
A Health-to-Peace H a n d b o o k

Ideas and Experiences of How Health
Initiatives Can Work for Peace



Edited by Mary Anne Peters
for the War and Health Program,
McMaster University

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"The 'Health-to-Peace Handbook', produced by the War and Health Program at McMaster University, is an extraordinarily useful guide for health professionals working in areas of war or in areas of tension that may lead to war or civil conflict. It provides excellent examples of ways in which health workers can contribute to understanding and amelioration of problems that may lead to conflict, to the mediation of conflict before violence begins and to ending violence once it has started."

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Co-President, International Physicians for the Prevention of Nuclear War;

A Health-to-Peace Handbook

*Ideas and experiences of how
health initiatives can work for peace.*

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November 1996

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This work was carried out with funding from the Partners for Children Fund, Health Canada, and with the aid of a grant from the International Development Research Centre, Ottawa, Canada.

ARCC /
172-11574
2-6

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Acknowledgments

The key researchers whose work led to this publication are Rick McCutcheon and Mary Anne Peters. Mary Anne Peters is the chief author of the document. Support and ideas have been provided by Graeme MacQueen and Joanna Santa Barbara of the War and Health Program. Further support and advice was given by Vic Neufeld, Paul Dekar, James Orbinski, Robbie Chase, Marilyn Weaver, Barry Hart, Seddiq Weera, Tom Miller, Andrew Ignatieff, Sara Swartz, Mary Anderson, Henrietta Langran and Vinya Ariyaratne. Necla Tschirgi and Brian Murphy provided many helpful suggestions on the first draft.

We are deeply grateful to these people who shared their experiences and knowledge by writing or being interviewed for the case studies: Risa Hontiveros-Baraquel, Secretary-General of the Coalition for Peace in the Philippines, wrote a description of her experience with the Immunization for Peace program in the Philippines. Dr. S.M.A. Fatimie, former Minister of Public Health of Afghanistan, and Dr. A.O. Gebreel, World Health Organization-Afghanistan Representative, told us the story of the Afghanistan Mass Immunization Campaign when they were in Hamilton in early 1996. Barry Hart took time from his very demanding work for the War and Health Program in Croatia to write a description of his previous work in Liberia on trauma healing and reconciliation. Marilyn Weaver and Robbie Chase from the Sri Lanka Working Group of the War and Health Program met with me many times and put up with hundreds of questions as we tried to distill lessons from the War and Health Program's work in progress in Sri Lanka. Sara Swartz, from the Division of Emergency and Humanitarian Action of the World Health Organization not only wrote a description and analysis of the Hedip program, but also provided a great deal of encouragement. Rachel Monroe-Blanchette, former country coordinator in Goma, Zaire for Medecins sans Frontieres-Doctors without Borders, spent several patient and honest hours on the phone with me to share what she and MSF learned from their work with Rwandan refugees. Henrietta Langran, World Court Project coordinator for Physicians for Global Survival (Canada), provided suggestions and information for the World Court Project case study.

We are grateful to the Partners for Children Fund of Health Canada for funding the Health of Children in War Zones Project, through which the research and writing was done, and to the International Development Research Centre for providing a grant for the publication and distribution of the handbook.

Mary Anne Peters, Hamilton, November 1996

About the War and Health Program of McMaster University

The War and Health Program

The War and Health Program (formerly Health Reach), is a coming-together of health workers and peace workers at McMaster University in Hamilton, Canada. Over the last three years with the “Health of Children in War Zones Project,” the War and Health Program has worked to assess and understand the effects of war on children and their communities in Sri Lanka, the former Yugoslavia, and the Gaza Strip, and to find ways to rapidly and accurately assess health in war zones.

An important part of the project has been exploring the use of health initiatives as peace initiatives, by researching what other people have done and by trying to integrate peacebuilding into our own work in the three study areas. As a university-based group, we have tried to use our strengths in research, analysis and education to address practical, down-to-earth concerns and to bring about real change.

Our values

The foundation of our work is a belief in certain values and its goal is a world based on them. These values are:

Peace: a relationship in which the participants do no damage to each other, each can develop her/his potential, and conflicts are resolved non-violently;

Health: complete physical, mental and social well-being;

Economic equity and sufficiency: an equitable distribution of resources and benefits, so that each person has sufficient to live a life of dignity and to develop her/his potential;

Human rights: the recognition of the inherent dignity, integrity and humanity of each person and the protection of each person’s fundamental economic, social, cultural, political and civil rights as enshrined in the Universal Declaration of Human Rights;

Political participation: the ability of all people to participate in decisions that determine the conditions of their lives;

Healthy environment: a harmonious and sustainable relationship between human beings and the ecosystem of which they are a part.

Preface

As the Minister of Public Health in Afghanistan, I learned an enormous amount about health-to-peace initiatives during the year long (1993-94) struggle to achieve one week of ceasefire so that we could avert diseases and prevent deaths among children and mothers through mass immunization. The beginning step was to keep the Ministry of Public Health neutral and out of politics. It took the Ministry of Public Health, including myself, my deputy Dr. Faizullan Kaker, and our great team including Dr. A. Omar Gebreel of WHO-Afghanistan to convince the leaders to stop bombing and shelling for a week so we could immunize children and mothers in the entire country. The concerted effort also included UNICEF-Afghanistan and the UN special envoy who also put so much effort into this holy struggle against disease and deaths.

Our concern was the health and lives of people, no matter what linguistic group they belong to, what religion they believe in, and what political party they support. We were convinced that today's children are the future builders of the country and will carry the heavy burden of reconstructing and developing their home. We knew that people are silently dying from preventable diseases. The seventeen-year long war not only disabled and killed civilians, but also indirectly contributed to morbidity and mortality. We could not wait for the complete political solution of the Afghan problem, which will take years to achieve, to immunize millions of children and thousands of women against diseases like measles, polio and tetanus.

This "Health-to-Peace Handbook" supplies health care professionals with background regarding the strategies of using health as a bridge to achieve peace and how health initiatives have been used for peacebuilding. The handbook will be useful for health leaders, organizations of physicians and other health professionals, and NGOs. In my view, this book is a great background document for future health and peace manuals for various levels of health workers in war zones.

Different sections of the handbook have stories with implications to various categories of health organizations and individuals. There are role models, examples, and lessons of commitment and persistence in achieving peace. Reading every individual case study in this book, I can imagine the endless effort and tireless work put into each one of them. As the readers will see, in some cases it took several years of dedicated work and persistence to achieve the goal.

I would like to thank and congratulate the War and Health Program team, particularly Dr. Graeme MacQueen and Mary Anne Peters for the great work.

Dr. Said M. Amin Fatimie
Former Minister of Health, Afghanistan

PART A: Introduction

Who is this handbook for?

If you are...

- a planner with an organization or institution that has health-related projects in an area where a war is going on, where a war has recently ended, or where there are tensions that could lead to war...

or...

- a health worker in such an area...

or...

- a health worker committed to peace as a preventive health measure...

or...

- a peace worker looking for new approaches to peacebuilding...

then...

we think this handbook might be useful to you.

What does this handbook do?

We have tried, with this handbook, to share some of what we have learned and to encourage others to explore the potential of health initiatives as peace initiatives.

Specifically, this handbook sets out to:

- explain the link between health and peace and the advantages of health-to-peace initiatives;
- give you an idea of some possible health-to-peace initiatives and the way they work, illustrating them with examples and case studies;
- provide some tools and resources to help you plan to use a health initiative as a peace initiative;
- provide you with a list of resources and of contact people and organizations to turn to for more information.

This handbook is an attempt at a practical starting point on a subject that needs a great deal more research and evaluation. We are not offering a thorough evaluation and critical analysis of the case studies and examples. Evaluating the impact of various

initiatives on the level of peace is difficult, but very important, and we hope that more of this research will be done. Neither are we offering prescriptions to use in every context. Although there is a great deal to be learned from what others have done in other conflicts, contexts and cultures, we must be cautious about transferring strategies. What we present in this handbook is merely a starting point to get you thinking about possible approaches for your own situation.

How is this handbook organized?

Part A is an introduction to the handbook.

Part B explains the link between health and peace and introduces the concept of health initiatives as peace initiatives. It then defines what we mean by “peacebuilding” or “peace nurturing.”

Part C is the real essence of the handbook--the stories of six different health-to-peace initiatives. Some of these case studies are told by people who were involved in them, others are based on interviews and research.

The first case study is about humanitarian ceasefires, in which a shared concern for the health of the civilian population, particularly children, brings combatants to an agreement to suspend fighting so that health workers can reach everyone in the war zone. This case study actually includes two stories--one from the Philippines and one from Afghanistan. The second case study comes from Dr. Barry Hart, who describes what he did and learned working in trauma healing and peacebuilding initiatives in Liberia and in former Yugoslavia. The third case study describes a study conducted by the War and Health Program in Sri Lanka, which integrated peacebuilding into research assessing the health and level of psychological trauma in children. The fourth case study is of the Hedip proam of the World Health Organization, which made use of participatory processes to help communities in post-conflict situations to cooperatively analyze problems, set priorities and begin working toward reconstruction of health services. The fifth case study reflects on the experience of Medecins sans Frontieres-Doctors without Borders providing medical aid to refugees from Rwanda. The last case study is about the World Court Project, an initiative to have the world’s highest court, the International Court of Justice, give an advisory opinion on the legality of nuclear weapons in view of their health and environmental effects.

Part D offers an analytical framework and suggests some approaches to planning a health-to-peace initiative. This section, called “Getting started”, begins by describing causes of violent conflict and depicting the cycle of violence on a diagram. There is also a list of questions to ask when trying to understand a particular conflict. The next part suggests a way to look for opportunities for peacebuilding and people to work with in a situation of conflict. Then we discuss the various strategies and mechanisms involved in

health-to-peace initiatives, many of which have been illustrated in the case studies. Finally, we present a list of indicators for evaluating the peacebuilding impact of health-to-peace initiatives.

Part E is a list of resources, both publications and organizations, to turn to for more information. The resource list is divided into the same sections as the text, so when you want more information about a particular publication or organization mentioned in the text, please turn to the appropriate section in the resource list. For example, in the “Peacebuilding” section of the resource list, we give names, addresses and a brief description of organizations mentioned in the text, as well as others, and we reference key publications to turn to.

Do you have experiences and ideas to share?

We see this handbook as an intermediate step in a longer process of learning and sharing about the peacebuilding potential of health work. There is a growing interest in this area, with people all over the world trying many different kinds of health-to-peace initiatives, but not much of this knowledge is yet gathered together in one place. We are offering what we have learned so far in the hope that this will help others to make use of some of the potential in their own work. We also hope that readers will in turn share with us your own experiences, so that in five years, perhaps, we will be in a better position to produce a more thorough and more useful version of this handbook.

To encourage you to share your experiences and knowledge with us, there is a feedback form at the end of the handbook. We look forward to hearing from you!

PART B: Why "Health-to-Peace"?

Not many people think of peacebuilding as part of the job description of health workers--after all, we're not diplomats. But it's hard to deny that war is very destructive of the physical and mental health of individuals, and of all of those institutions in society, from the family on upwards, that people rely on to stay healthy. Also, individual and social healing is often needed to make peace possible.

As someone concerned with health, you probably understand better than anyone the fundamental link between peace and health. What you may be wondering is what you can do to help build peace, without abandoning your work in health care and applying for a job as a diplomat.

Peace--not just a job for diplomats

The United Nations and national governments have an important role to play in peace work, but they tend to operate at the level of inter-governmental diplomacy. History has shown us that this has only limited success. The causes of peace are as complex as the causes of war--peace is the outcome of many different interacting groups and forces, not all of them intentionally working for peace.

The Institute for Multi-Track Diplomacy has proposed a model of peacebuilding with nine tracks: government; non-government; professional; business; private citizen; research, training, and education; activism; religious; funding; communication; and public opinion. Of course, not all nine sorts of activities always lead to peace, but sometimes they do, and the Institute is continuing to do research to better understand what factors can make these various tracks contribute to peace. Health isn't part of this list--but it should be.

Why can health workers also be good peace workers?

There are a number of very good reasons why health can serve as a track to peace, including access, infrastructure and community.

- Access to war zones is often open to health workers while closed to anyone who is seen as having a political agenda--which often excludes even the most neutral of peacemakers.
- The health infrastructure of a nation at war, if you include international and non-governmental health organizations along with the national health care system, is often in better shape than other systems in the country and can provide one of the strongest systems of communication, transport, technology and educational capacity.

Ten Ways that International Assistance Can Worsen Conflict

1. Introducing resources into a resource-scarce environment where there is conflict usually increases competition and suspicion among warring parties.
2. External resources brought into war situations by humanitarian and development agencies add to overall resources in the area and, thus, free internal resources to be used in pursuit of war.
3. International assistance can result in severe distortions in local economic activities, increasing or reducing income and employment opportunities for some groups, and thus increasing inter-group tensions.
4. When international assistance agencies hire armed guards to protect their delivery of goods to needy recipients, they "buy into" the terms of existing conflicts.
5. When humanitarian agencies circulate pictures or stories of war-based atrocities in their own publicity as a means of enlisting support for their work, they provide additional grist for the mill of accusation and counter-accusation which perpetuates conflicts among groups.
6. By working through existing regimes in order to gain access to people in need, international assistance agencies can buttress such regimes. In some cases, such apparent support for the legitimacy of a regime can prolong oppression and resultant warfare.
7. By adopting policies of solidarity with groups fighting for their legitimate rights under oppressive regimes, international donor agencies can contribute to the will of the people to engage in violent conflict over prolonged periods of time.
8. By targeting their aid to specific groups in societies, international donors may exacerbate and excite tensions within that society that eventually lead to warfare.
9. Through the processes that they use for selecting programmatic activities within recipient countries, international aid agencies set up systems which can pit groups against each other. When more than one agency works in an area, they may even become participants in competition and the furthering of inter-group suspicions.
10. The military aid which has often accompanied humanitarian or development assistance has left a legacy of armaments that in itself increases the chances of new violent conflicts and the perpetuation of old ones.

From "International Assistance and Conflict: An Exploration of Negative Impacts," by Mary B. Anderson

- Members of the health care community, as well as being committed to human well-being and closely connected to people suffering directly from armed conflict, are relatively well-educated and have a certain status and profile, giving their voice and actions weight.

The range of health-to-peace initiatives

There is a great variety in health-to-peace initiatives, with a range of how much “peacebuilding” they try to integrate, at what level they work, and at what stage of the conflict they work. (We offer a definition of “peacebuilding” in a couple of pages.)

- Health-to-peace initiatives are not confined to war zones. Many of the wars being waged today have roots outside of the war zone itself--think of the arms trade, for example, or the economic inequities within and between countries. There have been initiatives that address some of these causes from a health perspective. One of the examples that is referred to later is the World Court Project, which has worked to get an advisory opinion from the International Court of Justice on the legality of nuclear weapons use.
- Some health-to-peace initiatives have peace work as the main focus of activity, and so have greater potential to build peace than to deliver health care. Many try both to improve health directly and to build peace. Health-to-peace initiatives may work to prevent conflict from degenerating into war, to restrict war by banning or limiting certain types of weapons, to end war, and to increase the chances for real and lasting peace after a war ends. The case studies in this handbook illustrate some of these kinds of efforts.
- Others minimally qualify as health-to-peace initiatives because they are health projects that have been fully reviewed to ensure they won’t make the conflict worse--at the very least, health initiatives should not increase hostilities. Given that any external assistance to people in a zone of armed conflict may worsen the conflict, it is important to review all health initiatives to assess the chances that they will cause or intensify conflict. The box entitled *Ten Ways that International Assistance Can Worsen Conflict* suggests some possible negative consequences of international assistance in general. There are lessons to be learned about health projects from this list.

Peacebuilding

In this handbook, we use the term “peacebuilding” in a very broad way. “Peace nurturing” is another term we use to mean much the same thing as peacebuilding. We use

these two terms to encompass a whole range of activities that serve to increase the possibilities for peace.

Here are three other definitions of "peacebuilding" and "peace nurturing":

- Boutros Boutros-Ghali, in *An Agenda for Peace*, defined post-conflict peacebuilding as "action to identify and support structures which will tend to strengthen and solidify peace in order to avoid a relapse into conflict."
- Ken Bush, who has written about the challenges of rebuilding war-torn societies, uses the term peace nurturing, by which he means nurturing and creating the political, economic and social spaces within which local people can identify, develop and use the resources necessary to build a peaceful, just and prosperous society.
- Ernie Regehr from Project Ploughshares, a Canadian peace organization, defines peacebuilding as "the job of putting up the scaffolding that will enable a society in crisis to start working on the edifice of peace itself. The work on the main edifice of peace is common security. The foundations of common security are economic equity and sufficiency, political participation, individual integrity and respect (human rights), a healthy environment, and strict limits on the means of destruction, and the development of peaceful means of resolving disputes (demilitarization)."

Peacebuilding (peace nurturing) is something that can and should happen at any time before, during or after conflict. It is probably the most difficult in the midst of armed conflict, though there are always people and initiatives working for peace throughout even the most violent of conflicts. Peacebuilding, as defined by Boutros-Ghali, often takes place after an armed conflict has ended and aims to strengthen the structures and processes which are necessary for a society to have lasting peace.

As with disease, prevention is the most effective way of dealing with violence. Anthony Zwi comments: "Primary prevention is key: action should be taken early to prevent bloodbaths rather than in response to their aftermath. Perhaps even more important is 'primordial prevention': avoiding creating the conditions that may lead to internal conflict, violence and genocide, such as inequitable distribution of resources, repression of segments of the population, and massive international debt. We need to promote those forms of social policy and development which increase the chances of economic, social, and political benefits accruing to all sections of society and that reduce rather than increase inequities in access to resources" (the 1995 "Commentary" article this quote is from is referenced under "Local support for peace through health" in the resources section).

The case studies illustrate some of the wide range of what can be considered "peacebuilding"--and these focus only on peacebuilding through health initiatives.

PART C: Case Studies

The six stories that follow are the real essence of this handbook. Each is different, with different contexts, different aims, and different strategies, but each shows that individuals and organizations can effectively and positively use the connections between health and peace to contribute to a world that is both more healthy and more peaceful.

The way each story is told is different, too. Some are told by individuals who were directly involved, while others have been pieced together from interviews and documentation. Although some of the case studies offer a certain level of analysis and evaluation, we have not tried to do much more than document experiences to share with you. We hope that the stories themselves communicate the complexities of conflict situations and possible responses, and that you will draw from them insights, ideas and cautions to apply to your own work.

The first case study is about humanitarian ceasefires, which for us at the War and Health Program were the first and clearest examples we found of health initiatives as peace initiatives. In humanitarian ceasefires (also called “days of peace”, “days of tranquillity”, “corridors of peace” and other names), a health concern, often the need to immunize children against common but deadly childhood diseases, brings warring parties to an agreement to suspend fighting for a period to allow health workers access to children or civilians on all sides of the conflict. In this case study, we offer the stories of two different experiences, one in the Philippines and one in Afghanistan, as well as some of the lessons and principles discussed at a conference organized in 1991 by the Centre for Days of Peace, a Canadian organization dedicated to promoting humanitarian ceasefires as peacebuilding initiatives.

The second case study comes from Dr. Barry Hart, who worked with the War and Health Program (at that time called Health Reach) in the former Yugoslavia. In it, he describes his work in Liberia in 1991, 1992 and 1993, which combined mental health work--trauma healing--with bias reduction, peace education and community reconciliation. He also briefly describes how these ideas have been translated into a different context in Croatia.

The third case study describes a study conducted by the War and Health Program in Sri Lanka on the psycho-social effects of armed conflict on children. This study integrated peace-nurturing and community reconciliation activities into the research process, and has led to other creative initiatives.

The fourth case study discusses the Hedip program of the World Health Organization. This program involved three pilot projects in post-conflict areas which used participatory processes to help communities cooperatively analyze problems, set priorities and begin working toward restoration of health services.

The fifth case study reflects on some of the difficult lessons learned by Medecins sans Frontieres-Doctors without Borders from their work providing medical aid to refugees from the Rwandan crisis.

The last case study is about the World Court Project, a campaign to have the world's highest court, the International Court of Justice, give an advisory opinion on the legality of nuclear weapons. The campaign drew on traditions of international humanitarian law which restrict weapons and military strategies based on their effects on human health. The campaign argued that the use of nuclear weapons should be illegal under international law because of the devastating and indiscriminate effects on human health and the environment.

