

Health Work for Peace Work

A Theoretical Framework for Health Organisations to promote Peace in Conflict Settings.

Minor Thesis Disaster Studies - RDS 80724

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June 2012

Abstract

This paper examines the ways in which health care intervention can contribute to peace work. It first looks at the basic concepts that are important for this field, and clarifies how the different terms are used in this paper. Since violence occurs in a cycle, interventions can be done at different stage. The specific position of NGOs and especially health workers to make a positive contribution to peace work will be described. Their locality gives them the advantage of knowing the needs and desires of the local people, and can relate these to the (inter)national setting. By this they can connect to several levels in society. As health workers need legitimate reasons to interfere in peace processes, the link between health and peace is explained, as well as how violence has an impact on people's health. From this, we can make a distinction between implicit and explicit peace-building differentiating in the ultimate goal of a health programme. There are ten mechanism that can be used by health professionals to be involved with peace work, but each of them can only be used in certain circumstances, and by involving in one mechanism, others can be excluded. Different tools can be used to make the intervention a success, but since each situation is different, creativity is needed to find new solutions to new problems. But to this approach there do exist severe limitations. People may not see the need for intervention, or want health professionals to stick to their area of expertise. All pro's and con's of a programme should be extensively evaluated before implementation.

Key words; Health, Peace-building, Conflict Transformation, Context Sensitivity, Violence

Interviews

Egbert Sondorp, conducted on April 2, 2012
Lotte van Elp, conducted on April 11, 2012
Klaus Melf, conducted on April 25, 2012
Knut Holtedahl, conducted on April 25, 2012
Rachel Issa Djesa, conducted on April 25, 2012
Unni Sørensen, conducted on April 26, 2012

Meetings

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Introduction

Currently there are many violent conflicts in the world. In many cases, aid from outside the nation is needed to help the people that are suffering because of the conflict. A lot of the problems present during violent conflict are health problems. This inspired the idea that health workers in violent conflicts may help promote peace. It is very unfulfilling for health workers to help people improve their health, and see the effects negated by violence. To bring sustainable health, root causes of the health problems need to be addressed. This was one of the reasons that health professionals tried to find ways to contribute to conflict transformation and peace-building.

Besides the intentional contribution the health field wants to make to peace building, there may be unintentional aspects that play a role as well. Health care has many commonalities with peace, such as well-being and human security. Therefore, addressing health problems may indirectly also address peace problems. Possibly there are more ways in which health care has a positive influence on peace dynamics without realizing it.

If health organisation in conflict situations want to deal with peace, we can wonder if this is beneficial in the long run. There may be aspects within the health care sector that can be problematic in the field. Health workers may have a relatively safe position in field, but when engaging in peace issues this position may be compromised. This can have an effect not only on the organisation engaging in peace, but on all health organisations. An other issue is whether health organisation have the skills and resources to be involved in peace issues. After all, their main goal is to do health work, not peace work.

The purpose of this paper is to identify whether it is beneficial for both health organisations and peace-building activities if health professionals would be involved in the process. A main aspect is to identify the different ways in which health care may positively contribute to peace-building and conflict transformation and compare it to the limitations or problems that may be applicable for health professionals. The main question asked is: "In what ways may health organisations working in conflict areas have a positive influence on peace and conflict dynamics?". Research questions include; what are the basic principles for conflict management?; Why are NGOs in general in the position to influence violent conflict?; In what ways do health and peace connect?; How can health contribute to peace?; What are the problems and limitations for this type of approach?; What tools can be used by health professionals to positively influence peace? There are many concepts that touch on this topic, and to answer the main question, more basic knowledge on the different concepts involved are needed. The first two chapters will therefore explain the most basic terms, and the interventions that are relevant for NGOs. Before we explore the specific health field of conflict intervention, first we will look to general characteristics of NGOs, and their suitability to work in conflict situations. After this a small chapter will discuss the different levels and stages that can be distinguished in health-peace work. This information is needed to categorize the programmes that will be discussed in the next chapter. Besides the different programmes that have dealt with health work for peace work, I will discuss their main approaches or methods of action. After this the connection between peace and health will be explained, which provides reasons to strengthen the legitimacy of health workers doing this type of work. Also the limitations of health workers and problems that may occur are discussed here. The next chapter discusses several tools that can be used to develop a programme that incorporates peace action in health programmes. Finally, a

description of actions that can be taken in a conflict stage will be discussed, with some examples from already executed programmes

Together, the answers to these questions should give insight in the ways a health peace approach works, if an organisation can contribute in a certain situation and whether the organisation should contribute due to pros and cons. Also, it lays out the current knowledge of health and peace-conflict dynamics, thereby providing an reference frame for future research.

This paper was written as an minor thesis for the use of Cordaid. Currently, they are giving health care in Uruzgan, Afghanistan by supporting a local NGO named AHDS. They have found that they can only do their work in a proper manner when all parties involved approve of the way health care is given. To assure this approval, weekly meeting, or *shura's* are held to stabilize the relationship between the different tribes and AHDS. By maintaining this relationship, they have found that the region has become more secure. So, by doing their regular work they positively contributed to peace. Since peace is in the interest of all involved, Cordaid would like to see if they can expand this positive influence on peace.

For this goal several steps will be taken. First a theoretical and methodological framework will be developed. A conflict analysis will be conducted in Afghanistan, and in a later phase field studies in different districts will be done to examine the correlation between providing health care and conflict reduction. Using the frameworks assembled before, the field studies will be analysed.

This paper forms the theoretical framework of the whole project. Analysing articles, having informal meetings with different stakeholders and conducting interviews with experts were the main activities performed for this paper. An overview of the meetings and interviews is given on page ii.

Basic Terms related to Health and Peace

In this paper the central topic is how health work can contribute to peace work. Before we can enter this discussion, it is essential to clarify the main concepts used. This will help to understand the content discussed and also the implications of health being involved in peace practices. The four definitions discussed in the following section are health, peace, violence and conflicts. Not only are these the most important concepts, they are also used differently in literature. To prevent obscurity, the definitions given here apply for the entire report, unless otherwise indicated.

Health

The first definition of health that usually comes to mind is a state of medical wellbeing. However, this only states the biomedical state of health, but does not address any other aspects of life. As other aspects of life also have an impact on a persons wellbeing, the World Health Organisation (WHO) defined health in a more holistic way. In 1946 the WHO accepted the following definition: "Health is a complete state of mental, physical and social well-being, and not merely the absence of disease or infirmity" (WHO, 1978). This definition has not changed since 1948.

The first part of the definition is very helpful for health programmes, as it states what health encompasses. If only the second part would be taken into account, the goal of health work would be unclear. The complete state of health, as can be seen from the definition, may not ever be attainable. But it does provide the ultimate goal for health and other programmes (Rodriguez-Garcia *et al.* 2001).

Peace

Often, peace can be seen in three ways. Peace as a negation of violence, peace as the capacity to handle conflict in a non-violent manner, and peace as a state of harmony. Peace as a negation of violence is comparable to health being the absence of disease, and is only a relative term. It is logical that when violence is removed there is a peace benefit. But by removing the violence from a conflict, only negative peace is achieved. Underlying causes are not addressed. If peace was only perceived in this way, a ceasefire could be called peace (Melf, 2012a).

Peace as a way of non-violently handling conflict does tackle the underlying causes of a conflict. As we see in the definition of conflict (see below), conflict in itself is not something bad. Resolving the conflict in a violent manner is. So if conflict can be handled non-violently, there will be peace. From this it becomes clear that peace depends greatly on the appearance of violence. Therefore we can say that violence, and not war, is the opposite of peace. Tools to handle conflict in a non-violent way can be learned. If these tools are applied in an appropriate way, a conflict situation can become a situation of cooperation (*ibid.*).

Finally, we can see peace as a complete state of harmony. This goes beyond negative peace, and is about creating a positive state. To create a positive state a set of values, attitudes, traditions and modes of behaviour are necessary. Guidelines, such as respect for life, human rights, territorial integrity, and sovereignty, and freedom of expression, opinion and information need to be respected by all (*ibid.*). Such a positive state could be defined as peace. In a holistic way, peace can be "a state of society in which exploitation is minimized or eliminated altogether, and where there is neither overt violence nor structural violence that has the effect of denying people important rights such as economic opportunity, social and political equity, a sense of fulfilment and self-worth"

(Galtung, 1994, cited in Rodriguez-Garcia *et al.*, 2001:11). As is the case with the definition of health, it may be hard to attain this final state.

In this paper the holistic view of peace will be used. But it is important to be aware of the other meanings peace can have, when working in the peace-conflict field. The definition of peace often depends largely on the historical and cultural context of the conflict, and although there is a rough general concept, peace can mean something different depending on the context.

Violence

As we have seen in the previous definitions, violence is very important for peace studies. It is even stated that the opposite of peace is not war, but violence (Melf, 2012a). The WHO report (2002:5) defines violence as: "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in, or has a high likelihood of resulting in, injury, death, psychological harm, mal-development or deprivation". In peace studies violence is seen as the unnecessary insult of basic needs (Melf, 2012a). From these definitions it can be seen that violence is not bound to scale. A person can use violence against himself, and groups can use violence against other groups. Besides it indicates that violence can be more than the overt form of using physical force.

There are three different forms of violence that can be distinguished. Direct, or personal violence is the type of violence that is mostly associated with the term violence. Fights, murder, crimes and rape are all forms of direct violence. But also not providing certain things, like not providing sufficient food, is seen as direct violence. Crucial to direct violence is the intention of the violence. Accidents, like traffic accidents, are not considered to be direct violence. Direct violence has a documented mortality rate of 1.6 million people each year, and by that accounting for an average of 10% of the deaths world wide (*ibid.*).

Structural violence is violence that is exercised through socio-economic or political structures. It can be seen as the hidden repression into social and political structures. It manifests itself as social inequality, class and caste stratification, gender discrimination, hierarchy, patriarchy etc. Structural violence leads to poverty and powerlessness, and keeps people living in misery. This type of violence can do a lot of harm, especially in health related structures (*ibid.*).

The third type of violence is cultural violence. This encompasses ideas in religion, political thought, art, science, language and cosmology that justify and legitimizes the use of direct and structural violence. Cultural violence has a special role as it kills and harms through the other two types of violence. The use of stereotypes is one way of using cultural violence (*ibid.*).

Conflict

The definition of conflict, as provided by Melf (2012b) is: "[...] the real or perceived clash of incompatible goals in a goal-seeking system". Arya and Santa Barbara (2008) add to this that the goals the two or more entities in a conflict pursue are perceived, and therefore may not be truly incompatible. As opposed to the mainstream interpretation of the word conflict, conflict in itself is not a bad thing. It is an essential part of life, since without conflict change would not exist (Rodriguez-Garcia *et al.*, 2001). Conflict is therefore always present and everywhere, at all levels (Galtung in Melf, 2012b).

Conflict becomes a problem when there are no structures, institutions or mechanisms for its peaceful resolution. In that case the conflict will turn violent, which is an

undesirable situation. Violent conflict is the use of physical and psychological violence to solve a conflict. In literature however, just the word conflict is often used when violent conflict is meant. This may lead to confusion, since the use of force in the conflict may remain unclear. Sometimes the term armed conflict is used. This is similar to violent conflict, but in this case both (or more) parties have resorted to use of violence and weapons. It is therefore important to clarify whether violence is used.

There are six different levels of conflict, depending on the number of people that are involved. Intrapersonal conflict occurs within one person that has two or more incompatible goals. Other levels are interpersonal (between persons), intra-group, intergroup, national (or intrastate) and international (interstate) conflicts. Conflict on one level, and decisions made there, has also implications for other levels. Conflicts that are fought on macro level, do have an impact on the local people, who are influenced by the decisions and may continue the conflict on a local level.

Most of the time the perceived clash of incompatible goals is the only aspect considered in a conflict. Galtung argued that there are three aspects that form the input of a conflict, and therefore all three aspects should be dealt with. These aspects are attitude, behaviour, and content or contradiction. This is also referred to as the ABC triangle of conflict. Attitude refers to the position one takes in a conflict, behaviour to how one acts in the conflict and content to the perceived incompatible goals. Figure 1 shows this triangle. As can be seen, each aspect stands on it own, but all three are interlinked. Influencing one of these aspects will have an impact on the other aspects. These three elements are important to recognize because they give a deeper understanding of the conflict and provides possibilities for intervention (Melf, 2012b).



Figure 1: ABC triangle of conflict (Galtung, 1996, in Melf, 2012b)

Conflict consist, according to Mitchell (cited in Melf, 2012b), of four stages. The first stage is isolation or cooperation, when there are no known incompatible goals. The second stage is the beginning of the conflict, where some incompatible goals exist. These incompatible goals are however not clear to the parties involved. The third phase is latent or hidden conflict. Here the incompatible goals are identified by the parties, and the last phase is open conflict, where people express conflict behaviour to achieve their own goal. Other authors add settlement as the latest stage, when a conflict is ended. It is in reality hard to see where one phase stops and the other starts, and often different stages occur at the same time.

The phases can be identified for all conflicts, not just violent conflicts. In each stage the conflict can escalate and de-escalate. A conflict escalates when the party's attitude

becomes more aggressive and their behaviour becomes threatening. Here violence can enter and the conflict becomes a danger. The fact that a conflict can escalate or de-escalate can be used for the process of conflict transformation. With the use of conflict transformation we can try to guide the conflict towards the de-escalating process (Gawerc, 2006).

Violent conflict often follows a similar pattern. Arya (2003) put together the conflict cycle, as shown in Figure 2. In this figure it is shown that when a conflict is not resolved in a satisfying way, violence will occur and re-occur. Each cycle of violence has an impact on the conflict, and can be broken at different stages. There is no fixed timeline for the cycle, and conflict may be stuck in one phase for a long time.

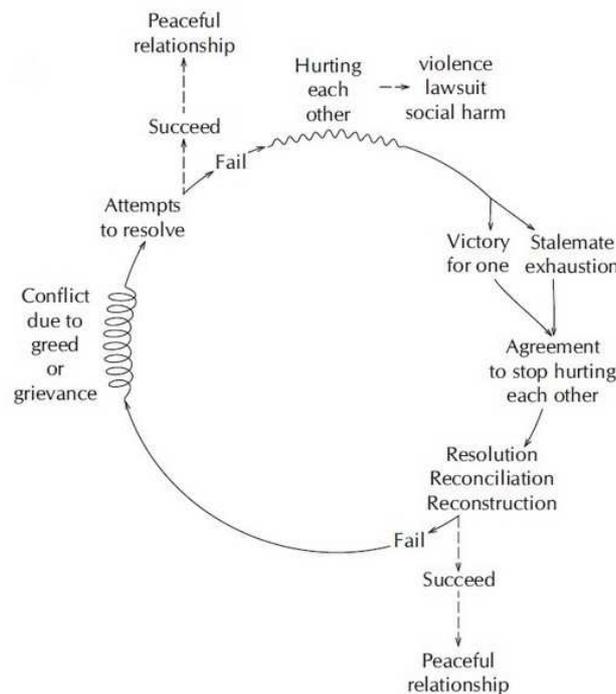


Figure 2: Cycle of violence (Arya, 2003)

When dealing with conflict, there are three main characteristics that should be taken into account. First, large scale conflicts are fluid. In each stage a conflict can escalate or de-escalate. Within a conflict several violent conflict cycles may occur, and they can greatly vary in length and even take backwards steps. Second, every conflict interact with other conflicts. Smaller conflicts can be present within large conflict, each having different opponents, each with its own internal fights, and each with a series of previous struggles that have an impact on their conflict. Thirdly, parties within a conflict usually have a number of strategies they rely on. This can be both violent actions, but also non-coercive inducements. Non-coercive inducement are often promised benefits or persuasive efforts to change the behaviour of other parties (Arya, 2004).

