documents and technical reports (discarding duplicates) | | | | | |
| | | 196 | (More than 25 % of reports could not be physically located) | | 37 |
| TOTAL | | | | | 56 |

There are several limitations to this literature search. First, there is a likelihood of some publication bias, as many HBP activities may not have been documented at all. Moreover, in at least eleven of the twenty-one actions identified, the World Health Organization appears as the

principal architect of the HBP activity, which may reflect the fact that, by and large, the WHO has supported the documentation of many of these efforts. It is also important to note the involvement of UN agencies in nearly every experience. Fewer experiences point to the role of NGOs in the design of the HBP activity. Nevertheless, the limited experiences seem to imply a larger role for NGOs in the implementation of the activity. It is important to highlight the fact that few of the documented experiences were written by or from the perspective of NGOs and other civil society actors so we may not be able to have access to the extent of the NGO experience through a simple literature review. In order to address this potential bias, NGO experiences will be solicited through key informant interviews in subsequent chapters of this document.

Table 3 presents a catalogue of documented experiences in Health as a Bridge for Peace as identified through the processes discussed above. The table presents an overview of the country or countries involved, the type and stage of conflict, the actors involved in the HBP activity, the main HBP interventions, and the source and quality of the data.

A total of 21 HBP experiences were identified. In terms of geographic distribution, six took place in Africa, five in Asia, two in the Americas, five in Europe and three in the Middle/Near East. Among those in Europe, all but one took place in countries of the former Yugoslavia. There are several cases (Bosnia-Herzegovina) where more than one HBP activity was implemented in the same country. These experiences were only listed separately if the HBP projects were independent of each other.

The data quality column is meant to give a crude indication of how well documented the specific HBP activity is. It is important to note, however, that these categories are meant to be relative only to each other. In general, very few of the documented HBP experiences appear to have been evaluated. The few that have been evaluated have been done so in an ex-post design. This means we can have little confidence of the effects of the program independent of other activities occurring simultaneously. More rigorous evaluation of HBP experiences

(whenever possible) would allow us to be more confident about the real strengths, weaknesses, and ultimate impacts of individual HBP efforts. Nevertheless, the qualitative descriptions of the different HBP programs provide a wealth of information about the context and the process of the HBP approach. In order to provide a somewhat crude ranking of evidence, the following classification scheme was used. E (Excellent) means the case study is well documented, detailed, and supported by other existing documents. In addition, there must be at least one external program evaluation of the HBP component. G (Good) means that there is a well-documented case study of the experience, but that evaluations of the HBP activities have not been located. P (poor) means that no written case study was located, the specific HBP activities were described as mentioned in other published documents. UK (unknown) means that we were unable to find a thorough description of the HBP activity, only an anecdote in another document. It is important to note that this classification system is based on the researcher's ability to locate and access documents. For this reason, discovery of new documents may lead to a re-classification of certain experiences. Nevertheless, for the purposes of this review, the data labels may give the reader an idea of the level of confidence the researchers had when reviewing each individual case.

The most frequently cited experiences are the original activities undertaken in Central America in the 1980s and 1990s. A variety of documents discuss the original HBP experience in Central America. The Pan American Health Organization prepared several monographs (see PAHO, 1990; Teruel, 1991) on El Salvador and Nicaragua (PAHO, 1990/1991) and the First and Second Madrid Conferences presented specific plans of action for cooperation in health (PAHO, 1985, 1988). These documents spell out quite clearly the process of utilizing health activities for peace-making. The emphasis in these documents is on government-to-government collaboration as the conflict was recognized as a regional/political civil war. Although the Central American initiatives appear to be the most frequently cited HBP activities, we are unable

to find an adequate description or evaluation of specific interventions on the ground. Evaluative information comes both from speeches presented to various international fora (Guerra de Macedo, 1994) and reports to donor organizations (PAHO, 1989).

A number of HBP documents recount the various approaches undertaken in countries of the former Yugoslavia. Activities carried out by the WHO European Office describes in detail the rationale for engaging health professionals in peace-building efforts (WHO-EURO, 1997; ODA, 1997) and related activities have been sponsored by the British (ODA, 1997) and Italian bilaterals (WHO, 1999; Italian Cooperation, 1998). These documents primarily describe the approach and specific aims of the activities to be undertaken.

One detailed case study of particular interest presents HBP activities undertaken to integrate the health sector of Eastern Slavonia, Croatia (Balladelli, 1997). These activities were facilitated by WHO and are unique in that there has been a fairly detailed evaluation of the HBP efforts (WHO, 1999a). This evaluation provides an excellent framework for some of the evaluative questions one would like to answer when assessing most HBP activities. It assesses the methodology of the HBP approach, its sustainability, the viability of interventions, and the appropriateness of the implementing organization (in this case WHO). In brief, the evaluation suggests that WHO was instrumental in the reintegration of the health sector in Eastern Slavonia, and acted as the principal mediator in this capacity. WHO's aim to advocate peace through health initiatives took place at the micro level (social peacebuilding) and at the macro level (structural peacebuilding). Evaluation findings are discussed more thoroughly in the Croatia case study.

Box 8: Selected Health and Development for Displaced Populations (HEDIP) Activities

Croatia (Split Municipality)

- Health education programs for elementary and high school teachers, social workers and health workers through "training of trainers" in psychological development, communication, youth, family and drugs, Alcoholism, smoking, psychological war trauma, AIDS and sexually-transmissible diseases
- Organization of art workshops for substance abusers
- Psycho-social counseling to war-affected families
- Vocational training
- Cultural and recreational activities for approximately 700 young people from collective centers
- Establishment of a Municipal youth information center through decentralized cooperation with Modena, Italy

Mozambique (Milange District, Zambezia Province)

- Support to the outreach activities of the District Health Office through placing 5 nurses in District health centers and 1 nurse for delivering mobile health services into Renamo-controlled areas
- Provision of motorcycles for mobile vaccination campaigns and refrigerators for vaccines
- Support to the rehabilitation of the district hospital and district health centers
- Socio-anthropological research to map the district in terms of services (health, education, communications), language and the system of traditional leadership
- Mediation between conflicting sides (Renamo and Frelimo) by encouraging involvement of traditional authorities and church leaders in mobilization and implementation of health-related activities in Renamo-controlled areas
- Support to Provincial Health Authority in coordinating health activities at provincial level with international organizations and NGOs

Sri Lanka (Colombo Municipality and Anuradhapura District)

- Building and rehabilitating MCH clinics and first aid posts
 - Construction of about 700 latrines
 - Assistance in obtaining birth certificates and legal documents
 - Literacy classes for children not attending school
 - Repair and upgrading of a community center as focal point for implementation of social and educational programs carried out by public institutions and local NGOs
 - Referral clinics for substance abuse victims and awareness programs for high risk groups
 - Family planning clinics
 - Skills training for female-headed households in income generating activities
 - Social and recreational programs for widows and elderly to alleviate isolation
- Networking of national and international NGOs to facilitate coordination of activities based on needs arising through the participatory Hedip process.

Source: Peters, 1996

Another WHO effort, the Health and Development for Displaced Populations (HEDIP) project undertook operational research in areas of conflict (Mozambique, Sri Lanka, and former

Yugoslavia) on the use of health and social interventions to promote reconciliation and development (Swartz as presented in Peters, 1996). Box 3 details some of the activities of the HEDIP project. Lessons learned from this participatory action and research program informed the approach undertaken by others in the development of the Decentralized Cooperation models.

In turning to individual country experiences, we have classified conflicts using the terminology suggested by Large (1997), as adapted from Cottey (1994). Types of conflicts include:

1. Genocide/large scale loss of human life: situations where central state authorities attempt to exterminate a particular ethnic group (e.g. Rwandan massacres of Tutsis in 1994);
2. Collapse of state authority: situations where conflict has resulted in collapse of central state authority and armed conflict continues (e.g. Somalia);
3. Ethnic civil war: conflict between (among) ethnic groups within a state where ethnic groups are not regionally divided and secession is not a central issues (e.g. Rwanda, Afghanistan)
4. Secessionist civil war: conflict within states fought over the issue of whether a particular ethnic group has a right to secede (e.g. Croatia, Eritrea, Bosnia);
5. Political civil war: conflict between states fought for political control of the state and/or over the political values the state is based on;
6. Armed challenge to legitimate state authority: use of armed force by nongovernmental groups to challenge the authority of a government within a state (e.g. Khmer Rouge in Cambodia, UNITA in Angola);
7. Low-level cross-border conflict: conflict across state borders, but falling short of full-scale war, involving either more limited forms of armed action (e.g. Lebanon-Israel; Sudan-Uganda-Zaire);
8. Inter-state war: classical conflict between national states, involving government controlled armed forces and challenge to state's territorial integrity (e.g. Iraqi invasion of Kuwait; Korean war 1950-53).

In attempting to classify each conflict, our intent was not to make any statement about the conflict, but rather to help determine if there may be some relation between a given type of conflict and the HBP activities implemented. It should also be noted that the categories presented above are not mutually exclusive and the nature of the conflict may actually change over time. Given these limitations, the analysis of the cases presented in Table 3 shows that nearly every type of conflict (with the exception of inter-state war) is represented. Case studies in further sections will analyze the relationship between the type of conflict and the kind of HBP actions implemented.

The literature reveals that a wide variety of HBP measures were implemented. About half of the HBP interventions included immunization cease-fires or cease-fires intended to permit the delivery of humanitarian aid. Documented experiences of immunization or humanitarian cease-fires include those of Afghanistan in 1994 and 1996 (WHO, 1995; Peters, 1996); Cambodia (WHO, 1994); El Salvador every year from 1985 to 1991 (PAHO, 1990; Guerra de Macedo, 1994); Lebanon in 1987 (Hammad, 1998), Uganda in 1985 (Peters, 1996), Sudan in 1989, 1994, 1995 and 1996 (CDC, 1995; Peters, 1996; WHO, 1994); and the Philippines from 1993 to 1995 (Peters, 1996).

In Hay's analysis, (Hay, 1990) of humanitarian cease-fires including immunization cease-fires, "corridors of tranquility" and other approaches he concludes that, by and large, these activities are ad-hoc measures proposed when humanitarian needs in a war zone become acute. He further states that the process of negotiating such a cease-fire can have spill-over effects in terms of building trust among conflicting parties and that the "spirit of conciliation fostered by such cease-fires can permeate the final settlement of a conflict." His analysis also points to the important role that an interested third party could play (often the UN or concerned donor countries) in helping to broker the agreements often with the threat of economic or political sanction or financial incentives such as increased humanitarian aid.