HUMANITARIAN CEASEFIRES: Shots of Vaccine Instead of Shots of Artillery

Written by Mary Anne Peters based on materials referenced in the resource list. The story of the Philippines "Immunization for Peace" program was written by Risa Hontiveros-Baraquel, Secretary-General of the Coalition for Peace in the Philippines. The story of the Afghanistan Mass Immunization Campaign was written by Mary Anne Peters in consultation with Dr. S.M.A. Fatimie and Dr. A.O. Gebreel, using information from two reports by WHO-Afghanistan. The author is grateful for the generous help provided by these individuals.

Beginning in 1985 in El Salvador, there were "days of tranquility" three times a year when the fighting stopped to allow children all throughout the country to be immunized. The agreement for these days of tranquility was negotiated between the government and the FMLN by the Roman Catholic Church and UNICEF, with the involvement of numerous other national and international organizations.

In Uganda in 1985, UNICEF negotiated a "corridor of peace" with the government and the insurgent NRA to allow the transport of medical supplies and vaccines so that children on both sides of the line of fighting could be protected.

In Lebanon in 1987, UNICEF negotiated with the many warring factions for a series of three-day ceasefires in order to vaccinate children.

In Sudan in 1989, UNICEF Executive Director James Grant, acting as a special representative of the UN, achieved an agreement with both the government and the SPLA to allow corridors of peace to deliver relief supplies to the desperate people of southern Sudan.

In the Philippines in 1988, the National Peace Coalition organized an Immunization for Peace program, which contributed to the building of peace agendas throughout the country. This was followed by the 1993 Ceasefire for Children Movement coordinated by the Ministry of Health, which successfully negotiated two ceasefires to immunize children throughout the country.

In 1994-5, and again in 1996, the Ministry of Public Health and the WHO in Afghanistan organized a Mass Immunization Campaign which reached children and mothers throughout the country and achieved unprecedented cooperation from the warring parties.

The following pages contain the stories of two of these initiatives and some lessons learned from others.

Immunization for Peace in the Philippines: Problems and Promise

Written by Risa Hontiveros-Baraquel, Secretary-General of the Coalition for Peace

In 1988, the Coalition for Peace in the Philippines began work on a program called "Immunization for Peace" (IfP). This program came out of a desire expressed by peasant women from the Central Luzon region who were members of KABAPA (Association of the New Filipina), a member organization of the Coalition for Peace. These women wanted to improve the health conditions of their children, especially in war zones--to have their children recognized as a sectoral zone of peace. This desire was born out of their experience in the People's Christmas Ceasefire, which we launched annually for several years beginning in December 1987 (which itself was inspired by El Salvador's "Shots for Peace" ceasefire--another story altogether!).

The first step in the program was to bring together a broad range of organized groups (community and non-governmental organizations, local health and other front-line agencies, peace groups, churches, governments and combatant groups) with existing or potential cooperative programs and relationships, through which they could undertake common action. The foundation of the program was the consensus amongst all these groups that caring for children, an imperative in itself, can also constitute a valid and effective call to communities in conflict areas and to combatant groups to address the peace question. We shared an understanding that enhancing peace creates an environment that is better for children's health.

IfP's goal was "to ensure the survival, development and protection of children throughout the country by providing health services and achieving peaceful cooperation and co-existence among various groups affecting child welfare in conflict areas." Its specific objective was "to facilitate the delivery of immunization and to promote the capability of local communities and service providers in ensuring the rights of the child and in peacebuilding initiatives."

The next important step in the program was organizing community- to national-level coordinating structures among all the groups. The Coalition and the Department of Health (DOH) signed a Memorandum of Agreement in November 1988, and organized the National Working Committee--composed of representatives from the four non-governmental organizations (NGOs), the Coalition, and the Community Health, Maternal and Child Health, and Public Information and Health Education Services of DOH. Field personnel of the NGOs and the DOH participated in a planning workshop in February 1989. Later, IfP facilitated a dialogue between the DOH service directors and the NGO representatives on DOH policy on IfP and areas of armed conflict, and helped to clarify roles.

In its first year, IfP involved 68 partner communities of the four NGOs in Abra, Batanes, Laguna, Quezon, and Sorsogon Provinces (in four out of the five regions on Luzon Island). At the mid-year evaluation-planning session in August, the implementing organization from each participating province forged a peace agenda for their province.

The National Evaluation and Planning Session in January 1990 belatedly formalized the terms of reference, criteria for the selection of the areas, and organizational set-up of the program.

Nine more municipalities were brought into the program at a consultation in March in the Cordillera Administrative Region (CAR, north Luzon). The Coalition reported in 1991 that: "In CAR, the IfP project became an entry point for the initiatives to deliver other child-focused services... With the strengthened peace efforts of the other partners... IfP also helped open venues for a dialogue situation with the combatant groups at the local and regional level. In some areas, IfP also helped strengthen the social mobilization possibilities not only for special immunization and medical 'missions' but for more regular health delivery programs for the most difficult-to-reach areas."

IfP faced a number of challenges and difficulties. There was a problem with some of the selected program areas which were found not to meet the criteria later identified, such as being recent, ongoing or potential armed conflict areas--these were among the areas where the peace component of the program implementation was inadequate. Some of the DOH's Rural Health Units and local NGOs did not have enough knowledge of peace education and the IfP program, and there was not a common analysis of the peace situation shared between the NGOs and the DOH.

The bureaucratic inertia of the DOH was a problem. For almost three years, the DOH did not issue any kind of policy statement on its involvement in armed conflict areas, which created unwillingness on the part of DOH personnel to fully mobilize for what they perceived as a solely NGO project. This caused difficulties in the coordination in the program areas between the government and the NGOs, and slowed the implementation.

Resources were also short: NGOs had a limited number of personnel to implement the program down to the field level, and funds were inadequate for logistical support such as transportation. The organizational set-up was weak and to an extent unclear.

The program implementors expressed a fear of miscommunication and suspicion of government and opposition armed forces. We came up against the perennial problem of the way the underground Left perceives programs which promote peace through means other than armed struggle. When these programs give communities greater access to the government to demand social services and thus renew or expand the role the government plays in these communities, especially in regions claimed as "liberated zones" or "red areas", the underground Left sees them as more counter-insurgency than peacebuilding.

Even inviting the participation of armed opposition groups did little to counter this perception. The Cordillera's People's Democratic Front suspected the IfP program in the Cordilleras was a counter-insurgency effort, because it served as an alternative to armed conflict and an entry point for local ceasefire negotiations and peace consultations.

Despite these difficulties, the program can count many achievements. Unfortunately, because we were unable to fully monitor the effects during the program and after we closed it, we can only guess at some of the positive effects these achievements brought about. IfP accomplished the immunization of children in the communities mentioned above, plus Bulacan Province--and in the context of a peace initiative. The provincial peace agendas that it helped the implementing groups to forge for their respective provinces may have served as frameworks for future action or references for future peace consultations. In those communities which were actually areas of recent, ongoing or potential armed conflict, the program managed to secure the de facto acceptance of any armed groups present, which could have been felt as a concrete victory by the communities, and by the armed groups themselves as perhaps a first experience of responding positively to peace initiatives.

In some areas, the program served as an entry point for the delivery of other child-focused services and for the strengthening of the social mobilization capabilities and peace efforts of allied community organizations in the region. Also, a government agency, perhaps for the first time, had to formulate its policy of operation in armed conflict areas from a peace perspective.

The program was sustained beyond the initial phase in six out of the ten participating provinces. It may also be possible that the government Health Department's participation in the IfP program served to inspire its own peace immunization campaign, the 1993 "Ceasefire for Children."

The program also built positive, long-lasting relationships between individuals and groups. The relationship within our National Working Committee was wonderful, and many of us remain friends to this day--this was what enabled us to stick to the process, despite our shortcomings, the opposition of a few in the DOH leadership, and conflicts within some local IfP working committees.

If there was a negative effect, it would have been that the less-than-excellent implementation of the peace component in certain program areas could have reinforced the perception of the unclear link between peace and other issues and frustrated some NGO and government workers involved.

Was it worth it? Of course! For the gains it did make and for the lessons, which are perhaps not lost on those now implementing similar initiatives.

The Afghanistan Mass Immunization Campaign

Written by Mary Anne Peters in consultation with Dr. S.M.A. Fatimie and Dr. A.O. Gebreel, using information from two reports by WHO-Afghanistan.

In November 1994, Afghanistan's warring parties promised to lay down their weapons for a week so that children throughout the country could be immunized. The window of peace and tranquility this opened lasted for two months.

The Mass Immunization Campaign (MIC) was a joint initiative of the Ministry of Public Health and the World Health Organization-Afghanistan. The first round in November 1994 was followed by second and third rounds in May and June 1995.

The Minister of Public Health of Afghanistan, Dr. S.M.A. Fatimie, and the WHO-Afghanistan Representative, Dr. A.O. Gebreel, were inspired by the examples of ceasefires for immunizing children that UNICEF had facilitated in other countries. Despite the scepticism of some agencies that such an initiative would succeed in Afghanistan, Dr. Fatimie and Dr. Gebreel pursued the idea with dedication and enthusiasm. Dr. Fatimie felt that the people of Afghanistan had united and succeeded in the "small jihad" to liberate their country from the Soviet Union, and so they would surely respond to the call for the "greater jihad" against disease, poverty and ignorance.

Dr. Fatimie and Dr. Gebreel sent a letter, signed by the Special Envoy of the United Nations Secretary-General, to all Afghan leaders and governors, emphasizing the objectives of the campaign and the benefits to mothers and children, and requesting that they cease fighting to facilitate the campaign. Dr. Fatimie also spoke to the leaders about the importance of a healthy next generation and succeeded in obtaining letters stating their support and cooperation. As the WHO report on the first round of the MIC observed: "Again, the ability of health issues to unite a nation was visible in the unanimous positive responses received." The leaders committed to a ceasefire of one week, but the tranquility of this period was so infectious that there was no fighting for two months.

The campaign organizers had to build consensus not only with the leaders of Afghanistan's various factions, but also with Afghan health officials throughout the divided country, other agencies involved in health care in Afghanistan, and with key individuals, organizations and countries in the international community. All of this work in communication and consultation was fundamental: "The success of the Mass Immunization Campaign in all these areas can be traced back to grueling hours in coordination of countless inter-agency meetings at all levels of planning," according to the WHO report. The investment in this kind of work may prove to benefit more than just the campaign itself--it may actually contribute to strengthening the social fabric of the nation.

The MIC truly relied on the commitment and cooperation of many parties, including national and international NGOs, UN agencies, and neighbouring countries. The Islamic Republic of Iran donated eight million doses of oral polio vaccine, and the National Institute of Health of Pakistan provided storage for three million of those doses. Leaders of two regions helped the campaign overcome the challenges of transportation by sending large aircraft to pick up the supplies from Peshawar, Pakistan. As WHO reported, "One really cannot truly appreciate this feat without taking note that most aircraft were reserved for military purposes in this time of high conflict in Afghanistan, and to release the planes for health supplies for a preventive program was quite a commitment from the political parties."

Social mobilization and health education were critical components of the campaign. All available means of communication were used to make the public aware of the campaign and of the need for immunization. The mullahs and imams of the mosques helped spread the word. Posters, banners and pamphlets were printed in local languages and distributed by WHO. Organizers arranged radio and TV spots, loudspeakers on cars, and even banners on the tanks in Jalalabad. One of the most important communication tools was the BBC World Service--WHO arranged a contract with the BBC to advertise the national vaccination campaign during the evening news program during the month of November 1994. WHO reported that "The publicity campaign had the effect of creating a demand for vaccinations among the people of Afghanistan. This demand was a powerful stimulant for the organizers at every level." According to Dr. Gebreel, when the campaign began many people asked if there was a vaccine against war!

Dr. Fatimie and Dr. Gebreel stress how vital it is to communicate and work directly with the people of Afghanistan in order to strengthen their commitment and desire for health, development and peace. With perhaps 60,000 people with arms out of a total population of 16 million, the key is to mobilize the majority for peace. When communities have access to the programs and services of health and development, they have a stake in peace and will resist those who promote war. Initiatives like the Mass Immunization Campaign and WHO's "Basic Minimum Needs" program, which works directly with communities to enable them to meet the needs they express, empower communities to solve their own problems, build a constituency for peace, and provide an incentive for young people to stay in the community and work to develop it rather than to take up arms with one of the factions.

WHO reported that the Mass Immunization Campaign of 1994 and 1995 reached two million children and 700,000 mothers. The campaign also strengthened the health system of the country--14,000 health workers were trained and participated in the immunization campaign, regional directors gained skills and knowledge, equipment and infrastructure were provided in many regions of the country, and the Afghan population learned about the importance of vaccinations, so that "they will work hard to support clinics and teams who can provide this service to their communities on a routine basis." Dr. Fatimie feels

that the health sector is now highly respected throughout Afghanistan, reflecting a real desire for peace.

Despite the divisions within the country, the Ministry of Public Health (MOPH) is committed to a policy of neutrality and impartiality, and it proved its neutral status by providing services and supplies to vaccinate mothers and children on all sides of the conflict during the MIC. A 1994 Ministry of Public Health policy statement emphasizes the MOPH and WHO commitment to primary health care serving the minimum needs of all Afghans: "To serve all on an equitable basis, the MOPH leadership has declared its utter neutrality in the current internal conflict and wishes to serve every Afghan regardless of his ethnicity or political or religious affiliation." It is a highly decentralized system, of necessity, with a team composed of representatives of various NGOs and UN agencies in each region, headed by a regional director appointed by the Ministry of Public Health. The World Health Organization plays a vital role in facilitating communication and coordination amongst the regional directors. The MIC strengthened this unifying network.

The WHO report describes important peace effects from the ceasefire. During the period of the ceasefire, there were no injuries or deaths due to "rockets, bombs and bullets." The ceasefire created an atmosphere of peace "to encourage thinking about working together to obtain permanent peace and to encourage other peace initiatives. Afghans began talking about cooperation in a small way rather than confrontation." It provided "a ray of hope for the Afghan people. The Campaign was the first good news of 1994 for Afghans who have been hoping for an end to the conflicts and for progress in rehabilitation of the nation."

The success of the campaign may also show international donors that Afghanistan is not a hopelessly war-torn country where nothing can be done until peace agreements are signed. Both Dr. Fatimie and Dr. Gebreel stress how important it is to begin rebuilding the country now, because development and rehabilitation will empower the Afghan people to demand peace from their warring leaders.

What have been the peacebuilding effects of humanitarian ceasefires?

Here are some observations, from participants at the Centre for Days of Peace conference in 1991 and from others who have written on the subject, on the effects of such initiatives:

- They show that it is possible to develop new channels of communication and establish an environment that promotes dialogue. The dialogue that took place in El Salvador, even if through third parties, and the confidence that came from successfully implementing the ceasefires contributed to the creation of an environment for negotiations to end the armed conflict.
- They provide a space of tranquility which can remind people what peace is like, inspire them with hope and strengthen their commitment to work for peace.
- Participation in humanitarian ceasefires helps to empower people and overcome the sense of isolation and helplessness which can drain their lives.
- They can bring a wide range of parties at the local, national and international level into dialogue and can encourage public discussion of important issues.
- They can draw national and international attention to the effects of the war on all people, especially children. The "bubble of tranquillity" that allowed humanitarian supplies into Iraq during the Persian Gulf War put the human cost of the war on the international agenda and forced the UN to consider it, even though the UN had previously sanctioned the use of force against Iraq.
- They can make communities aware of their rights to receive food and medical care.
- In the Sudan, the "corridors of tranquility" led to increased commercial activities in these regions, resulting in a more stable environment and almost a zone of peace.
- The corridor of peace in Uganda raised awareness of the issue of child soldiers in the armed insurgent group, the NRA, and "probably contributed to the NRA's decision to remove them from front line duty, releasing those who wanted out and providing a free education for those who went back to school," according to Cole Dodge, who helped to bring about the ceasefire.

What are the necessary ingredients of a humanitarian ceasefire?

The following suggestions have been drawn from the experiences of participants at the 1991 Centre for Days of Peace conference on ceasefires for children, from Cole Dodge's description of organizing a corridor of peace in Uganda, and from other sources (referenced in the resource list at the back).

Common ground

Intervenorers have to help parties identify a goal or concern that is common to both sides. For example, the well-being of children is an ideal superordinate goal that transcends the issues of the conflict. Even those groups involved in armed conflict can be appealed to on the fundamental principles of the value and dignity of human life. It is important to understand the nature of the conflict and how the parties perceive their interests, which might include an enhanced local or international image; genuine humanitarian concerns on the part of the combatants; and their desire for confidence-building measures to advance the peace process. Both moral reasons and public relations motives will usually be at work.

Impartiality and transparency

The benefits of the humanitarian operation must be delivered equally to all. Such operations need to exhibit transparency and impartiality, so that neither side fears being put at a disadvantage. The negotiations must clearly spell out the principles of the operation and what aid is to be delivered. According to Cole Dodge, in setting up the Ugandan corridor of peace, "One convincing point with both sides was the principle of giving assistance only to civilians, with the emphasis on children, something that UNICEF and the ICRC were adamant in enforcing and ensured that the government and NRA alike were aware of."

Understanding and respect for indigenous cultures

Interventions must be founded on a deep understanding and respect for indigenous cultures. Local NGOs are the best vehicles for providing aid, and in particular those NGOs who can trace their origins and roots to the field. Foreign NGOs need to take the time to understand the cultural and political realities of the country or region they are working in. NGOs must remain neutral, but be aware of the political problems their aid brings so that the operation is not bungled through ignorance or naivete. UNICEF and the Pan-American Health Organization (PAHO) understood the political intricacies of El Salvador, and most importantly, the interlocutor in the negotiations was the Roman Catholic Church, one of the foundations of Salvadoran society.

Trust and communication

It is essential to develop trust between people prior to agreeing to a ceasefire, and this requires considerable communication.

Intermediaries

The successful achievement of a humanitarian ceasefire is related to the combatants' confidence in the impartiality and trustworthiness of the agencies attempting to negotiate and implement that ceasefire. International non-governmental organizations, with their capacity for neutrality and their ability to act without the constraints of governments and official agencies, have played key roles in humanitarian ceasefires.

International pressure

International public opinion is crucial in motivating governments both to undertake special measures to protect children and to oppose measures that work to the detriment of their well-being.

Legal framework

Clear reference to international agreements and laws is an important part of bringing about a ceasefire and of making the most of its peacebuilding potential. Cole Dodge writes of the need that existed for a specific legal frame of reference when negotiating with the Ugandan government; he used UNICEF's Basic Agreement with the Government and the Geneva Conventions. "Without these we could not have persuaded the civil and military authorities."

Participation

The peacebuilding potential of humanitarian ceasefires is increased by participation of indigenous mediators (such as the church in El Salvador), national and local NGOs, and grassroots and people's organizations in the process. It is important to increase the negotiation and mediation capabilities of local partners by offering training in this area.

The voices of the affected people and communities must be brought into the peacemaking process. In particular, the perspectives of women and children are needed in promoting humanitarian measures and children's needs in war-torn areas. Women and children play an important role in promoting peacebuilding before, during and after a humanitarian operation.

It is important to involve the military in humanitarian operations and make them part of the solution. In order to involve the military, humanitarian assistance negotiators must address political and strategic questions and find creative ways to help the military leadership consider humanitarian needs. This can include recognizing that military personnel and militia men are often the victims of war.

Education and communication

Education is a critical part of the humanitarian ceasefire process. National education and media outreach about the effects of the war and the goals of the ceasefire are important. Combatants, donors and the international community must be educated about their obligations under international law. The public at large must be educated about the conditions of children in war zones in an effort to mobilize public opinion. Peace education, as part of the peacebuilding process, must be encouraged in war zones. Distance education through radio teaching or correspondence courses can complement

standard education and is an alternative when other means are not available. Training of community health care workers can strengthen the outcomes of these initiatives.

Standards and monitoring

It is crucial to secure agreement between parties on a minimum code of conduct and rules and to find a way to apply pressure to adhere to these rules. Attention needs to be provided to monitor and ensure the safe and successful delivery of aid under all circumstances.

There is an initial need to overcome the suspicions of both the government and the armed opposition that a humanitarian ceasefire may be used by the other to rebuild its forces and defences. This general concern is why the use of the term "ceasefire" must often be replaced with "days" or "zones of tranquility."