The characteristics of a conflict and its phases can be used to stop violent conflict. However, not all conflict can be stopped, and needs to be transformed at times. The knowledge gathered in this chapter will serve as input for conflict transformation and peace-building, which will be discussed in the next chapter.

Peace and Conflict interventions

There are many ways in which in- and outsiders can intervene in a conflict. These different types of intervention can take place on different levels of conflict, different stages of conflict and by different actors of a conflict. In literature there are many terms related to conflict and peace. In this chapter I will discuss only three. The reason for this is that this paper focuses on NGO actions and many processes concerning conflict involved military or economic sanctions. The terms discussed here are conflict management, conflict transformation and peace building. Conflict management is discussed because it can have different meaning in literature, and conflict transformation and peace-building are the two processes in which NGOs are most often involved.

Conflict Management

In literature, the term conflict management is used in two ways. Conflict management can mean the limitation, mitigation and containment of conflict. In that case it is not the sustainable elimination of the causes of conflict. Conflict management, in this case, is more about controlling the destructive consequences of violent conflict. Actions that can be taken within this type of conflict management are the use of military force, or separating the conflicting parties from each other so that they cannot harm each other (The Network University, 2012). Miall (2004) describes conflict management as the art of appropriate intervention to achieve political settlements. This can be done best by actors that have the power and resources to apply some kind of pressure on the conflicting parties, since this may speed up a settlement. Conflict management is also the art of designing appropriate institutions to guide the inevitable conflict into appropriate channels. Conflict management can be applied when resolving the conflict is no longer possible due to the complexity of the conflict. In these cases, the best thing that can be done is to manage and contain the conflict. Only when both parties in a conflict are willing to compromise, violence can be laid aside and normal politics resumed (*ibid.*).

Conflict management can also be used as the general term for all actions done for the benefit of peace. This can range from taking economic sanctions, military intervention or addressing socio-economic inequality. All terms concerning conflict and peace belong to the denominator of conflict management, among which are conflict transformation, conflict resolution, peace keeping, peace enforcement and peace-building (Verkoren, 2010:14,15). When using the term in this way it has a much wider range of possible actions than can be taken within conflict management.

The main difference is the way the conflict can evolve. If a conflict is contained, only the escalation is stopped, while the overarching term has actions that can de-escalate the conflict. In literature there is no preference for one definition. Therefore, one should always make clear what is meant. In this paper I will use conflict management as being the overarching term for all peace and conflict related processes. The reason for this is that there is no other term available for the combined set of these processes.

Conflict Transformation

Conflict transformation looks at the relationships between the conflicting parties. It is a process engaging with and transforming the relationships, interests, and discourses. Conflict transformation recognizes that conflicts are transformed gradually, through a series of smaller or larger changes as well as specific steps. A variety of actors can play a role in this. In the words of John Paul Lederach:

Conflict transformation must actively envision, include, respect, and promote the human and cultural resources from within a given setting. This involves a new set of lenses through which we do not primarily 'see' the setting and the people in it as the 'problem' and the outsider as the 'answer'. Rather, we understand the long-term goal of transformation as validating and building on people and resources within the setting (Lederach, 1995, quoted in Miall, 2004:4).

TransConflict has developed 16 principles of conflict transformation. All 16 principles can be found in Annex A. Most important is that conflict transformation is always a non-violent process. Other points are that conflict transformation goes deeper than containing a conflict. It involves all levels of society and works from micro to macro level. It is about seeking the root causes, and transforming them and the perception that people have of the causes. This process is long-term, gradual and complex. It needs sustained engagement and interaction if it is to succeed. The complexity also lies in the fact that conflicts are fluid and always changing. Conflict transformation must adjust to these dynamics, especially during pre- and post-violence phases. Conflict transformation can only take place if the tension between the parties can be overcome. A first step in this is for the involved parties to recognize that violence is not helping them protect their interests and second to decide what should be transformed and how. A third, impartial party should be involved to overcome perceptions of the "other", and dismantle the "us" versus "them" divisions (TransConflict, 2012).

The question what exactly needs to be transformed within the conflict is hard to answer, especially because conflicts are very dynamic. Parties go through a series of transformations, while the conflict escalates or deescalates. The transformation one party goes through is often mirrored by the other party, affecting the whole conflict (Mitchell, 2002). As we have seen in the previous chapter, conflict consists of three aspects, described by the ABC-triangle of Galtung. To change a conflict, all three characteristics need to be changed. To change Behaviour, technical cooperation is needed. When different parties cooperate, they become busy with their work and do not fight. However, underlying causes of conflict and violent attitudes are not necessarily changed. But this cooperation does provide an indirect positive impact on the conflict through better communication, building trust or disrupting the fighting agenda. The technical cooperation is not enough to let people meet at a deeper personal level. If there is willingness to listen to each other's feelings and needs, people can connect on a personal level and (re)establish friendships. This empathic connection is needed to change the Attitude of people in conflict. The 'other' is personalised, and with that the enemy is humanized. So the technical cooperation is a first step, that can grow into people connecting at a personal level. Finally, transformative connections can be developed to change the Contradictions (Melf 2012f).

According to Väyrynen (1991) there are several aspects that can be transformed within a conflict. Actor transformations is about the internal changes within parties or the appearance of new parties. This can open up new space for political action. Issue transformation deals with changing the agenda of conflict issues. The dissonant ideas are made less weighty and important, while the consonant interests are made stronger. Thirdly there is rule transformation. Here the norms of which actors are supposed to follow in their relationship are changed. When this transformation is made significant, actors will change their behaviour, and a new basis for managing the conflict can be used. Structural transformation is about transforming the entire structure of the

relationship. This is the case when power distribution of the conflict changes or if there is an increase in interdependence (*ibid.*).

The Berghof Foundation has identified five specific types of transformation. As does Väyrynen, they mention issue, rules and structure as important types of transformation. They also identified the actor transformation, although they focus on the goals actors have and how they try to achieve these goals. Actor need to be aware of the causes and consequences of their actions. The fifth type is the transformation of contexts. This involves the meaning and perception of the conflict, and in particular the attitudes and understanding of actors.

There are several ways to induce conflict transformation. A first way is intervention by actors that are not taking part, or at least are no primary adversaries, in a conflict. The intervention can assist one or all groups in finding an acceptable transformation. Often mediation is used for transformation, and can mean anything between deal-making muscular mediation and gentle facilitation. Mediation can help find new options, and make these options seem attainable for all parties involved. At the same time mediators can help cut through hostile beliefs and feelings that parties may hold to each other (Kriesberg, 2011).

The interaction between adversaries is the first step for the relation to be transformed. A theory of how the interaction should take place is Graduated Reciprocation in Tension-Reduction (GRIT). One party initiates a series of moves for cooperation which they announce. They invite the other party to join the cooperative actions. Even if the other party not accepts this right away, the conciliatory moves continue for an extended period. By doing this, the other party should realize that their prejudices and fears were unnecessary, and in the long term reciprocate to the gesture of the first party.

On a middle-range level, the initiation of mutually beneficial policies is a way to stop destructive conflicts. This may result in formal agreements between (former) opponents. To strengthen these policies, the political structures and other shared institutions are needed to have legitimate ways to manage the conflict (Paris, 2004). This is especially important if the former warring parties are living in the same country. Elections may seem like a good solution in this situation, but safeguards are needed to protect the minimal rights of everyone, including political participation (Lyons, 2005).

In conflict transformation theory, it is an important given that conflict occurs on many levels. To transform a conflict, engagement on many levels is needed. Non-governmental organisations that work across adversary lines, and have access to all (or many) socio-political levels have therefore an important role in preparing and sustaining conflict transformation (Montville, 1991).

Peace-building

In the context of development cooperation, peace-building can be defined as “measures designed to consolidate peaceful relations and strengthen viable political, socio-economic and cultural institutions capable of mediating conflict, as well as strengthen other mechanisms that will either create or support the creation of necessary conditions for a sustained peace” (Saferworld, 2004). Peace-building is going from negative peace to positive peace. Peace-building wants to address the root causes of a conflict and address the negative consequences of a conflict. Peace-building activities are: “Non-violent processes which attempt to prevent, mitigate and transform violent conflict and contribute to building societies in which people have fair access to

resources, which are based on social justice, and which respect fundamental human rights recognized under international law.” (Lewer, 1999:12).

Peace-building takes place after a conflict is resolved or transformed. Since it is not always clear when a conflict is completely transformed, these processes may overlap. Fischer (2004) identified four stages at which peace-building can take place. These are crisis, post-crisis, post-settlement and longer-term reconstruction. Annex B shows a matrix of what action can be done in each stage of the conflict. Most peace-building activities take place only after a crisis, but aid like essential health services and human rights monitoring also take place during conflict. To successfully build sustainable peace there are some key issues that need to be addressed. These are repatriation and resettlement; public safety; infrastructure recovery; food security and agricultural rehabilitation; health, education and social welfare needs; governance and; civil society and macroeconomic stabilisation (Fischer, 2004).

Serwer and Thomson (2007) have made five similar divisions as ultimate goals for a state when they developed their Framework for Success. These are Safe and Secure Environment, where the protection of 'human security' is a central issue; Rule of Law requires the security of individuals and accountability for crimes committed against them; Stable Democracy encompasses the development of legitimate systems of political representation, institutions, media and civil society; Sustainable Economy deals with infrastructure, regulation and employment; and Social Well-Being like food, health education and peaceful coexistence. As may be noted, some of these divisions are needed to achieve other goals. For example, a safe and secure environment is needed for a sustainable economy, besides being important on itself. Therefore, these five ultimate goals should be seen as interconnected and not as separate pillars. A great advantage of this framework is that it can be more easily standardized, as it focuses on ends, and not means. The way to get there however can not be standardized (Serwer and Thomson, 2007).

Organisations will try to rebuild society. The problem that often arises is that a society after conflict is perceived as a blank slate. Therefore a new state can be create in any way. A society has however a history and existing social structures that were kept in place during conflict. Therefore it is often suggested that conflict transformation and social change is more important, because they take into account the (past) dynamics of society. Conflict transformation and peace-building activities have in this way an opportunity to join forces by rebuilding a society. Peace-building activities include addressing socio-economic inequality, justice and truth seeking for perpetrators and victims, prevention future conflict and to establish access to power by all groups (Verkoren, 2010). This is done through reconstruction, reconciliation and resolution, and can be done by many actors. In this next chapter we will look closer at the role of NGOs in the conflict transformation and peace-building activities.

The Role of NGOs in Conflict Management

Since the UN Agenda for Peace was set up by Boutros Ghali in 1992, the realization that NGOs can play a vital role in peace-building is present. The way conflict management was provided shifted towards regional actors. In order to reach the regional actors, the help of NGO was needed. By involving NGOs in conflict management activities, they required procedures that would not compromise their independent status (Richmond, 2001). In this chapter the positive characteristics of NGOs to contribute to peace-building are highlighted. This does not mean that there are no limitations to their employability. But since this chapter is meant to show why NGOs can contribute, the limitation are not discussed here. In the chapter 'Ways to Contribute to Peace' the limitation specific for the health sector are discussed.

Humanitarian principles

Even though health organisation can work under different principles, humanitarian organisations strive to be impartial, neutral and independent. These are their main characteristics. However, holding up these principles may be problematic, as we will later see. Below will follow a short description of the humanitarian principles and what they encompass, to get a grip on the benefits and problems that humanitarian NGOs may face in conflict management.

Neutrality is defined as not taking sides in hostilities (ICRC, 2005). This means that assistance should be provided equal to all sides in a conflict. This is often not feasible for organizations, as they are stationed in a certain area or are mandated to work with a certain group of people. Also, for small organisations it might be impossible to be involved with all sides of the parties, since this requires more resources. When movement across the front line is impossible, organization will have to set up two or more geographically different projects, which is not always feasible for small organisations. It might be potentially dangerous for organisation not to be neutral, since the "other side" may find that they are unfairly treated (Birch, 2012). Even when organisations try to be neutral, their action may be interpreted differently by local people. Klaus Melf even stated that there is no such thing as neutrality, only perceived neutrality (personal communication). Therefore he says that all organisation working in this field should be aware of how they are seen, preventing misperceptions that can hinder their work.

Impartiality means that the actions undertaken by an organisation are solely guided by the needs of individuals. This is the key role of humanitarian agencies. Their aim is to care for everyone according to the need, regardless of who they are. Only active combatants will not be treated, since this would keep the conflict lingering. Keeping up this principle may be difficult because of the distribution of aid. Some regions are more easily accessible, but all regions that can be accessed should be provided with aid. Especially when in each region only one party of the conflict lives, this can cause tension (Birch, 2012).

Independence encompasses that organizations do not act as instruments of government foreign policy (Macrae *et al.*, 2004). If independence is not carried out, the distinction between military and humanitarian actors may blur. This blurring has become more frequent in recent developments. Humanitarian organizations have therefore reduced their visibility. They use a 'hands off' approach to keep working in the area without compromising their principles (Birch, 2012).

It is important to keep in mind that these principles help humanitarian NGOs to work in conflict areas, and that the continuation of this help may depend on these principles. However, it is not always clear whether keeping to these principles works in the advantage of the organisation. By remaining neutral one can be seen as an oppressor, because you are not helping the weaker side more. It is thus very important to keep in mind what your goal is, how you want to achieve that goal and what the consequences of your actions may be, also in the long term and as a precedent for other NGOs.

Characteristics of NGOs

The reason that NGOs have the possibility to make a contribution to different forms of conflict management, is because they possess some characteristics that allow them to work in these settings. Local NGOs have low profile responses to intractable conflicts and humanitarian abuses. In this way they are better able to address a larger range of security issues. Because of their low profile and because they work on a local level, they are better aware what is available and what is needed. They are a vehicle for broad activities at the civil level, but in the context of conflict management processes. NGOs are very flexible, have rapid responses and commitment in local environments to follow the dynamics of emerging conflict (Richmond, 2001).

NGOs are said to be very suitable to work in the field of conflict management, where multi-level and multi-dimensional work is the current standard. Since they know both the small and the big picture of the conflict, they can serve as a cross-cutting force from the global to the local and vice versa. They can provide humanitarian aid, and at the same time install early-warning systems, and set up peace-building and reconciliation projects. By this they can reframe the state sovereignty and social structures at all levels (*ibid.*).

According to Richmond, NGOs are needed for peacebuilding as they fill the gap between officialdom, state and human security. They have little concerns about sovereignty and therefore are able to work in a normative framework and do not have to deal with official and systemic interests, which may disrupt processes. As NGOs have close contact with the grassroots level they can gather information about arising tensions. In this way they are able to help the general conditions that may enhance peace-building and the promotion of peace among different regions. By doing this they include different sectors of society in the development of sustainable peace. This is important, since the success of sustainable peace depends on the participation of the actors (*ibid.*).