Other HBP activities range from brief descriptions of preventive diplomacy actions in Bulgaria and Turkey (WHO, 1996), to peace-making activities such as joint training and cross-border surveillance in Central America (Guerra de Macedo, 1994). Peacekeeping operations such as assisting in the demobilization, quartering and disarmament of troops were utilized in Angola (Zagaria and Arcadu, 1997) and several cases discuss rehabilitation of public health infrastructure in Mozambique (Mocumbi, 1996), Croatia (Balladelli, 1997) and El Salvador (Brentlinger et al, 1999). Coordination of humanitarian efforts features prominently in the case of Haiti (WHO, 2000a) and Cambodia (Lanjouw et al, 1999). Peacebuilding efforts include decentralized cooperation efforts in the former Yugoslavia (WHO, 1999) and reintegration of health workers in Cambodia (WHO, 1994; Peters, 1996) and Croatia (Baladelli, 1997). Efforts directed at promoting community-level reconciliation include experiences in Liberia with workshops and community development activities designed to promote mental health and ethnic tolerance (Peters, 1996) and the War and Health program's experiences in Sri Lanka designed to assess mental health needs through a participatory, multiethnic approach (Peters, 1996).

Although the majority of HBP literature is descriptive in nature, two training manuals were located that are designed to prepare health workers for undertaking a HBP project.

The first manual is the Health-to-Peace Handbook, developed by McMaster University and edited by Mary Anne Peters (1996). The handbook provides a brief overview of the concept of HBP and the rationale for how health workers and health programs can serve as conduits for peace-building. It also includes several important cautions about potential risks inherent in providing assistance in areas of conflict. These precautions include that such humanitarian cease-fires may have a limited impact if they are not rooted in a larger peace process. Risks include the possibility that one or both sides will use the cease-fires as propaganda for their moral superiority at the expense of the potential solidarity that could be gained from the cease-fire and further delay any eventual lasting peace process. Finally,

monitoring is essential to assure that one or more sides do not use the cease-fire as an opportunity to re-arm, reposition forces or smuggle in weapons or other supplies. The bulk of the manual presents anecdotes about six different HBP initiatives (humanitarian cease-fires in Afghanistan and the Philippines); mental health initiatives in Liberia and Sri Lanka; the WHO HEDIP program; lessons learned by Medecins sans Frontieres; and a description of ways health professionals can influence public opinion and international laws affecting weapons of mass destruction (Peters, 1996). The authors present the results of the 1991 Centre for Days of Peace conference on cease-fires as well as necessary ingredients of a successful humanitarian cease-fire. These ingredients include:

- The need for finding common ground among combatants
- The need for impartiality and transparency, meaning that the benefits of the humanitarian aid should be delivered equally to all and all transactions should be impartial and agreed to beforehand
- Understanding and respect for indigenous cultures should be the modus operandi in the delivery of humanitarian aid
- Trust and communication are necessary to ensure the success of the operation
- Combatants must have confidence in the trustworthiness and impartiality of the implementing organizations. This may be the reason why WHO and UNICEF have so often been involved in such initiatives
- International pressure in terms of public opinion (and perhaps threat of legal or economic sanctions) may be essential in convincing parties to agree to the cease-fire
- A clear legal framework spelling out references to international laws and agreements
- Community participation including local leadership, women and children, and the military is necessary in order to realize the true peacebuilding potential of the cease-fire.
- Education and communication including media campaigns can help maximize the confidence-building impact of the cease-fire.
- Standards and monitoring are crucial in order to maintain compliance with the agreements and to ensure that sides do not use the opportunity to re-arm.

The Handbook ends with a brief discussion on conflict analysis, peacebuilding, project planning and a brief list of resources in peacebuilding, human rights, reconstruction of health systems, and other HBP project descriptions.

The information presented in the *Handbook* is a step in the right direction in terms of practical guidance. However, it is not clear in the majority of cases (with the possible exception of Central America) to what extent the announcement of a cease-fire for immunization or delivery of humanitarian assistance actually served to further promote the official peace process.

Paula Gutlove's (2000) *Health as a Bridge for Peace* training manual is an excellent complement to the *Health-to-Peace Handbook*. The examples presented in the manual are much less varied and detailed, but the framework for how HBP can function (in terms of conflict theory) is more developed than in the *Handbook*. It provides concrete information on combining initiatives such as peacekeeping, famine relief, public health, and other humanitarian programs with conflict management. The *Briefing Manual* describes such "integrated action" as a way of bringing people together through concrete incentives for cooperation. Conflict management is emphasized as an effective strategy for brokering peace and community reconciliation. A basic framework for conflict management is outlined, and examples of its practice are provided in two contexts: the former Yugoslavia and the north Caucasus region. A large section is dedicated to tools for developing a health bridge strategic approach. In addition, skill-building exercises are provided in the areas of developing dialogue, active listening, mapping of the status of public health, generating options, strategic planning, and goal setting. The *Training Manual* is meant to be a generic guide and should be adapted to specific circumstances.

Based on our assessment of the two training documents, it is clear that both can serve important functions within the limitations of their scope and content. The *Health-to-Peace Handbook* by McMaster University provides a range of detailed examples of how health has

been and may be used to broker peace in various country contexts and aid individuals and communities in the post-conflict recovery process, with the aim of rebuilding societal health and preventing future violence. Lessons learned are also discussed. However, unlike Gutlove's manual, the Handbook provides only limited information on concrete tools for building or employing health-to-peace strategies, while training and skills development issues are not addressed. In addition, while a major focus of the Handbook is on providing examples of health-to-peace initiatives, little evaluative information is included. The authors acknowledge a dearth of evaluative research in this area, and dedicate a short section on conducting evaluation of health-to-peace initiatives and on indicators that may be important.

Two other important literature streams emerged from the literature review. First, documents on actions by international groups such as International Physicians for the Prevention of Nuclear War, the International Campaign to Ban Landmines, and others working to influence the international policy dialogue regarding weapons and the conduct of warfare (See WHO, 1997; IPPNW, 1997; Kaplan, 1999). Second, a large body of literature has developed on the health, social, and psychological impact of warfare, complex humanitarian emergencies, and population displacements (Summerfield, 2000; Ugalde, et al, 2000; Toole and Waldman, 1997; Zwi et al, 1989 and 1996; Fitzsimmons and Whiteside, 1995). Each of these sources has in some way enriched the HBP perspective and approach. However, given the focus of this review on linkages between health and peace actions, particularly within the context of complex humanitarian emergencies in developing countries, these literature streams were not examined in depth as part of this review.

Finally, the literature review also revealed criticism of health to peace ideology (Macrae 1995, 1997, 1998 and Lanjouw, et al., 1999). Critics of HBP ideology argue that mixing development and conflict resolution objectives with humanitarian objectives is likely to diminish the ethical basis of humanitarian interventions, which is derived from principles of neutrality and

impartiality. In this vein, relief aid is seen as becoming a form of political action, putting pressure on relief actors to take sides and make decisions about preferred outcomes. Relief actions, then, may be looked upon as being partial to a particular side or warring party, and may be identified as a legitimate target for attack.

Table 3: Summary of HBP Experiences Worldwide

| Country | Year | Organizations | Type and stage of conflict | HBP actions undertaken | Data quality | Source |
|----------------------------|-----------|---|--|---|--------------|-----------------------------------|
| Afghanistan | 1992-1996 | WHO, UNICEF, ministry of public health, NGOs | Ethnic and political civil war Stage: War | Peace-making -Immunization cease-fires -Corridors of tranquility for humanitarian relief | G | WHO, 1995 Peters, 1996 |
| Angola | 1990s | WHO | Armed challenge Stage: War | Peacekeeping -Disarmament, quartering and demobilization of armed forces | G | Zagaria and Arcadu, 1997 |
| Bosnia-Herzegovina (1) | 1991-1997 | WHO, UNHCR, UNMIBH | Secessionist civil war Stage: Post-crisis | Peace-building -Integrating peace-building awareness into capacity-building efforts -Leadership in health coordination committees -Joint training activities -Community-based health promotion activities | G | WHO/EURO, 1997 Peters, 1996 |
| Bosnia-Herzegovina (2) | 1993-1997 | WHO, NGOs, HEDIP, Governments of Europe | Secessionist civil war Stage: Post-crisis | Peace-building -Decentralized Cooperation approach between European cities (Italy) and cities in BiH | G | WHO, 1999a |
| Bulgaria/Turkey | 1990? | WHO, Bulgarian and Turkish medical associations | Mild political conflict | Preventive diplomacy -Assistance in mediation of political dispute | P | WHO, 1996 |
| Cambodia | 1990-1994 | WHO, UNTAC, UNHCR, MOH, NGOs | Armed challenge Stage: War, Post-crisis | Peace-making -Immunization cease-fires -Coordination of humanitarian and refugee aid Peace-building -Re-integration of health workers -Unification of health services among opposing factions | P | WHO, 1994 Lanjouw, et al, 1999 |
| Eastern Slavonia (Croatia) | 1991-1997 | WHO, UNTAES | Secessionist civil war Stage: Post-crisis | Peace-keeping -Leadership of joint implementation committees -Joint meetings/seminars on technical issues Peace-building -Re-integration of Serb and Croat health workers -Immunization campaigns | E | Balladelli, 1997 WHO, 1999b |