There has to be an exact delimitation of the "zones of tranquility" or the "corridors of aid", clear identification of the trucks, trains or boats to be used, and an assurance that no arms will be transported or military information passed. Time limits also have to be defined.

Careful attention must be paid to the technical obstacles that may make it difficult for combatants to comply effectively with the terms of the ceasefire, such as their command and control capacity and their ability to police and implement their role in the ceasefire.

Making use of the peacebuilding potential

Humanitarian ceasefires may fulfill two functions: they meet human needs through the delivery of adequate supplies of required aid; and they can be part of a larger process of peacebuilding. When it is appropriate, the opportunities that present themselves for conflict resolution should be capitalized upon. It is important to build systematically on the cooperation required to implement a humanitarian ceasefire--civilian peacemaking does not have to wait until war is over. Even children caught in conflict have the potential maturity to engage in a longer-term peacebuilding process through experiencing solidarity with each other.

Opportunities must be pursued so that the humanitarian measures undertaken during a ceasefire are extended, where possible, into rehabilitative and reconstructive measures. The process of a ceasefire must not take place in a socio-economic vacuum.

Words of warning

The value of such ceasefires is limited unless they are part of a peace process which deals with the underlying causes of conflict.

The danger of temporary ceasefires that are not rooted in the peace process is that they can be used to score propaganda points and therefore have the potential to stall the peace process.

There is also a risk that belligerents will abuse ceasefires in other ways, for example by taking the opportunity to reposition forces or smuggle in weapons.

TRAUMA HEALING AND PEACEBUILDING: The Liberian Experience

Written by Dr. Barrett S. Hart. Barry is a lecturer with Eastern Mennonite University in Virginia, USA, and continues to work in the former Yugoslavia with CARE.

During the Liberian civil war of the early 1990s, I worked for a health organization in Liberia that saw a need to link health and peace in its war-torn society. The Christian Health Association of Liberia (CHAL) recognized that there were immense and difficult physical health problems caused by the civil war, and also that the mental state of stressed and traumatized persons affected by the war was a vital health concern.

CHAL provided health care throughout Liberia--about 45% of all the health services in the country. Its services included curative and preventive health care, environmental health, and health information and communication, and it saw a need to add psycho-social health care in response to the war. My colleagues at CHAL understood that if trauma awareness and healing methods could be integrated with insights and skills from conflict resolution, prejudice reduction and peace education, psycho-social health care could help in the personal and group changes needed for reconciliation and rebuilding society. They began to build the bridge between health and peace.

CHAL had always worked with internationals and in early 1991 invited a Mennonite psychologist to do a psycho-social assessment. As a result of this I first went with a team in June of 1991 to work with persons who were leaders in the communities before the war--nurses, doctors, educators, pastors and so on, who would be looked to as "healers" by the people in a post-war situation. These people were traumatized themselves, so our workshops used elicitive methods to begin to deal with their issues and at the same time to help them to develop a model of healing that could be used with their constituents.

We called the workshop "Seeds of Growth", and referred to the Liberian cycle of farming, where rice is planted in ashes. Seeds could be planted in the ashes of war, and growth and change could happen--that is, through a long period of work and waiting, healing could take place.

The first day of the week-long workshop was called "Seeds of Loss and Change", and we led people to address the grief, loss, stress and changes the war had caused them. The second day was "Seeds of Conflict and Forgiveness", in which we discussed both the negative and positive aspects of conflict, and looked at forgiveness from a Christian perspective (CHAL being a Christian organization). The third day, "Seeds of Hope and Healing", we worked for a recognition of oneself within the group and for an understanding of one's place in the healing cycle. During the fourth day, "Seeds of Mediation, Conflict Resolution and Reconciliation", participants looked at these issues within their understanding of their own cultures.

During the fifth day, "Seeds of Peace and Reconciliation", we shared our understanding of peace, from the Mennonite and Lutheran perspective of the facilitators and from each of the cultures represented. We learned what "peace" meant in each of the Liberian languages--"settled heart", "cool heart", "the heart lay down", and "lack of noise and confusion" were some of the literal translations.

We brought children in during the workshop to talk about their experiences of the war, which enabled the participants to put into practice some of the skills, such as active listening, that they had learned during the workshop. The participants also wrote in journals all week, and at the end, they were asked to write about the steps they could take in their own work or village to rebuild a peaceful society. Some put the model of the workshop as a whole into their own languages, while others took bits and pieces of it. For example, some of the pastors drew on the Biblical understandings of forgiveness and reconciliation, while nurses integrated the trauma healing components into their experiences of working with people hurt by the war. Schoolteachers working in newly re-opened multi-ethnic classrooms were interested in trauma healing and bias and prejudice reduction activities. They proposed using drawing, art, journal-writing and "ethnic days," where children would talk about their own ethnic group to the other students.

The issue of ethnicity and identity, and its relationship with trauma, seemed very important to me, and I continued to think about it and paid more attention to it in later workshops. I was able to build on the learning process of these workshops when I returned in January, 1992 for two years as the coordinator of CHAL's Trauma Healing and Reconciliation program.

CHAL brought me in to use my skills in mediation and conflict resolution and to work with the excellent local trainers, some of whom had training in trauma, to tie together these various elements into a new program. Together we did trainings all over the country and worked to develop a core group of trainers who could continue the program. We also developed a relationship with UNICEF and other NGOs working in the country, and published a newsletter (REACH--Reconciliation, Education, Advocacy, Conflict resolution, and Healing) in which we all shared our experiences.

We started doing trainings in June of 1992, and we followed up with the participants for several months until the war started again in October. The participants were very positive, saying that the people they were working with in their communities, though initially reluctant to look back at what had happened, came to acknowledge that it was important, and then felt it was necessary to move on and make use of the conflict resolution skills they had learned.

What worked well about this program was that we began with the past--trauma--and worked toward the future--prejudice reduction, conflict resolution and peace. This worked because it dealt with pain, brought it to the surface and used rituals, such as

naming the dead, to release it. Skills in conflict resolution were used to build toward the future and for the healing of society. We were constantly drawing on what had worked in society before the war and building on it. Even so, many things had changed, and we tried to integrate new directions and ideas from other situations and contexts.

Initially the participants were CHAL members. With its network of clinics associated with churches, schools and hospitals throughout the country, CHAL was connected with the doctors, nurses, pastors and others who were mid-level leaders in the country. Later, the workshops also brought in the traditional leaders like the paramount chiefs and the village chiefs, who were also mid-level leaders. Unlike the political leaders of the country, these leaders still had the respect of the people.

As an organization, CHAL is widely known and respected by both the people and the leadership, and we were able to travel easily throughout the country. It is a neutral and multi-ethnic organization that includes Muslims and traditional leaders as well as its Christian base.

When the war started again in October 1992, we continued the workshops, often bringing together members of warring groups. I also travelled to Ivory Coast to work with the Liberian refugees there. CHAL continues to train people and to conduct workshops throughout most of the country. Among the people CHAL has reached with the workshops are members of the legislature.

Although we can't know what the impact of this work is in the bigger picture, we saw very real effects in the people we worked with. Many of the people in the workshops had experienced the trauma of seeing loved ones killed in front of their eyes. Often rebel checkpoints targetted members of particular ethnic groups or chose people at random to be killed. The survivors had no choice but to flee, and afterwards lived with feelings of guilt over abandoning their dead without proper burial and ritual. For example, an elderly man who was being taken to seek medical care by his family was shot by a soldier at a checkpoint. The CHAL rituals of naming the dead enabled his family to deal with the guilt of not being able to save him and not being able to bury him. I saw the relief this brought them, enabling them to forgive themselves--and perhaps others.

In another example, a pastor who had seen his parents' throats cut in front of him had sworn to avenge their deaths. He didn't know the individuals who had done it, but he knew the ethnic group--and in Liberian culture, the individual is a representative of the larger group, which is held responsible for its members' actions. As a Christian, this pastor knew that he should forgive, but he couldn't. In the workshop, we told him that his reaction, this desire for vengeance, was one of the ways that people respond to trauma, and we also helped him to identify other reactions that he had experienced. He was relieved to understand his feelings as a normal reaction to abnormal circumstances, and this gave him hope that there might be light at the end of the tunnel, that he might be able to move towards acceptance of his loss. He participated in the ritual of naming the dead,

and also in a ritual of forgiveness in which he wrote on a piece of paper what he wanted to forgive himself for and what he wanted to forgive others for, and then burned the paper. At the end of the week, the pastor said he felt hope that in a few years he would be able to forgive.

War, trauma and healing

War is "the great traumatizer" since it disrupts continuity with the familiar past--socially, politically, economically and spiritually. War destroys people's lives, homes and villages; it separates loved ones; it takes away material possessions. It also destroys safety and predictability, trust in others, and hope for a future of friendships, jobs, and peace with justice.

War shatters hope through the destruction of social relations, a primary value and source of identity. Individuals, families, occupational groups, and larger groups such as ethnic and religious groups have and need identity, a sense of who they are in relation to their social environment. Identity is a basic human need since it is about the self in real world terms and about being safe and able to predict something about life. People are traumatized because that which made them who they are is now gone. That which allowed them to know what to do and say next is no longer a part of their reality. Identity is radically altered and persons are in a state of shock, bewilderment, denial and/or anger because of their new and frightening circumstances.

Although not everyone is traumatized by war, the stresses and trauma of war affect most people at some point during or after the conflict. Persons respond to the shock of war in what can be called normal ways: through denial, anger, guilt, remorse, anxiety, physical reactions, apathy and hopelessness. And finally, after what is usually a considerable amount of time of grieving, with acceptance and readjustment.

So my goal in workshops and in certain counselling cases is to help people grieve their war experiences. Helping persons (and groups) to speak about their loss and grief, I believe, not only helps in the process of healing their trauma, but also begins a much larger process of conflict resolution and peacebuilding. In asking people to probe their pain a process is started toward individual and group emotional health, thereby helping to stabilize people so that they might participate in rebuilding their society after the war.

An important part of the healing process is getting in touch with one's self, one's group and others, and their needs and what threatens the meeting of these needs. War can make us conscious of who we are, what makes us who we are, and how we react when threatened.

It is also my belief that this new knowledge people develop of their individual and their group identity can help them to see why they have stereotypes of their own group and of other groups. It can also help them understand how certain malignant stereotyping

(such as depersonalization and demonization) leads to "enemy thinking" and eventually to conflict or the escalation of conflict.

Moreover, the trauma healing process enables people to understand their feelings of fear and stress as natural reactions to trauma, which can help them to feel less threatened in their individual and ethnic group identity. The trauma healing process therefore starts a process of evaluation and healing within and among groups that can lead to a greater sense of security when coupled with prejudice reduction exercises, conflict resolution training and genuine reconciliation procedures within and across ethnic lines, religious or national boundaries. This then aids the peacebuilding process.

The challenge, therefore, is to establish a health-peace link within the chaos of war and post-war contexts. Even more important is to use this link to help in the process of ending war and preventing future conflicts. Preventing violent conflict and war requires methods that are culturally attuned, psychologically sensitive and pragmatically steeped in the reality of an ever-evolving political and economic world. The experiences learned from trauma awareness and healing as a result of the war should provide new understandings of the internal conflicts of individuals and groups and how these conflicts, along with other real world issues, cause the escalation of conflict. Breaking the cycle of this escalation is the immediate as well as long-range challenge in the related fields of trauma healing, conflict resolution and peacebuilding.

Post-Script: Former Yugoslavia

In 1995 and 1996, I worked for Health Reach (now the War and Health Program) in the former Yugoslavia, mostly in Croatia. I went to share my skills in mediation and conflict resolution and my experiences in Liberia and elsewhere, and to find out how these concepts of trauma, healing and peacebuilding might be relevant in this context.

I worked with the Society for Psychological Assistance in Croatia, as well as with numerous skilled and dedicated individuals with backgrounds in conflict resolution, in psychological work with children, and in education. These people all have high levels of education and a great deal of experience--my role was to bring these people and their different skills together into an integrated program.

We worked to develop programs for addressing the needs of children for trauma healing, bias reduction, conflict resolution and peace education. We started with a pilot project in two cities in Croatia that were terribly affected by the war, training and supporting teachers and developing a training manual. This work was being done in cooperation with UNICEF, so that UNICEF may be able to apply what was learned from the pilot project throughout former Yugoslavia.

We are still very much in the process of doing this work and of learning. What I have learned is that it is helpful to start with trauma healing and bias reduction with children,

as a way of getting at the past--both what they themselves have experienced and the history behind the conflict. It is equally important to provide them with skills in nonviolent conflict resolution and to help them to envision a peaceful future. This approach may make an important contribution to breaking the cycle of hatred and violence.

RESEARCH FOR PEACE: The War and Health Program's study in Sri Lanka

Written by Mary Anne Peters in consultation with Marilyn Weaver and Robbie Chase, from the Sri Lanka Working Group of the War and Health Program.

The War and Health Program of McMaster University (formerly Health Reach) is a joint initiative of the Centre for Peace Studies and the Centre for International Health. Through the Health of Children in War Zones Project, the War and Health Program set out to gather information on the impact of armed conflict on the health of children and their communities in Sri Lanka, former Yugoslavia and the Gaza Strip. The Sri Lanka study attempted to create an environment where peace-nurturing activities could be integrated into the research process itself. As with the other studies, a strong focus on mental health evolved, and the Sri Lankan study assessed the psychological impact of the war on children.

The War and Health Program had originally seen its work in two phases: health assessment, then follow-up interventions which encouraged peace-nurturing and community reconciliation. It soon came to understand, however, that a foundation of trust and sensitivity to people's needs and security concerns had to be built at every stage during the research process if communities were to be willing participants in future peace-nurturing activities. Peace-nurturing initiatives had to be integrated into the entire process, including the research.

Furthermore, communities no longer wished to be the subjects of academic studies which required them to expose the details of their personal lives and their pain to outsiders who contributed little to changing their situations. Therefore, it was important to give the communities access to the results in local languages. Funding constraints and timelines did not allow for long-term follow-up interventions, so the Sri Lanka study aimed to build the capacity of local partners and to explore other forms of healing initiatives.

The Research Process

The War and Health Program brought together a multi-ethnic, multi-disciplinary research team to coordinate the study, and formed a partnership with two regional counselling centres.

The study aimed to understand the relationship between conflict-related violence and the occurrence of psychological problems such as post-traumatic stress disorder (PTSD), grief, anxiety and depression. It involved Year 6 schoolchildren from all three ethnic communities-- Sinhalese, Tamil and Muslim--in the Kurunegala, Polonnaruwa and Batticaloa districts affected by both the ethnic conflict and the southern insurgency. The

10- to 13-year old age group was chosen for interviewing as they were more able to articulate their own experiences and feelings than younger children who often take on their mother's emotions. This age group was also more vulnerable to recruitment into armed militant movements.

The War and Health Program used an educational approach to demedicalize trauma and to avoid stigmatizing individuals who had very normal reactions to very abnormal events in their lives. Since there is no one word to define trauma in the Sinhala and Tamil languages, it was necessary to build a "feeling dictionary" with the interviewers to help them to understand the concepts. The training course in basic counselling, still a relatively new concept in most districts of Sri Lanka, explored events in their own lives as focal points for understanding the connection between those events and their emotional well-being.

The interview teams consisted of young female community workers, who served as "older sister" figures. This lessened barriers of class, gender and language that would have been greater if university-educated medical students had interviewed rural communities. However, the young women needed a longer period of training in the general concepts and in completing survey questionnaires than university students would have. The interviewers received in-depth training in conducting survey questionnaires, interview techniques, basic counselling and facilitation of focus groups.

The War and Health Program used the model of "befriending" and of "barefoot counsellors" that has some history in Sri Lanka. The project might also have rooted its work further into local cultures by building on traditional support systems for healing grief and trauma. Earlier, extended family networks were the primary source of support to children, but the conflict displaced large numbers of the population and disrupted these networks.

Work with children affected by conflict requires a safe environment and sufficient time to build rapport and trust in order for the children to express themselves. The extended four-day interview created a time of bonding and trust-building between the interviewer and child. Even so, interviewers said they needed more time with the children. Culturally, Sri Lankan children often defer to adults in their presence, so interviewing the children in a secluded quiet space allowed them to speak openly for themselves. Artwork was integrated into the interview, enabling children to communicate their feelings not only verbally but also through creative expression. These drawings prompted discussion between the interviewers, families and communities and helped to create a better understanding of the children's emotions and experiences.

Once the children had talked about their experiences, many of which had never before been talked about, the interviewers were able to follow up with skillful, empathetic listening with the families of children selected on the basis of PTSD scores and interviewer evaluation. A woman-to-woman connection enabled the mothers to speak

more frankly with the interviewers, although age differences did create barriers--the mothers were often reluctant to share some of their personal experiences within the household, such as domestic violence and alcoholism, with the young women interviewers.

The Sinhalese, Tamil and Muslim interview teams were overlapped as much as possible during the study. For many of these young women, it was the first time they had the opportunity to make friends with someone from another district and ethnic community. They were able to share their common experiences of suffering from the conflict. This opportunity to bring divided communities together enabled the growth of some long-term bonds between these women, as well as an understanding that "our people have also done harm."

The War and Health Program discovered that some of the interviewers experienced a form of secondary traumatization at times during the interview process, triggered by the painful events evident in the children's stories. The project provided a support system by holding debriefing sessions at the close of each day and having experienced counsellors available at all times during the interviews.

Follow-up

Unfortunately, renewed violence collapsed the window of peace in which the study was conducted shortly after completion of the research. This made access to several remote village communities for follow-up activities difficult and dangerous. While it seems valuable that children have an opportunity to tell their stories and express their feelings, it is essential that proper follow-up support systems such as counselling and appropriate referrals for medical care are in place. With the renewed violence in the eastern province of Sri Lanka and with limited access to these communities, there is a chance that some children may have been made more vulnerable by the initial intervention.

The commitment and responsibility felt by the interviewers because of their involvement did lead many to revisit the children on their own. Since that time, some of the women have been hired by the two regional counselling centres which were the War and Health Program's partners. The Professional Psychological Counselling Centre in Batticaloa is maintaining contact with children and interviewers from the Tamil and Muslim communities, and Sarvodaya has committed to maintaining contact with children and interviewers from the Sinhalese community. Sarvodaya is Sri Lanka's largest NGO, which implements a nation-wide program of psycho-social development of children through a network of child development centres and pre-schools. It has a particular interest in participatory methods of mental health assessment.

Research of this kind can reveal immense and complex needs in communities which organizations like the War and Health may not be well placed to deal with. For example,

one boy who was interviewed spoke very recklessly, as if seeking attention, about his growing involvement with a militant movement. Since the study, it appears he has been recruited. In this case, adequate support was not available to respond to this child's need, and although the research may not have made the problem worse, it raises difficult questions about what responsibility an organization such as the War and Health Program has for the well-being of the people it interviews.

Members of the research team are continuing to work with children at risk through two healing gardens that are being developed in Colombo and in Batticaloa. These gardens are modelled on the Spiral Garden, which is situated on the grounds of the Bloorview MacMillan Centre in Toronto, but they will evolve in their own way in Sri Lanka. The Spiral Garden joins gardening with play and creative arts, and so extends the notion of rehabilitation beyond the physical to the emotional and ecological. Though the garden centres around children and play, its roots grow deeply into the community. It teaches the importance of caring not only for the earth but also for oneself and others. It is a sanctuary where the wounded hearts and minds of children can grow and heal. The Sri Lankan gardens will involve play programs, facilitated by trainees from the local gardens working in conjunction with barefoot counsellors from the study project, radiating out from the central sites to nearby villages. The hope is, in time, to link the garden sites to create a mutual sharing of the arts and foster understanding between divided communities.

The Research Results

The Sri Lanka partners identified the need to create "consciousness" in their society about the effects of armed conflict on children and civilian populations. In recent years, newspapers have carried articles about PTSD in countries other than Sri Lanka, which has provided an opening to begin a discussion on the subject. The War and Health Program research results will contribute to this process and support the commitment made by the Sri Lankan government to the survival, protection and development of children when it ratified the U.N. Convention on the Rights of the Child in 1991.