As NGOs often try to remain neutral and apolitical, they may be perceived as having little power in, for example, negotiations. However, besides having a low profile and their good position in the field, NGOs can rely on several bases of power that can be used in conflict management. Rubin (1992) distinguished six different bases. Not all types of power are equally strong, and the power differs depending on the situation.

First, the informational power can be very strong. It is the ability to access information that the parties want or need. NGOs can bring messages from one party to another, and help them recognize and define their needs. This power can be very important, because warring parties often lack the means to communicate in a constructive way. If parties are not willing to talk to each other, NGOs can serve as shuttle mediators. However, when using this type of power, NGOs need to have some degree of legitimate power and referent power as well. But if these conditions are met, informational power can help parties to see beyond their current situation (Aall, 2007).

Legitimate power is the power a third party has, in the eyes of the conflicting parties, to make a request. This power can come from the fact that a third party is a powerful

institution or from a long-term relationship or conflict management partnership in the past. Parties often have different reasons to see a third party as legitimate and therefore it is hard to find a third party that is legitimate in the eyes of all parties involved. NGOs are often involved because the both (or all) parties want them to, but this is a weak position for making request. Still, they can play a role in reframing and rethinking their positions, objectives and attitudes (*ibid.*).

Referent power is the power to influence one or both sides, because the parties value the relationship with the third party. Often they need the resources of that third party, since they cannot provide those for themselves. Especially when the third party does not leave the situation after the negotiation is over, trust in a third party can be established. Wehr and Lederach (in Aall, 2007:484) described these parties as insider-partials, a mediator from within the conflict. Local NGOs can take up this role, because they are operating in the conflict situation, and will be affected by the agreement.

Expert power exists when the NGO knows more, or appears to know more, about how to resolve a parties dispute. Because of this knowledge, they gain respect from the warring parties, as well as a chance to use this expert knowledge. Expert power may come from sharing similar experiences, showing that they have experience in dealing with conflicts. Expert power can also work against the "neutral" party. If a party is convinced that the knowledge of the expert will not work in their favour, or is not neutral, they may decline this expert as a mediator (Aall, 2007).

Reward power and coercive power are used to promoting or punishing changed behaviour. These powers may not be very strong for non-governmental actors. Because NGOs are not as powerful as INGOs or states, they need to make sure that the threats and rewards are credible. If not, conflicting parties will not be convinced to make changes, and NGOs lose legitimacy. But NGOs can pressure the international community on behalf of reward and coercive processes, which may be valuable to the parties involved (Aall, 2007).

Enhancing Conflict Management

Besides the positive characteristics of NGOs to contribute to conflict management, there is always room for improvement. First of all, the humanitarian principles need to be followed, since it is the basis of the organisation. But as we have seen, this is not easy, because NGOs have to deal with the perceived neutrality and impartiality. Involvement in conflict management activities is therefore not always possible (Richmond, 2001).

An other aspect that needs improvement is to whom NGOs are accountable. Currently they are more accountable to the funders and government than to the people they work with in the conflict situation. This is understandable, since without their funding, they would not be able to give the help. But it leads to lack of or little communication between civil society organisations and NGOs when project proposals are written (Fisher and Zima, 2009). In this way an opportunity is missed, local people know the main problems in the conflict and have an insiders view to the conflict (*ibid.*). Therefore programmes should be guided by a representative group of indigenous operators. People from outside the community might identify other needs, that may be more important in their eyes. Often they look at conflict and health care needs with a Western view, and in this way not properly consider the cultural needs and problems (Curle, 1996). Besides, if local people are not part of the development of a programme, their commitment to positive peace, justice and well-being may not be as big as would be hoped (Fisher and Zima, 2009). If they would take part in de programme development, they have more ownership of the programme, increasing the chances that the

programme will be sustainable. Outsiders can provide knowhow and economic and material support, but the local communities is the most potent resource for public health of a community (Curle, 1996).

The need for local empowerment has been known by NGOs for a long time, but to implement this has proven to be problematic. Changing power relations should be one of the core peace-building principles according to Fisher and Zima, but this encompasses political and economic structures. They describe it as: "... it is not possible to be serious about such change and stay out of politics" (Fisher and Zima, 2009:29). By entering politics, NGOs are in danger of losing their neutral status. Empowerment could be promoted through educational and other information programmes, or support already existing non-violent initiatives. In this case, although entering politics, the low profile actions may give NGOs the possibility to still being perceived as neutral.

Improvement of network and linkages is a third point for enhancing the peace-building capabilities of NGOs. Often separate projects are being done at a local level, but they remain unconnected to the wider context. If peace is to succeed, it will have to spread beyond the local level. Fisher and Zima recommend that all organisation that are working in these kind of contexts need to share their information and resources in a systematic way. This will save time, effort and also creates a new source of legitimacy and power. Linking different sectors, like NGOs and government, can also be very valuable. Governments can in this way have access to information of NGOs, and may on basis of this information change their approach to peacebuilding. People within governments and other businesses now lack the information and arguments to change their approach.

A fourth very important point of improvement is the evaluation and needs assessment. Projects do mostly want to deliver the outcomes of a project. The ways a projects may influence the bigger picture is often overlooked. The process of the project should be as important as the outcomes, while affecting not only the small scale goals, but also influencing policies of others. The ultimate goal is always to transform the total conflict. Even when your projects focuses on a local scale, it should be remembered that in the end it will affect the large scale conflict (Fisher and Zima, 2009).

A final advise for peace workers is to learn from your own and other people actions in the field. This requires open sharing of failures and successes, also the ones unintended. Programmes are often designed as if causes and consequences are linear, even though this is not the case. By sharing their experiences peace workers and other sectors will be in a better position to be prepared in the field. Training for peace workers and others that want to contribute to the transformation is needed to increase the success of a programme (*ibid.*).

While NGOs may be in a position to make a positive contribution to conflict management activities, there are limitation to this potential. Not all types of NGO will be suitable to contribute to peace-building and conflict transformation. They have their specific mandates, resources and characteristics that influence the way they are perceived by the local community, and thus their conflict management potential. In this paper the health sector is the point of attention, and will be analysed on it positive and negative points. In the chapter Connection Health and Peace we will see specific reasons why health organisations should and should not interfere in peace processes. First will discuss in more depth the different institutions that each have developed their own theoretical ideas about health work for peace work.

Levels and stages of intervention

Before discussing the different programmes that do health work for peace work, some knowledge is required about the general idea of these programmes. First we must make a division between implicit and explicit peace work. Not all contributions made by health professionals to peace building are done deliberately. Health organisation, whether they only do health work or also strive to contribute to peace work, should be aware that they may always influence the conflict. The moment a conflict is entered, you become part of it and therefore your actions also will have an effect on the conflict. Further, peace work can be done in different stages of conflict. As we have seen before a conflict goes through several stages, each with its own characteristics. Because of this, each stages requires different actions for conflict management. A third difference in health and peace work can be made at a societal level. There exist three levels in society on a vertical level (Melf, 2012f), where changes can be made. These different levels also require different actions.

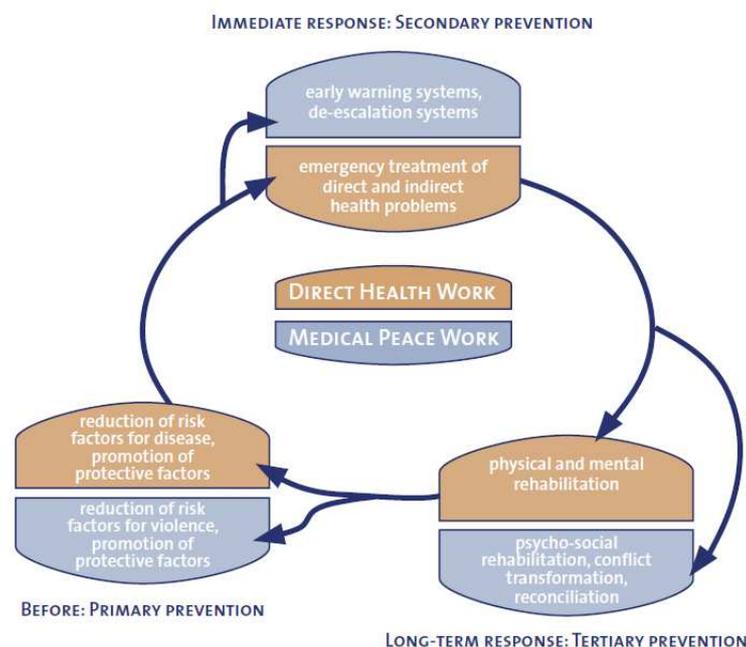


Figure 3: Different in implicit and explicit peace work in the prevention stages (Melf, 2012e)

Implicit versus explicit peace work

According to Melf (2012c) the goals of peace work and health work overlap on several points. They both fight for the well-being of people, try to defend basic human needs and human rights, and work for the absence of suffering, trauma and other types of harm. Therefore, when health workers do their normal work, a contribution to peace work will be made. When the contribution to peace work was not a goal of the health programme, it is called implicit peace work. On the other hand, when health workers make specific efforts to positively contribute to peace, it is called explicit peace work. Implicit and explicit peace work can work towards the same goal but by different means. Both ways can have advantages and disadvantages. The advantage of doing implicit peace work is that the chances of being identified as politicized are very small, but since the peace work is done indirectly and not a main goal for the health sector this contribution may be small and slow. Explicit peace work will have a more prominent contribution, but

must monitor the opinion of the people and the situation of the conflict. Explicit peace work will therefore require a greater effort from the health professionals. Figure 3 shows the difference in implicit (in the figure direct health work) and explicit peace work (medical peace work in the figure). As can be seen in the figure, different action will be taken, depending on the goal of the programme. The difference in prevention type is also shown. These types of intervention will be explained below.

Types of prevention

As with the different conflict stages, we can divide the types of intervention into three or four prevention types, depending on the author. In Figure 4 is shown which prevention type is needed for which stage. These stages are derived from the public health approach (which will be discussed in the next chapter), and coincide with stages of diseases and actions to be taken to tackle a disease (Melf, 2012d) Arya (2004) distinguished four prevention types, beginning with primordial prevention. Primordial intervention refers to the risk factors for the development of (violent) conflicts. It looks at the root causes that might lead to conflict escalation. Root causes can be about political exclusion, human rights violations and suppression of identity. Vaccination and better hygiene are examples of measures that can be taken (Melf, 2012d). Health related frameworks deal with different root causes like Global Health, and Health and Human Rights (Melf, Arya and Buhmann, 2008). When doing primordial prevention there is no conflict yet. Primary prevention for Arya is the prevention of war in a situation where conflict already exists. Limitation of arms, combating propaganda and diplomacy are examples of actions that can be taken. Melf sees these two prevention types as one, calling it primary prevention. Often, primary prevention activities are seen as political, since it involves dealing with governments to stop conflict from happening (Arya, 2004).

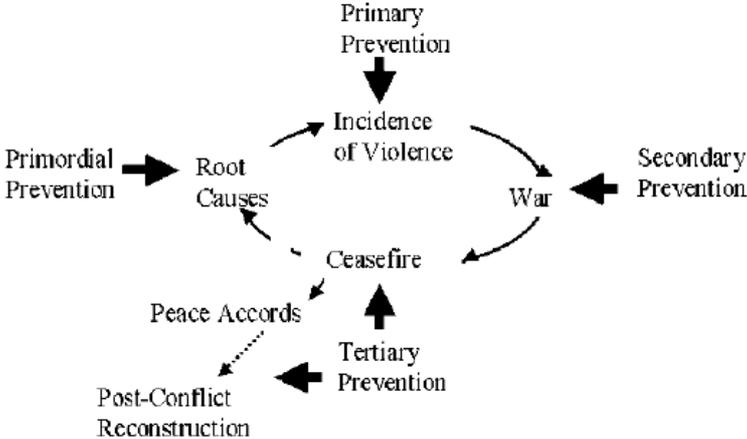


Figure 4: Breaking the chain of war (Arya, 2004)

Secondary prevention refers to a situation where violent conflict has broken out, and methods to make peace are needed. It focuses on preventing further deterioration. On the ground training is part of secondary prevention. Tertiary preventions describes interventions that take place when acute health problems are under control. It work on the long-term negative effects after the problem (Melf 2012d). The three R's, reconstruction, resolution and reconciliation are part of tertiary prevention. These initiatives often already start during violent conflict. Even though a distinction is made in prevention phase, that does not mean that the intervention does not have an effect on an other phase. Clear distinctions are therefore very difficult to make (Melf, Arya and

Buhmann, 2008). Figure 3 shows an example of different actions that can be taken in each conflict stage.

Societal levels

Health bridges can be built between three levels in society, as shown in Figure 5. For civil society an enormous feeling of solidarity and involvement is directed at saving life and health. Since health is a universal basic need, it connects people. Provision of health care can help people to survive. If the support is coming from 'outside' it can give a sense of respect and hope. People feel no longer neglected and marginalization and other forms of structural violence can be reduced.

At a middle range level we have the professionals, in this case the health workers. Health workers are by definition concerned about health. Professionals from all the conflicting parties have this in common. This provides a common ground and field of interest from which they can have a dialogue. Besides, many public health challenges, like diseases, do not respect national boundaries. Therefore, it requires regional and international cooperation from all sides. This bridges political, cultural and ethnic divisions.

On a political level decision-makers are also concerned about health. Shared concerns about war and violent conflict can connect political leaders. Examples of health bridges on this level are cease-fires that enabled health workers to immunize children. This not only enhanced the children's health, but also developed new channels of communication, brought confidence between the warring parties and created an environment that enabled negotiations (Melf, 2012f).

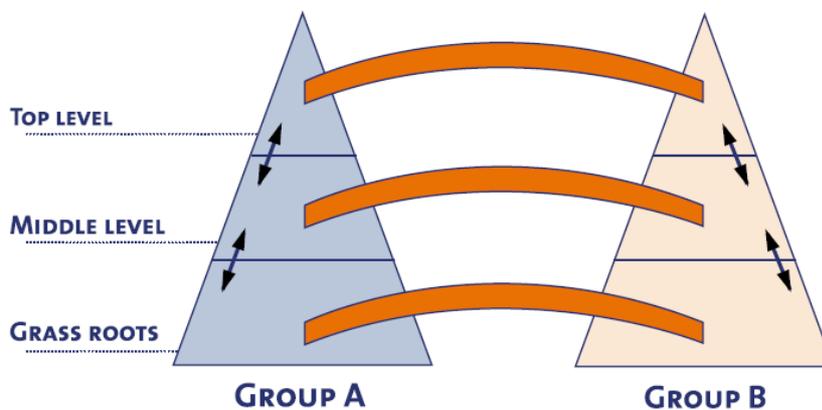


Figure 5: Health bridges at three societal levels (From Melf, 2012f)

Knowing the different levels at which health work for peace work can be done, we can better classify the programmes discussed in the next chapter. Also, these levels can help organisations to develop their own programme. By considering which levels a programme want to target, the actions will better connect to the envisioned goals. Even though distinctions are made, the fluidity of conflict and society make that these distinction are not rigid. So it is good to be aware of the connections between different levels in society and stages of a conflict and the effect a programme may have in the bigger picture.