| | | | | | | |
|---|-------------|---|---|---|---|--|
| El Salvador (Nicaragua, Belize, Panama, Guatemala, Honduras) | 1984-1994 | PAHO, governments, bilateral donors, NGOs, UNICEF, Spain, USA | Political civil war Stage(s): War, Post-crisis | Peace-making and peace-building -Ministerial-level meetings to assess and plan health activities -Immunization cease-fires (each year from 1985-1991) -Joint border monitoring -Technical and training exchanges -Drug and vaccine exchanges and joint purchases -Joint working group to assess health threats and plan actions | E | PAHO, 1985 PAHO, 1989 PAHO, 19909 PAHO, 1990/1991 Guerra de Macedo, 1994 |
| Former Yugoslavia (Croatia, Montenegro, Serbia, BiH, Macedonia) | 1990s | Medical network, IRSS | Secessionist civil war Stage: Post-crisis | Peacebuilding | P | Gutlove, 1997, 2000 |
| Haiti | 1991 – 1994 | | Collapse of state authority Stage: Post-crisis | Peacekeeping | E | WHO, 1999 |
| Iraq | 1990? | WHO | | Peace-making | P | Hammad and Bassani, 1996 Hammad, 1998 |
| Lebanon | 1987 | WHO | Low-level cross border Stage: War | Peace-making -Immunization cease-fire | P | WHO, 1994 Hammad, 1998 |
| Liberia | 1990s | Christian Health Association of Liberia (CHAL) | ? Stage:? | Peace-building -Health promotion activities geared toward conflict resolution, reconciliation, and “prejudice reduction” | P | Peters, 1996 |
| Mozambique | 1992-1996 | WHO, UNOMOZ, Government, HEDIP | Armed challenge, low-level cross border Stage: Post-crisis | Peacekeeping -Incorporate health as component of peace-building efforts | P | Mocumbi, 1996 WHO, 1996 |
| Northern Caucasus (Chechnya) | | WHO | Secessionist civil war Stage: Post-crisis | | P | WHO, 1999 |
| Philippines | 1988 | WHO, UNICEF | ? | Peace-making | G | Peters, 1996 |

| | | | | | | |
|-----------|------|-----------------------------|---|--|----|--|
| | | | Stage:? | -Immunization for Peace program | | WHO, 1994 |
| Rwanda | 199? | WHO | Genocide Stage: Post-crisis | Peace-building? | UK | |
| Sri Lanka | | WHO, HEDIP | Secessionist civil war Stage: War | Peace-making? | P | Peters, 1996 |
| Sudan (1) | 1989 | Operation lifeline Sudan | Secessionist, ethnic civil war Stage: War | Peace-making -Corridor of tranquility for delivery of humanitarian supplies | G | WHO, 1994 Peters, 1996 CDC, 1995 |
| Sudan (2) | 1995 | Carter Center, UNICEF, NGOs | Secessionist, ethnic civil war Stage: War | Peace-making -Immunization and health cease fire (March to July) | G | WHO, 1994 Peters, 1996 CDC, 1995 |
| Uganda | 1985 | WHO? | Low-scale cross-border conflict Stage: War | Peace-making -Corridor of tranquility | P | Peters, 1996 WHO, 1994 |

V. Selected Case Studies

This section provides a detailed analysis of specific HBP initiatives, focusing particularly on issues related to new planning, implementation, and evaluation. Cases were selected based on the availability and quality of data and on the need to represent a wide range of geographic regions, HBP actions, and conflict types. Specific case studies will be reviewed to compare and contrast the extent of the HBP approach, its strengths, and its potential weaknesses.

This section seeks to address the following questions:

- What is the nature of the conflict and the stage during which the HBP activity took place?
- What role did different organizations and professionals working in the health field play in initiating and implementing the HBP activity? To what extent and how did health organizations/workers engage with other sectors?
- What specific HBP activities were undertaken? Does the appropriateness of the specific health response depend on the nature/timing/stage of the conflict?
- What elements are most likely to have contributed to the success of the initiative? What types of barriers presented themselves? How were they overcome?
- What lessons have we learned from the initiatives?

A. Case Study 1: El Salvador

Health as a Bridge for Peace was born out of the civil conflict, economic stagnation and human suffering dominating Central America throughout the 1980's. More than 160,000 Central Americans died in wars or civil violence, and the numbers of wounded reached several hundred thousand. Over two million people fled their homes, finding temporary refuge in neighboring countries, adding to an already heavy economic and social burden in their new countries of residence (Guerra de Macedo, 1994). In July, 1981, the first concern about the Central American situation was expressed publicly by the international community during a meeting of foreign ministers of Canada, the United States, Mexico and Venezuela in Nassau, the

Bahamas. Participants of the meeting reached an agreement stipulating that external cooperation should be utilized for the promotion of economic and social development, and that the donor countries would provide financial support for these efforts.

In 1982, the United States presented the "spheres of action initiative"¹ at the Organization of American States (OAS) annual meeting, an action that led to the creation of the Caribbean Basin Initiative by the Central American Foreign Ministers and to a joint declaration to work together under the auspices of the American Development Bank for the purpose of obtaining more resources for the region. In 1984, a Central American Consultative Group was created.² Development, peace and social justice were among the group's objectives (PAHO, 1985).

In 1983, in an effort to contribute to this growing regional peace effort, the Pan American Health Organization called on the nations of Central America as well as the Contadora Group nations³ to create a Central American health initiative--the Plan for Priority Health Needs in Central America and Panama (PPSCAP). This initiative was formally approved on March 16, 1984 at the first meeting of the health sector of Central America and Panama in San Jose, Costa Rica. It marked the beginning of a unique initiative in the region, which promoted the improvement of the health of its inhabitants. More importantly, it changed the way countries cooperated with each other by promoting a broad spirit of solidarity and "peace-searching" (PAHO, 1990). The initiative was strongly rooted in the belief that health, because of its unique value and universal acceptance, could serve as a bridge for peace, solidarity and understanding among the peoples of Central America and Panama.

The first phase of the plan (PPSCAP) took place from 1984 through 1990, under the name "Health as a Bridge for Peace". Although it was not the only answer to the urgent needs

¹ The three spheres of action comprised commerce, investment and financial assistance.

² Banco Interamericano de Desarrollo (BID). Reunion Especial del Programa para el Desarrollo del Istmo Centroamericano. Bruselas, 13-15 de setiembre de 1983. Washington, DC: 11 de octubre de 1983.

³ The countries of Colombia, Mexico, Panama and Venezuela form the Contadora Group.

of the population, it served as a pivotal mechanism for coordinating efforts, planning and mobilizing resources, and improving access to health services and programs in the region. From the outset of the Central American Health Initiative, critical health disparities existed across the spectrum of health indicators among countries in the region. These were especially apparent between the countries of Costa Rica, Panama and Belize on the one hand, and El Salvador, Honduras, Guatemala and Nicaragua on the other.⁴ Additionally, the economic vulnerability of the region was augmented by the destruction of a once growing regional market, the sharpest decline in international terms of trade in forty years, the heavy weight of civil conflict, and a massive and growing debt burden (PAHO, 1988).

Seven priority areas of cooperation were identified: a) strengthening of health services, b) development of human resources, c) essential drugs, d) food and nutrition, e) control of tropical diseases, f) child survival, and g) water and sanitation (PAHO, 1988). Efforts were targeted to vulnerable population groups such as children under five, mothers, refugees and displaced persons, and the poor. UNICEF joined with PAHO and other donor agencies to help the countries in their pursuit of child survival objectives.

An international donor conference sponsored by the Government of Spain was held in Madrid in November 1985. Spain united with fourteen European countries, Canada, the United States, Japan, the Vatican, several Latin American countries, the Contadora Group countries, and multilateral cooperation agencies in order to offer support for the Central American Health Initiative and to assure firm commitments of political, material, technical and financial support. During this conference, 123 sub-regional and 30 national projects were presented. Five years later, the vast majority of these projects had been implemented with over two-thirds of the sub-regional projects receiving donor funding (Guerra de Macedo, 1994).

⁴ For example, from 1981-1985, the estimates for Panama, Costa Rica and Belize showed infant mortality levels just below 25 per 1,000 live births, while El Salvador, Guatemala, Honduras and Nicaragua ranged near 80 per 1,000.

One of the major achievements during the 1980s was a series of *immunization cease-fires* (Guerra de Macedo, 1994). Successful cease-fires were conducted in El Salvador each year between 1985 and 1991. The immunization campaigns were coordinated by the Ministries of Health with the support of PAHO, UNICEF, Rotary International, the International Committee of the Red Cross, the private sector, and the highest level representatives of the Catholic Church in Latin America. International organizations, the Ministry of Health and Non-Governmental Organizations (NGOs) collaborated in the planning and the implementation of the cease-fires. PAHO, as manager of the Expanded Program on Immunization, worked with Ministry of Health officials on the technical side, UNICEF assured mass communication and coordinated many of the NGOs' efforts to generate the necessary social mobilization. The International Committee of the Red Cross played a crucial role in carrying the campaign into areas controlled by the guerrillas. (Guerra de Macedo, 1994).

In addition to immunization cease-fires, many other HBP actions were employed. For example, because meetings between leaders of the warring factions were not feasible, regular meetings were organized for representatives of each country's Ministry of Health. The meetings were intended to build trust and eventually included representatives from Belize, which had previously been excluded from these multilateral fora/exchanges. Furthermore, cross-border health projects allowed countries to collaborate in joint border-monitoring of populations and infectious diseases outbreaks (PAHO, 1990). Toward the end of the PPSCAP initiative, Guatemala, Belize, and Mexico, and Honduras, Mexico and El Salvador signed tri-partite agreements on the exchange of medicines and vaccines. Joint procurement of essential drugs also allowed for substantial discounts (PAHO, 1989).

Key lessons learned from the Health as a Bridge for Peace activities in Central America include:

- The involvement of the international community (OAS, Spain, United States, other European countries, UN agencies) was essential to the conceptualization and implementation of the

HBP efforts. The leadership role of PAHO was essential in bringing health to the forefront of the peace-building agenda, while the actions of UNICEF, the ICRC and NGOs were essential in coordinating efforts at the field level.

- The international community showed political will, but also provided important sources of funds, vaccines, medicines, and equipment to back up their promise of assistance. Many of the innovative projects undertaken are not likely to have taken place without substantial donor support. Estimates range from \$50 to \$100 million invested in the Health as a Bridge for Peace effort over the years 1985-1989 alone (PAHO, 1989).
- Although immunization cease-fires were the most highly visible HBP activities, many other tactics were undertaken to build confidence and instill trust among all sides in the conflict. Other HBP activities include cross-border projects including surveillance activities, joint agreements for procurement of medicines and vaccines, and regular meetings of MOH and Social Security Departments of each of the countries involved in the conflict (Guerra de Macedo, 1994).
- Although the HBP actions may have aided the peace process by building trust and establishing institutional measures for collaboration, it must be acknowledged that the governments of each country were willing to concede to these preliminary measures. This indicates at least partial willingness to collaborate on joint problems. This willingness to consider cooperation may not always be present in all conflicts or among all parties involved in any specific conflict.