The results of the study are being published in a document that will be available in English and excerpted in the local languages of Sinhala and Tamil. The results are seen as "belonging" to the Sri Lankan partners. They are best placed, with their deep understanding of the complex dynamics of the conflict, to provide an understanding of the context of the study results and to ensure that there is an appropriate balance in the interpretation made to the popular media and the professional community. There is a great deal of interest and commitment amongst partners, colleagues and contacts in Sri Lanka to use the results to educate the public, academics, professionals and policy-makers about the effects of armed conflict on children. The editor of the results document is also a member of the National Peace Council, and so will be able to disseminate the findings throughout a community committed to peacebuilding.

In contrast, the project has been weak in terms of advocacy in Canada for child rights in situations of war. A clear advocacy plan would have helped the War and Health Program to better use the research results to make the world more aware of the impact of war on children. The methods and the results may also have great relevance for the Sri Lankan community in Canada who have undergone traumatic experiences due to the conflict and then again in adjusting to life in a new country.

The War and Health Program study has spurred interest in the psycho-social needs of children affected by armed conflict and has generated momentum to coordinate an effective response by proposing a conference for early 1997. This conference would provide an important forum for building on the results of the War and Health Program study as well as for sharing the learnings around processes and initiatives that encourage community reconciliation and peacebuilding.

Lessons Learned

The War and Health Program brought together a multi-disciplinary, multi-ethnic research team. The composition of the team had many benefits, not least of which was building bridges across ethnic differences and perspectives. Trust and understanding developed amongst the team members and interviewers, as well as a shared commitment to the health and well-being of children. For many, it was the first opportunity to work together on a creative initiative addressing the psycho-social needs of children affected by conflict-related violence.

The working group brought together students, professionals and volunteers with experience in mental health, peace, community development and the arts. This multi-disciplinary group worked well, despite the challenging differences of working styles, knowledge, language and beliefs amongst the different fields--difficulties which were compounded at times by the group's international and inter-cultural makeup.

The connection between health and peace was very important in this project. The group was able to sensitively approach the peace aspect of its work by referring to recognized health goals identified by international conventions. The Spiral Garden model takes a holistic approach to healing which embraces health and peace at every stage of its development. The War and Health Program also established a Sri Lankan Directory of Peace Groups, presented to the National Peace Council, which contributed to increased networking among organizations.

The Sri Lanka Field Study aimed at building partnerships that went beyond a donor-recipient relationship and which provided a more equitable distribution of resources and opportunities. The War and Health Program found great value in providing opportunities to its partners from different regions to come together in Canada to share their experiences of living and working in a conflict zone. These opportunities were mutually fortifying and educational, built solidarity, and provided fora to contribute and learn from

others. They also allowed partners who were often living and working in dangerous, stressful, demanding environments to get away and "recharge" somewhat.

The project aimed to build the local partner's capacity to conduct community-based research and to strengthen the counselling outreach programs. Since the project was initially conceptualized in Canada by the War and Health Program and the funding rested with a Canadian university, it was difficult for the Sri Lankan partners to ever feel a sense of ownership and to assume full responsibility for decision-making as the project developed locally.

This project, like many others, was defined by a three-year funding timeline. Given the fluid, unpredictable and sometimes volatile nature of working in a conflict zone, the timeframe was unrealistic. Trust, which has been eroded by conflict, is an essential factor in laying a foundation for peacebuilding--and trust needs time. Also, partners must feel secure in that their concerns are respected and acted upon.

A long-term commitment and regular communication are needed to build relationships amongst individuals and to understand the political, social and cultural context in which the project operates. International organizations contemplating working in zones of armed conflict should ensure that they consult individuals who have expertise in the region. Acting from a mere sense of goodwill could endanger partners in the field.

In relation to the scope of the psycho-social needs of Sri Lankan children in situations of armed conflict, the War and Health Program's work has been very modest--and it is still work in progress. It does, however, show promise in some of the approaches used, and it may well have catalyzed concern for children's health and well-being while supporting local peacebuilding initiatives.

LOCAL SUPPORT FOR PEACE THROUGH HEALTH: The Hedip Program of the World Health Organization

Written by Sara Swartz of the Division of Emergency and Humanitarian Action of the World Health Organization.

The first vaccination campaign organised in a Renamo-controlled area of Milange District (Mozambique) with the support of Hedip was a reason for serious worry for the nurse from the District Health Office. "I was really afraid", he told us afterward. "I had always thought of them as violent bandits but I didn't really know them. That time I had to do a vaccination campaign with one of their health workers. We had discussed the campaign with their representative who had sensitised their leaders on the importance of vaccinating the children. We arrived with the vaccines, together with the Hedip project officer, on the motorcycles that the project had donated to the District Health Office for these activities. I felt reassured by his presence because I knew he was used to working with their representatives and had their confidence. We talked with the Renamo vaccinators and did some informal training. Everything went all right. Now I go by myself and we continue to vaccinate together. We talk about the other things that need to be done there: there are so many. And sometimes I take some other things on the motorbike, you know, so we can make a little party with the people there..."

Milange District, where the Hedip project operated in Mozambique, is part of the province of Zambezia. Following the civil conflict, large areas of the district were controlled by the armed opposition party (Renamo). In the district, a committee supported by WHO/Hedip was made up of representatives of the district government, of Renamo civilian officers, religious organisations, local businessmen, local NGOs and traditional leaders. The committee decided by consensus which activities to support. Deciding on who would participate in training courses for health activists, how to organise vaccination campaigns in Renamo areas, where to position new health centres or which centres to begin rehabilitating had strong political implications in a district such as Milange.

Through this approach, areas under Renamo control were slowly opened for health outreach activities carried out jointly with Renamo health workers and government staff from the District Health Office. Initially, WHO, through Hedip, supported these activities and acted as a neutral cushion between the conflicting parties, but slowly, the process created openings for similar activities, which were supported by international NGOs also working in the District who decided to join the process initiated by Hedip.



In 1991, the World Health Organization began a program called Hedip--Health and Development for Displaced Populations. Hedip set out to find national and international strategies for conflict prevention and peacebuilding through health and health-related initiatives. As such, it fit into the larger UN process of developing overall strategies for humanitarian assistance in situations where armed conflict has caused mass population displacement.

WHO's preliminary research showed that there was agreement, in theory, on appropriate strategies and approaches but only a few examples of their being used successfully. Hedip was a participatory action research study, designed to attempt to translate into practice through concrete field activities the sustainable development approach to emergencies commonly described in UN language as the "continuum". Hedip conducted pilot projects in three conflict-affected countries to develop and refine methods for:

- using action in the health and health-related sectors to strengthen and encourage reconciliation at the community level;
- providing assistance so that humanitarian and development aid benefits the entire community, not just one specific group;
- facilitating effective local coordination and inter-sectoral actions;
- bridging the gap between emergency assistance and long-term sustainable development.

The program took a collaborative approach from the beginning, involving technical representatives of UNDP, UNHCR, DHA/UNDRO, IFRC and WWF in deciding the direction it would take. At the international level, the program brought together health experts from the pilot project countries and from other conflict-affected countries so that they could exchange experiences and contribute to developing the policies that the program would promote.

One such meeting brought together experts from 16 countries and from the major international organisations to discuss the strategic role of the health sector in situations of conflict and in support of peace processes. These experts, some of whom were from conflicting countries and factions, met to propose concrete health and social initiatives in their regions and recommend strategies for international cooperation in support of such initiatives. The newsletter "Hedip Forum" documented the Hedip pilot projects and similar activities of other organisations and compared them to identify aspects which could be usefully applied in other contexts and which could become the basis for general policy development.

Decentralisation, participation and inter-institutional collaboration were the three key strategies that were applied and developed in each pilot area:

- The projects were implemented at a local level--"local" meaning a decentralized administrative area like a province, district or municipality. The strategy was to work in a well-defined geographical area, small enough to permit real participation and large enough to have the resources to carry out the agreed actions.
- Hedip defined participation as creating the opportunity for different groups-- government authorities, entrepreneurs, social services, public and private associations, citizens groups--to meet, analyse the problems and potential of the area, set priorities, and decide what to do, how to do it and with what resources.
- The emphasis in each of the three local projects was on finding ways to help local institutions, technicians, community representatives as well as the various social and economic forces present in the community to work together. To this end, Hedip formed local inter-institutional committees which discussed and prioritized local needs, debated possible solutions, identified potential resources, and decided on institutional responsibilities for various activities. In most cases, the committees invited international organisations and NGOs to participate in this process with their available resources. The objective was to produce coordinated plans of action for integrated area development based on the widest participation and collaboration possible (see box).

From 1992 until 1995, Hedip developed and implemented projects in Milange district, Zambezia province in Mozambique, in Colombo municipality and Anuradhapura district in Sri Lanka, and in Split municipality in Croatia. In each case, the planning phase of the project was a long process--around 12 months--which concentrated on learning about the priority problems and establishing relationships with local and international organizations working in the area who were potential partners. The more conflictive the area, the more complicated the process.

Each project gave priority to addressing health problems whose solution also required action in sectors other than health. In Split (Croatia) the project focused on the health and social problems of the youth. In Milange (Mozambique) the focus was on extending primary health services to the previously unserved population in areas under Renamo control. In Colombo and Anuradhapura (Sri Lanka) the project focused on the psycho-social needs of marginalised communities, including many groups displaced by the civil conflict. The specific project objectives and activities differed according to the priorities and context of each local community, but in each case the aim was to foster local peacebuilding through action in health and health-related sectors.

Each of the Hedip projects succeeded in bringing other resources and a wide range of partners into the activities decided on by the local committees. These resources came from local institutions and NGOs, international NGOs and UN organisations, and, in one case, from a citizen's committee from Modena, Italy. In each case, very limited WHO resources (approximately \$150,000 in each area) had initiated processes and produced

Local Committees as Instruments of Participation

The following is taken from an article written prior to the first elections which took place after the signing of the peace agreement in October 1992 (by Guglielmo Riva of WHO/DGCS Collaborating Centre for Emergencies in *Hedip Forum* No. 2, Nov. 1993).

In the case of Mozambique, it took almost twelve months to develop the formal inter-institutional committee as Hedip's coordinating and planning body. Hedip began by hiring a skilled, local socio-anthropologist to study the social, cultural and political variables at work in Milange district, a complex area. This helped to identify traditional leaders and other significant social forces and to map the district in terms of the health service network, schools, roads, etc. It also brought to light major problems, such as land use and ownership--there were different, often antagonistic, points of view on the land problem, but also a number of criteria for resolving eventual conflicts informally decided upon by traditional leaders, the community and even the district authorities.

The committee was made up of formally delegated representatives from district government, Renamo, religious organizations, the local economic sector, local NGOs, and the traditional leadership system, as well as the local Hedip project manager. Representatives of other organizations with resources to invest in the district were invited to participate in meetings.

It was difficult to properly represent the traditional leadership system on the committee because there was no form of coordination amongst the 13 "regulados" (traditional leadership areas) in the district. One of the committee's priorities was to establish sub-district committees to cover smaller areas such as "localidades" and "regulados", which would help to include those who have no power, traditional or otherwise, and who have greatest difficulty in making their needs felt.

results that could be sustained with the limited public and private resources of the local community. As well, the participatory methodology and emphasis on local involvement made, in the words of the program's evaluators, "a visibly positive impact on the communities" and produced projects that were accepted by the communities as their own, rather than as projects of external agencies carried out in their territory.

Although it is still difficult to arrive at definitive conclusions based on the limited experience of the Hedip projects, some lessons in methodology are worth mentioning here. One lesson relates to the appropriate scale of peacebuilding interventions. In the three Hedip cases, as in all civil conflicts, the sources of conflict were linked to struggles for power between central government interests and those of other groups in the country who felt that their interests were not represented by these governments. It was crucial, therefore, to adopt a methodology which did not support either side but which could stimulate negotiation among government and opposition forces and other groups whose real problems were not taken into consideration by either government or opposition forces in their struggle for power.

Hedip, with its limited resources and political clout, did not have the capacity to identify and give voice to these different, often marginalised groups of people at national levels--but it was possible at more decentralised, local levels. At these levels, it was possible to identify public authorities with institutional responsibilities (and some resources), active citizens' groups (associations, local NGOs, businessmen, women's groups, religious organisations, etc.), local professionals such as teachers, health and community workers, and others who were closer to the needs and aspirations of people frequently excluded from the larger political and development processes. Within this context, health problems offered an excellent entry point to identifying other problems in the community and finding potential comprehensive solutions which the community could sustain with its own resources and limited support from external actors, such as WHO.

The creation of the local inter-institutional committees formalized this decentralised and participatory process. The project's resources, however limited, could only be used for activities that the committees had decided were priorities--without consensus agreement, project funds could not be spent. This reshuffling of the rules of the development and humanitarian aid game is, in our experience, the key to turning sectoral projects into peacebuilding initiatives. This method has been successfully applied on much larger scales by other UN organisations such as ILO, UNDP, UNHCR and WHO/PAHO in Central America through the Prodere program, also financed by the Italian government.

In each pilot area there were large numbers of uprooted people, and the participatory process allowed the projects to go beyond the "camp" mentality of a lot of work with refugees and displaced people. In each project area, displaced people were represented, directly or indirectly, on the local committees, and this participation gave them an

opportunity to have their concerns included in the priority problems the community would address.

The projects considered the problems of the displaced people within the community at large and looked for solutions to their problems which would also benefit the resident population over the short and long term. A good example of this method in practice was the organisation of recreational activities for the youth of Split in Croatia. Apart from the presence of large numbers of people displaced from Bosnia, of both Croat and Muslim origin who were housed in collective centres, hotels and individual families, Split was faced by the serious social and economic consequences of the protracted war in the region. Unemployment levels were sky high, especially among youth. Organised crime, prostitution and drug abuse were major social problems. The local population felt the weight of the extra burden put upon them by the presence of so many refugees and displaced people--and hostility was rising.

The inter-institutional committee decided to address some of these problems by creating social and job-training opportunities for young people. But how? In the short-term, the committee decided to implement a series of cultural, recreational and job-training activities in collaboration with the public health and social welfare institutions, the labour board, local NGOs and the UNHCR office in Split. These activities took place in collective centres, camps, schools, and local government buildings. Representatives from youth groups, local professionals, institutional partners and the youth from the various centres housing the displaced and refugees helped to define and promote each activity. This was a chance to identify common problems and strategies, exchange experiences, benefit from each other's resources, break down the depression and isolation caused by war and displacement, and regain a sense of normality.

In the long-term the objective was to rehabilitate a municipal building as a youth information centre. Through this centre, public institutions would run their programs for health education, job training and promotion, sports, culture and others. The centre would also act as a clearing house and information centre with the prerequisite that all activities would be designed jointly according to the Hedip approach and that both local and displaced youth groups would participate fully. This centre is now operational although the Hedip project, as such, has ended.

Instrumental to the development of this strategy was the collaboration of a citizens' committee from Modena, Italy. Modena's committee was also a mixed committee of public institutions, professionals, NGOs and citizens' groups which agreed to support the Hedip process in Split. Each committee learned about the problems and potential resources of the other through an exchange of visits, and they agreed on a plan of action, supported with the public and private resources Modena's citizens had raised.

At a time when the reality in Split was dominated by the war, aggressive nationalism and a sense of psychological and economic isolation, this grassroots cooperation opened

new channels for professional exchanges, dialogue and debate about different development models. It created, in the words of a colleague from Split, "a new sense of purpose, energy and optimism in our work, even under these difficult conditions, and interrupted the sense of isolation we suffer from". From the Italian side, creating a citizens' committee meant gathering all the local NGOs, associations and groups already active in solidarity with Croatia and the former Yugoslavia and focusing this support into one coordinated and more effective plan. The continued support and exchanges with Modena have helped to sustain the activities in Split even after the conclusion of the Hedip project.

The role of WHO in this process cannot be overstressed. Each pilot project was clearly defined as a WHO initiative. The individual project managers were professionally qualified nationals, locally contracted as WHO staff. The institutional weight of an authoritative United Nations organisation such as WHO provided the credibility required to forge new policies and enter into dialogue with major national and international institutional partners. WHO had the moral authority and perceived neutrality necessary to bring conflicting parties--as in the case of Mozambique--into a local process of dialogue centred on the basic issue of people's health.

The Hedip methodology shows great promise, but further research and analysis is needed on the role of the health sector in vulnerability reduction, conflict prevention and peace consolidation, including further analysis of the results of the Hedip experience and related experiences such as the Prodere program. At an evaluation meeting, the external evaluation team (from the "War-torn Societies Project" of the United Nations Research Institute for Social Development), the project partners, the local project managers and other technical staff urged UN organisations and WHO in particular to apply the lessons learned from these experiences through their humanitarian and development programs in countries affected by or vulnerable to social crises. The meeting also called on WHO to provide increased institutional support, at Headquarters, in regions and in countries, to processes and initiatives of this sort.

The Hedip experience has shown that health initiatives can promote local processes of reconciliation and mutual cooperation. It is possible to overcome barriers of prejudice and distrust and to work in the interests of all groups living in an area without fueling micro-conflicts among different categories of poor and disenfranchised people. Local processes of inter-institutional planning can promote coordination and synergy among local partners and between internal and external actors working in the same area. And the adoption of a participatory, problem-solving approach applies the holistic vision of health that is the basis of the primary health care strategy promoted by WHO. The methods we used could be applied in vulnerable areas as part of a preventive strategy to reduce the risks of conflict as well as part of a larger initiative for peace consolidation.

Supporting national peace processes, however, was beyond the scope of the Hedip projects. We are convinced, in fact, that for health initiatives to have an impact in

national peace processes they must be included in larger, more wide-reaching inter-sectoral initiatives that result from a political commitment to peace, and involve a concerted effort on the part of the entire UN system, the Bretton Woods Institutions and the international community.

Hedip was promoted and managed by the then WHO Division for Emergency Relief Operations (ERO) through its Emergency Preparedness and Response Program. Other UN agencies and international organisations, in particular, UNDP, UNHCR, DHA/UNDRO, IFRC and WWF also participated in the the program's development. Hedip was financially supported by the Italian Government while technical collaboration was provided by the WHO Collaborating Centre for Emergencies located in the General Directorate for Development Cooperation of the Italian Ministry of Foreign Affairs.

The positive achievements of the pilot projects were due principally to the dedication and professional capacity of the three project managers: Dr Esther Amarasekera, Mr. Antonio Santiago Esteves and Mr Vedran Mardesic. In WHO Headquarters, the support and technical guidance of Dr Samir Ben Yahmed, coordinator of the emergency preparedness program, was invaluable.

Activities supported by Hedip in the pilot areas

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 drug addicts
- psycho-social counseling to war-affected families
- vocational training
- cultural and recreational activities for approximately 700 young people from collective centres, privately accommodated refugees and local youth through local NGOs and public institutions
- establishment of a Municipal youth information centre through decentralised 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 centres and 1 nurse for delivering mobile health services into Renamo-controlled areas, provision of motorcycles for mobile vaccination campaigns and refrigerators for vaccine conservation
- support to the rehabilitation of the district hospital and district health centres
- socio-anthropological research to map the district in terms of services (health, education, communications), language and the system of traditional leadership, identify potential problems and solutions
- mediation between conflicting sides (Renamo and Frelimo) by encouraging involvement of traditional authorities and church leaders in mobilisation and implementation of health-related activities in Renamo-controlled areas
- support to Provincial Health Authority in coordinating health activities at provincial level with international organisations 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 centre 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.

BAND-AIDS AND GENOCIDE: Medical Aid to Rwandan Refugees

Written by Mary Anne Peters in consultation with Rachel Monroe-Blanchette, former MSF country coordinator in Goma.

Medecins sans Frontieres-Doctors without Borders (MSF) is an international emergency medical relief organization which sends over 2000 medical and non-medical volunteers out on missions every year. It was one of the main non-governmental organizations (NGOs) providing emergency medical care during the Rwandan crisis.

MSF began working with refugees from Rwanda in Goma and the Kivu area, Zaire in 1992, providing basic medical care and sanitation. The camp at Goma was a small one, with about three to five thousand Tutsi refugees who had fled the earlier massacres. MSF also began working with refugees from Burundi inside Rwanda after the 1991 ceasefire.

MSF staff within Rwanda had developed a good understanding of the history of the Rwandan conflict, monitored the radio and sensed that the situation was extremely volatile. No one, however, could quite believe just how dangerous and terrible the possibilities were, until the genocide began on April 6, 1994. Soon after, the Rwandan Patriotic Front (RPF), the armed opposition movement composed mostly of Tutsi exiles, began moving into the country to take over power and to halt the genocide being orchestrated by the Hutu extremist army and militias.