Programmes of health and peace work

Since the early 1980's the idea of health work for peace work was established. The Pan America Health Organisation (PAHO), which is part of the WHO launched its first programme in 1983 in El Salvador. The programme was initiated because of the civil conflict and human suffering during the 1980's. The reason health was chosen as a means was that it has unique value and universal acceptance, and therefore could bring understanding to people. The first phase of the plan took 6 years, where it served the most important health needs of the population, but also was the central mechanism for coordination, planning and resource mobilization. One of the most important achievements was a series of immunization ceasefires. Other HBP actions included organizing meeting for the representatives of each country's Ministry of Health. Meetings between the warring parties was not feasible, but in order to build trust among the parties meeting with the representatives were a good alternative. Adding to this that health projects were cross-border, these meetings were necessary for countries to collaborate on these projects (Arya, 2008).

The main idea of health work for peace work is to integrate peace-building concerns, concepts, principles, strategies and practices into health relief and health sector development (WHO, 2012). The general idea is shown in Figure 6. All these programmes are based on this similar idea, and therefore have a great overlap on their conceptual framework and approach to this type of work. Often prominent people and authors have worked for several programmes, and the institutions have worked together on programmes as well. In the field of health work for peace work there are four main institutions that have their own programmes. These are the Institute for Resource and Security Studies (IRSS) with Health Bridges for Peace, the Leonardo University with the Medical Peace Work, the McMaster University developed the Peace through Health model, and the WHO with their programme Health as a Bridge for Peace. There are however some differences with regard to taken actions and target group.

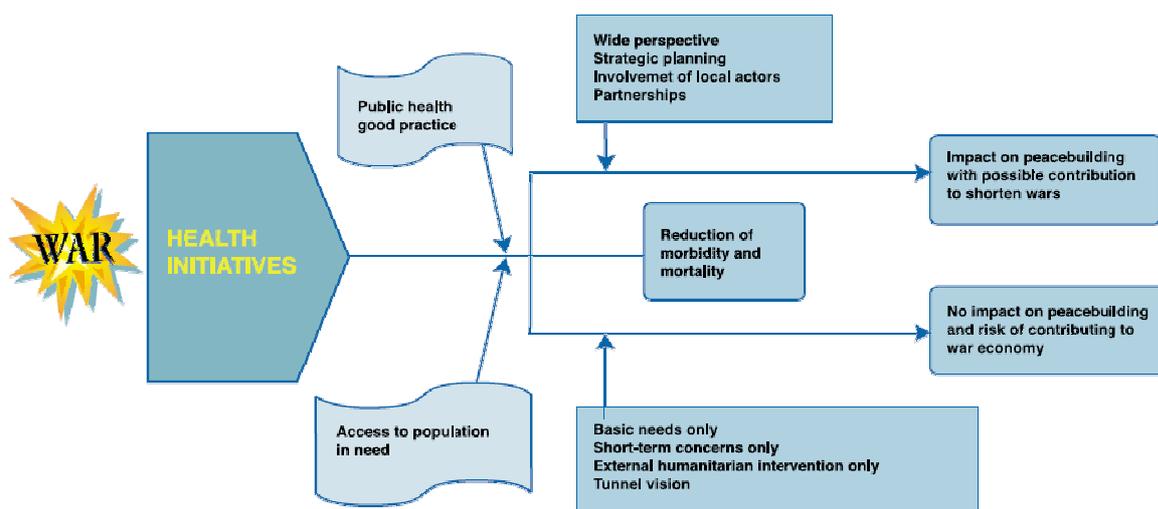


Figure 6: Health initiatives' outcome in war (WHO poster)

Health Bridge for Peace

The IRSS mainly focuses on providing dialogue and training for different types of health professionals. Dialogue takes place between health professionals from warring parties.

Because health is seen as a common goal that is more important than the causes for war, physicians and other health professionals come together and try to rebuild public health. Furthermore these professionals are trained in community reconciliation and conflict management. After training, IRSS helps the health professionals to design and implement inter-communal activities. These activities integrate community reconciliation and conflict prevention strategies into health care delivery (Gutlove, 2000).

Because health care is integrated with conflict management and community reconciliation, the IRSS has called their approach the integrated approach. Conflict parties are brought together to work on a humanitarian, and in this case health, goal. The parties then have significant, concrete incentives to work together. The humanitarian or health programme in turn gains conflict management expertise (Gutlove, 1997). In this approach four stages of intervention are identified. Most activities up to date have occurred in phases I and II. As we have seen for the phases of conflict, phase II does not necessarily have to end when phase I stops. Since the conflict itself is dynamic, the process of conflict management has to be dynamic as well (Gutlove, 1999).

Phase I; Initial intervention. During this phase, assessment or diagnosis of the conflict is needed. It is important to map the conflict, identify appropriate parties for future activities and engage them in planning the intervention. As conflicts are dynamic, the organisational parties should monitor the conflict and take into account any changes. During this phase meetings are convened to facilitate dialogue, mediation, consensus building and collaborative problem solving. Phase II; Building indigenous capacity. During this phase the conflict management training will start, both in theory and in practice, and this is integrated in humanitarian and development activities. Conflict management operations are encouraged by raising funds from external sources to support local operations. Also, giving advice or assistance in organizational development is part of this phase. Phase III; Improving Effectiveness. Systematic documentation of conflict management intervention and early warning conflicts become important in this phase. The information exchange among conflict management practitioners should be improved, but also parties outside of the conflict management field should be included. The conflict management interventions should be assessed and evaluated. With that information, coordination of conflict management activities should be improved. Phase IV; Establishing Sustainable Institutions. Most NGOs have no or little guarantee of long-term funding. The sustainability of the conflict management structures depend on financially sustainable, nongovernmental conflict management institutions. Often governments may provide part of this funding, but for the institutions it is essential that they do not compromise their independence (*ibid*).

When looking at the ABC-triangle of conflict, IRSS is clearly trying to change the behaviour within the conflict. The topic of discussion is health, and not the actual reasons why there is a conflict. The position a health worker takes in the conflict is also not of importance. But by changing the behaviour of health professional by working on a compatible goal, the other aspects may be affected as well. The programme is aiming for the ripple effect that can be established. By facilitating dialogue between and training for health professionals, the IRSS provides the basis for further dialogue. They heavily rely on the high position of health professionals in society for the expansion of conflict transformation. The powers of IRSS mainly are referent, expert power, and as all examples that follow, informational power. Because the IRSS has a reputation as a facilitator between professionals many times they are asked to be involved in the

dialogue, as was the case in Yugoslavia. This emphasizes the expert and referent power of the IRSS. When looking at types of transformation, IRSS most clearly strives for issue transformation. They are emphasising the health problems that both parties have, putting their differences temporarily aside. At the same time the rules transformation takes place, at least during the dialogues between the professionals. People are not judged on basis of their ethnicity, but on their profession.

Medical Peace Work

Medical Peace Work has a mainly educational function. MPW makes health professionals aware of the possibility of doing peace work while doing health work, and provides seven online courses (medicalpeacework.org). All relevant issues concerning peace work and associated problems for health workers are discussed in these courses. Even though they do not have programmes that bring different parties together, they do provide the most important theories on health work for peace work. This information can be used by health professionals when developing such a programme. Also they make people aware of the possibility of doing peace work while doing health work (Salvage *et al.*, 2012). An other point of difference is that they address all types of conflict regarding number of persons involved. As discussed before, there are six types of conflict, depending on the number of people involved. Most programmes focus on inter- and intragroup conflict. MPW finds it important that all types of conflict are addressed, including interpersonal conflict. According to their theory everything may have an effect on the conflict, so one person can make a difference. Their theory can therefore be used in more situations, including situations of small scale conflict in a peaceful nation (Sørensen, personal communication, Melf, personal communication).

Since MPW has its focus on educating other health professionals, they do not have an approach that they use themselves. They do however recommend the public health approach to be used by health professionals aiming to do peace work. The primary goals of the public health framework is to prevent health problems at a societal level. The public health approach is interdisciplinary and draws knowledge from medicine, epidemiology, and sociology among others. According to MPW this makes the approach innovative and applicable to a wide range of illnesses and injuries (Melf, 2012d).

The problem that needs to be tackled according to MPW is violence, since this is a main cause for health problems in conflict areas. When applying a public health approach to conflict and violence, it includes the classification and measurement of violence, the identification of risks and protective factors, the development and evaluation of interventions and the implementation of effective interventions at population level (*ibid*). Cooperative efforts are needed to solve 'medical' problems. Each sector can address the problem of violence in its own way, and collectively, they have the potential to reduce the violence (WHO, 2002).

The public health approach has four different stages. Figure 7 shows the public health approach to a problem. In the first stage the problem is defined. This is done by the collection of data and surveillance. Information that is needed includes questions concerning who, when, where, what and how. This information can be obtained by patients, clinical records, agency and institutional accounts, community and government files, population based and other surveys and special studies. In conflict situation health professionals can obtain information of different forms and levels of violence, frequencies and circumstances, mortality and morbidity rates specific health outcomes and the economical burdens on the health sector and society.

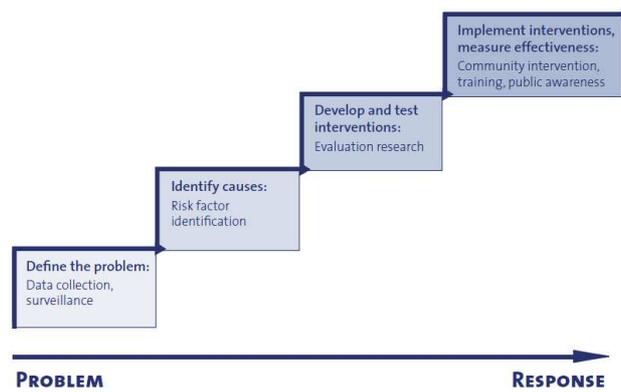


Figure 7; The public health approach (Melf, 2012d, adapted from Mercy *et al.*, 1993)

In the second stage the different risks are identified. In this way health professionals are able to not only treat the symptoms, but also address the underlying causes. Often the underlying cause is very complex interplay of different factors. The ecological model identifies four level at which risk factors can occur. Figure 8 shows the ecological model.

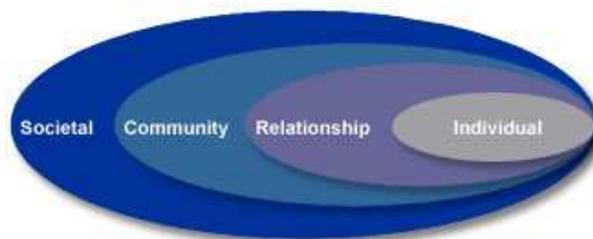


Figure 8: Ecological model (Dahlberg and Krug, 2002)

First, there is the individual level. It looks at the characteristics of an individual that increases the likelihood of being a victim or perpetrator. This includes the biological and personal history factors that can influence a persons behaviour. Also demographic factors and prior history of aggression, and abuse are considered (WHO, 2002). Risks factors for this level are victim of child maltreatment, personality disorder and alcohol or other substance abuse (Melf, 2012d). The relational level explores how relationships with peers and family can increase the risk for the perpetration of violence. When negative behaviour is encouraged by personal relationships, people are more likely to engage in that negative behaviour (WHO, 2002). At a relationship level poor parenting, violent friends and a low socioeconomic household can play a role. The community level examines the community contexts in which social relationships are embedded. It seeks to identify the characteristics that are associated with being victims or perpetrators of violence (WHO, 2002). On a community level things like poverty, mobility (move many times) and high unemployment are risk factors (Melf, 2012d). The societal level is about the larger societal factors that create an acceptable climate for violence. This can be cultural norms, or general norms and values that are typical for a society (WHO, 2002). Also economic inequality, high firearm availability and the post war situation pose risks (Melf, 2012d).

The third stage is about intervention and evaluation. The most important intervention of public health is the modification of risk factors and strengthening of protective factors. Evaluation of this intervention is very important. Even though there have been many case control and longitudinal studies and control trials to assess the micro-level violence, there is still little knowledge about what lessens or eliminates macro-level violence such as war. The last stage is about the implementation of the intervention

itself. The effectiveness of a certain intervention may look promising in theory, but there is no guarantee that the findings can be generalized to community conditions. Furthermore, cost effectiveness is important and needs to be taken into account (*ibid.*). By trying to address the root causes of the violence, the public health approach wants to change the means of how the conflict is solved. This can be done by addressing either attitude, behaviour or content. As can be seen from comparing this approach to the one of IRSS, the public health approach is more general and can be seen as an extensive first stage of the integrated approach. The public health approach can be used by any health organisation that wishes to expand its deliverables. On its own MPW has the informational power, and depending on the characteristics of the specific health organisations, the different types of NGO strengths can be implemented in the programme. Also they focus on health as a superordinate goal, changing the issues if the conflict. This approach also gives the freedom to adapt a programme to different contexts and different stages of the conflict, where other risk factors may be of importance. Disadvantages are that the large amount of freedom gives little support for steps that need to be taken after the analysis has been done, and that by changing the means of conflict only negative peace will be reached. As MPW strives for positive peace, more than just the means of conflict need to be addressed. The question is whether this can be done by having people's physical health as the main goal.

Peace through Health

The concept of Peace through Health (PtH) from the McMaster University is very broad. They consider all action taken by health organisation to make a contribution to peace as a Peace through Health action. They are using epidemiology to approach a problem. Epidemiology seeks to find out who is affected by the health problem and what factors are causing that these people are affected. Epidemiology is therefore not addressing root causes of a conflict, but about identifying relations between cause and effect (Chase and Arya, 2008). A simple example could be that in one area more people are murdered than in another. The only difference is that in the first area more people carry fire arms. Therefore the cause that more people are murdered is because of the fire arms. The reason that these people are murdered are however still unknown. But by removing the fire arms the number of deaths will go down.

The field of epidemiology in conflict areas however is not well developed because of several problems. First of all there are many political problems that can form an obstacle for consistent data collection. Because the situation is so delicate, access to an area is difficult and security can not be granted. Therefore the data collection can be troublesome. The design of the study largely depends on the situation and needs to be changed for every study. This makes comparison between different studies difficult. According to Chase and Arya (2008) scientific and ethical principles need to be followed extra carefully to not endanger the study.

In their own projects McMaster has focussed on the mental health of children in Croatia, Sri Lanka and the Gaza area. Their main action was to foster dialogue between groups of children, by letting them share their experiences. By focussing on mental health more than on physical health their interventions for positive peace activities had more legitimacy. However, they point out as long as the health issue is the focus of conversation, dialogue with the collateral goal of peace is possible (Arya and Santa Barbara, 2008). Their most important project was the Butterfly garden in Sri Lanka. After doing a research in the area, health professionals felt it was unethical to not address the mental and social problems found in the study and founded the Butterfly

garden. Children from divided communities were brought together in the Butterfly garden once a week to do creative activities in mixed groups with the intention to learn from each other. The staff were local people trained by teachers and other professionals. Findings of evaluations showed that the Butterfly garden is very successful for mental and social rehabilitation (Chase, 2008).