Table 4: Summary of El Salvador HBP Experience

| Domain | El Salvador |
|---|---|
| Nature of the conflict | Political civil war |
| Key stakeholders | Government, Military, FMLN, WHO, PAHO, OAS, Catholic Church |
| At which stage of conflict was HBP action initiated? | War |
| Who triggered the HBP initiative? | WHO/PAHO, OAS, UNICEF, Catholic Church, Government of Spain |
| Who were the key stakeholders in the HBP activity? E.g. government, NGO, WHO, etc. | Government of El Salvador, Catholic Church, FMLN, WHO, OAS, International donors (Government of |

| | |
|---|---|
| | Spain) |
| How did sides get together to work on the HBP initiative? Was there cooperation/ conflict? | Series of international meetings and agreements |
| What events led up to the adoption of the HBP actions? | Madrid Conference, Central American Health Initiative |
| What HBP activity(ies) were undertaken (e.g. immunization cease-fire, joint planning, etc. see the humanitarian asst book chapter table) | Immunization cease-fires, Joint surveillance activities, Joint agreements for medical item procurement, Regular meetings of MOHs and Social Security departments by each country formerly involved in the conflict. |
| What type of personnel participated in the HBP activities (physicians, politicians, soldiers, etc.) | Health workers, physicians, military, ministers of health, social security administrations, church |
| What were the outcomes? | Successful regional cooperation in areas of common interests which "spilled over" to other areas of conflict |
| How were outcomes achieved? | <ul style="list-style-type: none"> - Series of meetings and agreements - International pressure to resolve long-standing conflict - Generous offers of international aid |
| Did outcomes affect different stakeholders in different ways? | Not clear |
| Who thought the effort was a success/failure? Why? | All parties involved seemed to welcome the end of the fighting and resolution of conflict. |
| Did some activities seem better at promoting health as the expense of peace or vice-versa? | Not clear |
| What barriers were there to the achievement of the objectives? How could they be overcome in future? | Initially one party of conflict was not willing to partake in dialogue. International backing greatly assisted in this resolution process. |
| Recommendations for specific groups (WHO, NGO, MOH, military, etc.) | Yes. HBP will work even when one side of conflict is not initially willing to begin dialogue. However, international impetus is greatly beneficial in these instances. |

B. Case Study 2: Angola

The WHO experience in Angola centered on assistance in the disarmament, quartering, and demobilization of soldiers from armies on both sides of the conflict. After signing the Lusaka protocol in 1994, WHO played an important role in the development and implementation of the health program during quartering and demobilization phases. Key activities included: designing common protocols for collaboration between groups; brokering arrangements for joint data collection activities; working with communities to develop public health programs; training military health personnel; setting up health units in the quartering areas; developing an agreement for a joint medical team to classify disabilities; and supporting a legal basis for institutionalizing benefits for disabled war victims and demobilized soldiers.

Challenges faced by the HBP team, headed by WHO, included the fact that the speed and evolution of the peace process on the health sector are often unpredictable and priorities can change rapidly warranting re-planning and new strategies (Zagaria and Arcadu, 1997). In response, a conceptual framework was developed linking the context of the peace process with operational modalities and health sector priorities. The framework allowed the health actions to keep pace with and adapt to the changing peace process.

In Angola, health interests did seem to form a common ground for cooperative efforts. This point is clearly reflected in the following statement by Dr. Zagaria, coordinator of the demobilization process in Angola:

When two conflicting parties perceive a health issue as a problem, there is the opportunity for the health sector...to promote and implement control activities on problems of public health relevance through joint team work. This can contribute to the national reconciliation process, giving a sense of the evolution of the peace process at peripheral as well as central levels, and thus becoming important precedents for dealing with other problems quicker and again jointly in the future (WHO, 1997: 5).

Dr. Zagaria insists further that, in the Angola experience, the health sector had a critical role in the demobilization process, and was able to work in such a way as to promote joint understanding and peace-building among the different sides previously in conflict. However, he also points out that the potential for using health as a bridge for peace should have been a specific subject of the briefing sessions for health personnel working at different levels—from decision making to management to implementation of the operation. He believes that training military and civilian workers to communicate and collaborate together would improve the process and outcomes of such cooperative efforts.

The following lessons can be drawn from the Angolan experience:

- Training is a key activity to guarantee the passage from relief activities to rehabilitation of the health system. It also helps to engage the full participation of program beneficiaries.

Health professionals including WHO staff require certain skills in order to work in these health/peace initiatives. These skills include:

- Understanding of and sensitivity to the political, legal, socio-economic environment of the country, specifically in relation to the peace process;
 - Capacity to identify opportunities and crucial issues to bring technical people from conflicting parties to meet and work together;
 - Problem solving skills;
 - Leadership capacity to seek joint solutions to meet common needs and to bring the parties to the negotiating table;
 - Negotiation and mediating skills;
 - Proposing clear technical principles as basis for negotiations to avoid political manipulation of aid (Zagaria, et. al. 1997).
- Health can furnish a working environment in which confidence between the parts can be built and from which the process of the extension of the state administration of the new government of reconciliation can benefit.
 - HBP cannot substitute for interventions on the political level, but instead must monitor the political evolution of the process in order to take advantage of opportunities to reinforce peace-building efforts.
 - Technical coordination can only be done in accordance with the epidemiological situation and the various phases of the peace process. Otherwise, there is the risk that health assistance will not correctly target proper health and peace needs.
 - Health organizations, by virtue of their perceived impartiality, may serve as “jurists” in debates among conflicting sides. This was evident during the incorporation of military and civilian health personnel of UNITA with the national health system. It was also crucial in supporting local

authorities in discussing and agreeing upon appropriate solutions to work within the legal framework of the country.

Table 5: Summary of Angola Experience

| Domain | Angola |
|--|---|
| Nature of the conflict | Armed challenge to legitimate state authority |
| Key stakeholders | UNITA(FMU), Angolan Armed Forces, UN Observation Mission in Angola, MOH, Humanitarian Assistance Coordination Government Unit (UCAH), UN Angolan Verification Mission (UNAVEM), Government of Unity and National Reconciliation, NGOs, UNICEF, WHO |
| At which stage of conflict was HBP action initiated? | At the end of conflict once Lusaka Peace Protocol was signed |
| Who triggered the HBP initiative? | UN |
| Who were the key stakeholders in the HBP activity? | UN Security Council, UCAH, UNAVEM |
| How did sides get together to work on the HBP initiative? | Signing of the Lusaka Peace Protocol (UN mandate) |
| What events led up to the adoption of the HBP actions? | Signing of the Lusaka Peace Protocol |
| What HBP activity(ies) were undertaken (e.g. immunization cease-fire, joint planning) | <ul style="list-style-type: none"> - National guidelines on specific health issues (malaria, diarrheal disease, etc.), were presented to the health authorities of UNITA and implemented - A dialogue between health personnel of both sides on mutually important issues was promoted through technical meetings - A simplified health information system for epidemiological surveillance during the demobilization process was implemented and monitored by personnel from both sides - Training courses were jointly developed and implemented by health personnel from both sides dealing with standard protocols for diagnosis and treatment of common diseases |
| What type of personnel participated in the HBP activities | Health workers, physicians, nurses, demobilizing military personnel |
| What were the outcomes? | UN mandate |
| How were outcomes achieved? | Through implementation of the UN mandate. |
| Did outcomes affect different stakeholders in different ways? | Not clear |
| Did some activities seem better at promoting health at the expense of peace or vice-versa? | All activities that physically brought personnel from both sides to an area where they were forced to acknowledge each other were very conducive to the peace-building effort |
| What barriers were there to the achievement of the objectives? | Initial distrust and reluctance on the part of both parties |
| Recommendations for specific groups (WHO, NGO, MOH, military, etc.) | <ul style="list-style-type: none"> - The presence of humanitarian staff during diplomatic talks are key to guaranteeing a coherent implementation of humanitarian programs toward a common goal of peace-building - Donors are more likely to support a comprehensive humanitarian strategy rather than independent programs - A multisectoral approach in designing humanitarian activities connecting all actors in the peace-implementation process is an effective peace-building tool - The health sector has a central and pivotal role in providing a comprehensive vision of the basic human right to guarantee the |

C. Case Study 3: Croatia

Since 1992, the WHO has been engaged in assisting the countries of the Former Yugoslavia to secure health for their population. Since November 1995, WHO programs for Croatia have focused activities in the Eastern Slavonia region. According to the Dayton and Paris Agreements, the region was not yet under the control of the Republic of Croatia and was to be reintegrated into Croatia after the transitional administration by the United Nations. During the transitional administration, WHO chaired the process of reintegration of the health sector. A high-profile program called the “Joint Implementation Committee on Health” (JIC) was established to facilitate reintegration of the health sector and overcome tensions among health workers. Through the JIC, the former parties to the conflict including local Serbian leaders and the Croatian Ministry of Health, were committed to improve the quality of the disrupted local health system and define clear steps forward to achieve the reintegration of the local health sector in Croatia.

Local health providers worked together with WHO and other international agencies in various fields of intervention: physical rehabilitation, mental health, vaccination, and health information systems. Four different phases have been implemented through the JIC: confidence building, joint analysis of health matters, planning/ implementation of joint activities, and administrative – legal reintegration of the health sector into Croatia. Specific activities included developing commissions on administrative reintegration, technical activities in mental health, physical rehabilitation and epidemiology, health research, organizing a sub-national immunization day against poliomyelitis, and provision of essential drugs.

The modus operandi for the project was to present the JIC as a safe forum for dialogue on technical issues, creating the basis for mutual understanding and cooperation within the health sector. This included emphasizing the respect for both sides’ roles as health

professionals, and emphasizing their traditional neutrality and impartiality in situations of conflict. The case study presents preliminary evidence that the initiative increased reciprocal acceptance of the two groups of health professionals, partially increased the number of Serb and Croat health employees working together, and began to provide for more equal opportunities to the local Serb health workers.

Shortcomings include the fact that only a few Serbian health professionals received their contract to work under the Croatian administration, no Serbian professionals were selected for key positions in the health system, and only about 50 percent of the Serb population are covered by the Croatian National Insurance System.