MSF assigned one of its staff members from Goma to monitor the situation and explore possibilities for providing assistance inside Rwanda, but it was not possible to enter the country from Zaire. MSF continued working within the country, and along with the International Committee of the Red Cross was the only NGO to stay in Kigali, the capital, during the genocide and civil war.

During this period, only five to ten Tutsi refugees per day were actually making it across the border into Zaire; many were very badly injured with machete and club wounds. MSF provided medical aid and gathered testimonies from these refugees, and also talked to the Zairean border patrols, who were often able to observe the massacres taking place at the border. Many of these refugees formed ad hoc camps way out in the bush, where MSF sent staff to visit them, provide medical assistance, and gather information. MSF staff explained that they wouldn't be able to provide on-going aid to the refugees because they were so far away, but the refugees felt safe where they were and wouldn't move. Part of the reason for their desire to be isolated was a war in Masisi, North Kivu, which had displaced 350,000 Rwandan Zaireans to the Goma area in 1993.

At the end of April, the first massive exodus of Hutu refugees fleeing the RPF took place--300,000 arrived in Tanzania. MSF began working in the Tanzanian camps, sent

reports to Europe and tried to evaluate whether to launch a big operation in Goma. It was very difficult to predict what would happen in Rwanda, and whether many refugees would arrive in Zaire. MSF decided to prepare for 300,000 refugees. There was some concern that 300,000 was too large a figure, because huge amounts of resources are required for such a state of emergency preparedness--medical supplies need to be flown in, volunteers need to be put on stand-by around the world.

Then, in July, one million people crossed the border into Zaire in three days. MSF was just overwhelmed, and all of the volunteers on stand-by had to arrive "tomorrow."

The United Nations, the international community and the media all resisted calling what was happening genocide. This made it difficult for many NGOs to adequately understand the crisis and respond appropriately--most did not begin working in the area until the mass exodus of refugees began.

With MSF's experience in emergency relief, it was able to predict the health crises that would arise, such as cholera, as well as the chaos and potential for conflict in any situation of mass population displacement. What was amazing to relief workers in Goma was how well organized the refugees were, in view of the large numbers. At first, NGOs welcomed this organization and control--there was no way they could have responded to the massive numbers and huge needs otherwise, and they were grasping at straws to deal with the crisis, particularly the cholera epidemic, at the height of which 3000 people were dying every day.

It was not until several months later that the NGOs began questioning why the food was not going to the people who needed it, many of whom were badly malnourished, but instead to the camp leaders. Aid workers began to realize that many of the people organizing the refugees in the camps were the same extremists that had organized the Hutu people to commit genocide. The NGOs were working within and thereby strengthening the very same structure that had just killed up to one million people.

What could MSF and other agencies have done differently? As Rachel Monroe-Blanchette (who was MSF's country manager in Goma until April 1994 and then responsible for the Rwanda emergency from Goma) said, there was no option at first. Humanitarian principles demanded a response to the emergency and the epidemic, and there was no way that the relief agencies could have coped with the scale of the emergency without the organization within the refugees. This crisis ranked as the largest humanitarian disaster the world had known. Each agency's efforts involved huge numbers of staff and volunteers--MSF alone had around 360 volunteers and 1500 local staff in Goma at the height of the crisis--all of whose energy and attention was focused on meeting the most basic survival needs and saving the lives of the refugees.

Earlier efforts to analyze and understand what was happening, however, might have prevented NGOs from becoming part of the problem. In such a situation it is not possible

to expect the emergency relief personnel to be able to do this analysis, so it is important to have a team of people whose function is to gather information, study the history and the current situation, and to analyze the context. If this had been done during the Rwandan crisis, MSF and other agencies might not have spent scarce resources, resources that were needed for other emergencies in other parts of the world, in an operation which not only fed and supported the engineers of a genocide, but also reinforced their control of the population.

Towards the end of 1994, a large amount of money came in from the international community for work with the refugees. This money generated a momentum of its own, as is often the case, pushing NGOs to develop projects and continue working in the camps despite the questionable circumstances. At the same time, the international community still lacked the political will to come up with long-term political solutions to the problems of the region. After having ignored the warning signs before the genocide and withdrawn the UN peacekeepers and refused to expand the mandate of those remaining just when they were most needed, the international community used NGOs as a band-aid solution to the deep and festering wounds of the region.

MSF participated in a coalition of NGOs working in the camps which issued a common statement about concerns around security of staff, diversion of food, control by the extremists, and lack of international attention to the fundamental issues of justice, and threatened to withdraw unless the international community responded. This action achieved some (limited) gains, such as the UN deployment of a security force for the camps.

MSF's experience in Goma during the two years before the genocide, working with the earlier Tutsi refugees, does provide an example of how aid can support reconciliation. The refugees in the Goma camp had recently fled Rwanda, but there were also refugees who had fled the country in earlier decades, who had moved out of the camps and into the countryside. Through its work in Goma, MSF became aware of a conflict in the Masisi area of North Kivu, between the local Zairean population and the long-term Rwandan population, in which over 6000 Rwandans were killed and 350,000 displaced towards Goma. MSF became involved in the reconciliation process, by providing transportation and other resources for elders to attend reconciliation meetings. MSF also solicited advice from the elders on how to make MSF's aid consistent with and supportive of the reconciliation process. Unfortunately, when the massive numbers of Hutu refugees arrived in Goma in July 1994, the chaos and crisis left no time for integrating the wisdom gained through this earlier experience into the response to the new emergency.

On the positive side, MSF gave assistance to the most vulnerable and succeeded in lowering the death rate and infant mortality by improving sanitation and providing basic medical services. MSF also gave some refugees training as health care workers, in sanitation, auxiliary nurse duties, and community health outreach and education. Refugees who already had some training were taught more technical skills, which would

help them to reintegrate on their return. This empowering of people through education addresses some of the fundamental problems at the root of the conflict.

A number of peacebuilding initiatives came out of the individual efforts of MSF volunteers. They looked for ways that people could support each other, and tried to encourage initiatives at a small level. Many gave their own time to support community groups, particularly women's groups.

Within Rwanda, a nurse who had previously worked with Sudanese refugees began unofficially organizing support efforts for people suffering from post-traumatic stress disorder. By bringing people together who had witnessed the genocide and allowing them to talk with each other and publicly share their emotions, this nurse helped them to heal--and to better understand prejudice and nonviolent means of settling differences. MSF adopted this work as an official project.

MSF's commitment to impartiality and neutrality--working with both sides of the conflict, inside and outside the country--was also extremely important. Because MSF had projects both inside and outside Rwanda, it was well placed to gather and communicate information both for advocacy purposes and for developing a coordinated and effective response. It could make the link between what was happening in the camps and what was happening inside Rwanda in order to address the situation as a whole.

Through developing relationships with the Rwandan government, it was also able to do some low-key and personal lobbying to push the government to make a public statement encouraging the refugees to return. MSF limited itself publicly to giving out factual information regarding its own work, feeling that only the government should encourage refugees to return because only the government could take responsibility for their safety.

MSF's role as witness and advocate was also very necessary, for education and lobbying in the international community. MSF has been strongly demanding support for the justice system within the country, believing that justice is fundamental to reconciliation. MSF has published two reports documenting the continuing crisis in the region and demanding justice and an end to the impunity. Two years after the genocide, the refugees still have not returned to Rwanda and the Rwandese government still lacks the money to deal with the pressing need for reconstruction--particularly of the judicial system. The International Tribunal does not have the resources to administer justice to those who engineered the genocide--and without this justice, there can be no peace in the region.

Rachel Monroe-Blanchette recommends better training for field staff and volunteers. She feels training should include development of skills and knowledge in context analysis, conflict resolution, human rights and addressing the root causes of conflicts. There are no prescriptions that can be applied to all situations, but if field workers--

particularly the field coordinators--have some basic training in these areas, they can integrate it into their work in the field.

The capacity of MSF and other NGOs to gather and analyze information must be strengthened and brought to bear on the difficult questions that often surround humanitarian aid--questions that the Rwandan emergency showed in the extreme.

In July 1995, MSF stated: "MSF faces a moral dilemma when it provides humanitarian assistance to a refugee population of thousands of innocent civilians who are living in these Rwandan refugee camps alongside the authors of the genocide who are making preparations for a new military attack. For an organization such as MSF the debate is whether it should continue to provide humanitarian assistance to a refugee population which is used by the perpetrators of the genocide as a means to increase their power. Whether in these circumstances it would be justified to cease the humanitarian assistance to the refugee population presents a moral dilemma for the organization. Some say such a situation is contradictory to the principles of humanitarian assistance. Others say that humanitarian principles demand the continuation of humanitarian assistance while at the same time raising a critical voice. This debate has forced MSF to reconsider the boundaries of humanitarian aid." MSF no longer works in the Goma camps, but continues to provide medical care and humanitarian assistance in the Masisi region in North Kivu where ethnic violence has increased.

THE WORLD COURT PROJECT: Are Nuclear Weapons Legal?

Written by Mary Anne Peters based on materials from the World Court Project and the International Physicians for the Prevention of Nuclear War, with the help of Joanna Santa-Barbara and Henrietta Langran of Physicians for Global Survival.

In view of the health and environmental effects, would the use of nuclear weapons by a state in war or other armed conflict be a breach of its obligations under international law? This clear, simple question was put to the International Court of Justice by the World Health Organization. The United Nations General Assembly supported this move by posing a similar question concerning use and threat of use. The campaign by citizens and peace groups around the world to have the court consider the legality of nuclear weapons is known as the World Court Project.

The World Court Project grew out of an idea by Harold Evans, a retired judge in New Zealand, who in 1987 sent an open letter to the Prime Ministers of Australia and New Zealand asking them to help bring the question of the legality of nuclear weapons to the International Court of Justice (the World Court). The view that the use of nuclear weapons violates international law is not new, and there is a strong body of supporting legal opinion, but Harold Evans believed that getting the World Court to formalize this position would strengthen the anti-nuclear movement.

Although conventions of international warfare explicitly ban the use and even the manufacture or possession of certain forms of weaponry, nuclear weapons are not explicitly prohibited. The case for their illegality looks to existing conventions and treaties which prohibit the use of weapons that cause unnecessary or aggravated devastation or suffering, which do not discriminate between military and civilian targets, or which cause severe damage to the natural environment. The International Court of Justice, the “principal judicial organ” of the United Nations, had not previously been asked to rule on the legality of particular weapons. Its role is to judge contentious cases between states and to give an advisory opinions, which only the UN General Assembly, the Security Council, and other UN organs and specialized agencies can request.

Evans’ initial effort did not succeed, but he persevered by writing to all UN member states and several non-governmental organizations seeking their support. His idea caught the attention of the New Zealand affiliate of the International Physicians for the Prevention of Nuclear War (IPPNW-NZ). Members of IPPNW-NZ, notably Erich Geiringer and Robin Briant, took the proposal to the International Congress of IPPNW in Montreal in 1988 and again in Stockholm 1991, where there was complete support for the initiative.

The International Physicians for the Prevention of Nuclear War (IPPNW)

In the early 1960s, as the United States began a massive shelter program to provide safety against a Soviet nuclear attack, a group called Physicians for Social Responsibility published a series of reports on the medical consequences of nuclear war. These reports undermined the bunker notion of security that the US government was promoting, and publicly showed that there could be no useful medical response to nuclear war.

In December 1980, three US and three Soviet physicians met in Geneva, Switzerland and formed the International Physicians for the Prevention of Nuclear War. According to Bernard Lown and Eugene Chazov, two of IPPNW's founders, "the exclusive task for IPPNW was to promote abolition of genocidal nuclear weapons....Stopping the nuclear arms race did not demand profound expertise. It required educating people on the issues and involving millions in the struggle for human survival."

The example of US and Soviet physicians cooperating and trusting each other was a powerful one in the midst of the Cold War and the arms race insanity of the 1980s, and it drew global attention. Following in the footsteps of the first Physicians for Social Responsibility reports, IPPNW succeeded in creating wide public understanding in both the US and the USSR about the indiscriminate devastation nuclear war would cause, the impossibility of limited nuclear war, and the futility of any response, other than prevention, to the medical and environmental effects of nuclear war. IPPNW won the Nobel Peace Prize in 1985 for its work.

IPPNW grew to a worldwide network with 200,000 members in nearly 80 countries. It learned that when physicians speak from the perspective of their humanitarian commitment, they are listened to seriously by the public.

IPPNW's mandate has now expanded to include the prevention of all forms of warfare and the promotion of alternative means of conflict resolution. IPPNW members have been involved not only in the struggle against nuclear weapons, but also in peace initiatives in their own countries. For example, Greek and Turkish physicians have come together to speak out against hostilities between their two countries.

In May 1992, the World Court Project was officially launched by three international organizations: the International Physicians for the Prevention of Nuclear War, the

International Association of Lawyers Against Nuclear Arms, and the International Peace Bureau. IPPNW's involvement in the campaign was fitting given its years of work mobilizing the medical profession against nuclear weapons and educating the public, governments and politicians about their medical effects.

The co-sponsors of the project agreed that they should approach the request to the World Court through two official routes, the World Health Organization and the UN General Assembly. The World Health Organization was an obvious choice because of IPPNW's long association with it and because of its commitment to health, defined as "complete physical, mental and social well-being and not merely the absence of disease," as a basic human right. Furthermore, WHO had already conducted numerous extensive studies on the health and environmental effects of nuclear weapons use.

Although the World Court Project organizers knew that approaching the Court through the UN General Assembly would be more difficult, they felt it was crucial. The importance of the issue warranted discussion in the full world arena, where all dimensions of the issue could be considered along with health and human rights. A reference by the General Assembly would also gain the most publicity and would ensure greater follow-through on the eventual ruling.

A great deal of thought went into developing the strategy for the World Court Project. The organizers decided that the question to be referred to the Court should focus on use of nuclear weapons, and let questions of testing, transfer and so on flow from the decision on use. The organizers also wanted to make sure the initiative would be strategically wise in the context of the global political scene and anti-nuclear movement. An IPPNW brief on the project states: "The goal of the project is not merely to get the Court to declare that nuclear weapons use is illegal under international law, but to do so in a manner which makes it possible for the nuclear weapons states to live with such a determination. The link between nuclear weapons use and a public health catastrophe is unassailable and is therefore much less vulnerable to political attack and obfuscation."

The first move was made when the Colombian Ministry of Health sponsored a resolution at the May 1992 World Health Assembly (WHA) instructing WHO to petition the International Court of Justice for an advisory opinion on the status in international law of the use of nuclear weapons in view of their serious effects on health and environment. The USA and the UK immediately launched a counter-offensive, rallied support from the Western bloc, and buried the resolution without debate. In May 1993, however, perseverance paid off when a similar resolution was introduced and passed by an overwhelming majority of WHO member states.

Erich Geiringer: Tireless Campaigner

The World Court Project is the result of the work of many dedicated and outstanding individuals and groups. One such individual was Erich Geiringer. It was Erich's initiative at the Stockholm conference in 1991 that launched the World Court Project within IPPNW. His efforts were critical to IPPNW's success in securing the WCP resolution at the World Health Assembly in 1993.

For more than 30 years, Erich Geiringer campaigned on health and social issues. He was an early member of IPPNW, and for the last ten years of his life dedicated his tremendous energy and intelligence to the anti-nuclear cause. Inspired by judge Harold Evans' idea to ask the International Court of Justice to rule on the legality of nuclear weapons, Erich decided that a campaign with such a goal would be an important focus for the continuing battle against nuclear weapons. He saw it as a campaign for doctors, one that they could take to the World Health Organization, and he persistently promoted this campaign to IPPNW for several years before it gained international support.

Erich "was able to see through problems, cut them down to size and improvise an intelligent solution--not always at the drop of a hat, but often after careful thought and careful rephrasing," according to long-time friend Peter Munz. Perhaps just as important as his keen intellect, however, was his tremendous creative energy and flamboyance. He is remembered for his wild white hair, his flowing cloak, the plays he directed in his backyard--and his penchant for irreverent verse.

One of his early anti-nuclear treatises was called "Malice in Blunderland," and IPPNW New Zealand's position papers, "Don't be vague when you ask for Hague," "Courting the Question," and "Why World Court Project and Why Now?" bear the stamp of Erich's style. They reflect his clear analysis and tactical thinking, and communicate it all in his lively and idiosyncratic style--strengths that have contributed to the successes of the World Court Project.

The 1993 success was due to a mobilizing of support around the world. IPPNW sent lobbying teams to Geneva and mobilized its affiliate network, asking them to send letters to their own governments and others, requesting support for the World Health Assembly resolution. In addition, strong support came from small island states--in particular, the Minister of Health of Vanuatu was extremely active in favour of the resolution. Further support came from the international public health community. A few days prior to the 1993 World Health Assembly, 48 countries represented at the World Federation of Public Health Associations unanimously passed a similar resolution.

However, even after the resolution passed at the May 1993 World Health Assembly, the political pressures and struggles continued. Usually it should take only a period of days to refer a question to the World Court--the longest period previously was eight weeks--but in this case the WHO secretariat took four months. WHO was reportedly concerned that it might lose its funding from the nuclear powers opposed to the resolution. WHO contacted the UN Secretariat after the WHA vote to say that it would be in severe financial difficulties proceeding with the request to the World Court and requested technical and financial assistance. Again, IPPNW mobilized its affiliate network to lobby WHO and the UN Secretary General.

Later in 1993 at the United Nations General Assembly, the nuclear powers and their allies did succeed in preventing a similar resolution from being voted on, by applying intense pressure on the Non-Aligned Movement states supporting the resolution--including threats to withdraw aid and to impose trade sanctions. In December 1994, however, they were unable to prevent the same resolution from being voted on and passed by a majority of UN member states. The question to be posed to the International Court of Justice was: "Is the threat or the use of nuclear weapons in any circumstances permitted under international law?"

The nuclear powers and their allies continued to oppose the World Court even considering the legality of nuclear weapons, insisting that nuclear weapons are a political issue, not a health or environmental or legal issue. IPPNW dismissed this argument: "WHO has already determined that the use of nuclear weapons constitutes a health hazard which needs to be countered by preventive international action. All important international health issues have political and legal implications. The distinction is artificial and to take it seriously would preclude WHO from doing anything. In particular, preventive health programmes almost invariably involve legal action."

The Court received written legal briefs from 43 countries before the oral hearings; at least two-thirds of the briefs argued for illegality. Public hearings took place between October 30 and November 15, 1995 at the Hague. Judges heard oral presentations from 23 countries and the World Health Organization, as well as from several nuclear bombing victims from Japan and from bomb testing areas in the South Pacific and the United States. For the first time in its history the court accepted citizens' evidence--over three million signed Declarations of Public Conscience and petitions totalling over 100 million

Hilda Lini: Minister of Health and Peace Activist

At the 46th assembly of the World Health Organization in May 1993, Vanuatu seemed like a natural co-sponsor of the resolution which requested a ruling from the International Court of Justice on the legality of use of nuclear weapons. That the resolution was passed by the Assembly was in no small measure due to the energy and persistence of Hilda Lini, Minister of Health of Vanuatu.

The Republic of Vanuatu, like the many other small island states scattered in the Pacific, has been affected by the nuclear arms race since the early 1950s, having suffered the effects of uranium mining in Australia and the manufacture, testing (both atmospheric and underatoll), deployment and storage of nuclear weapons.

Hilda Lini got involved in her country's independence movement when she was still in school in the early 1970s, and started a campaign for a nuclear free and independent Pacific. The issues were clearly linked. The struggle against colonialism included opposition to the French nuclear tests in Micronesia and the American missiles fired from California across the Pacific to Kwajalein atoll. Hilda concerned herself further with the rights of indigenous peoples and land rights as Secretary of the Social Concerns Committee of Pacific Concerns, an organization started in Vanuatu in 1980. By 1983, popular concern had reached the point where an Act was passed declaring Vanuatu a nuclear-free state.

In her statement supporting the resolution at the May 1993 World Health Assembly, Hilda said: "As a result of nuclear activities, the Pacific Island states are now already suffering and facing the complicated health issues which they do not have the expertise to diagnose, the resources to make studies and the money for treatment overseas... As a member of the Non-Aligned Movement Vanuatu...reiterates the vision of those countries for a nuclear weapons-free world. I speak as an indigenous Pacific woman who lives and already is affected by past nuclear activities. I also speak as a Government Minister."