Since the epidemiological model only investigates problems that already reflected in society, it can only address secondary and tertiary prevention. The disadvantage of this is that negative consequences have to happen before something can be done. Preventing a conflict has priority above changing and resolving a conflict. Therefore, epidemiology will not be the most cost effective way for conflict management. However, it does address both attitude and behaviour from the conflict cycle. Doing this with children can be more effective than with adults, since the experiences from the children are not rooted as deep as those of adults. If both attitude and behaviour can be changed, this may prevent further escalation of the conflict when children grow up. This can be identified as actor transformation since the parties are internally changed. Also the relationship between warring parties is changed, inducing rule and context transformation. The powers practised by this PtH concept are informational power, because they have access to a lot of information since they are part of a university. They also exercise referent power, since they provide resources and by doing research have build a relationship with the people. The example given above clearly is tertiary prevention, even though the conflict was not ended before initiating this project. But since healing the scars from conflict was the main goal, we can state that the Butterfly garden addresses tertiary prevention. What is missing though is the clear link between health and the way the problems are addressed, especially in the example given. The activities are not lead by health professionals, and from the literature it remains unclear whether the local staff is trained by health workers. If not, than all the health field attributed to this initiative is the problem determination. One can wonder whether that is enough to be called health work for peace work.

Health as a Bridge for Peace

The World Health Organisation did a wide variety of programmes using health as a contributor to peace. The HBP concept takes into account the different stages in a conflict cycle, saying that in different stages different action are appropriate. They take a holistic approach to the health for peace concept, focussing on the interconnectedness of five dimensions in the field. Their conceptual framework with the five dimension is shown in Figure 9, and will be further explained below. The Health Bridges for Peace concept (HBP) believes that these five dimension are connected, and influencing one dimension may very well have an effect on an other. It is therefore important to monitor all dimensions, and consider the possible effects that an initiative in one dimension may have on the others. This enables WHO to intervene in a broad range of situations.

The health dimension has a clear link with health for peace actions. All health actions are done in a specific environment, where conditions of housing and living may differ. According to the HBP concept, these conditions have an impact on action to reduce conflict and promote health. Gender is an important condition, especially when looking at differences between conflict perpetrators and victims. The economic situation connect to the health dimension because unemployment and instability may lead to the creation of vulnerable groups, which can exacerbate the conflict. As the economy deteriorates, funding for public health services also goes down, leading to breakdowns in disease surveillance, inadequate primary and preventive health care, deterioration of

water and sanitation services, and ultimately a higher level of morbidity, premature mortality, and increased economic costs. This leads to lower social and economic productivity, and can extend to post-conflict generations. Third, social factors such as poverty, poor housing, the breakdown of community structures, and poor educational opportunities may promote aggressive behaviour. This behaviour is harmful for people's health and lays a negative base for future generations. The political dimension encompasses the lack of political participation by citizen, either because of lack of accountability of the government or because the political system does not allow citizen participation. This prolongs violent conflict, and maintains the negative consequences for public health. Finally, conflict takes a heavy toll on human development. Besides the above mentioned dimensions, violations of human rights and the persistence of unresolved conflict can lead to devaluation of life. Children and youth raised in such hostile environments may think that these conditions are normal. This in turn may lead to sustaining the conflict, which does not allow for improvement of health and overall living conditions (Rodriguez-Garcia *et al.*, 2001).

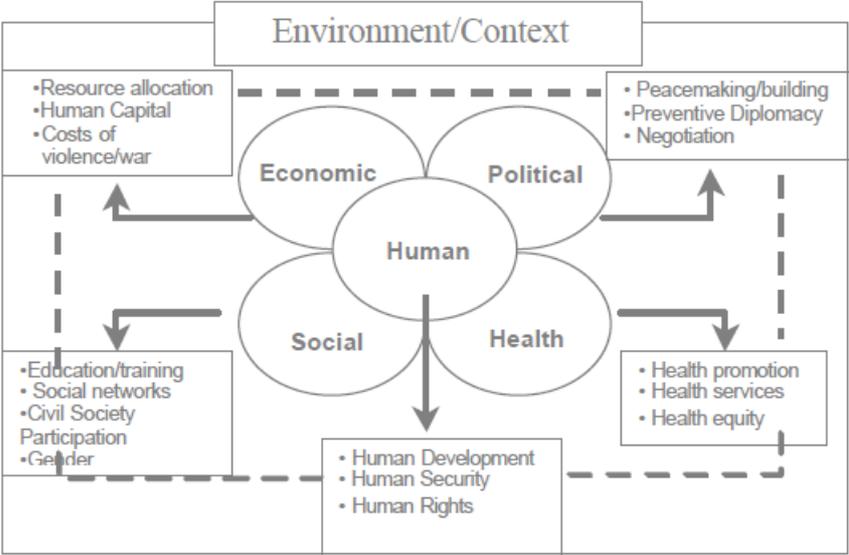


Figure 9; Conceptual framework (Rodriguez-Garcia *et al.*, 2001)

Since the WHO is a large international organisation, they have the resources to intervene in a large range of situation. They have provided training on health-peace issues for health professionals, workshops to improve dialogue between health professionals and between governments (similar to the IRSS), implementation of ceasefires, as well as programmes on a local level to improve both health and peace. The HBP framework allows for this to happen and can be used for a multidisciplinary analysis, including causes of conflict, stakeholders and institutional features that need to be addressed. By accounting for different actions in different stages of the conflict, a distinction in actions can be made, addressing health and peace problems more targeted. As is the case with the approach of MPW, the broadness gives very little direction as to what actions to take in a certain situation. It is good to look at each (part of a) conflict, since every situation is different, but the guidelines given remain very general. Because of the broadness of the concept, it is hard to distinguish in what aspect of conflict the HBP concept wants to make a change. This depends on the situation and prevention type that is appropriate for the context. Also the type of power used and the type of transformation envisioned for a project may differ, and does not become clear from this framework. The

possibilities that WHO has can be all types of power, except maybe reward and coercive power, because those are mostly attributed to political organisations.

Table 1; Programmes with their main focus

		IRSS	MPW	PtH	WHO
Conflict type	Intrapersonal		X		
	Interpersonal		X		
	Intragroup	X	X	X	X
	Intergroup	X	X	X	X
	Intranational	X	X	X	X
	International	X	X	X	X
Target group	Grassroot level			X	X
	Middle range level	X	X		X
	Top level				X
Type of activities	Dialogue	X		X	X
	Training	X			X
	Education		X	X	X
Aspect of conflict	Attitude		X	X	X
	Behaviour	X	X	X	X
	Content		X		X
Power used	Informational	X	X	X	X
	Legitimate				X
	Referent	X		X	X
	Expert	X			X
	Reward/Coercive				
Type of transformation	Actor			X	X
	Issue	X	X		X
	Rule	X		X	X
	Structural				X
	Context			X	X

Table 1 shows the differences and similarities in programmes/institutions. It is important to notice that the divisions made here are not as rigid in reality. When a category is not marked this does not mean that the possibility for this category is not there, but that the focus of the programme lies in an other category. As is the case for WHO, not every programme will include all categories marked in the table. But their range of activities is so large that they have experience in all areas. For all programmes the direct influences they can have are marked, effects that may be reaches by person affected by the original programme are not included in this table.

When an organisation want to develop their own programme, these programmes can be used to see what approach is appropriate for a certain situations. Also programmes may be mixed to fit a certain situation or goal. When developing their programme, they

should take into account the wishes, desires and needs of the local people. This will be different for every programme, but makes the programme more successful. If programmes are unwanted, or do not target the main problems for the local people, the project will not be sustainable (Djesa, personal communication).

Connection health and peace

As we have seen, NGOs can contribute to conflict management in several ways. Although health aid first and foremost addresses the health issues, health and peace are inextricably connected through several common goals such as human well-being. In this chapter I will discuss the links between health work and peace work and explain why health care workers can have legitimate reasons to interfere in peace processes. Also, the mechanisms that can be used by health professionals to use in the processes will be discussed.

Reasons for health organisations to interfere

There are several ways for health and conflict to be connected. If we look at the definitions of health and peace in a holistic way, there are immediately some aspects that overlap. Both are related to well-being, basic needs, human security and human rights. In both fields people work for the prevention or reduction of harm, suffering and trauma. Since the two fields share several ultimate goals, Melf states that all health professionals will do some peace work. When they are improving the right to health, meeting human basic needs or promoting life-enriching structures, this may very well lead to a reduction of direct and structural violence (Melf, 2012c).

Secondly, armed conflict has serious negative consequences for the health of entire populations. It is a catalyst for diseases and disabilities. War destroys health care facilities and other infrastructure, which will lead to deterioration of hygiene. Populations are displaced and crowd together in for example refugee camps, adding to the spread of contagious diseases. The indirect effects of war also have a great effect on public health. Conflict drives away the scarce resources that are needed for the promotion of health, medical care and other human services (Kitts, 2008). Due to malnutrition and childbirth complications many people die. Among women and children the mortality rate due to these indirect effects is even higher than that of direct violence. These indirect effects may linger on for many years, even when the conflict is ended, causing even more deaths (UNSW, 2004).

The health sector plays an important role in fragile communities since the health of a society is critical to its resilience. Poor health creates a burden and poverty in society. It reduces the capacity of individuals, families and collectives to work. So good health enables other entitlements and rights to be exercised (UNSW, 2004). When resilience is weakened, a community is more likely to enter violent conflict. Good health is needed for communities and individuals to exercise their rights, and projects may provide a focus for contributing positively to building peace (Zwi *et al.*, 2006). The scope for health to contribute to peace reaches beyond basic care and service delivery. It includes possibilities for building trust and supporting reconciliation, promoting social cohesion, addressing psychosocial responses to conflict and creating healthier environments.

Health can be a promoter of non-violence, implicitly or explicitly. According to researcher from the University of New South Wales (UNSW) it can promote respect, dignity and non-discrimination in everyday practices. Also it can provide treatment for those who have been abused or are in need of psychological help. Since public health care needs institutions, these institutions will be (re)built and in this way can induce social change. If health services are designed appropriately, they can promote social forces that reduce discrimination and inequity and in this way mitigate the conflict. Health institutions can provide a 'neutral' space and allow sectors to work towards a common goal. It can offer collaborations between various sectors of society. Health may

be a catalyst for promotion social cohesion, being a reference point in seeking assistance and support in times of conflict. Because health is valued by all, when distributed in a accessible and equitable manner, it may serve as a rallying point for community action and empowerment. This empowerment can later on be expanded to other aspects of social life (UNSW, 2004).

Health and peace are also connected through the Ottawa Charter for Health Promotion. The first prerequisite described for the secure foundation of health is peace. Other conditions are shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity (Kitts, 2008 and Arya, 2004). This underscores the importance of achieving peace by rebuilding society and civic structures. Health professionals are in good position to facilitate this.

Health is also recognized as a security issue. Human security is described as the freedom from want and the freedom of fear. To be without fear, violence can not take place in a community. In the United Nations Development Programme (UNDP) of 1994, human security is divided into seven areas. Health is a crucial domain of human security. Therefore we can state that without health security, human security can not occur. Working through existing institutions and promotion of collaboration can be an effective strategy to promote both health and peace. It is especially important that people and institutions whose focus has been on national defence and security find a common purpose with their counterparts whose focus is health, social justice and human security.

The concept of human security into health programmes can be used to mobilize new resources to support the agenda. Besides, human security can help found new partnerships that recognize global interdependence and complement of the action agenda. Thirdly, the human security perspective can link health issues with related objectives - like prevention of violent conflict - and in this way enhance the effectiveness of both efforts. Integrating health and human security is possible because health can create a neutral forum for discussion and collaboration. Health care programmes that include health care professionals from both (or all) sides of the conflict, can be used for collaborative action and help to create a sustainable community infrastructure. One can think about immunization campaigns and public health education (Gutlove and Thompson, 2003).

Position of Health workers

When health organisation are contributing to peace, this means that their actions will be executed by health workers. If health workers are to contribute to peace in a positive way, they need to be aware of their position in the field. This position has both advantages and disadvantages to be used for peace. Besides this, health workers need good reasons to become aware of the aspects they can bring into a conflict.

There are three reasons that health professionals should be aware of dealing with peace work. First, violence in its different forms severely and often irreversibly affects the health of individuals and communities. Secondly, health professionals can easily become actors of violence or a part of a violent structure. Health workers are highly educated and have access to power. However, they do not always use this power for the good. Examples are the way health professional treated prisoners in the Abu Ghraib prison, or Guantanamo Bay. And thirdly, health workers can unintentionally worsen a conflict situation. Despite good intentions health workers can be exploited in violent situations. Also trying to make rapid changes in stead of long-term, sustainable improvements can

be counter-productive (Melf, 2012c). This will be discussed later on in the Do No Harm tool.

Health workers possess many skills that may contribute to peace building. Health professionals are expert in identifying threats to large populations, epidemiology, research, evaluation, and educating the public. Other skills are the competence in improving access to health care and rebuilding the health sector; healing physical and mental trauma; empathy and sensitive communication; respecting confidentiality and acting impartially; and commitment to health and wellbeing, human dignity, social responsibility, and worldwide solidarity with fellow professionals. Health professionals have access to people and communities in need, close professional contact, health as an overarching goal, professional ethics and codes, reliable information, public trust and social status, and huge international networks with their own resources and infrastructure (Melf, 2012e).

The medical profession is associated with characteristics as altruism, solidarity and credibility. They have an intimate association with the people who have suffered mentally and physically from violent conflicts (Gutlove and Thompson, 2003). Health professions are therefore in an excellent position to have influence on the population and can make great contributions to the peace-building field (Buhmann, 2007).

Health professionals have an ethic to preserve life and to promote health and well-being. This makes them able to act "as champions of peace" (UNSW, 2004:1). They are often seen as leaders of their community, and in this position they can promote reform and social justice across society. They are trusted because of the work they do. However, health workers are not necessarily neutral. They are players in the community and local political processes (UNSW, 2004 and Buhmann, 2007).

Multi-track peacebuilding

Peace through Health is an approach that assumes a multi-track diplomacy. In the original concept of Montville only two tracks were distinguished. Track 1 encompasses the governmental actions to resolve conflict, while Track 2 describes the non-governmental, unofficial actions. Track II offers a bottom-up approach for building from the grassroots approach in contrast to the top down mediated solutions often touted in the past. In this process, NGOs who have become deeply embedded in societies can act as facilitators and conduits, as agents who make productive exchange among players possible and who provide "ground truth" to governments and other interested parties (Kelleher and Taulbee, 2006).

However, since the scope of unofficial activities was not fully recognized when all official actions were put under Track 2, the term multi-track diplomacy was developed. Some models of multi-track diplomacy now have as many as 9 tracks (government, conflict resolution professionals, business, private citizens, research training and education, activism, religion, funding or philanthropic community and public opinion/communication). The different tracks do not always produce peace, but under some circumstances they do (MacQueen, McCutcheon and Santa Barbara, 1997). Therefore peace can best be reached by multiple interaction groups and forces, some aimed at peace and some not. Peace is not an outcome of one cause, nor the outcome always of a process explicitly labelled as "peace making" or "peace building". Health however is not part of multi-track diplomacy. Arya (2004) argues that health workers have worked for peace as well, and therefore should be part of the multi-track diplomacy as well.