The case study also highlighted a number of operational challenges for WHO, including:

- The realization by WHO in this context that health concerns are not automatically politically neutral.
- The question of whether neutrality and impartiality can be divorced from the concept of human rights, as defined by international conventions.
- A related question is: How can WHO take a stand in protecting human rights and also avoid political implications? What about conflicts that arise between conflicting humanitarian assistance and country programs because one of the sides in the conflict is a Member State?

Table 6: Summary of Croatia/Eastern Slavonia Case

| Domain | Croatia |
|--|--|
| Nature of the conflict | Secessionist civil war |
| Key stakeholders | UNTAES, UNICEF, UNHCR, MSF, Belgian Red Cross, ICRC, IFRC, Catholic Relief Services, Japanese Emergency Network, Care Canada, Dutch NGOs |
| At which stage of conflict was HBP action initiated? | At the end of conflict (i.e. once Dayton Peace Accord was signed) |
| Who triggered the HBP initiative? | WHO (through the Health Coordination Task Force for the Eastern Slavonia region, Croatia) |
| Who were the key stakeholders in the HBP activity? | Joint Implementation Committee on Health (WHO) |
| How did sides get together to work | Cooperation was mandated and enforced by the UN (through |

| | |
|--|---|
| on the HBP initiative? | peace agreements) |
| What events led up to the adoption of the HBP actions? | NATO Campaign, UN mandated Peace Agreement |
| What HBP activity(ies) were undertaken (e.g. immunization cease-fire, joint planning, etc. | <ul style="list-style-type: none"> - JIC served as the principal mediator in health - JIC brought together conflicted health workers and built confidence among them through joint health activities - JIC served as a focal point for international organizations for all health issues in the region |
| What type of personnel participated in the HBP activities | - Health care workers, NGOs, international organizations, UN |
| What were the outcomes? | Successful so far |
| How were outcomes achieved? | Through mandate |
| Did outcomes affect different stakeholders in different ways? | Not clear |
| Did some activities seem better at promoting health as the expense of peace or vice-versa? | Thus far, all parties to the original conflict have their own differing position on the issue. One of the most effective activity included bringing all the medical professional organizations together under one roof to interact (Norwegian initiative). |
| What barriers were there to the achievement of the objectives? How could they be overcome in future? | ethnic antagonism |
| Recommendations for specific groups | HBP will work even if all warring parties are not initially willing to interact with each other in a peaceful manner. International resources in the form of money, personnel and supplies, must be available for successful implementation of HBP. |

D. Case Study 4: Haiti

Humanitarian assistance programs in the health sector (Health HAPs) were implemented in an extraordinary context in Haiti between 1991 and 1994. In response to the overthrow of the legitimate government of Jean-Bertrand Aristide in October 1991, the international community sought to restore constitutional order by imposing global economic sanctions (WHO, 2000a; FitzSimons and Whiteside, ND). While there was hope that strict enforcement of this embargo would quickly bring an end to the military regime, international health organizations, such as the World Health Organization, sought to protect the general population from the impact of sanctions by advocating for and establishing Health HAPs. Despite efforts to maintain neutrality, the provision of health services by the international health community within the context of global sanctions became a politically-charged undertaking.

There were two schools of thought within the international community with respect to the provision of humanitarian health programs in Haiti during this period. For some, the

establishment of Health HAPs suggested an implicit admission that sanctions would not work, and was seen as indirectly helping the military regime to remain in power. Accordingly, proponents of this argument favored strict enforcement of the sanctions, the evacuation of all health personnel, and breaking all relations with the *de facto* authorities.

The second perspective saw a need for the continuation of their health mission among the most vulnerable segments of the population and argued that health interventions, while needing to remain strictly apolitical, were necessary to avoid excess morbidity and mortality among an already suffering population. While attempting to respect and support the internationally-imposed sanctions, these agencies advocated for maintaining relations with the *de facto* government, arguing that suspension of external cooperation would have a disastrous effect on the future of the country.

This second school of thought, led by WHO, ultimately prevailed. The decision to put assistance programs in place forced the international health community to walk a delicate line in attempting to respect international will while carrying out programs requiring the agreement of *de facto* authorities. In order to avoid collaboration with the illegitimate government as much as possible, Health HAPs were implemented through local NGOs and institutions using human resources already available in the country, rather than international emergency teams. In order to preserve their neutral position, Health HAPS distanced themselves from formal peace processes, concentrating instead on the more technical aspects of humanitarian assistance. In short, the Health HAPs placed importance on maintaining a technical focus, keeping a low profile, and not pursuing persuasive activities, except in favor of humanitarian assistance, which in the Haitian context seemed to be the only realistic positions available in order to ensure the continued delivery of health services. Pursuing peace-oriented objectives such as striving for safe and fair inclusion, reducing polarization, and bringing parties together were not possible in

Haiti because of the brutal repression activities of the illegitimate government. It was thought that such reconciliatory actions would have constituted implicit support of *de facto* authorities.

Following the return to constitutional order, the Health HAPs were evaluated as to their contribution to the peace-making or peace-building process in the country. There was general consensus that the Health HAPs had been successful in providing the population with access to medical assistance which, in some cases, was of better quality than in the pre-crisis period. The Health HAPs prevented the deterioration of the health situation and the collapse of Haiti's health network. In addition, despite the general collapse of public infrastructure, the private, non-profit network fared relatively well under the crisis due to their active involvement in HAP activities and services. This partnership between humanitarian aid agencies and local organizations not only allowed the preservation of the country's health system, it also promoted innovation and the development of indigenous expertise, thereby strengthening this segment of civil society.

Critics of the Health HAPs point to their role in legitimizing the *de facto* government, their contribution (direct or indirect) to the general weakening of civil society, the loss of momentum of the popular movement, and the slowing of the democratization process in the country.

A lesson learned from the Haitian experience is that health issues are not neutral in and of themselves. They only become neutral if all concerned find it to be in their best interest. In Haiti, it was impossible to reconcile the technical imperatives of health and political constraints, thereby limiting the scope and nature of peace-building alternatives available to health personnel (WHO, 2000a).

Table 7: Summary of Haiti Case

| Domain | Haiti |
|--|---|
| Nature of the conflict | Collapse of State Authority Overthrow of democratically-elected government |
| Key stakeholders | United Nations, Haitian health professionals, NGOs |
| At which stage of conflict was HBP action initiated? | During the imposition of economic embargo |

| | |
|--|---|
| Who triggered the HBP initiative? | WHO, PAHO, International Organizations, NGOs |
| Who were the key stakeholders in the HBP activity? | UN, WHO, PAHO, local NGOs |
| How did sides get together to work on the HBP initiative? | HBP efforts were primarily among international actors and local NGOs. Collaboration with <i>de facto</i> authorities did not occur and peace-oriented objectives were avoided due to repression activities of the illegitimate government. It was thought that reconciliatory actions would have constituted implicit support of <i>de facto</i> authorities. |
| What events led up to the adoption of the HBP actions? | Economic sanctions |
| What HBP activity(ies) were undertaken (e.g. immunization cease-fire, joint planning, etc. | Medical treatment clinics, medical supply distribution |
| What type of personnel participated in the HBP activities | Health workers, physicians |
| What were the outcomes? | -HAPs prevented the deterioration of the health situation and the collapse of Haiti's health network. Partnerships between humanitarian aid agencies and NGOs promoted local innovation and the development of indigenous expertise. -Negative outcomes may have included the legitimization of the <i>de facto</i> government and general weakening of civil society. |
| How were the outcomes achieved? | Outcomes were achieved through implementation by local NGOs, using human resources already available in the country. HAPS concentrated on technical aspects and distanced themselves from formal peace processes in order to preserve neutrality. |
| Did outcomes affect different stakeholders in different ways? | Financial and technical inequalities between donor agencies and local organizations may have led to the adoption of donor agencies' priorities over local priorities. |
| Did some activities seem better at promoting health at the expense of peace or vice-versa? | Activities were specifically designed to promote health. Peace-building outcomes, such as the strengthening of the local NGO sector, were secondary. |
| What barriers were there to the achievement of the objectives? How could they be overcome in future? | Barriers mainly political. In a context in which illegitimate forces have displaced a democratically-elected government, very little can be done by the health sector to overcome political barriers. |
| Recommendations for specific groups | International health community should attempt to come to consensus on protocols of action in contexts similar to the one in Haiti during this period. |

E. Case Study 6: Bosnia Herzegovina

The war in Bosnia-Herzegovina began in earnest in 1992 and lasted until 1995. Injuries and death of both civilian and military populations devastated the country. Some of the most vulnerable of society, including women, children, and the elderly were among the hardest hit. A severe refugee crisis developed, with approximately 300,000 Bosnians relocating to Croatia by 1994. During this period, government buildings, civilian homes, and public institutions on all

sides became targets for bombing, the damage of which is still visible today. Hospitals were destroyed and much of the health system became geared to the needs of the conflict. Available healthcare systems could be characterized as fragile at best, plagued by shortages of supplies and lack of secondary and tertiary care for civilians. Two major health issues took center stage, including the physical and emotional trauma of the war itself and the risk of communicable disease (Horton, 1999). During this period, WHO responded with emergency humanitarian programs, which included activities such as technical assistance, coordination of international health partners, and provision of medical supplies and equipment in support of the country's ailing health infrastructure (WHO, 2000b).

Since the end of the war, the international health community has been actively involved in peace-building initiatives. Specific initiatives include WHO's *Health as a Bridge for Peace* and *Peace through Health* programs, aimed at fostering post-conflict resolutions. As a part of these efforts, WHO and various European partners have employed the concept of "decentralized cooperation" (DC), an innovative development designed to promote community empowerment by breaking isolation and encouraging bottom-up initiatives. DC links local communities in donor countries with local communities in countries needing support. The objective of these links is to create and/or consolidate long-term cultural, technical, and economic partnerships as a way to promote human development and peace. Through an emphasis on working in partnership with one or more entities on issues of common interest and need, DC plays an important role in promoting conflict resolution and peace building.