Hilda Lini first became an MP in 1987. After a four-year term she ran again and was made Minister of Health. In August 1993, the Prime Minister relieved her of her ministerial duties. She was given no reason, and some suspect that her stand at the World Health Assembly may have cost her job.

Hilda continues to travel and lobby for a nuclear free Pacific. She urges those who support her cause to call for independent research to be done into the extent and effects of radioactivity, especially in those countries close to the testing sites.

signatures. Creative material such as photos, quilts, other works of art, musical scores and arrangements, articles, poems and short stories were also presented and referred to more than once by states presenting to the court.

The World Health Organization opened the proceedings by saying that it had to observe a stance of strict neutrality but neutrality did not mean indifference to the issue of nuclear weapons. It submitted a dossier of documents to the Court, which included reports on the effects of nuclear war on health and health services and descriptions of nuclear disasters such as Chernobyl.

In its statement, France questioned whether WHO had exceeded its authority and scope by requesting a ruling from the Court, arguing that the only function of the UN body was to prepare to treat the victims of nuclear war, not to try to prevent their suffering. Mexico responded to this argument by saying: "To postpone giving a legal opinion on the threat or use of nuclear weapons until an actual case occurs is like substituting medicine with an autopsy."

Tuiloma Neroni Slade, Ambassador to the UN from Western Samoa said: "Abolition of the danger of death from nuclear radiation is as important to a preventive health perspective as the abolition of the danger of death from smallpox or tuberculosis" and "It is difficult to live in the shadow of nuclear annihilation and be in 'a state of complete physical, mental and social well-being.'" The delegate for the Marshall Islands, Theodore Kronmiller, referred to the 67 nuclear tests that took place in the Marshall Islands during the period of its United Nations Trusteeship and said: "We are assured by the responsible party that every reasonable effort was made to avoid any human injury, as well as any damage to inhabited islands. The only conclusion that we may reasonably reach, then, is that the weapons are, by their nature, indiscriminate in their effects--and very seriously so."

The International Court of Justice delivered its ruling in July 1996. It said that the threat or use of nuclear weapons, like any other weapons, must come under international law. Therefore, the UN charter applies and force cannot be used except in self-defence, after every other avenue, including UN mediation, has been exhausted. Likewise, international humanitarian law applies, and weapons and strategies which harm civilians, cause more than necessary suffering to soldiers, or hurt the environment or neutral countries cannot be used. This would mean, the Court said, that generally nuclear weapons use and threat would be unlawful. But, disappointingly, it also ruled that the use of nuclear weapons might be lawful if the survival of the state were at stake. Of the 14 judges, 7 plus the President's casting vote were in favour of this position of "probably illegal but possibly legal under extreme survival circumstances." Of the remaining 7, 3 thought they were definitely illegal under all circumstances, and 4 thought they were legal weapons.

International law and weapons:

There is a well-established tradition of restricting certain weapons because of their effects on human health. These examples from international law reflect the growing recognition that military and political considerations of a weapon or a military strategy cannot be separated from the real effects on human beings.

- In 1868, the Declaration of St. Petersburg banned the use of exploding bullets and prohibited any weapons "which uselessly aggravate the sufferings of disabled men or render their deaths inevitable."
- The Hague Conventions of 1899 and 1907 forbid the use of poison and all weapons which would cause unnecessary suffering, and contain the "Martens Clause" which states that when a weapon or tactic of war is not specifically prohibited, the "dictates of public conscience" shall apply.
- The Geneva Gas Protocol of 1925 prohibits the use of asphyxiating, poisonous or other gases, and all analogous liquids, materials and devices.
- The 1949 Geneva Conventions deal with treatment of civilians and wounded, prohibit the infliction of unnecessary suffering, and require the parties to an armed conflict to distinguish between combatants and noncombatants.
- Protocol I of 1977 of the Geneva Conventions expands upon what was established in the earlier Geneva Conventions regarding legitimate military targets. It codifies the rule of "proportionality" which requires that weapons or military tactics that would cause excessive incidental civilian losses (in relation to any concrete and direct military advantage) be condemned. It also prohibits reprisals against civilians and the use of methods or means of warfare which may be expected to cause widespread, long-term and severe damage to the environment.

The U.S. Lawyers Committee on Nuclear Policy summarizes the "Basic Rules" as follows:

1. It is prohibited to use weapons or tactics which cause unnecessary or aggravated devastation or suffering.
2. It is prohibited to use weapons or tactics which cause indiscriminate harm as between combatants and noncombatants, and military and civilian personnel.
3. It is prohibited to use weapons or tactics in warfare which violate the neutral jurisdiction of non-participating States.
4. It is prohibited to use asphyxiating, poisonous or other gas, and all analogous liquids, materials and devices, including bacteriological methods of warfare.
5. It is prohibited to use weapons or tactics which cause widespread, long-term and severe damage to the natural environment.
6. It is prohibited to effect reprisals which are disproportionate to the antecedent provocation, or disrespectful of persons, institutions, or resources protected by the laws of war.

From "The World Court Project. Appendix C: International Law and Nuclear Weapons" by Lawyers for Social Responsibility.

All 14 judges thought that there is an obligation to proceed to conclude nuclear disarmament, as promised in the recently renewed Non-Proliferation Treaty.

Where to now? Presumably, the military manuals of the nuclear powers and the NATO allies need to be revised to incorporate this extreme narrowing of the possibility of lawful use. Commander Rob Greem, who on retirement from the British Royal Navy worked nearly full-time on this issue, points out that: “Military personnel are required under the military law manuals to refuse an order which violates the Geneva or Hague Conventions.”

Although the Court’s ruling is not “binding,” it does establish a legal, moral and political norm for all countries. It will put added pressure on countries to honour existing treaties of nuclear disarmament and non-proliferation and it will support the case for more urgent measures toward disarmament.

Moreover, the organizations and individuals involved with the World Court Project have been encouraged by its success. Abolition of nuclear weapons is increasingly seen as not only desirable, but feasible, and the abolition movement is gaining momentum. This ruling has strengthened the position of citizens who question the morality of the continued adherence of nuclear states to a defence strategy based on nuclear deterrence. And it has re-focused world attention on an issue which has faded from public attention since the end of the Cold War and the dissolution of the USSR.

Perhaps the greatest lesson from the success of the World Court Project is that real change depends on the initiative and hard work of ordinary people. This lesson will be an important one to carry forward through the years of steady and creative work that are still needed to hold the nuclear power states to their recent promise to accomplish elimination of nuclear weapons and to the ruling of the International Court of Justice.

Other restriction efforts

The International Campaign to Ban Land Mines

Groups around the world have been working for years for a ban on land mines. Land mines kill and maim indiscriminately for many years after they are deployed, and the majority of the approximately 26,000 people they kill and injure each year are civilians. They are a massive drain on health, social services and scarce economic resources. They delay the return of refugees to their homes and prevent people from farming the land to support themselves. Land mines are cheap and easy to deploy--and very expensive, difficult and dangerous to remove.

The International Campaign to Ban Land Mines has been working for a complete ban on the use, production, stock-piling, trade and export of anti-personnel mines. During

1995 and 1996, the Campaign has been mobilizing grassroots support and lobbying at a series of international conferences reviewing international agreements controlling indiscriminate and excessively injurious weapons like anti-personnel mines. The first of these conferences took place in Vienna, and was followed by sessions in Geneva.

Although there is growing support for a total ban on land mines, these conferences have concentrated on aspects of technical restriction, such as self-destructing mechanisms, detectability, and so on. Steve Goose, a representative of the Campaign attending the session in Geneva, explained: "In Vienna, there was no discussion whatsoever of the humanitarian and socio-economic impact of land mines. There has been no serious consideration of a comprehensive ban on anti-personnel land mines though a total ban has been endorsed by the U.N. Secretary General, UNICEF, UNHCR, UNDHA, ICRC, and the Holy See. Anti-personnel land mines are illegal under existing humanitarian law because of their indiscriminate nature. The long-term humanitarian impact of mines far outweighs their limited, short-term military utility."

Despite the disappointing lack of attention to banning land mines, the Vienna and Geneva conferences show positive steps in the long-term process. The International Campaign to Ban Land Mines has 400 affiliated groups in 36 countries. A ban is now supported by 22 governments, most major humanitarian agencies, and the media. UNICEF recently launched a 10-point anti-war agenda, which includes support for a ban on land mines. The International Committee of the Red Cross (ICRC) launched an international media campaign to mobilize the public in favour of a ban on anti-personnel mines.

A few years ago, not many people were thinking about land mines. Because of the work of the Campaign and others, it is increasingly in the public discourse. The Vienna conference would not have happened at all if not for the work of the Campaign--specifically Handicap International pressuring France to start the process. More than 100 people from nearly 70 NGOs in 20 nations came to Vienna--the strength and force of that participation was not lost on governments. The fact that countries are so concerned about world opinion in how they deal with the land mines crisis was a factor in their decision to suspend the Vienna proceedings. One view of the Vienna process is that increased public awareness has shattered governmental consensus as to how to deal with the land mine problem. It can be argued that while governments made little progress in Vienna, the Campaign continued to gather strength.

Progress in banning blinding laser weapons

There was good news from the Vienna conference: the Review Conference adopted "Protocol IV" banning the use and transfer of blinding laser weapons. According to the International Committee of the Red Cross, prohibiting a weapon before its seemingly imminent production and proliferation "is an historic step for humanity. It represents the first time since 1868, when the use of exploding bullets was banned, that a weapon of military interest has been banned before its use on the battlefield and before a stream of

victims gave visible proof of its tragic effects." This achievement should not be underestimated.

In December 1995, 135 governments attending the International Conference of the Red Cross and Red Crescent unanimously urged adherence to the new ban on blinding laser weapons adopted at the Vienna Review Conference. Such support for the ban points to the universal abhorrence of blinding weapons. As President Molander recently reflected on the new protocol: "Deliberate blinding has been recognized for what it is--a barbaric and unacceptable way of waging war."

Part D: Getting Started

Thinking about peacebuilding is rather daunting. The complexities and risks of any situation of armed conflict can be overwhelming. So where do you start? This section describes some concepts and tools to help you approach your own situation. Every situation of conflict is complex and dangerous, and the fields of conflict analysis and peacebuilding do not offer any easy answers, so we caution you that what we provide here merely scratches the surface. The resources section can direct you to other sources for greater detail and other perspectives. Planning a health-to-peace initiative requires far more than what we describe here--we only promise to get you started!

The first and most important step in planning any kind of peacebuilding intervention is to clearly and profoundly understand the context. If you come from outside the area of conflict, it is especially important to take the time to listen to how local people understand their situation. It is valuable to work with social scientists who can help to develop a thorough analysis of the political, military, social, economic and cultural contexts.

It is not possible to work towards peacebuilding without a clear analysis of the dynamics of the conflict. To attempt any kind of action, health or otherwise, without this analysis risks making the situation worse. There are many different approaches and theoretical frameworks for conflict analysis. What we offer in the next few pages is one approach, made brief and simple, to help you get started on analyzing the situation of conflict where you are working. We begin with a few words about some of the fundamental causes of violence and instability, and then represent them on a diagram of the cycle of violence. Accompanying the diagram is a suggested list of questions to ask about the conflict.

Once you have an understanding of the overall context, the next step is to analyze the particular situation in which you are working. We describe a tool called “capacities and vulnerabilities analysis” which can be usefully applied to planning for health-to-peace initiatives. Since peacebuilding is not a matter of imposing solutions, but rather of nurturing opportunities for local people to find their own solutions, there is also the task of identifying people to work with. A diagram entitled “Actors and peacebuilding foci across the affected population”, from a book by John-Paul Lederach, helps to represent some of the options.

The next section describes some of the strategies and mechanisms that we have seen at work in health-to-peace initiatives. We are sure that there are more, and we look forward to hearing what you have identified!

Finally, we offer a starting point for evaluating the impact of peacebuilding activities, a list of indicators to look at to assess an increase or decrease in the level of peace.

Causes of violent conflict and instability

Ideology and interventionism

Ideologies, especially those held by global and regional superpowers, can contribute to violent conflict, as the larger powers intervene to support "their" side of the conflict. During the Cold War, the ideological struggle between the two superpowers and their intervention in many conflicts played a major role in increasing violence and instability. This is still an important factor, but with the end of the Cold War, it is clear that national and local factors are also extremely important.

Ideology also plays an important role in conflicts between the state and insurgent movements, where the social inequality between classes is dominant.

Militarism

The Cold War reinforced armed struggle as the mechanism for redressing deeply rooted differences, and flooded the world with weapons. Arms races between hostile countries may precede and contribute to the eruption of violence. Also, it is no longer only governments that have access to weapons and the use of violence, and insurgent groups are finding it increasingly easy to take up arms.

Identity

Most wars in the post-Cold War period are internal, where the lines of conflict are drawn along group identity lines, with fighting aimed at achieving collective rights in opposition to other groups of differing ethnicity, religion or race.

Kumar Rupesinghe writes that: "Identity has been defined as an abiding sense of selfhood, the core of which makes life predictable to an individual. To have no ability to anticipate events is essentially to experience terror. Identity is conceived of as more than a psychological sense of self; it encompasses a sense that one is safe in the world physically, psychologically, socially, even spiritually". A sense of identity, of belonging to a group with ethnic, religious, racial, or some other form of distinctiveness is important to people, and becomes even more important when people feel that their other needs are not being met--that their situation is insecure and that they have no ability to participate in the processes that determine the conditions of their security.

We all have multiple forms of identity, based on our ethnicity, race, language, religion, age, gender, occupation, region, and so on. In a healthy, pluralistic society, these multiple identities weave us together. But identity is often manipulated. It is worth remembering that it is not often the poor who start wars--it is usually political opportunists who use others' sense of poverty and exclusion to motivate them to fight in wars which the opportunists start and use to their own advantage. Some segments of

society may choose to place primacy on one form of identity (such as ethnicity), which forces people to submerge their other forms of identity. This causes people's identities and alliances to take on a single, rather than a multiple focus, which deepens and hardens social divisions.

With all of the pressures and threats to their security, people tend to seek security in identifying with something close to their experience and control, resulting in increasingly smaller and narrower identity groups. This is why most contemporary conflicts are along the lines of ethnic, religious or regional affiliations, rather than along the lines of ideology or class.

Because economic globalization has tended to reduce the role the state plays in ensuring the well-being of all citizens, there has been a decline in the sense that people of different identities within a society have of belonging to a civic body with common goals and aspirations. When people feel that their society respects and meets their common needs, they are more likely to feel an interest in the society as a whole--to have a sense of civic identity.

Inequitable distribution of resources

Most armed conflicts are taking place in the deeply-impooverished regions of the world where historical inequities have marginalized countries in the world order and created terrible poverty and inequity within countries. These inequities among and within countries have left many people in the world without adequate food, homes, education, health care and other necessities for realizing their human potential. Economic globalization, national debt and structural adjustment policies are dismantling social institutions and services, leaving the majority of the world's population increasingly marginalized and dependent within the global economy--and causing instability all around the world.

Political exclusion and human rights abuses

The exclusion of many people from participation in the decision-making processes that govern their lives is a major cause of conflict. In many countries, people are forcibly excluded and repressed. Even in countries where human rights abuses are fewer and there is some form of democracy, people often have no meaningful participation in political processes.

Perceptions and propaganda

The real issues at the root of conflict are sometimes less important in keeping an armed conflict going than the perceptions of the groups involved. Many armed conflicts involve deep-rooted, long-standing hatred, mistrust and paranoia, which is fueled by

direct experience of violence and atrocities. Media and propaganda also contribute to groups' perceptions and animosity towards each other.

Understanding the Conflict

The following diagram (on the opposite page) and questions to ask about the situation where you are working represent one approach that may help you get a sense of the factors that cause and perpetuate conflict.

Some questions to ask about a conflict

Who are the actors?

- Who are the direct parties to the conflict?
- What are the power structures within the parties?
- Is there external involvement? From whom?
- Who else is being affected?

What are the causes of the conflict?

What were the issues at the beginning of the conflict?

- e.g. - ideology
- international involvement
 - inequitable distribution of resources
 - political exclusion
 - human rights abuses
 - identity (ethnicity, race, religion, etc.)

What is contributing to the continuation of the conflict?

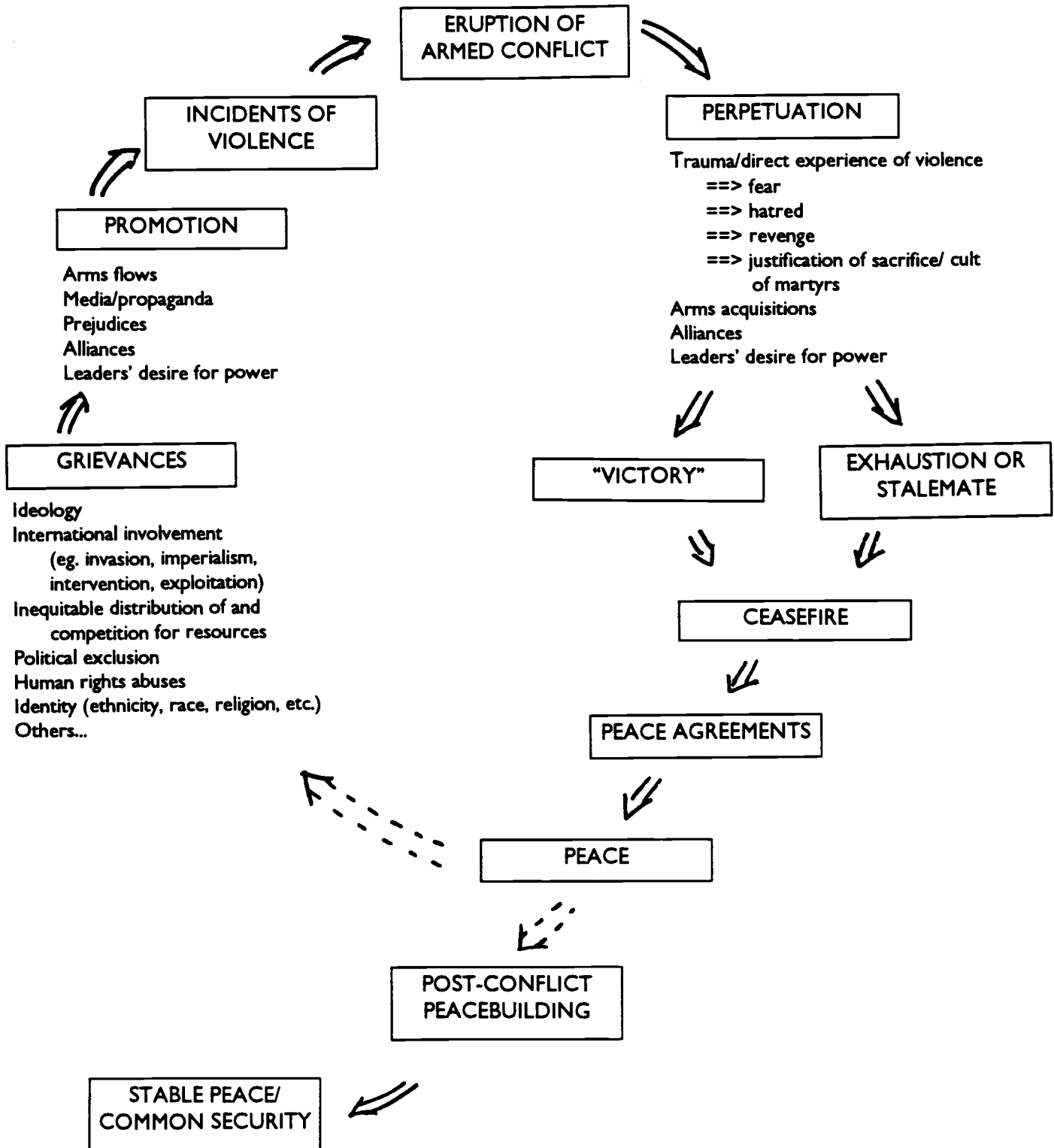
- e.g. - arms flows
- media/propaganda
 - trauma/direct experience of violence
 - fear
 - hatred
 - revenge
 - justification of sacrifice
 - leaders' desire for power
 - alliances

What have been the dynamics of the conflict over time?

What stage in the cycle of violence is the conflict at now?