MacQueen (2008a) identified six elements why health should be a separate track. First, the altruism that is attributed to health workers is an enormous advantage, because health workers are more easily supported, funded, appreciated and given legitimacy. Also health workers work from a scientific procedure. Therefore they will not accept hypotheses that are not grounded in evidence. In circumstances where myths, lies and propaganda flourish, this is very important. Because of the overlap between health and conflict (as described earlier), it is easy for these two sectors to work together and understand their analyses and skills. And since health is very highly valued in society, it is relatively easy for the health sector to get funding and support. When this support can be extended to peace building activities, this will be very helpful. Another advantage of the health sector is that they have access to war zones, which is denied to many other sectors. In this way they can help on the spot, making them invaluable aids to peace building. Finally, the health community is a strongly integrated community. Through journals, conferences and technology knowledge is easily shared and can be applied in different locations. Because there is a great emphasis on learning, health workers can adapt to new conditions and put new ideas into practice (MacQueen, 2008a).

Mechanisms of health work for peace work

The McMaster University evaluated many case studies related to the concept of health work for peace work. By analysing the actions taken by health professionals, they identified ten different mechanisms of how health professionals can work for peace. The mechanisms are described below.

1. **Redefinition of the situation.** In conflict management, societies have to deal with the violent situation in a humane way with the means they have. Therefore the basic understanding the population has of war needs re-evaluation (MacQueen and Santa Barbara, 2008). Health professionals can make clear that war is not a political game, but a human disaster, and that violence can be perceived as a public health problem. This gives handles to tackle problems from a different point of view. By redefinition of war or violent conflict other problems may arise that are more important, and more easily solvable (Melf, 2012e).

2. **Superordinate goals** are visions, needs and norms that are highly valued by all conflicting parties. These goals are more important than the opposing positions and interests. By superordinate goals cooperation is enhanced, and the tension between warring groups declines. Superordinate goals are especially helpful when the goal can only be achieved if groups work together. It can be a basis for trust if both parties stick to the agreement. Superordinate goals do not automatically lead to sustainable peace. Besides, they enhance humane values, feelings and actions. When the superordinate goal involves health issues, the chances of success are bigger. These causes are seen as noble, and therefore people are more inclined to make it work (MacQueen and Santa Barbara, 2008). The immunization of young children has often served as a superordinate goal for cease-fires.

3. **Mediation and conflict transformation** is a third mechanism through which health can work. In mediation, an impartial third party is needed. An important tool for the mediator can be the psychology of severe conflict; what goes on in the minds of people, for example leaders, and what happens to groups themselves and their sense of identity and security after involvement in armed conflict. Mediators can report the needs, perceptions and proposals of parties to the other party. They may sometimes be in a position to provide important information unavailable to any of the other parties. The mediator should always be unbiased. When a mediator can no longer do this, it would be

better for the process if the mediator steps down. Health workers can be a mediator or facilitator because they will be required to carry out their health work within groups and organisations that are experiencing great stress, when conflicts inside the group will be common, and more often, more destructive than in everyday life. Second, they will typically be working in an environment overwhelmed with governmental and nongovernmental aid organisations of all kinds, and it is important that these groups work effectively together. Thirdly, health practitioners may have opportunities, both large and small, to promote peace between belligerents (MacQueen and Santa Barbara, 2008).

4. Dissent and non-cooperation describes the refusal of medical personnel to participate in unjust war campaigns or human rights violations. If health practitioners refuse to take part in civil defence exercises that were part of their government's preparation for nuclear war. In addition, by not participating attention is drawn to this topic. One should not resort to dissent and noncooperation lightly. If physicians or medical organisations are perceived as acting outside their area of expertise, or if they are seen as inappropriately "politicizing" health care, they may sacrifice long-term influence for short term gains. Protest and dissent raise awareness of the issue and of the need to address them. describes the refusal of medical personnel to participate in what are considered unjust war campaigns of their governments. It is not enough to point out the superordinate goals to the two (or more) involved parties. Often trust building is needed, This can be done best by parties who have expertise in mediation and conflict transformation (MacQueen and Santa Barbara, 2008).

5. Discovery and dissemination of knowledge is used to show what war does to a society. For example, mortality numbers that also indicate the cause of death can be used to identify root causes. During war it is not easy to find real and truthful knowledge. Propaganda and lies are spread, making it hard to obtain correct data. Evidence of some topics can help communities to reconcile after atrocities have been perpetrated. Because health professionals have better access to truthful information, they can obtain unique information about the impact of war and violence on health care. Since this information is becoming better available, all people have more information about a certain conflict. They themselves can take action, or pressure their government to take action. The disadvantage of much information is that people can become insensitive to atrocities. It is the job of the health sector to keep this information alive. In war zones medical professionals participating in organisations such as the ICRC and MSF dare to tread where few outsiders might venture. They assist with dissemination of knowledge, thereby putting a human face on suffering and may be considered the most credible, unbiased sources of information (MacQueen and Santa Barbara, 2008 and Melf, 2012e).

6. Rebuilding the fabric of society is needed after the violent situation has ended. Violent situations cause a depletion of the social capital, former warring groups may still hold a grudge, and financial situation is deteriorated. At that moment there is a large change that violence may reoccur. Old and new grievance must be tackled, and reconciliation between different parties is needed. Health infrastructure also needs to be rebuilt. By bringing groups together to rebuild health services, both problems can be tackled in the same time. Forming multi-ethnic teams that provide equally accessible health care for all, and take into account cultural needs of all involved, the social fabric can be improved (MacQueen and Santa Barbara, 2008 and Melf, 2012e).

7. Solidarity and support of people that are the most in need of help is standard in health practices. Even though in conflict a neutral, impartial position is most desirable,

in some cases health professional can step up to make the voices of a subordinated group heard. Especially in the case of injustice and human rights health workers can choose to express solidarity with the oppressed group. If they decide to take up this role, other mechanisms may no longer be available to access, like mediating in a conflict. Medical personnel can extend solidarity merely by their presence; that is, by risking their own lives to treat people in war zones. Such actions can give hope to the relatively powerless side of a conflict, strengthening their struggle for fundamental human rights (*ibid.*).

8. Social healing takes care of the mental problems that are involved in violent conflict. Anxiety, depression and posttraumatic stress disorder are examples of problems that need to be addressed. It is not always necessary to treat the symptoms individually. Due to limited resources, the stigma attached to mental health problems in many societies, and the greater importance for social support, social healing can be a good way to address these problems. Children learn about nonviolent conflict resolution, concepts of human rights, reconciliation and a vision of a peaceful society (*ibid.*).

9. Evocation and extension of altruism carries out that all humans are equal in a polarized situation. Because of their ethical codes, health professionals can not make a distinction between friend and enemy. By not making this distinction, the "us" and "them" categories in a conflict fade, and the "other" is no longer an anonymous persons. By re-humanizing "the enemy " he is brought back into moral consideration and regains human dignity (*ibid.*).

10. Limiting the destructiveness of war can be done by reducing the means of warfare, human rights violations and micro-level violence. This can be done by taking measures against certain types of weapons, food destruction, deliberate starvation and more. Measures taken by the IPPNW are examples of this mechanism. By drawing attention to the destructiveness of war, atrocities can be reduced or eradicated (*ibid.*).

All mechanisms of the Peace through Health model can be used in any stage of the conflict. This is shown in Figure 10. The model differentiates between Character, Knowledge and Activity. Character represents 'who we are', what we are perceived as being, including our talents and defects. The characteristics of health workers make them more noticed than other groups, giving their engagement in dissent and diplomacy more attention than other group may get. Knowledge is about the expertise of a group. For health professionals this may include individual and group mental health, cycles of violence and post-traumatic stress disorder. Because of this knowledge, health workers can engage in community healing and rehabilitation. Activity refers to the professional activity, 'what we do', how we work and what gives us access. The activities refer to generally recognized professional activities such as patient education, physical medical, surgical and psychological treatment, and the administration of immunization. Redefinition of the situation plays a role in each category.

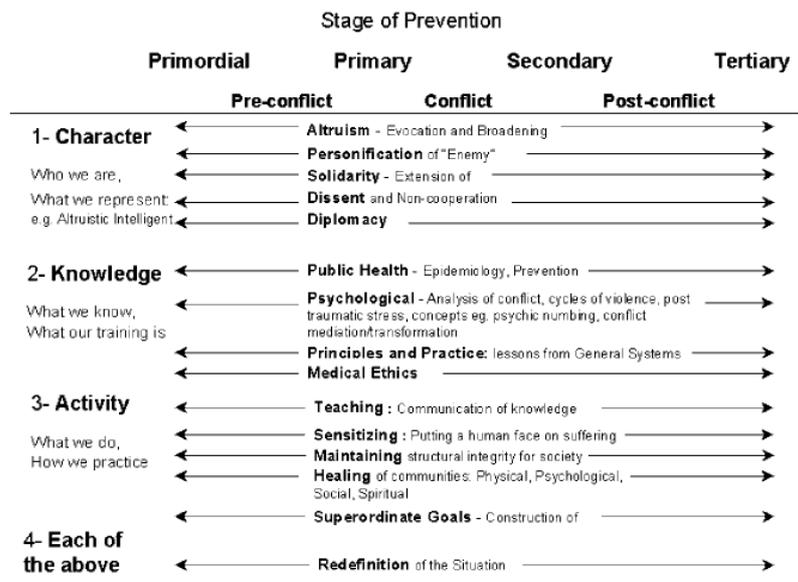


Figure 10: Working model of Peace through Health (Arya, 2004)

Limitations

Although there are many arguments in favour of a health approach to peace building, there are some limitations. The above model has been criticized for its Euro-centricity, and is said to be neglectful of other professionals and alternative practitioners. It also limits the discussion to the roles of outsiders in a conflict (Arya, 2004). Furthermore, this ideology mixes development and conflict resolution objectives with humanitarian objectives, which is likely to diminish the ethical basis of humanitarian interventions, that is derived from principles of neutrality and impartiality. Relief aid is seen as becoming a form of political action. This not only reduces the legitimacy and effectiveness of health and peace work (MacQueen, 2008a), but also puts pressure on relief actors to take sides and make decisions about preferred outcomes. Relief actions, then, may be looked upon as being partial to a particular side or warring party, and may be identified as a legitimate target for attack (Rodriguez-Garcia *et al.*, 2001).

A second problem for health professionals is the misperception of them engaging in peace work. People might perceive this as going beyond they area of expertise. Since the situations they work in are politically sensitive, and they are trying to change the situation, they are directly or indirectly challenging power structures. Patients and other people may expect from health workers that they only do classic health work. Engaging in peace work can mean addressing the underlying causes of the violence and ill health. This puts the workers at risk of being perceived as ideological, extreme or confrontational. People may argue that you activism distracts you from saving lives and improving health (Arya and Melf, 2012).

Health workers from outside the conflict may also be perceived as biased or neo-colonial. For example, when the health workers try to employ security forces for their safety. The health worker may perceive himself as generally appreciated by the people, and their opinion should therefore be more highly valued than others. They do not have to consult others. This attitude may be very harmful, as they are alienating the populations they are trying to help.

In conflict situations, the term peace and related terms, like human rights or conflict mediation, may be problematic when there are powerful groups that have different values or interests (Klaus Melf, personal communication). The even may see peace as a

threat. If they are powerful enough they can try to stop the work or take measures against local staff and the people that benefit from the health aid (*ibid.*). Though the international community has shown political will in implementing health initiatives for peace, there are often not enough resources support all in need. The success of an initiatives depends, in part, on the will of a sometimes illegitimate national government. In cases where there is willingness to allow the international community to work, political obstacles may prevent any real peace actions (Rodriguez-Garcia *et al.*, 2001).

Also, most programmes only start after violent conflict has broken out. According to Gutlove (1998) taking action in the prevention phase will be more cost effective because it avoids the human and material costs of violence. Therefore the skills to identify problems before violence occurs need to be enhanced. Most health workers are not trained in areas such as negotiation and diplomacy and often lack the necessary skills to engage effectively in peace work. Many opportunities to engage in peace activities may be lost in this way (Rodriguez-Garcia *et al.*, 2001). If they do attempt to do peace work and fail, they may betray the confidence that others placed in them. This also leads to losing trust and legitimacy (MacQueen, 2008a). They may need diplomatic, peace practitioners and lobbying skills to do good peace work. Furthermore they must balance their responsibilities to their patients, to the institution and to society. The deficits in attitude become clear when health professionals ignore their professional obligations for individual gain or 'the greater good'. Therefore, some health professional only want to do pure health work, to minimize the opposition of organs of power. They then only do implicit peace work (Arya and Melf, 2012). Also, in a conflict situation workers are under a lot of stress. When there is no institutional support and sympathetic understanding of other agencies in the field, attempted peace work is likely to fail. This again leads to losing trust and legitimacy (MacQueen, 2008a).

Health initiatives for peace-building have mainly been implemented in conflicts that have been internal, and relatively little evaluative research has been conducted. There is no standardized methodology for the evaluation of programmes. The effectiveness of such programmes is therefore hard to measure (Gutlove and Thompson, 2006 and Buhmann *et al.*, 2010). When results can not be measured, organisation have no concrete evidence of their success, which may lead to less funds from donors. This is currently the situation with the Health and Peace group of the McMaster University and the Health Bridges for Peace from the WHO (Madan, van Hall, personal communication). Gutlove and Thompson (2006) suggest to implement an evidence based approach in the HBP field. In this way the interventions used by health practitioners have evidence of effectiveness, efficiency and comparative advantage. This is not only beneficial for the health organizations, but also for administrators and patients. The evidence can be found at every level of the health sector, from delivery of service to establishing of international health policy.

It is very important that there is adequate information exchange among the parties involved in the health for peace programmes, but also between different programmes, conflict management organisations, humanitarian and development agencies, relevant NGOs and government and intergovernmental agencies. In this way organisation can learn from each other, and know what already has been done by other agencies in the conflict. Through a process of structured learning, programme assessment and evaluation in all programmes it should be possible to reach efficient and sustainable programmes.

Tools for programme development

When health organisations want to develop programmes for conflict transformation and peace-building, preparations need to be made to give the programme the best chance of success. This can be done by doing the least amount of harm and the most amount of good. This Do No Harm approach, developed by Mary B. Anderson started in 1994. It was initiated to help agencies working in areas of violent conflict learn how to provide humanitarian assistance in areas of violent conflict. Many organisations try to do as little harm as possible (Wallace, 2008).

Wallace points out that it is important to remember that when aid is brought into a context of conflict, it becomes part of that conflict. Even though aid agencies strive to remain neutral and try to stay out of the conflict, the impact of their aid is never neutral in the context. For programmes it is important to keep this in mind, and design their programmes to be and seen as impartial. The perspective of the aid agency may be different for local people and the agency itself. Furthermore it is important to remember that violence is not normal and that most people will not participating in the conflict.

The framework of Do No Harm has six steps. The first step is to analyse the conflict context. The conflict context refers to the circumstances under which people live and work in the conflict area. Their socio-economic status or gender, their languages, school systems, and religions (Engelstad, 2012). Conflicts are characterized by two sets of factors. Dividers/tensions and connectors/local capacities for peace. The identification of these factors is of importance, because the programmes will interact with these factors (Wallace, 2008). Without knowing the context, aid may unintentionally exacerbate the conflict.