In the case of Bosnia and Herzegovina, WHO took on the role of facilitator and catalyst, bringing together institutions, health and social services, professionals, and lay people from conflicting parties in Bosnia and Herzegovina and linking them with Italian local governments and civil society. In so doing, the health and social sectors of 22 Bosnian towns were linked with 29 Italian local committees, representing 164 municipalities; 10 provincial administrations; 7

regions; and 120 NGOs, associations, and other civil society groups. Community members of these 22 Bosnian towns, who once faced each other from opposite sides of the conflict, were given the opportunity to work together and in conjunction with their Italian counterparts on activities such as preliminary meetings, needs assessments, planning exercises, and training sessions, thereby strengthening the trend towards reconciliation. Throughout the process, WHO assisted in the coordination of activities and provided technical assistance in order to ensure that activities were in line with national policies, reform trends, and international standards. This coordination role was deemed important in order to promote complex changes, such as mental health reform, and avoid fragmentation.

Through this joint action, goods and services have been made available, infrastructures have been put in place, capacity building has been fostered, and new human relations developed. In addition, Decentralized Cooperation has been successful in promoting ideas of peace and peaceful coexistence, the integration of vulnerable groups, and sustainable development, at a cost that does not require extensive external funding (WHO, 2000b).

In evaluating DC in Bosnia and Herzegovina, it should be noted that concern and interest in health is one of the few common denominators uniting former conflicting parties. Previous experience has shown that through localized projects, such as DC, where emphasis is placed on joint action and common points of interest, gradual renewal of trust and sense of mutuality, necessary for viable peace building, is possible. In the Bosnia and Herzegovina experience, DC has been successful in bringing together Croat and Bosnian parties in a shared focus and meeting ground. Interpersonal skills development and group development have been the basis of local reconciliation initiatives. However, despite these early successes, evaluation of long-term effects of DC has not been possible. It is too early to say whether the positive short-term outcomes of DC initiatives will make real contributions to the peace process or the

improvement of health status and services in the long term. These long-term outcomes should be the subject of future research and evaluation activities (ODA, 1997).

Table 8: Summary of Bosnia Herzegovina Cases

| Domain | Bosnia Herzegovina |
|--|---|
| Nature of the conflict | Secessionist Civil war |
| Key stakeholders | General population, local communities in Bosnia and Herzegovina and Italy |
| At which stage of conflict was HBP action initiated? | Post-conflict |
| Who triggered the HBP initiative? | WHO and the Italian government |
| Who were the key stakeholders in the HBP activity? | WHO, 22 Bosnian towns and 29 Italian local committees, representing 164 municipalities; 10 provincial administrations; 7 regions; and 120 NGOs, associations, and other civil society groups. |
| How did sides get together to work on the HBP initiative? | Facilitation by WHO |
| What events led up to the adoption of the HBP actions? | Preliminary meetings between local communities in Italy and Bosnia Herzegovina, WHO and the Italian government |
| What HBP activity(ies) were undertaken (e.g. immunization cease-fire, joint planning, etc. | Joint planning |
| What type of personnel participated in the HBP activities | Institutions, health and social services, professionals, and lay people from conflicting parties in Bosnia and Herzegovina and Italian local governments and civil society. |
| What were the outcomes? | Goods and services made available, infrastructures put in place, capacity building fostered, and new human relations developed. Successful promotion of ideas of peace and peaceful coexistence, integration of vulnerable groups, and sustainable development, at a cost that does not require extensive external funding. |
| How were outcomes achieved? | Through preliminary meetings, needs assessments, planning exercises, and training sessions, thereby strengthening the trend towards reconciliation. |
| Did outcomes affect different stakeholders in different ways? | Short-term effects seem not to have affected stakeholders differently, little is known about long-term effects. |
| Did some activities seem better at promoting health at the expense of peace or vice-versa? | Activities were geared equally towards peace building and improvements in health. |
| What barriers were there to the achievement of the objectives? How could they be overcome in future? | Lack of initiative in donor country to inform, train, and coordinate DC network, lack of continuity, dependence on public funding, a "welfarism" approach, lack of an organized and structured network, adventurism and voyeurism on the part of some actors. |
| Recommendations for specific groups | -WHO, its European counterparts, and recipient countries should work together to strengthen the DC approach, especially with regard to the barriers identified above. -Further evaluative research is needed on long-term outcomes of DC. |

F. Case Analysis

In analyzing the case studies presented above, patterns and commonalities were found among the data. The main findings of this analysis are organized into seven categories, 1.) Nature of conflict, 2.) Stakeholders, 3.) Leadership and development of HBP actions, 4.) Specific HBP techniques employed, 5.) Personnel, 6.) Outcomes, 7.) Strengths and limitations and 8.) Lessons learned.

1. Nature of the Conflict

➤ In all cases analyzed in this study, conflicts were internal in nature. Three may be categorized as full-blown civil wars, while the other two involved armed challenge to a legitimate state authority, which, in the case of Haiti, resulted in the overthrow of a democratically-elected government. This may reflect the assertion that the trend in modern warfare is toward internal strife, instead of the more classical conflict between nation states.

2. Stakeholders

➤ The involvement of the international community was found to be paramount to the conceptualization and implementation of HBP efforts. The leadership role of WHO and/or other health organizations was essential in bringing health to the forefront of the peace-building agenda and in facilitating the meeting of conflicting sides. The actions of NGOs and UN agencies were important for the coordination of efforts at the field level.

➤ Local efforts were effective, as demonstrated by the decentralized cooperation formed between communities in Bosnia and Italy. However, appropriate support of and facilitation by international agencies (in this case WHO) and national governments was found to be important in both the development and implementation of such initiatives.

3. Leadership and development of HBP actions

- The international community must show political will, but must also provide sources of funds, personnel, supplies, and/or equipment to back up promises of assistance.
- In order to launch a HBP initiative, governments must be willing to participate in preliminary discussions and measures. This willingness to consider cooperation may not be present in all conflicts or among all parties involved in any specific conflict.

4. *Specific HBP techniques employed*

- A range of HBP techniques were utilized with varying degrees of success, including immunization cease-fires, joint surveillance activities, joint medical supply procurement, health services provision, dialogue and cooperation among health workers, training courses, decentralized cooperation (DC), joint implementation committees on health (JIC), the development of health protocols, demobilization of troops, and more general mediation activities. The types of HBP initiatives undertaken, and their eventual levels of success, reflected the larger political environment in the nation as well as the stage of conflict. Table 10 provides a complete list of HBP techniques utilized in each of the five stages of conflict.

5. *Personnel*

- Personnel involved in HBP activities ranged from representatives of warring factions, health workers, physicians, nurses, military personnel, religious figures, lay people, national government officials (especially from Ministries of Health), local governments, members of civil society, professionals from local and international NGOs, heads of state, and representatives of international organizations.
- The perceived impartiality of health professionals and/or organizations was found to be critical in initiating HBP initiatives.
- Health personnel are not traditionally equipped with the skills required for effective peace work. Training of health personnel is needed in areas of political/legal/socio-economic understanding and sensitivity, problem solving, leadership, mediation, negotiation, and

diplomacy. In addition, capacity building should focus on preparing health workers to identify appropriate opportunities to bring conflicting parties together.

6. *Outcomes*

- Though outcomes varied among the cases studied, a common thread was found emphasizing that joint action and common points of interest can engender a gradual renewal of trust and sense of mutuality among former combatants, which can lead to local reconciliation and successful peace building.
- When conflicting parties perceive health as a neutral and mutual problem, there is the opportunity for the health sector to promote joint team work, thereby contributing to national reconciliation processes.

7. *Strengths and Limitations of the HBP Approach*

This review of six case studies points to some strengths and weaknesses of the Health as a Bridge for Peace approach.

Strengths include:

- Health initiatives have been able to broker peace or foster reconciliation in a number of different contexts and at different stages of conflict.
- Choice of HBP actions is broad, allowing for tailoring of activities to suit the political, social, cultural, and economic realities of the country, region, or locality in question.
- There is opportunity for actors from all levels to participate in HBP initiatives, though it has been documented that involvement of the international community helps to facilitate proper training and coordination, with the goal of developing a comprehensive and multisectoral strategy towards peace.
- HBP initiatives often succeed because of the perceived impartiality of health professionals and/or organizations. This general perception makes the health sector an obvious choice in peace work.

- The very nature of health issues is also a strength. Concerns involving such things as infectious disease and maternal and child health care are generally viewed as neutral and important to all sides of a conflict. This helps in creating an opening for peace negotiation efforts.

The main weaknesses of the HBP approach include:

- HBP initiatives have mainly been implemented in conflicts that have been internal in nature, with relatively little evaluative research conducted. Even less is known of the effects of HBP efforts in more classical inter-state warfare.
- Most of the documented HBP initiatives have been conducted with the support of WHO. To date, little has been written about the experiences of other organizations. Please see Section VI, below, which outlines the findings from the key informant interview, detailing the experiences from representatives of a range of organizations.
- Though the international community has shown political will in implementing HBP initiatives, there is often a lack of resources to back up such pledges of support.
- The success of HBP initiatives depends, in part, on the will of a sometimes illegitimate national government. However, governments are not always willing to corroborate with international initiatives. Even in cases where there is willingness to allow the international community to work, political obstacles may prevent any real peace actions.
- Most health workers are not trained in areas such as negotiation and diplomacy and often lack the necessary skills to engage effectively in peace work. Many opportunities to engage in HBP activities may be lost in this way.
- There is a general lack of guidelines, protocols, and conceptual frameworks for designing and conducting HBP activities.

8. Lessons Learned

- Health is not always viewed as neutral, and the question arises as to how organizations such as WHO can avoid political implications that may accompany HBP actions.
- Even when one or more parties of a conflict are initially unwilling to interact in a peaceful manner, HBP can work to bring sides closer together.
- Health as a Bridge for Peace cannot substitute for first-track peace negotiations. It can, however, work alongside official diplomatic activities to take advantage of opportunities to reinforce peace-building efforts.
- A conceptual framework, such as the one developed in Angola, which links the context of the peace process with operational modalities and health sector priorities may assist health workers to keep pace with and adapt to rapidly changing contexts and target proper health and peace needs.