THE CYCLE OF VIOLENCE

(This diagram is adapted from one developed by Dr. Joanna Santa Barbara)



Planning responses

When planning a health-to-peace initiative, it is important to understand the overall context in which you are working. A useful way to take a more focused look at the conflict and how you might respond is a tool called "capacities and vulnerabilities analysis."

Capacities and vulnerabilities analysis was developed by Mary Anderson and Peter Woodrow (the full reference is in the resources section) for humanitarian aid agencies to understand how best to respond to societies in crisis, usually after natural disasters. They argue that charging in and providing for the immediate needs of a society may undermine its existing abilities to deal with the crisis itself. This kind of response may not address, and may even increase, the conditions that made the society vulnerable to the disaster in the first place. Therefore, it is important to have a solid analysis of the capacities and vulnerabilities of the society or community where you work. Anderson and Woodrow define development as the process by which vulnerabilities are reduced and capacities are increased.

"The peacemaker needs to be aware of the different streams of energy within the system. Where in the systems is the resistance to reconciliation, and how is it expressed? Where is the positive momentum for change? What is the relative strength of these systems vis a vis one another? What emotions are allowed expression, and by whom? What emotions are disallowed? Which parts of the conflict are "hot" and which are "cold", and which are waiting to be rekindled? What are the wounds, and how do they find expression in the system? What are the myths, and who are the mythmakers? Who are the heroes, and who the villains, and who the magicians and messiahs?"

From Peacemakers in a War Zone, an Institute for Multi-Track Diplomacy occasional paper by Louise Diamond.

This idea has some usefulness applied to war situations. If we acknowledge that every society has capacities for peace, we have to ask ourselves what factors overwhelmed these capacities and threw the society into violence: Every society has political, legal, cultural and religious processes for resolving conflict non-violently. Within every conflict situation, there are individuals and groups who are striving for peace, and there are many cooperative events happening. Some of the issues mentioned earlier, such as economic inequities, exclusion from political processes and the arms trade, may undermine a society's ability to deal with conflict non-violently and make it vulnerable to violence.

The Afghanistan Mass Immunization Campaign provides an example of a health-to-peace initiative building capacity for peace. It tapped into a willingness of military leaders to cooperate with an initiative to meet the health needs of the population as a whole, and strengthened the popular will for peace.

This understanding can lead us to think about peacebuilding as the process by which vulnerabilities to violence are decreased and capacities for peace are increased. It is also important to realize that outsiders can never make peace for those within the conflict, but they may be able to strengthen and support the internal capacities for peace.

The importance of thoroughly assessing the situation is illustrated by the experience of MSF and other humanitarian NGOs working with refugees from the Rwandan crisis. A better understanding of the dynamics and actors of the situation might have enabled the NGOs to avoid strengthening the Hutu extremists in their control of the refugee population.

Approaches to assessing the situation:

- When the World Health Organization's Hedip program began working in Mozambique, they hired a skilled local socio-anthropologist to study the social, cultural and political factors at work in the area, which helped to identify key groups and individuals, some of the problems and conflicts--and the processes that had already been developed locally to deal with the problems. For example, land use and ownership was a major problem in the region, but the local traditional leaders, the community and even the district authorities had already informally decided upon a number of criteria for resolving eventual conflicts.
- The Prodere program in Central America used the technique of producing community need and resource maps as a starting point. (Information on this is available from the WHO/DGCS Collaborating Centre for Emergencies and Training.)

To know how you can best respond to the complex situation in which you are working, you also have to look at the role of yourself and your organization. What influence can you have on the situation? Are you local or external? Do you work best at the grassroots community level or with national or international institutions? What are your capacities and vulnerabilities?

Two examples of groups knowing themselves, their strengths and their weaknesses:

- The Christian Health Association of Liberia saw a need to expand their health care services to address the psycho-social wounds caused by the Liberian civil war. They understood that the people of their country needed not just healing but also skills to somehow move beyond the hatred and violence. They had a lot of strengths: a network of community leaders throughout the country, excellent local trainers, some with experience in trauma work, and a good reputation throughout the country as a neutral and caring organization, but they needed someone who could add conflict resolution and mediation training to an integrated program. They sought out a person with these skills to work with them to develop their health-to-peace program.
- The strategies used in the World Court Project also reflect an understanding of how and where the participating groups were best able to work. When the International Physicians for the Prevention of Nuclear War wanted to take on the issue of the legality of nuclear weapons, they decided to work from their strengths--they made use

of their existing relationship with the World Health Organization and their extensive network of affiliates throughout the world to bring the question to the International Court of Justice.

Effective peacebuilding requires an understanding of the root causes of the problems and of the long-term structural changes that are needed. This understanding is necessary so that ideally even responses to the immediate crisis can be designed to be part of a long-term process of fundamental change. At the very least, responses should not make the society more vulnerable to violence and instability.

An example of planning for a long-term process of change:

- The Coalition for Peace in the Philippines responded to women from a war zone who wanted to improve the health of their children by organizing the Immunization for Peace Program. This program not only immunized children, but also developed peace agendas in various provinces and strengthened the ability of community groups and alliances to mobilize people for peace and social justice.

Working with people in the society in conflict:

At the heart of the peacebuilding process are people: the diversity of individuals, groups and institutions that make up a society. Which of these people and groups should you work with? And how? Capacities and vulnerabilities analysis should begin to reveal the forces at work for and against peace in a society, and help you to understand what role you might be able to play in supporting the forces for peace.

Your relationship to the society in conflict (whether you are internal or external), the kind of organization you represent (grassroots, national, international, community development, service, advocacy), and its own capacities and vulnerabilities will influence with whom you will be able to work most effectively and the kinds of approaches available to you.

Just as it is useful to think of a “multi-track” or “multi-sectoral” approach to peacebuilding (where health is one track or sector), it is also very useful to think of a multi-level approach. John Paul Lederach, in his book *Building Peace: Sustainable Reconciliation in Divided Societies*, advocates working at the level of middle-range leaders: ethnic and religious leaders, academics, leaders of non-governmental organizations and other sectoral leaders who have more real links to the people and more flexibility than the high-profile political and military leaders, and more widespread influence than grassroots leaders. The diagram, from his book, represents some of the options:

Diagram: Actors and Peacebuilding Foci Across the Affected Population

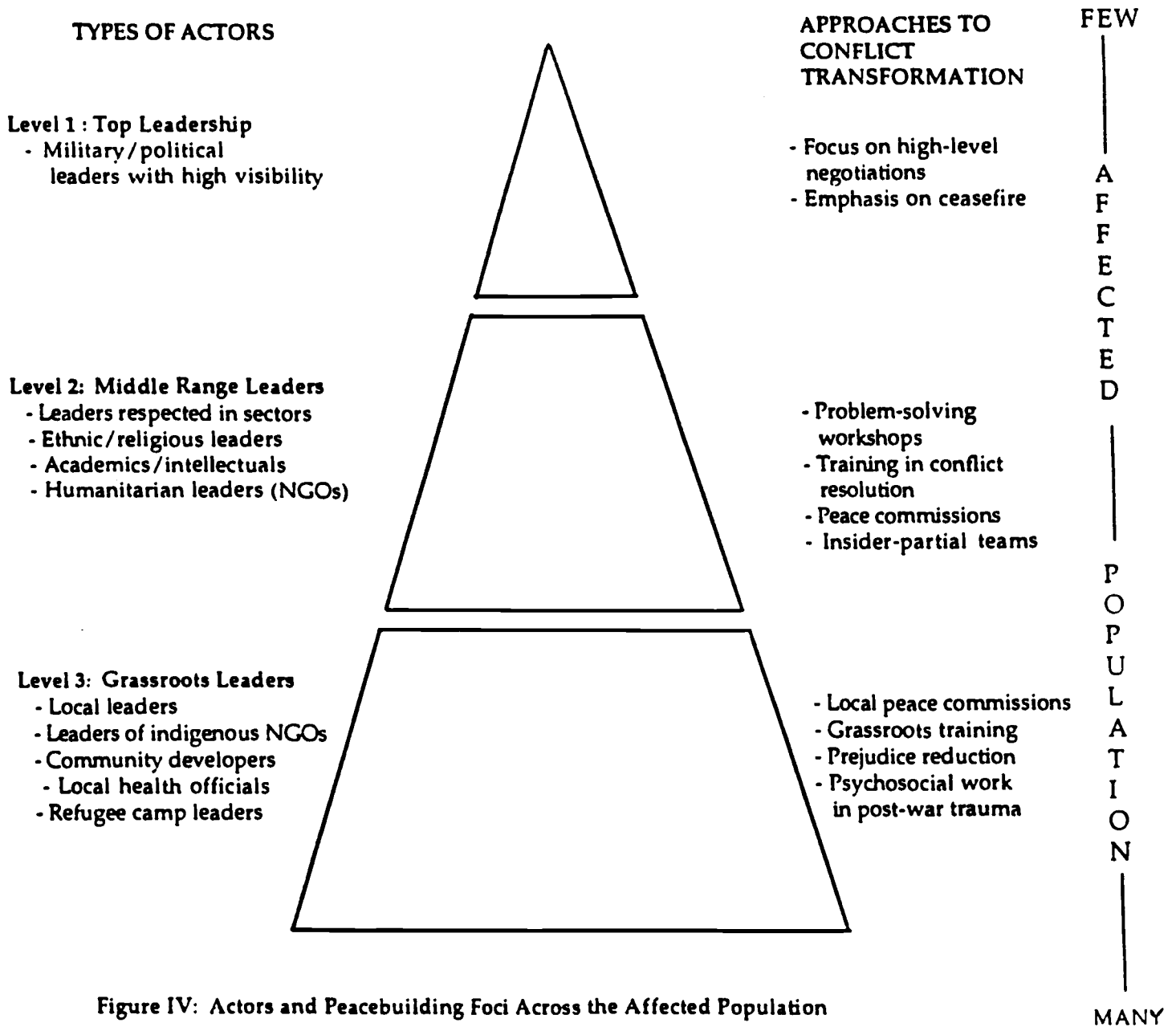


Figure IV: Actors and Peacebuilding Foci Across the Affected Population

Principles of partnership:

A challenge for those of us who are trying to contribute to peacebuilding in a society that is not our own is how to build fair and positive partnerships with local people and organizations. Here are a few lessons gleaned from the experience of the War and Health Program and other initiatives:

- treat partners as equals;
- use outside funds to employ local people, when possible;
- emphasize communication;
- create clear agreements through written contracts;
- base partnerships on mutuality and shared needs;
- commit to long-term relationships;
- foster inter-personal connections, because true partnerships are based on friendship and mutual respect.

Strategies and mechanisms

Health workers and health care systems and projects have important roles to play in peacebuilding, whether at the grassroots community level or in the international arena. The following are some of the strategies and mechanisms at the disposal of health workers. Many of them are illustrated in the case studies, while some are drawn from other examples. Most health-to-peace initiatives involve more than one mechanism. In fact, the interaction and overlap between mechanisms makes any breakdown somewhat artificial. These are the broad themes that we have identified:

Research, education, advocacy and activism

Physicians and other health workers are well placed to gather important information on the health effects of various problems, including armed conflict in general, specific weapons such as land mines, and economic policies such as structural adjustment. Even more importantly, health workers can make use of the legitimacy and moral force of their position and their dedication to human health. The voice of the medical community can be a powerful addition to other voices advocating changes to the structures and policies of violence. By redefining these structures and policies as health problems and telling the truth about their effects, they are no longer the exclusive domain of the political "pragmatists", and a more human and moral understanding of them can be communicated to the public and to policy-makers.

The information and knowledge that health work can generate can also, if used properly, hold up a mirror to a society so that it can know itself more accurately--almost an "innoculation" against propaganda.

We see this strategy at work in the World Court Project case study, which shows how the International Physicians for the Prevention of Nuclear War and other groups have used information on the real effects of nuclear war to educate the public, national governments and international organizations and to lobby for having them declared illegal. It also plays a role in the War and Health Program's study in Sri Lanka, where the process of the research itself helped those involved to better know the effects of the war and the results will be used for broader education and advocacy. The case study of Medecins sans Frontieres' work in the Rwandan crisis also illustrates the importance of their role as witness and advocate.

Superordinate (shared) goals

Peace researchers recognize that superordinate goals form the basis of some of the most powerful peacebuilding strategies. Superordinate goals are those that transcend the immediate goals sought by the parties in conflict. They are goals that are valued in the long term by all parties and so have the capacity to bring them into a more peaceful and cooperative relationship.

Health, particularly the health of children, can often serve as a superordinate goal. Health is so fundamental to human security that it can bring people together across many divisions. Initiatives which aim to protect or improve children's health can unite combatants in work for a common goal.

For example, humanitarian ceasefires get warring parties to agree to stop fighting so that health care workers can have access to all children in the country. Humanitarian ceasefires have made use of this shared commitment not only to reach children, but also to open a window of tranquility for the people.

Initiatives that bring people from different sides of the conflict to work together, get to know each other, and learn about the effects of war on all people enable people to see past stereotypes about the "enemy" and to recognize the harm done by their own group.

This mechanism was at work in the War and Health Program's study in Sri Lanka, and in the World Health Organization's Hedip program, which formed broad-based local committees to address local health care needs.

Fostering a "civic identity"

Health care is one of the most important institutionalized ways in which people within a society care for each other. A health care system that is equally accessible to all members of society can promote a feeling of belonging to a broader and more inclusive group which respects and meets their common needs. This civic identity does not replace or displace other forms of identity, but it makes hate-based mobilization of ethnic or other identity groups more difficult.

The Hedip program got people to sit down together to agree on priorities for the health care system in their area, and brought in people--professionals, businesspeople, women, public institutions, NGOs and others--who did not represent one side or the other to be equally involved in the process.

In several regions of the former Yugoslavia, hospitals have declared themselves "zones of peace," where staff of various ethnicities work together to treat patients of all ethnicities. These health workers are deliberately resisting the hatred and stereotyping of war.

Health care as basic security need

Maintaining the health system through armed conflict and rebuilding it after armed conflict helps to give people a sense of security and normalcy. To the extent that it is equally accessible to all, it will lessen feelings of persecution and denial of needs and will reduce competition for resources.

A study of the rehabilitation of the Ugandan health care system observed that the physical rehabilitation of the system was linked to the wider process of social recovery; the rehabilitation of the health structure encouraged people to return home (described in a 1995 article by Joanna Macrae, Anthony Zwi and Lucy Gilson, referenced under "Local support for peace through health" in the resources section).

Participation

Any kind of initiative should aim to encourage participation in the decision-making processes by different sectors of the community. This reinforces democratic and non-violent processes for making decisions and resolving conflicts and gives people a sense of being able to participate in making the decisions on issues that affect their security and well-being. It also brings people together to get to know each other and to develop a sense of common purpose and concern. People must have the opportunity and information to express needs, set priorities, and defend their position.

Macrae, Zwi and Gilson describe how this worked in Uganda (in the above-mentioned article): "Where communities have participated in the rehabilitation of the physical infrastructure, these programs are reported to have contributed to reconciliation. Describing a small rehabilitation programme in Gulu district, one informant suggested that 'up until now, the people had no cause to work together; with the health centre it was make or break--either they joined together or they had no health centre'". The Hedip methodology supports the integration of all basic needs, which include not only health, shelter, food security and so on, but also such rights as access to information and the right to full participation in the democratic process. Mary Anderson suggests that projects that create a common investment of all sides contribute to peacebuilding.

Trauma healing

People need a peaceful environment to be truly healthy. Likewise, physically and mentally healthy people contribute to creating a peaceful environment. A crucial part of peacebuilding is healing the internal wounds of individuals--the trauma and the pain inside them. The process of trauma healing also provides opportunities for people to examine themselves and their own identity, and to develop a positive sense of identity, not one based on hatred of the other. This strategy is clearly illustrated by the case study of the Liberian trauma healing and reconciliation initiative, which integrated bias reduction, conflict resolution training, and peace education into trauma healing programs. Healing the individual wounds of trauma can contribute to reconciliation--the healing of the social wounds that play a big role in the cycle of violence.

Human rights work

Health workers have an important role to play in protecting human rights, by examining, treating and counselling victims of human rights abuses, documenting those abuses and advocating for the protection of human rights. This contributes to a climate of respect for human rights and encourages greater participation in political processes, essential characteristics of peaceful societies.

Human rights work can be particularly powerful for peacebuilding when physicians from different sides of the conflict speak out on behalf of the human rights of all people. There are Israeli physicians, for example, who are working to protect the human rights of Palestinians--a major contribution to healing some of the wounds of mistrust.

The American Refugee Committee (ARC) worked with Cambodian physicians to develop a program on "Human Rights for Health Professionals in Cambodia" (see box).

Solidarity

Organizations and individuals working for health and peace in areas of armed conflict can be isolated and at risk. Organizations from within and outside the country can connect with each other to boost morale, foster hope, bring needed resources, and lend some protection in dangerous conditions.

The fostering of solidarity was important in the Hedip project in Croatia. The direct connection made between citizens of Split, Croatia and Modena, Italy had many valuable effects, particularly overcoming the sense of isolation felt by the people of Split.

Mediation and diplomacy

MEDACT, Medical Action for Global Security, (a British affiliate of IPPNW) has been studying ways in which physicians and other health care workers could serve as

Human Rights for Health Professionals in Cambodia

This project is part of an overall United Nations strategy to promote education about human rights amongst all facets of Cambodian society. The American Refugee Committee sees human rights education as fundamentally necessary in Cambodia's reconstruction, and feels that health care providers are a key group to involve.

The project brought together Cambodian health professionals and students from inside and outside the country for training. According to Allen Keller, an American physician who participated in the training: "There's an important reconciliation happening in our project between Cambodian health professionals who were trained at the border and those who received their training in Cambodia."

The training program consisted of ten two-hour lectures based on a 100-page syllabus in Cambodian and English explaining fundamental human rights, as outlined in the Universal Declaration of Human Rights, and the special role of health professionals in documenting and preventing abuses. Physicians for Human Rights served as an important resource, providing human rights educational materials.

The training draws on Buddhist principles to teach health professionals how to talk effectively and compassionately with their patients, how to practice "active listening", and how to provide emotional support to victims of rape and torture.

The project also aims to make human rights education a permanent part of medical education in Cambodia, and to encourage the formation of professional societies, because such organizations have played important roles in protecting human rights in other countries.

mediators. Health care workers can cross national and communal boundaries more easily than many other professional workers, and are generally seen as neutral and impartial in their commitment to the relief and prevention of human suffering. Nick Lewer sees possibilities for well-trained and supported health workers to "intervene in a conflict situation as neutrals to help facilitate the removal of psychological obstacles (such as misperceptions, stereotyping, mirror-imaging, mistrust, etc.), and so bring together belligerents for meaningful talks. He cautions that this kind of involvement requires a long-term commitment: "Mediation requires continuity, commitment and confidentiality, and credentials can only be built up slowly over a period of time."

Evaluation

One of the weakest area of knowledge about peacebuilding, particularly about health-to-peace initiatives, is in evaluation. It is difficult to assess what factors contribute to improvement or worsening of the conflict situation. Many organizations and individuals involved in peacebuilding have few resources, and are not often able to conduct thorough evaluations of their work--particularly of its impact on the larger context. There are not many evaluation tools around, either. We hope that more research and work in this area will soon be done!

Despite the shortage of tools available, it is crucial to evaluate the peacebuilding impact of health initiatives in areas of armed conflict or potential armed conflict. It is easy to think you are going in one direction and find you have been going the opposite way.

As a start, here is a list of indicators that may be helpful in assessing the peacebuilding impact. It is adapted from Ken Bush's 1995 paper, *Fitting the Pieces Together: Canadian Contributions to the Challenge of Rebuilding Wartorn Societies*. Choose which indicators are best suited to the scale of your activities. Obviously you will not be able to monitor all of these indicators, but any change, however slight, in these conditions, provides some indication of the impact of overall peacebuilding initiatives.