The second step is to analyse the connectors. Connectors are the ways in which people remain tied together across sub-group lines. This can be trade, churches, education or health (Engelstad, 2012). Health services can be used as a connector or potential connector, since many people believe that all sides should have access to health care (Wallace, 2008). However, not all connectors are genuine. By analysing the conflict context in the first step, you learn which connectors can be used as connectors and which not (Engelstad, 2012).

The third step is to analyse the dividers. They are sources of tension that divide individuals, groups and communities. They can be deep-rooted, historical injustice, but can also be short-lived problems. Dividers are normally easy to spot in a conflict. Many groups exploit dividers for personal gain and want to upkeep the status quo. Not all dividers are necessarily bad. Just like conflict, dividers can represent different opinions within society (*ibid.*).

Step four is analysing the aid programme. It involves a thorough review of all aspects of the aid programme. Where and why aid is offered, who are the staff, who are the intended recipient of the aid, and who decides how the aid is delivered are questions that need to be answered when working with the Do No Harm tool.

Step five is analysing the aid program's impact on dividers and connectors. The assistance given has an impact on the dividers and connectors (Wallace, 2008). The important question is here; who gains and who loses from our aid. Do these groups overlap with the dividers we identified as (potentially) destructive (Engelstad, 2012)? The resources an agency bring into the conflict can also have an influence. The impact can be estimated by taking into account the local wages, profits and prices; through being distributed along lines of conflict; through substituting for local governments; through providing legitimacy for local actors or undermining this. Besides the resources

agencies (implicitly) bring along messages. The behaviour of the staff and their interaction with the local community, the way security is arranged, and hiring practices carry messages that can reinforce the mindsets of people in conflict. Assistance workers should be aware of the use of armed guards, the way they behave towards local people and the other staff members, the expression of powerlessness and through the way agencies portray the conflict in their publicity (Wallace, 2008).

Step six is choosing programming options. If the analysis is to be useful it must lead to action, even if the ideal implementation is not possible due to mandates or funding. When implementing Do No Harm, aid workers should always remember that their main goal is to help people. But when this is not the case, Wallace feels that a project should not be abandoned, because this could do even more damage. Instead, one should look for a way to undo this and turn it into positive impact (*ibid.*).

For the description of the tools that can be used to analyse this, it is most practical to distinguish three different stages. First, a conflict analysis of the situation that an organisation is entering needs to be made. This can be done in several ways, which will be discussed below. Secondly, when a programme is developed on paper it needs to be evaluated before it is implemented. The interaction between the programme and the conflict can be evaluated with the Peace Conflict Impact Assessment tool (PCIA) and the Health Conflict Cube. A third stage would be to see if the programme will have to envision a goal. This can be done by using the Health and Peace-building tool used to check whether if all problems that a programme wants to address are indeed addressed.

Conflict Analysis

Conflict analysis is very important and is becoming more difficult with new complex emergencies. Wars used to be within state, they are now more within states. Often civil groups are involved. This makes it harder to distinguish who is a combatant and who is not (Kaldor, 1998). Furthermore, conflicts are dynamic and power relations may shift during conflicts. Often they involve many actors at local, national and international levels. If an actor wants to intervene in a conflict they therefore need to understand the whole situation, otherwise they may do more harm than good (Anderson, 1999).

Before people can intervene in an armed conflict they must understand the actors and their relationships, the conflict dynamics and processes, the issues and drivers of the conflict and the linkages between the different levels and elements of the conflict.

A conflict analysis will not give a simple explanation or an immediate conflict resolution process. It does however give a detailed picture of the situation and help identify factors that can contribute to peace. This in turn helps to design peace interventions more carefully. (1) The context in which conflict analysis is used must be considered. For example, a verbal narrative method might be more appropriate than a written method. (2) The process of conflict analysis could hurt or offend certain parties, so it is important to take a cautious and open approach when conducting the analysis. (3) It is important to ensure that data collected on the conflict are unbiased and as complete as possible, so that a full analysis can be made. (4) Emotions play a significant role in conflict situations, so it is important to acknowledge them and bring them into the process of analysis, to ensure that both rational and emotional elements are analyzed. And (5) the analysts must maintain impartiality. This may be difficult if they are also involved in the conflict.

Conflict analysis can be done in several ways. A first method is to make a time line of the key events during a conflict. Key events do not have to be the same for all parties

involved. So when doing this type of conflict analysis to get a most complete overview of the conflict, all parties need to be asked what they think the key events are if this is possible (Lewer, 2012).

A second method is conflict mapping. Here you identify all parties involved (directly and indirectly), their role in the conflict and their relationships. Also the relative power a party has can be made clear in this way. After this, one decides that the key issues or problem are between the parties. Here again it is important to ask all parties, because they can identify different problem. Finally, it is important to situate your self or your own organization in the conflict, because organizations have relations and power themselves when entering a conflict situation. Figure 11 shows how a conflict map may look like.

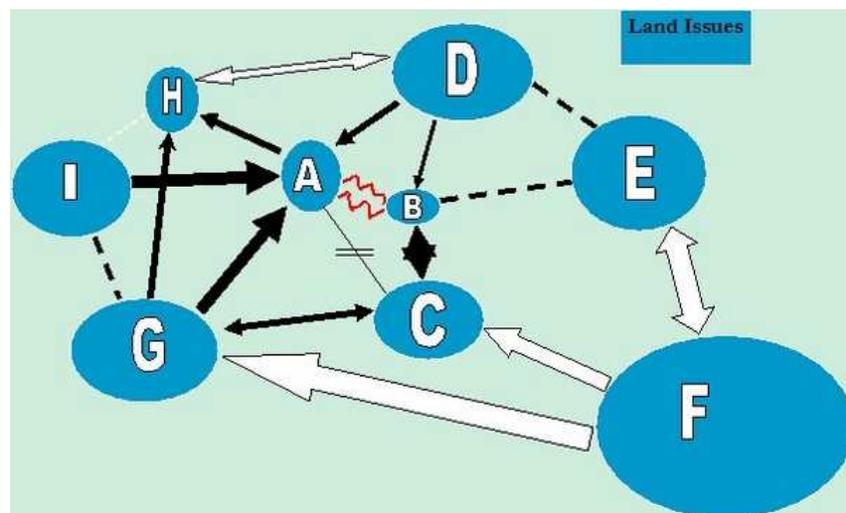


Figure 11: Conflict mapping (From Fisher *et al.*, 2000)

Analysing the impact of programmes in conflict settings

PCIA is used to anticipate, monitor, assess and manage the ways in which an intervention may affect the dynamics of peace or conflict in a region prone to violent conflict. The greatest challenge for PCIA is political, it is about who will control an initiative. This depends what questions will be asked, who are the stakeholders involved. PCIA is open for interpretation, as it is not a fixed method. It is based on observations, which can be used to apply simple ideas in fluid and complex settings, within bilateral and multilateral organizations, and in the field within community based organizations (Bush, 2008).

PCIA is made out of three parts. First a mapping of the stakeholders of the peace and conflict context is needed. Second, an assessment of the impact of the peace and conflict environments on an initiative needs to be done. And thirdly, the impact of an initiative on the structures and processes in a conflict is needed (*ibid.*).

Peace and conflict mapping helps to develop an understanding of the complex and fluid structures and processes of conflict in the environment surrounding an initiative. It also points to the many dimensions of peace and conflict dynamics. It looks at social, political, militarized, economic, historical, interpersonal, intergroup, and inter- and intra-organizational aspects. Of particular importance is the fact that this mapping opens up the possibility of understanding and anticipating when, why, and how nonviolent conflict turns violent. If this is not done, there is the risk that the planned intervention has component in it that will aggravate violent conflict. Mapping the stakeholders allows

to do more than just not exacerbating the conflict, but allows an organisation to actively contribute to peace.

The Risk and Opportunity Assessment, which is the impact of the environment on the initiative, or has affected in the past, is assessed in both positive and negative forms. The central reference in this case are the a priori objectives, not the peace and conflict impact. Things to consider when doing an ROA are the location, timing, different contexts and stakeholders and their influence on the initiative. Furthermore, these factors influence the effectiveness or efficiency of the initiative. Beforehand, it would be wise to think of ways to reduce or avoid these negative impacts. The positive impacts should be, if possible, be increased (*ibid.*).

Finally, the impact of an initiative on the peace and conflict situation can be assessed. The goals of an initiative is the enhance peace and reduce violence. This type of effect is hard to measure. Bush poses two questions that can be answered with yes when a project has a positive impact.

- Is the initiative increasing the capacities of the participants to (a) identify the real and potential peace and violence impacts of an intervention; and (b) formulate and implement their own solutions non-violently and effectively?
- Is the initiative build on a partnership that leads toward genuine ownership by local partners?

The Health-Conflict Cube combines the conflict analysis with health assessments. This can be used by health organisations to identify opportunities for addressing root causes of conflict through health. It assesses whether a programme exacerbates conflict or if it will build peace. The Health-Conflict Cube addresses the influence on the health outcome, the various stages in the conflict cycle and the actors involved. Figure 12 shows the Health-Conflict Cube.

The actor dimension draws attention to consider all the actors that are involved in the conflict. This ensures inclusiveness, participation, ownership and cooperation. If one of the key sectors are excluded, tensions may arise. The timeframe helps to identify in which stage the conflict is, so that action can be taken according to the phase. It helps planners to see which elements need to be considered at any one time. However, most often aspects of all four stages coexist in a situation. Health outcomes reflect core health indices and disease patterns within a context of human security, and the broader political social and economic framework (UNSW, 2004).

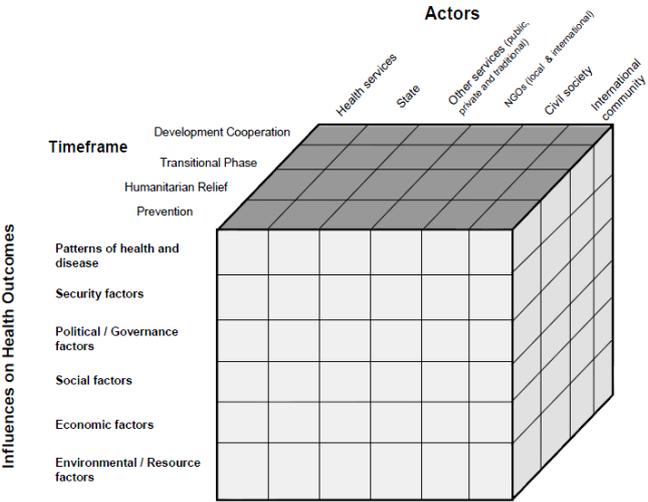


Figure 12: Health-Conflict Cube (From UNSW, 2004)

Evaluation of the programme before initiation

The Peace building Filter tries to combine the conflict impact assessment with a health assessment. This could give more informed understanding of how health initiatives could be designed and monitored to enhance their contributions to peace building in unstable settings. According to Bunde-Birouste and Zwi (2008) the ideal tool for combining health and conflict assessment should allow the assessment of existing health service and promotion activities in terms of their violence prevention and peace building potential and early guidance in new program design and development to ensure the incorporation of peace building elements.

The makers of the Peace building Filter draw attention to the use of language when using the Filter. This can be dependent on context. Although the aim of a project may be to build peace, when there is no violence yet, but the situation is fragile, it is better to speak of unity building or building harmony. An other example is social mobilization. The goal of social mobilization might be to connect to the community, but because of the history of a place people think it is about mobilizing threatening forces. When implementing a programme one should always be aware of this, so not to create confusion between organizations and local people (Zwi *et al.*, 2006)

The Peace building Filter is composed of five sections that reflect the core principle underlying a peace building approach to health. The five sections are: Cultural Sensitivity, Conflict Sensitivity; Social Justice; Social Cohesion; and Good Governance (Bunde-Birouste and Zwi, 2008).

Cultural Sensitivity takes into account the cultural diversity, and demonstrates awareness of cultural beliefs, customs, rituals and religious practices of groups and communities. The goal is to combine traditional and conventional interventions for health and community development. When it comes to using health as a way to transform violent conflict, values about both health and violence are to be considered. Imposing 'Western' concepts may not be appropriate in some contexts, as can be considered too imposing. Also not implementing changes at an appropriate rate is important, as they may be unrealistic or even damaging for the goal. But new ideas can give people a common language and provide a new common approach to enhance community well being (Zwi *et al.* 2006)

According to Zwi *et al.* when entering a conflict situation, one should completely understand the conflict they are working in. This includes the history, culture, resources, interest of groups and different disputes. In that way you can better understand the interaction between the context and your intervention, minimize the negative impacts and maximize the positive impacts (Conflict Sensitive Resource Pack, 2003). A way to make sure that the conflict is understood well, is to include local people in the project. They have lived in the region their whole lives, and therefore understand what it is like to live in these conditions (Zwi *et al.*, 2006). This is especially true for insecure areas, where trust in foreigners is very low (Sondorp, Van Elp, personal communication). So promoting trust between staff and community groups is supposed to be essential for the projects. By providing training to staff, a non-violent model for the resolution of local disputes and incorporating positive elements of local beliefs in relation to violence and conflict resolution, a project acts sensitive to the conflict (Zwi *et al.*, 2006).

Health programmes can promote social justice by respecting patients, responding to inequalities and discrimination, and providing transparent and fair grievance procedures. The project should, in the opinion of Zwi, strive to include all these aspects in their programme. In conflict affected situations, there is a considerable pressure to

promote social justice and human rights. This can not happen overnights, so projects must be careful to not introduce these concepts to quickly (*ibid.*).

Violent conflict disrupts social networks and destabilized the political, social and economic life of a community. Social cohesion reflects the quality of social relationships and the trust, mutual obligations and respect within communities. When working on social cohesion it is important to consider the ways in which people identify themselves. It is important to understand the ways in which a community is, and was, divided. To prevent further escalation, giving attention to this divisions may be helpful. Health care can be an opportunity to bring people together, providing an avenue to repair fractured social relations and build new ones. Since access to health can also become a point of dispute on its own, doing this can be a point of discussion. At the same time health can contribute to the psychological well-being of a community. Often building peace may depend on providing basic need within a community. Also, personal and social recovery reflects confidence about the ability of a community to manage its recovery (*ibid.*).

The last principle is good governance. Good governance in the health sector involves ensuring sound approaches to project design and implementation, coordination with other sectors, equitable distribution of services and information and effective mechanisms of accountability. This can be done by training people who can take on more responsible roles in the future. Also community capacity-building, sustainability and coordination, and transparency and accountability should all be implemented according to Zwi *et al.* (2006).

In short, Zwi *et al.* state that when developing an action plan, projects strengths and opportunities are identified, to develop further activities when needed. All aspects of the project should be clear before implementation, otherwise more detailed and refined information should be obtained. The five principles mentioned above are all equally important. They often overlap and are cross-referenced. The attention they need in the field greatly depends on the context an organization is working in.

The peacebuilding filter helps to describe and reflect on what the project is achieving, or not. It can help to transform concepts that are usually dealt with at a national level to concrete points on a local level. Case studies have shown that the Peace building Filter provided a particularly useful platform for dialogue. Its utility is in highlighting the challenges inherent in conflict-affected areas and in drawing attention to developing strategies to ensure that services and programs do no harm. The Peace building Filter assessment tool is provided in Annex C (Health and Peace building Filter).