Table 10. Summary of Health as a Bridge for Peace Actions.

| Stage of Conflict | HBP Actions |
|----------------------------------|--|
| I. Stable Peace | <ul style="list-style-type: none"> - Promote: <ul style="list-style-type: none"> Health for all, equity Human development Human rights - Prevent inhumane weapons/warfare |
| II. Impending Crisis | <ul style="list-style-type: none"> - Predict areas/sources of future conflict - Develop decision-making and capacity- building tools - Health and human rights monitoring - Good offices function |
| III. Outbreak of Violence | <ul style="list-style-type: none"> - Conflict-resolution training - Problem -solving workshops - Targeted preventive health and economic aid - Health cooperation and coordination - Establishment of Health Humanitarian Assistance Programs (HAPs) - Special envoys, mediation, arbitration - Active regional, international, civil, NGO, media organizations |
| IV. Warfare | <ul style="list-style-type: none"> - Promote/ initiate confidence-building measures (CBM) - Provision of health and humanitarian services - Technical cooperation in health (control of epidemics), water, and sanitation - Coordination of health and humanitarian activities |

| | |
|-----------------------|--|
| | <ul style="list-style-type: none"> - Monitor health effects of sanctions and other diplomatic efforts - Joint-border surveillance of public health threats - Immunization cease-fires - Vaccine & medicine exchanges - Joint medical supply and vaccine procurements - MOH cooperation |
| V. Post-Crisis | <ul style="list-style-type: none"> - Facilitation of dialogue among health workers from both sides of the conflict - Cooperative health projects - Sustainable development - Decentralized Cooperation (DC) projects linking donor and recipient communities to work on common health problems and promote ideas of peace and peaceful coexistence - Peace-building awareness and capacity-building - Rehabilitation of health services and training of personnel - Development of programs to integrate military health personnel - Joint programs addressing issues of mental health/ disabilities - Integration of vulnerable groups - Establishment of Joint Implementation Committees (JICs) on Health for the reintegration of health systems - Design of common protocols for collaboration between groups - Joint design of training programs in the diagnosis and treatment of common diseases - Cooperation in social, economic, political, human, health development - Demobilization of troops |

VI. Contemporary Applications and Opportunities

A. Results of Key Informant Interviews

This section draws on interviews with seven key informants from organizations such as the Carter Center, Centers for Disease Control and Prevention, World Health Organization, the Pan American Health Organization, and the US Army Medical Services Corps. These individuals have had extensive experience working with HBP initiatives in various regions, including Africa, Asia, and Latin America. The main question addressed was: What are the determinants and conditions in which future health actions can serve as a bridge for peace?

The interviews centered on the following specific questions:

- *Health as a Bridge for Peace Activities.* What specific health actions could be used in an attempt to trigger peace (e.g. medicine and vaccine exchanges, joint border monitoring of health threats, joint training sessions, cease-fires, health situation analysis, mechanisms for international meetings and intergovernmental collaboration).
- *Stakeholders.* Who are potential parties involved, how/why could leadership take place? How could the activity relate to other on-going peace efforts? How might the action relate to the specific conflict at hand?
- *How do we prepare for the future?* What types of skills and knowledge would be necessary for decision-makers, health workers, international agencies, NGOs, military, diplomatic corps, governments, others?

Health as a Bridge for Peace Activities

In addressing this issue, all key informants saw a role for health in peace negotiating and peace building. One stated it this way, “Just as disease can be seen as a shared or common enemy, so can eradication and other health programs be seen as an acceptable way for groups to work with their adversaries. Each success provides a level of comfort with other groups that was not present before. Success in small projects encourages attempts at larger activities.”

The non-partisan nature of health has allowed its use towards peace even in the most fragile situations. One key informant described his experience with a polio eradication program in Sierra Leone. This was the first operational application of the Lome Peace Accord, and so was forging into unknown territory with government and rebel leaders. This initiative was successful in bringing the sides together for discussion and planning meetings. Rebel leaders saw a great political benefit to them in supporting this high profile, global initiative aimed at improving the lives of children.

Several informants stressed the need for neutrality. One key informant defined neutrality as, “a negotiated role in a violent environment.” This informant went on to state that

organizations involved in HBP initiatives often fail to practice true neutrality, thereby allowing their resources and the populations they serve to become strategic objectives among combatants.

Having a proper approach to health assistance and a focus on outcomes were two issues discussed by the respondents. We asked participants to identify the elements of health interventions, technical assistance, service provision, training and skill building, epidemiological surveillance, and/or health promotion that they believe were most important. One interviewee stated that all of these approaches have the potential to contribute towards building peace, citing PAHO's experience in Central America as a classic example in which the various parties accepted that health represented a non-conflictive issue that was a basis for dialogue. A similar remark was made within the context of the Colombian experience.

One informant asserted that the type of health assistance was not important. Instead, being able to demonstrate outcomes was key to keeping parties returning to the negotiation table to engage in additional joint activities. This respondent stressed that, in order to achieve positive outcomes, any approach such as surveillance, health education, health interventions, supervision, etc., must be conducted in a sensitive and neutral manner. If approaches are applied improperly, they can cause more harm than good.

Service delivery was singled out as a “powerful assurance and demonstrable exercise of a peace accord.” Health service delivery, when administered impartially and equitably, can give hope to war-weary populations that lasting peace is possible. Impartiality, fairness, and equity must be stressed because if health initiatives are perceived to be less than fair and equitable, service delivery can become highly politicized among factions, causing resentment and misunderstanding. However, whatever the approach employed, it was noted that health actors and organizations cannot effectively promote peace without adequate support, including proper funding, training, and infrastructure.

Key informants noted several elements necessary for successful HBP application. One interviewee stated that genuine thrusts toward peace and reconciliation must be present before health can be effective in peace-oriented efforts. This person provided two examples. In Mozambique, health was successfully used to spearhead and give credibility to the peace process already underway. On the other hand, peace efforts by the health sector in Angola, while successful in some efforts toward demobilization, were met with failure with the global collapse of the peace process there. In summary, this informant asserted that success of HBP initiatives depends on informed reading of each political situation rather than principled strategies or guidelines developed out of context.

Even when there is a favorable climate for peace, it was noted that it is often difficult to convince conflicting parties that they have issues in common. This may be especially true in cases of ethnic conflict. The art of persuasion was seen as a necessary skill in order to promote joint dialogue towards the recognition of common problems. Since the desire for good health is universal, health may be used as a motivator in order to persuade conflicting parties to work together. Informants cautioned, however, that diplomacy is also needed, in that persuasion deemed too aggressive can be seen as coercive and inappropriate.

Other necessary ingredients for the success of HBP initiatives, as described by one informant, include overarching facilitation and leadership. This informant noted the “multiplicity of autonomous players in conflict and post-conflict situations, all pursuing their own agendas in isolation.” This person indicated the need for coordination among the whole health sector, thereby reducing fragmentation and inconsistencies.

Stakeholders

In looking at roles of various stakeholders in linking health with peace and conflict resolution, one key informant noted that, “Health organizations, such as NGOs and international agencies, should first do no harm, adhere to the concept of neutrality, and focus on outcomes.

If successful, the result will necessarily be a bridge to peace. Any departure from these, no matter the degree, puts the organization, staffs, and populations served at risk of harm.”

Another informant saw an important role for international organizations such as WHO, UNICEF, USAID, and Rotary International, along with domestic organizations such as NGOs and Ministries of Health, in guiding the planning and implementation of HBP interventions. The example of Sierra Leone was cited, where activities were guided by an Interagency Coordinating Committee (ICC), which was able to leverage national, regional, and international political support for peace building initiatives. International agencies were also seen to have a role as brokers and facilitators of dialogue and in the mobilization of resources. The United Nations was singled out for its role in public relations, noting its high level of name recognition worldwide.

Including the topic of health as a bridge for peace in their own employee training programs was seen as a role for NGOs and Ministries of Health. These entities were also seen to have supportive and executive roles, which would include the task of resource mobilization. In the case of Ministries of Health, this would also include the provision of personnel and infrastructure as well as commitment to the health-peace process. In addition, Ministries of Health were noted for their leadership role.

Responsible reporting was identified as the role of the media. Universities were seen to have a role in integrating conflict analysis into programs of public health. The diplomatic corps was seen as important in facilitating dialogue and mobilizing the interest of their respective governments. A role for professional organizations was noted, though what this role might be was not specified. Health workers were thought to have a pivotal role as providers of health services, however, one interviewee cautioned that this will somewhat depend on how they are generally perceived in each given context, causing them to be either welcomed or shunned by some or all conflicting parties.

The role of policymakers was emphasized. Though NGOs and other organizations may be equipped to implement HBP initiatives, it is up to policymakers to make decisions enabling this to happen. Civil society was seen as essential in establishing a conducive environment for HBP initiatives to occur. Further it was asserted that civil society should take on supportive and executive roles, along with resource mobilization and promotion of dialogue.

How do we prepare for the future?

In looking at the skills needed for future HBP initiatives, informants emphasized mediation, conflict analysis, negotiation, communication, neutral brokering, and problem solving. In addition, training on coping mechanisms and techniques for multisectoral and community mobilization will be important. Sensitivity to local culture and context should be raised for each given situation, in order to facilitate the implementation of appropriate and successful interventions. Finally, persuasion skills were seen as important in convincing warring parties to work together on issues of peace and health.

When asked about the type of knowledge and/or research needed to maximize future HBP initiatives, the importance of case study research was stressed, including the examination of both successful and unsuccessful initiatives. However, before case study analysis can be conducted, more HBP initiatives need to be better documented.

Overarching guidance in conducting HBP activities is needed to better coordinate the efforts of the international health community. This would include the development of a framework for analysis, operating principles, codes of conduct, blueprints for appropriate interventions and skills at different levels, and information on the most effective policies/investments in health in both pre- and post-conflict periods.

Finally, fostering a deep understanding of the issues of the specific conflict was seen as extremely important in implementing HBP activities. This will help health professionals to identify appropriate opportunities to intervene in the name of peace. It was asserted that more

aggressive actions are needed on the part of the international health community in its peace efforts. However, the need to be forward looking and the willingness to take risks was seen as appropriate only when informed by robust analysis of the respective conflict situation.

B. Discussion

The findings outlined above are in line with the conclusions derived from the case study review. Respondents placed emphasis on the importance of neutrality and non-partisanship of HBP actions. In terms of ensuring continuing participation on the part of all conflicting parties, the type of approach, whether service provision, training and skill building, epidemiological surveillance, or health promotion was not stressed as much as achieving positive outcomes. Most respondents did not support the use of generalized criteria when selecting HBP interventions, and instead favored tailoring interventions to fit the political, social, and cultural context of the nation or region in question. Respondents also emphasized the need for in-depth conflict analysis in order to design appropriate interventions.