Indicators to monitor to assess the impact of peacebuilding activities:

Physical health indicators:

- infant mortality; population mortality
- deaths and injuries caused by weapons of war
- nutritional status
- communicable diseases

Psychological health indicators:

- perceptions of security and personal safety
- obedience; acceptance of high levels of violence
- stereotyping and prejudice
- desire for vengeance
- prevalence of depression; prevalence of post-trauma symptoms

Security indicators:

- number of internally displaced people; outflow of refugees
- riots; demonstrations
- disappearances; human rights abuses
- systematic rape; torture; cruel, unusual or degrading treatment
- political detainees
- arrest or detention without probable cause or warrant; incommunicado detention
- inhumane prison conditions
- withholding food as a weapon
- portion of GNP spent on social welfare compared to military expenditures
- killings in violation of the rules of war (civilians or combatants)
- use of children in war zones

Social indicators:

- freedom of thought, belief and religion; freedom of speech; freedom of the media
- level and type of social interaction; intermarriage; desegregated education
- family reunification
- number of multi-communal organizations
- economic or employment discrimination
- use of media for hate-inciting propaganda

Political indicators:

- level of public political participation
- multi-communal political parties; fair and free elections
- political representation
- emergency rule in parts or all of a country
- freedom of movement
- the right not to be deprived of one's nationality or to be exiled

Juridical indicators:

- rule of law; due process guarantees
- human rights legislation
- judicial freedom from political interference
- equality under the law; repeal of discriminatory laws;
- prosecution of war criminals

Economic indicators:

- progress in addressing economic grievances
- reduction in level of dire poverty and unemployment
- distribution of land, goods and services in a way considered fair in the culture of the immediate region and within in the evolving body of international agreements and expectations

PART E: Resources

WHY HEALTH-TO-PEACE?

MacQueen, Graeme, Rick McCutcheon and Joanna Santa Barbara. "The Use of Health Initiatives as Peace Initiatives".

This is the concept paper first developed by the War and Health Program on the idea of using health initiatives as peace initiatives, and as such, is the best source of the theoretical framework for this handbook.

Lewer, Nick. (1992). *Physicians and the Peace Movement*. (London: Frank Cass).

A fascinating overview of the many ways that physicians have worked for peace in European and North American history, including modern approaches by IPPNW and other medical anti-war groups.

Cahill, Kevin M. (1988) *A Bridge to Peace*. (New York: Haymarket Doyma, Inc.)

Kevin Cahill, a US physician, reflects in this collection of articles on his experiences in Nicaragua, the Middle East, Northern Ireland and Somalia and argues that physicians should engage themselves in the struggle for broader social well-being.

Schneider, Mark. (1987) "Health as a Bridge to Peace", *World Health*, October 1987.

Health: A Bridge for Peace: Priority Needs in Central America and Panama, Progress Report, II Madrid Conference, 27/29 April 1988.

Peacebuilding

Lederach, John Paul. (1995). *Building Peace: Sustainable Reconciliation in Divided Societies*, (Tokyo: United Nations University). (A revised edition, correcting publishing errors, will likely come out in late 1996. Contact the author at Eastern Mennonite University, Harrisonburg, Virginia 22801 USA, Fax: 540-432-4452, e-mail Qualyd@emu.edu).

This 80-page book is one of the most thorough and relevant guides to peacebuilding that we found. Lederach begins with an analysis of contemporary armed conflict, including a global overview and a description of the characteristics of deeply divided societies and then presents a framework for building peace that he draws from his own experience in Somalia and elsewhere. Lots of extremely useful ideas and approaches.

Bush, Kenneth D. (1995). *Fitting the Pieces Together: Canadian Contributions to the Challenge of Rebuilding Wartorn Societies*, a paper prepared for the International Development Research Centre in Ottawa, Canada.

An analysis of the peacebuilding effects of Canadian development work.

Diamond, Louise. (1993). *Peacemakers in a War Zone*, Occasional Paper Number 1, November 1993, (Washington: The Institute for Multi-Track Diplomacy.)

If you are an outsider going to work in a war zone, this short paper will stimulate you to think about many of the most profound issues that will affect your engagement with the people and the dynamics of the situation where you will be working.

Diamond, Louise and John McDonald. (1993). *Multi-Track Diplomacy: A Systems Approach to Peace*. (Washington: Institute for Multi-Track Diplomacy).

The Institute for Multi-Track Diplomacy, 1819 H Street, NW, Suite 1200, Washington, DC 20006, USA. Telephone: 202-466-4605. Fax: 202-466-4607. E-mail: imtd@igc.apc.org. Web: <http://www.igc.apc.org/imtd/INDEX.HTML>

Anderson, Mary B. (1994). *Promoting Peace or Promoting War? The Complex Relationship between International Assistance and Conflict*. (Cambridge, Massachusetts: Collaborative for Development Action) This paper is based on a presentation at a conference sponsored by The War and Health Program in May 1994.

Anderson, Mary B. (no date) *International Assistance and Conflict: An Exploration of Negative Impacts*. (Cambridge, Massachusetts: Collaborative for Development Action).

The Collaborative for Development Action, led by Mary B. Anderson, is exploring international assistance and the potential for peacebuilding in a project called "Local Capacities for Peace." Contact them at 26 Walker Street, Cambridge, Massachusetts 02138, USA. Tel: 617-661-6310 and fax: 617-661-3805.

Miller, Robert (ed.). (1992). *Aid as Peacemaker: Canadian Development Assistance and Third World Conflict*. (Ottawa: Carlton University Press).

Weiss, Thomas G. and Larry Minear (eds.). (1993) *Humanitarianism Across Borders: Sustaining Civilians in Times of War*. (Boulder, Colorado: Lynne Rienner Publishers).

Weiss, Thomas G. and Larry Minear (eds.). (1995) *Mercy Under Fire: War and the Global Humanitarian Community*. (Boulder, Colorado: Westview Press).

Cahill, Kevin (ed.) (1993). *A Framework for Survival: Health, Human Rights and Humanitarian Assistance in Conflicts and Disaster*. (Council on Foreign Relations/Basic Books).

The Journal of Refugee Studies is a good resource. For example, Volume 8, Number 4 (1995) carried an article by William DeMars, "Waiting for Early Warning: Humanitarian Action after the Cold War" and responses by Alex de Waal, of Africa Rights, and Larry Minear, from the Humanitarianism and War Project.

International Alert is an organization dedicated to intervening to build peace at any stage before, during or after armed conflict. It provides information, training and field workers to war zones, and helps to bring together coalitions for preventing and responding to violence. International Alert: 1 Glyn Street, London, England, SE11 5Ht. Fax: 44 0171 793 7975. Phone: 44 0171 793 8383. E-mail: intlalert@gn.apc.org.

Weiss-Fagen, Patricia. (1994). *Research and Sources: A Bibliographic Essay* (State of the Art Review), paper prepared for "The Challenge of Rebuilding Wartorn Societies," a project of the United Nations Research Centre for Social Development (UNRISD) and the Programme for Strategic and International Security Studies (PSIS), the Graduate Institute of International Studies, Geneva.

CASE STUDIES

Humanitarian Ceasefires

Contact the Centre for Days of Peace at 145 Spruce Street, Suite 208, Ottawa, Ontario K1R 6P1, Canada.

Dodge, Cole P. and Magne Raundalen. (1991). *Reaching Children in War: Sudan, Uganda and Mozambique*. (Bergen, Norway: Sigma Forlag).

The chapter on "Corridors of peace across the lines of civil war in Uganda and Sudan" is a detailed personal account of Dodge's involvement, on behalf of UNICEF, in negotiating corridors to take medical supplies, particularly vaccinations, from government-held into rebel-held territory in Uganda, and food and other supplies to the desperate population of southern Sudan.

Reid, Richard. (1993). "Lifelines to the Innocent: Children Caught in War" in Kevin M. Cahill (ed.), *A Framework for Survival: Health, Human Rights and Humanitarian Assistance in Conflicts and Disasters*. (New York: Basic Books and the Council on Foreign Relations).

Reid reviews the days of tranquility and corridors of peace initiatives in El Salvador, Lebanon, Sudan and Iraq.

Walker, John R. (1993). *Orphans of the Storm: Peacebuilding for Children of War*. (Toronto: Between the Lines).

This book is based on the 1991 conference organized by the Centre for Days of Peace on Humanitarian Ceasefires: Peacebuilding for Children and summarizes the discussions and learnings of that conference.

Centre for Days of Peace. (1991). *Humanitarian Ceasefires: Peacebuilding for Children. Report of a Conference to Promote the Implementation of Paragraph 25 of the World Summit for Children Plan of Action, November 24-27th 1991, Ottawa, Canada.*

This report is an excellent resource, as it summarizes the discussions of participants who had been involved in humanitarian ceasefires and those contemplating the possibilities in their regions. It is full of good advice and frank evaluation.

Hay, Robin. (1990). *Humanitarian Ceasefires: An Examination of their Potential Contribution to the Resolution of Conflict*. Ottawa: Canadian Institute for International Peace and Security. Working Paper 28, July 17, 1990.

A good discussion of the context, legal frameworks, mechanics and effects of humanitarian ceasefires, looking at El Salvador, Lebanon and Sudan. Hay also discusses the possibilities of integrating humanitarian ceasefires and peacekeeping missions.

Trauma healing and reconciliation

Hart, Barry, James N. Doe and Sam Gbaydee Doe. (1993). *Trauma Healing and Reconciliation Training Manual: A Handbook for trainers and trainees (Liberia: Reconciliation and Healing Program, Christian Health Association of Liberia)*. For information on how to obtain a copy, contact the War and Health Program at McMaster University.

This manual takes you through all of the steps of the trauma healing and reconciliation program.

Hart, Barry with Joe Gbaba. (1993). *Kukatonon: Training manual of conflict resolution, reconciliation and peace*. (Monrovia, Liberia: UNICEF). Contact the Mennonite Central Committee, P.O. Box 500, Akron, Pennsylvania 17501, USA for information about copies.

This manual is based on the experience of the Kukatonon Children's Peace Theatre, and contains sections on conflict, active listening, conflict resolution, reconciliation and peace education.

Damir and Zamir is a training manual for trauma healing, bias reduction, conflict resolution and peace education with children, produced by the War and Health Program, the Society for Psychological Assistance and UNICEF in Croatia. An English version will soon be ready--contact the War and Health Program for information.

Research for Peace

A "tool kit" for health assessment in war zones will soon be available from the War and Health Program.

International Study Team. (1991). *Health and Welfare in Iraq after the Gulf Crisis: An In-Depth Assessment*. (Cambridge, Massachusetts: International Study Team). Reprints are available from Sarah Zaidi, Centre for population and Development Studies, Harvard University.

This document was produced by the International Study Team after the health assessment research done in Iraq in 1991.

Local Support for Peace through Health

Hedip Resources

Contact Sara Swartz at the World Health Organization, Division of Emergency and Humanitarian Action, 20 avenue Appia, CH-1211 Geneva 27. Telephone: 41-22-791-26-22. Fax: 41-22-791-48-44.

Arias Foundation for Peace and Human Progress, (1995). *External Evaluation Report of the Central American Programme for Refugees, Displaced and Returnees (Prodere)*, commissioned by UNDP/UNOPS, presented in New York, February 1995.

Deng, Francis M. (1993). *Comprehensive Study by the Representative of the Secretary-General on the Human Rights Issues Related to Internally Displaced Persons, Submitted Pursuant to the Commission on Human Rights Resolution 1992/73*. UN E/CN.4/1993.5, Commission on Human Rights, January 1993.

Maxwell, Simon and Margaret Buchanan-Smith (eds.). (1994). *Linking Relief and Development*. IDS Bulletin, Vol 25, n.4, October 1994.

Singer, Hans W. (1995). *Linking Relief and Development*. Institute of Development Studies, University of Sussex, September 1995.

Stiefel, Matthias. (1994). *UNDP in Conflicts and Disasters, An Overview of the "Continuum Project"*. UNDP Project INT/93/709, Geneva, PSIS, 1994.

UNDP Human Development Reports 1990-1994, New York: Oxford University Press.

Perez del Castillo, Gonzalo and Marika Fahlen. (1995). *CIREFCA: An Opportunity and Challenge for Inter-Agency Cooperation*, Geneva: UNDP and UNHCR.

World Health Organization. (1995). *World Health Report 1995: Bridging the Gaps*. Geneva: World Health Organization.

From Disaster Management to Sustainable Development: How the Public Sector, Private Sector and Voluntary Organizations Can Work Together, a Report of the Main Committee Session of the United Nations World Conference on Natural Disaster Reduction held in Yokohama, 1994, from the World Health Organization and the United Nations International Decade for Natural Disaster Reduction.

Other Resources on post-conflict reconstruction of health systems

Macrae, Joanna and Anthony Zwi with Vivienne Forsythe. (1995). *Post-Conflict Rehabilitation: Preliminary Issues for Consideration by the Health Sector*. (London: London School of Hygiene and Tropical Medicine).

Macrae, Joanna, Anthony Zwi and Lucy Gilson. (1995). "A Triple Burden for Health Sector Reform: 'Post'-Conflict Rehabilitation in Uganda," *Social Science and Medicine*.

Zwi, Anthony. (1995). "Commentary: Life in the real world is more complicated," *BMJ* 311: 1001-1002. 14 October 1995.

Macrae, Joanna, Anthony Zwi, and Harriet Birungi. (1993). *A Healthy Peace?: Rehabilitation & Development of the Health Sector in a Post-Conflict Situation-The Case of Uganda*, a report on a pilot study published by the London School of Hygiene and Tropical Medicine).

The Health Policy Unit of the Department of Public Health and Policy at the London School of Hygiene and Tropical Medicine has been studying post-conflict rehabilitation of the health sector. Contact Anthony Zwi at Keppel Street, London WC1E 7HT.

Band-Aids and Genocide: Medical Aid to Rwandan Refugees

Deadlock in the Rwandan Refugee Crisis: Virtual Standstill on Repatriation, MSF paper, July 1995.

MSF-Canada: 355 Adelaide St. W., 5B, Toronto, ON M5V 1S2, Canada. Telephone: 416-586-9820. Fax: 416-586-9821. E-mail: msfcan@passport.ca

MSF-International: 39 Rue de la Tourelle, B-1040 Brussels, Belgium. Telephone: 32-22-80-18-81. Fax: 32-22-80-01-73.

The World Court Project (and other restriction efforts)

The World Court Project:

Contact the International Physicians for the Prevention of Nuclear War, at 126 Rogers Street, Cambridge, Massachusetts 02142, USA. Fax: 617-868-2560. Phone: 617-868-5050. E-mail: ippnwbos@igc.apc.org.

In Canada, contact Physicians for Global Survival, at 145 Spruce Street, Suite 208, Ottawa, Ontario K1R 6P1, Canada. Fax: 613-233-9028. Phone: 613-233-1982. E-mail: pgs@web.net.

Lown, Bernard, and Eugene I. Chazov. (1995). *Physician Responsibility in the Nuclear Age*. *JAMA*, August 2, 1995, Vol. 274, No. 5.

Bernard Lown and Eugene Chazov were two of the founding members of the International Physicians for the Prevention of Nuclear War. In this article, they describe IPPNW's work and its achievements since its inception in 1981, and reflect on what they have learned out of this experience.

Cahill, Kevin M. (ed.). (1995). *Clearing the Fields: Solutions to the Global Land Mines Crisis*. (New York: Council on Foreign Relations/Basic Books).

International Campaign to Ban Landmines: 1347 Upper Dummerston Road, Brattleboro, VT 05301 USA. Telephone: (1) 802 254 8807. Fax: (1) 802 254 8808. E-mail: jwlandmines@igc.apc.org
or c/o IDF, Ave de Joli-Mont, 11, 1209 Geneva, Switzerland. Telephone: (41 22) 788 8033. Fax (41 22) 788 8035. E-mail: 10472.3105@compuserve.com

Blinding Weapons, Campaign Brochure published by the International Committee of the Red Cross, Geneva, 1994.

The International Committee of the Red Cross, 19, avenue de la Paix, 1202 Geneva, Switzerland. World Wide Web: <http://www.icrc.ch>. E-mail: webmaster.gva@gwn.icrc.org (for information on web site and other publications); press.gva@gwn.icrc.org (for press information); and listserv@unicc.org (to be included on e-mail mailing list, send a message saying "subscribe info-press your name")

GETTING STARTED

Conflict Analysis

Azar, Edward E. and John W. Burton (eds.). (1986). *International Conflict Resolution: Theory and Practice*. (Sussex: Wheatsheaf Books).

This volume contains chapters written by academics in the field of conflict analysis and resolution. The chapter by Azar, "Protracted International Conflicts: Ten Propositions," is a nice summary of some of his very useful ideas around what he calls "protracted social conflicts," on-going and seemingly unresolvable conflicts.

Rupesinghe, Kumar and Marcial Rubio C. (eds.) (1994). *The Culture of Violence*. (Tokyo: United Nations University Press). Rupesinghe, of International Alert, and Rubio C., a Peruvian peace researcher, edit this collection of essays on the interface between cultures and violence.

Birkhoff, Julian, Christopher Mitchell and Lisa Schirch (eds.). (1994). *Annotated Bibliography of Conflict Analysis and Resolution* (George Mason University: Institute for Conflict Analysis and Resolution).

This publication is a great place to look for the key resources in conflict analysis and resolution.

Capacities and Vulnerabilities Analysis

Anderson, Mary B. and Peter J. Woodrow. (1989). *Rising from the Ashes: Development Strategies in Times of Disaster*. (Boulder, Colorado: Westview Press and Paris: Unesco).

Strategies and Mechanisms

Human Rights

Keller, Allen S. and Sin Kim Horn. (1993). *Human Rights for Health Professionals in Cambodia*. (Published by the American Refugee Committee and the United Nations). This is a 100 page syllabus developed for the ARC training program (also available in Khmer).

Contact the American Refugee Committee at 2344 Nicollet Avenue, Suite 350, Minneapolis, MN 55404 USA; telephone 612-872-7060; fax 612-872-4309.

Physicians for Human Rights has worked to promote respect for human rights since 1986. Contact them at 100 Boylson Street, Suite 702, Boston, Massachusetts 02116, USA. Telephone: 617-695-0041. Fax: 617-695-0307. E-mail: phrusa@igc.apc.org.

Physician as diplomat

Lewer, Nick. (1990). "Mediation: Developing a New Role for Physicians in Peacemaking Processes", *Medicine and War* Vol. 6, 33-36.

Contact Dr. Nick Lewer at the Department of Peace Studies, University of Bradford, West Yorkshire BD7 1DP, U.K.

Marmon, Louis M, Christopher M. Seniw, and Allan E. Goodman. (1994). "The Diplomat/Physician in the Emerging International System", *Medicine and Global Survival*, December 1994, Vol. 1, No. 4.

FINAL NOTE...

In order to keep this section manageable, we haven't listed every resource that we have come across. If there is something in the handbook that you would like more information on, but you can't find a reference to follow up with, please contact us at the War and Health Program and we will do our best to point you in the right direction. Also, please let us know of useful resources that we haven't listed here.

Please share your ideas with us...

This handbook is a starting point for a network and process for learning, sharing ideas and experiences, and developing more knowledge about the use of health initiatives as peace initiatives. If you have ideas, experiences or knowledge to share, please write to us. If you have nothing you want to share right now, but want to be part of the network exploring these ideas, please let us know. We will try to keep the information flowing through what we hope will be a continually growing network. We hope that in a few years we will be able to produce a revised version of this handbook.

Feel free to tear this page out to write on and send to us, or simply write to us at:

The War and Health Program
of the Centre for Peace Studies and the Centre for International Health
McMaster University
1280 Main Street West
Hamilton, ON L8S 4M4
E-mail: healthr@mcmaster.ca
Phone: (905) 525-9140 extension 27592; Fax: (905) 525-1445

Please be sure to give us the following information, so that we can include you in the network:

Name _____

Organization/affiliation _____

Address _____

Phone number _____ Fax number _____

E-mail address _____

Comments, suggestions, ideas... (please don't confine yourself to this small piece of paper!)

We look forward to hearing from you!



"I was really afraid. I had always thought of them as violent bandits but I didn't really know them. That time I had to do a vaccination campaign with one of their health workers.. We had discussed the campaign with their representative who had sensitized their leaders on the importance of vaccinating the children. We arrived with the vaccines, together with the Hedip project officer, on the motorcycles that the project had donated to the District Health Office for these activities. I felt reassured by his presence because I knew he was used to working with their representatives and had their confidence. We talked with the Renamo vaccinators and did some informal training. Everything went all right. Now I go by myself and we continue to vaccinate together. We talk about the things that need to be done there: there are so many. And sometimes I take some things on the motorbike, you know, so we can make a little party with the people there..."

Nurse from the District Health Office after the first vaccination campaign in a Renamo-controlled area of the Milange district (Mozambique).