The role of WHO or other international organizations as facilitators and leaders of HBP initiatives was almost universally supported. The value of local efforts was also highlighted, though respondents identified the need for local entities, such as NGOs, to become better trained and to coordinate their efforts with those of other organizations also engaged in HBP work. Nearly all respondents saw the need for national governments as well as international entities in committing additional resources in support of HBP activities, including funds, personnel, and infrastructure.

Respondents identified priorities for future work, including the development of overarching guidance in the form of general protocols and lessons learned and the training of health workers in mediation, conflict analysis, negotiation, communication, neutral brokering, and problem solving skills. The need to document more fully past HBP efforts was emphasized.

Case study research was noted as an appropriate methodology for comparative research and identification of best practices.

Most of the responses from survey participants were consistent and congruent with the literature review and case study analysis. Responses from representatives of WHO were comparable to those from other organizations. However, one interesting difference was found among those respondents who are members of the US armed forces, who emphasized the need to “persuade” conflicting sides to participate in HBP efforts. One informant went so far as to state that “ethnic groups, especially, will not acknowledge each other’s presence unless *coerced*.” Whether the use of this language reflects a difference in approach among military personnel as compared with personnel from civilian organizations is not clear.

VII. Conclusions and Next Steps for Operationalizing Health as a Bridge for Peace

Our experiences to date have included successful, as well as unsuccessful HBP operations. We have seen that the presence of certain critical elements in any given conflict situation may increase the chances of a successful HBP operation. We now focus on specific strategies, skills, and tools as related to future HBP work, especially in the context of contemporary Sub-Saharan Africa.

The first theme emerging from the research activities undertaken is the need for training programs for health personnel in skills relevant to peace building, such as negotiation, mediation, and diplomacy. USAID, in conjunction with CERTI partners and local and international NGOs may focus on this need by developing and implementing training programs especially designed for the Sub-Saharan African context. Such training programs should be comprehensive and focus on developing local health workers and representatives of local

NGOs to identify opportunities for peace work and provide them with skills necessary to effectively implement HBP efforts.

Information technology is likely to play an important role in mobilizing health personnel in future HBP initiatives. Media and other information campaigns describing HBP concepts, goals, and training opportunities should be targeted to health workers. Such messages will be important in orientating health workers to their potential role towards brokering peace and encourage their participation in training programs and future HBP activities. Information targeted to national government officials, representatives of conflicting parties, and local NGOs may also be important in legitimizing the role of health in peace work.

Secondly, there seems to be an overwhelming need for further evaluative research of HBP initiatives to date. Methodologies should be developed and tested in the course of new and ongoing activities, leading to overarching guidance in the form of general protocols and lessons learned. As part of these efforts, the theory behind Health as a Bridge for Peace should continue to be built and developed.

Thirdly, commitment to the concept of health as a bridge for peace is needed on the part of national governments, civil societies, international organizations, and the global health community. This will entail the commitment of financial, human, and other resources, including infrastructure and information technology. In order to secure such commitment, the international health community along with CERTI partners must be able to demonstrate positive results of HBP initiatives. The research activities described above will be an essential part of this.

Finally, it is noted that there are many types of mediators/negotiators working towards peace goals today, ranging from government leaders, religious figures, lawyers, diplomats, and professional arbitrators. All of them have the same goal: To resolve a given dispute. The incentives each may offer, however, are not the same (Kheel, 1999). Health personnel are in the unique position to be able to leverage something universally important to everyone, irrespective of the details of any given conflict: The promise of good health. This makes the international health community a potentially powerful force in peace efforts through out the world, and one that should be tapped further through expanded HBP initiatives and continued research, evaluation, and training activities.

With these issues in mind, recommendations for next steps for the Health as a Bridge for Peace component of the CERTI project include: 1) Develop evaluation indicators and criteria, and 2) Capacity building and tools development.

1) In the development of evaluation indicators and criteria, a situation analysis of 2 – 3 countries where health was used as a bridge for peace will be conducted. From this analysis protocols and indicators will be conceptualized. This will lead to the second phase of activities, that of capacity building and tools development.

2) The capacity building and tools development component will include the development of a HBP Toolbox succinctly outlining options for training and tools development. This toolbox will consist of one-page fact sheets detailing potential impact evaluation indicators and criteria as well as the conceptualization of tools and capacity building programs.

Each Toolbox fact sheet will provide a summary of a training module or tool that can be modified as appropriate. For example, a fact sheet on early warning systems will include an alert signs checklist, which will identify indicators for disease outbreaks, poverty, basic needs, unemployment, youth without jobs, food shortage, famine, violence, oppression, political instability/corruption, disintegration of government/institutions, and migration.

The goal of early warning systems is to avoid or minimize violence, deprivation, or humanitarian crises that threaten the sustainability of human development. Early warning systems buy time not only to prepare for short-term containment and relief strategies, but also to design, build support for, and implement longer-term proactive strategies and development programs that can reduce the likelihood of future disasters. Such systems can also generate analyses that identify key factors driving instability, providing a basis for recommendations on appropriate options for local and international policy makers oriented towards preventive action (Davies, 2000).

Fact sheets targeting health and relief personnel will provide outlines of training modules on topics such as negotiation, conflict management, forecasting skills, risk communication, conflict communication, working with stakeholders, working with the media, problem resolution, institutional reconstruction, and crisis assessment. Fact sheets detailing training programs for

clinical personnel will include topics such as emergency preparedness, assessing and managing disaster/risk relief, managing for reduced loss, and conflict impact reduction.

Other fact sheet topics will include international law and how it relates to health workers working in neutral zones and health organizations during times of conflict; curriculum development on HBP issues, with importance placed on introducing this curriculum into schools of public health and medicine; and common definitions on international humanitarian law, human security, peace-keeping, second track diplomacy, and human rights.

We will craft an information-sharing strategy, which will allow the toolbox to serve as a stimulus in the cooperative development with local partners of in-depth training programs and tools tailored specifically to African populations. We believe that for training programs and tools to be relevant to the people of Sub-Saharan Africa, African input into their content and design is crucial on an on-going basis. The toolbox will also serve as an informational tool with which to elicit input from USAID Missions, NGOs, and civil societies. This will allow all partners the opportunity to analyze and provide feedback on the relevance and importance of each component within their community and/or country context. To facilitate this, information-sharing seminars will be organized in Washington along with one field trip to the region. Once this valuable input has been received, the development of training programs and tools may proceed in a way consistent with the real needs of the African nations served.

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Appendices

Lists of persons consulted and interviewed

Instruments

Basic Tenets of Conflict and Negotiation

Appendix 1: Lists of persons consulted and interviewed

- George A.O. Alleyne, The Pan American Health Organization
- Dennis King, Centers for Disease Control and Prevention, on detail to the World Health Organization
- Alessandro Loretto, World Health Organization
- Captain Michael Smith, US Army Medical Service Corps
- Colonel Gregg Stevens, US Army Medical Service Corps (Retired)
- Virginia Swezy, Center for Disease Control and Prevention
- P. Craig Withers, Carter Center

Appendix 2: Instruments

Appendix 3: Basic Tenets of Conflict and Negotiation

Negotiation

“Negotiation is a decision-making process by which two or more people agree how to allocate scarce resources. There are three main elements: judgement, interdependence and cooperation.” (L. Thompson)

- *Judgement*: negotiation is not a contest of wills or a match of strength, but rather, involves logic and reasoning.
- *Interdependence*: The presence of two or more people implies that what one person does affects the other party.
- *Cooperation*: The desire to reach mutual agreement.

Negotiation is essential for anyone who must interact with other people to accomplish their objectives.

Negotiation performance is frequently far less than optimal, but this conclusion is based on single negotiations. In contrast, every day life provides evidence of the importance of experience as a feedback to amend errors of judgement.

In negotiation, as in other social interactions, knowledge matters.

The influence of tactical knowledge in frequency of behavior and systematic sequences of response-in-kind negotiator behavior.

Tactical knowledge: how to solve specific negotiation problems.

Tactics: explicit and implicit behaviors.

The most difficult aspect is trying to balance integrative and distributive components of mixed—motive negotiations.

Naïve negotiators tend to hold a zero-sum assumption and primarily use distributive tactics by default.

Negotiators with tactical knowledge will respond to distributive behaviors with integrative behaviors more than will negotiators without tactical knowledge.

Negotiators with tactical knowledge will employ for a longer time integrative behaviors and less distributive behaviors than those without knowledge.

Distributive behaviors were responded to in-kind with other distributive behaviors.

Response-in-kind to integrative behavior was less than distributive behavior.

Negotiators often respond to integrative behaviors with substantiation rather than reciprocating the integrative behavior.

Accuracy of negotiators' judgement about the other party was directly related to performance, suggesting that judgement accuracy is a key ingredient for reaching integrative agreement.

Basic architecture of conflict

Conflict

- Is the perception of differences of interest among people.
- Negotiation is one of many methods that may be used to resolve perceived conflict of interest.

Conflict, in and of itself, is not good or bad; it merely reveals perceived differences of interest

- *Intrapersonal*: is conflict that occurs within one person.
- *Interpersonal*: is conflict that occurs between two or more people.
- *Intergroup*: is conflict that occurs between members of different groups representing personally relevant social, cultural, or political categories.

Consensus conflict occurs when one person's opinions, ideas, or beliefs are incompatible with those of another and the two seek to reach an agreement of opinion.

Scarce resource competition exists when people perceive one another as desiring the same limited resource.

Policies

Simple Choice

Negotiation

Third-party intervention

- Parties

A party is a person (or group of persons with common interests), who acts in accord with his or her preferences.

- Issues

The issues are the resources to be allocated or the considerations to be resolved in negotiation.

A central element of successful negotiation is identifying the issues.

- Alternatives

The alternatives correspond to the choices available to negotiators for each issue to be resolved.

- Interests and Positions

Positions are the stated wants a negotiator has for a particular issue
Interests are the underlying needs that a negotiator has.

A key to successful negotiation is to move away from *positional* bargaining into a discussion of underlying *interests* and *needs*.

- Negotiation Process

The negotiation process is the events and interaction that occur between parties before the outcome.

The process includes all of the verbal and nonverbal interchange among parties, the enactment of bargaining strategies, and the external or situational events affecting the interaction between negotiators.

- Negotiation Outcomes

The negotiation outcome is the product or endpoint of the bargaining.

Conflict Tree Model



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