The tools described in this chapter can be helpful when a programme is being developed. When used properly, they can make a positive contribution to the development of a sustainable programme. For some tools it is however questionable if they can be used by health professionals without training on these analysis. Conflict analysis and Impact Assessment can be quite complicated, especially when multiple conflicts build up one national conflict. The dynamics of a conflict add to the complexity of the conflict and they analysis that needs to be done. This is echoed by all tools described above. Also the fact that everything that one does or not does, affects the outcome of the programme and thereby the conflict. Therefore it is fair to say that developing a health work for peace work programme should not be taken lightly, and can best be developed in cooperation with conflict specialists.

Actions for health work for peace work

As we have seen in the paper, there exists a large range of actions that can be taken by health professionals in the field. In this chapter I will outline the different actions according to their prevention stage, and illustrate them with examples from the field. It is important to note that these examples can not be transferred one on one in the field. As made clear in this paper, the cultural and conflict contexts may be very different, and actions taken in one place may not be successful in an other. However, it is helpful to have a grasp of the problems that one might encounter in the field, and how to handle these problems. The actions and examples given here serve as inspiration for new programmes. Table 2 shows a list of possible actions that can be done. This list was created by Rodriguez-Garcia *et al.* (2001) after analysing some of their field work. This table also makes a distinction between conflict stages. This table will serve as a basis for this chapter. At the end of the chapter an analysis is made by D'Errico *et al.* on projects of HEAL Africa, also distinguishing primary, secondary and tertiary prevention.

Primary Prevention

Before conflict breaks out, doctors and other medical professionals can work on possible causes and means of conflict. The prevention of inhumane weapons is one of the most exercised actions. The International Physicians for the Prevention of Nuclear Weapons fight against nuclear weapons, because according to them the negative health consequences are so large that it is impossible to have an adequate medical response. Therefore the only thing that physicians can do is to prevent nuclear weapons (Maddocks, 2008). Similar, the International Campaign to Ban Landmines was founded with the help of many health organisations. They pointed out that landmines cause injury beyond repair, leading to disability for life. The reason to campaign against landmines was that often young children en civilians are victim of these landmines. By getting the support of governments and high placed persons, the actions of the ICBL eventually lead to the Ottawa Treaty, that discourages the use of landmines, even in the countries that did not sign and ratify the treaty (*ibid.*).

Secondary prevention

When violence has broken out, most of the actions taken by health programmes are focussed on taking care of the victims of this violence. As can be seen in Table 2, another action is health cooperation and coordination and technical cooperation to control epidemics. An example of this are the cease-fires that will be established to immunize children. This has been the case in 1985 in El Salvador, where the cease-fire was brokered by UNICEF, PAHO and the Roman Catholic Church. Other examples are Lebanon in 1987, Afghanistan from 1994 to 1997 and again in 2000-2001. Even though these cease-fires are only temporarily, they can in some circumstances lay a foundation for future cooperation, because warring parties see that they can trust each other to follow agreement (Arya, 2008).

An other way to do secondary prevention is to share information on the conflict and its health problems through medical journals. *The Lancet*, *British Medical Journal*, and the *Croatian Medical Journal* are examples of journals that published articles on this topic. In the Israelian-Palestinian conflict, health professionals from both sides work together to publish their own public health magazine, called *bridges*. It covers problems that affect both parties, and analyses the impact of conflict on the health and well-being of both sides. When producing a magazine in such a delicate situation, one should be sure

Table 2; HBP actions for each conflict stage (Rodriguez-Garcia *et al.*, 2001)

Stage of Conflict	HBP Actions
I. Stable Peace	<ul style="list-style-type: none"> - Promote: <ul style="list-style-type: none"> Health for all, equity Human development Human rights - Prevent inhumane weapons/warfare
II. Impending Crisis	<ul style="list-style-type: none"> - Predict areas/sources of future conflict - Develop decision-making and capacity- building tools - Health and human rights monitoring - Good offices function
III. Outbreak of Violence	<ul style="list-style-type: none"> - Conflict-resolution training - Problem -solving workshops - Targeted preventive health and economic aid - Health cooperation and coordination - Establishment of Health Humanitarian Assistance Programs (HAPs) - Special envoys, mediation, arbitration - Active regional, international, civil, NGO, media organizations
IV. Warfare	<ul style="list-style-type: none"> - Promote/ initiate confidence-building measures (CBM) - Provision of health and humanitarian services - Technical cooperation in health (control of epidemics), water, and sanitation - Coordination of health and humanitarian activities
	<ul style="list-style-type: none"> - Monitor health effects of sanctions and other diplomatic efforts - Joint-border surveillance of public health threats - Immunization cease-fires - Vaccine & medicine exchanges - Joint medical supply and vaccine procurements - MOH cooperation
V. Post-Crisis	<ul style="list-style-type: none"> - Facilitation of dialogue among health workers from both sides of the conflict - Cooperative health projects - Sustainable development - Decentralized Cooperation (DC) projects linking donor and recipient communities to work on common health problems and promote ideas of peace and peaceful coexistence - Peace-building awareness and capacity-building - Rehabilitation of health services and training of personnel - Development of programs to integrate military health personnel - Joint programs addressing issues of mental health/ disabilities - Integration of vulnerable groups - Establishment of Joint Implementation Committees (JICs) on Health for the reintegration of health systems - Design of common protocols for collaboration between groups - Joint design of training programs in the diagnosis and treatment of common diseases - Cooperation in social, economic, political, human, health development - Demobilization of troops

that content is provided equally by both sides. But it does provide an platform where health professionals can debate conflict related health problems, setting an example of cooperation for the rest of the community (Manenti, 2008).

Tertiary Prevention

In tertiary prevention dialogue is one of the main actions that can undertaken. Annex E provides more information on dialogue, and important conditions for the dialogue to be sustainable. Dialogue was also facilitated during the conflict in Yugoslavia. A regional network of medical professionals was established, including physicians from both sides of the conflict. They were called the Ex-Y Medical Network. Through carefully facilitated meetings, training sessions and the creation of a collaborative infrastructure, this network evolved to a forum for the exchange and collaborative use of medical resources and skills. Practitioners could learn from each other how to cope with specific post-war medical situations, to support each other as they deal with similar problems and to co-operatively develop creative solutions for the complex problems of restoring individual health, public health and community harmony. This will promote co-operation between individuals and organisations. The Ex-Y Medical Network tries to integrate community reconciliation and education into all aspects of post-conflict medical care delivery. In so doing, the medical professionals involved can promote a climate of mutual understanding, tolerance and respect for different cultures while being a model of intercultural co-operation (Gutlove, 1998).

Activities they engaged in include:

- To serve as a communication channel among participants
- To develop a resource library for medical support and information exchange
- To publish a bulletin for practical exchange of medical supplies and equipment among practitioners.
- To create training programmes in dialogue, mutual learning and community reconciliation
- To develop Health and Reconciliation teams.

(Gutlove, 1997:19)

HEAL Africa

HEAL Africa is an organisation that operates in Eastern Congo. It provides emergency health care, and in this way tries to reduce key factor that influence conflict and rehabilitation. They are enabling the communities to transform and become healthy and dynamic.

The situation in the DRC is very complex, and in terms of conflict stages there are no clear boundaries. Even though the official end of the war was in 2002, and a peace accord was signed between the government and the rebels, rebel groups such as the FRF and FDLR continue to fight the national army and the United National peacekeeping force. Because of this continued fighting, around 1.4 million people remain displace in the East, of which 750.000 were forced to leave their houses after 2008. Adding to this, the sexual violence as a weapon of war still goes on.

The conflict is very dynamic, and allegiances between individual leaders and rebel groups are fluid. Regional powers still have enough capacity to remain military groups, and because of the FDLR and LRA are inclined to use this power. On a local level issues over land, resources, and ethnic identity remain unresolved. This can lead to new outbursts of violence, because the pressure on land resources will increase in the coming years (D'Errico *et al.*, 2010). Therefore, strategies of conflict prevention also

need to be implemented, as conflict may take on new forms. This means that all three types of intervention are needed in this complex conflict.

HEAL Africa mainly works with vulnerable groups on community level. On a primary prevention level they reduce common risk factors like the lack of access to meaningful employment opportunities, gender inequality and interethnic conflicts. An example of the project is the training in agriculture. Beneficiaries no longer have to resort to a trade related to violent conflict. This empowers them, but also lessens the need for the continuation of the conflict to make a living. In an other region the focus lies on inter-ethnic conciliation. Vulnerable individuals are selected for inclusion in the HEAL initiatives or for treatment at a hospital. In this way a broad representation across HEALs community projects is ensured, combating the volatile inter-ethnic dynamics.

As a form of secondary prevention, HEAL is treating patients for a wide variety of medical conditions in its hospital, rural health centres and other emergencies areas. The medical help is provided to all civilians and military patients in need. Besides the direct consequences of violent conflict, HEAL also works to treat some of the indirect consequences. Examples are HIV and other infectious diseases, which thrive during conflict and migration. Due to insufficient funding, corruption and crime, the state hospitals are not always able to provide sufficient help. Because of this, people will turn to HEAL, because immediate help is available. This is not in favour of the long-term rehabilitation that HEAL wants. Therefore, state institutions need to be helped to achieve sustainable peace. Unfortunately step taken have done little to address the health needs of the population in the East. Even though state institutions are losing credibility, HEAL has been able to begin filling the health gap.

An other stand point of HEAL is to address the gender-based violence. It create the Safe Motherhood programme to oversee the creation of maternity insurance groups. These groups are meant to provide financial support during pregnancy, delivery and neo-natal care. This programme has had three positive outcomes. First, the programme protects mother who would otherwise been neglected, as many of the children are conceived through rape. Because of stigma, these mother would otherwise be neglected. Second, the programme supports the local health system by increasing the demand for doctors and nurses has gone up. The funds of the programme are spend in local hospital, enabling them to be more independent. Lastly, the programme addressed some of the gender imbalances. By giving women both knowledge of maternity and family planning, and by giving them access to money, they have gained more power in the eyes of men (D'Errico *et al.*, 2010).

HEAL's goals for the tertiary prevention largely overlap with the goals of primary prevention. They provide psychological and social support for rape survivors by training appointed women in counselling, providing husband-wife mediation and conducting community education classes on reintegration. The people that are being trained can later pass this on to others. HEAL also provides micro-credits for women. In this way a livelihood is provided, but also provide financial security and rebalances gender relations. HEAL found that this empowers participants to feel more physically secure and personally confident. This in turn may lead to better protection from rebel groups and sexual violence. Owning livestock was given a degree of protection, as rebels limited their violence in turn for livestock.

Reconstruction of the social tissue was part of a programme, where committees were elected. The members of the committee could be invited to mediate in a dispute. When intervening in such conflicts a form of community based conciliation could be accessed.

As the committees were composed of different ethnicities, religions and genders allowed them to participate in a wide range of confrontations. Lastly, HEAL provides training to lawyers, judges and victims to take cases to court if appropriate. By giving this training and other legal assistance, 234 cases were brought to court in 2008. In this way punitive justice and respect for basic human right is brought under attention.

The main activity of HEAL remains to be giving emergency health care, maternity issues and treating other form of 'war trauma'. Already on their own, these activities are worthwhile, and should stay the primary function of health workers in conflict areas. This basic activity for HEAL has given them the opportunity to arrange other forms of conflict transformation and peacebuilding. Their perceived neutrality gained by this activity has been the reason HEAL was able to engage in tertiary prevention. HEAL has increased this tertiary prevention over several years, and in this way allowed them to build up the role of advocating on behalf of sexual violence. This could later be expanded to activities of non-discrimination between ethnicities and tribes. In this way HEAL can operate without enflaming ethnic tensions and potentially serving to build trust.

The position that HEAL has in the field and connecting to local people helps them reach the most vulnerable groups. Because their field targets different types of communities, they can identify which people and place need the most attention, and the ones that are most vulnerable for the underlying risks for conflict. Their emphasis on the humanitarian aid gives HEAL legitimacy amongst the different communities, and gives them the opportunity to do more than just secondary treatment. Health actors can, when trust is established, do more for health in the holistic sense. HEAL has, through several of their projects, been able to take on post-conflict rehabilitation, be it in limited ways. When the state is not able to provide this, for example because of the legacy of the conflict, this may be a task for health professionals. A final aspect that helps HEAL gain trust is their permanence in the field. By being there always, people not only gain trust in the organisation, but also enables HEAL to bring people together to work on common goals. The secondary prevention activities, which are the main focus of HEAL, are thus the building blocks that open up opportunities to work more on the peace-building aspect.

Of the limitations described by the McMaster group is that adding peace building activities to health workers may stress the work load and compromise the quality of health care given, HEAL did not find this effect. The reason they give is that the teams of HEAL are multidisciplinary and always include health professionals and because they put the prioritise secondary health care over all other aid forms. This does have the effect that in times of emergencies doctors and nurses will work in the hospitals, other programmes will be delayed, cancelled or understaffed.

An other problem that may occur is that while HEAL programmes are opening up opportunities for interventions, they can not always address these problems. Because of this it can feel like one step forwards is accompanied by several step backwards. New problems are found because of the progress there is made in the programme. Doing evaluative studies will also be limited because of this.

A third limitation that HEAL has looked at is the danger of becoming politicized. So far, no findings have found that people think HEAL is politicized. The authors think this is because the staff of HEAL are individuals from a variety of the region's native ethnic groups. Because ethnicity in the East of the DRC is easy recognizable by name or looks,

this composition may have discouraged the perception of their activities as politically motivated.

The table presented in this chapter gives a good overview of possible action that a health organisation can take in different conflict stages. The examples given provide an insight in which form these actions can be implemented. From these example once again becomes clear that there are a lot of activities in which a health organisation can engage in, and that activities done in one stage can have an effect on other stages of conflict as well. But before programmes and actions can be executed in the field, it is and will always stay important to evaluate if the action is appropriate for the situation, and how well the programme can be adapted if the situation changes.

Conclusion

The aim of this paper was to investigate the ways in which health professional can contribute to peace work. As we have seen, there is a distinction in the type of peace work that they do, either implicit peace work or explicit peace work. The difference is that by giving health care, in almost all cases a contribution to peace work is made. Because peace and health have so many goals in common, this is almost inevitable. This is called implicit peace work. When doing explicit peace work, doing peace work is not a side effects, but a predetermined goals of the programme.

Because conflict goes through different stages, peace work by health professionals can also be done in different stages. Even though the boundaries of the different stages are not clear, and a conflict can be in two or more stages at the same, it is helpful to categorize the actions that can be taken in each stage. A distinction is made between primordial, primary, secondary and tertiary prevention. Tertiary and primary prevention action may be the same, because after a cycle of violence reconciliation actions need to address problems that can become root causes for a next cycle of violence.

There are ten mechanisms through which health professionals can work. These are redefinition of the situation; superordinate goals; mediation and conflict transformation; dissent and non-cooperation; discovery and dissemination of knowledge; rebuilding the fabric of society; solidarity and support; social healing; evocation and extension of altruism and; limiting the destructiveness of war. However, using one type of mechanism may exclude the use of an other type. Again, which type of mechanism to use is depending on the stage of the conflict, history of the conflict, the culture in which the conflict takes place and the position of the health worker or organisation in the conflict. Several characteristic of NGOs and health professionals especially make that they may be in an excellent situation to make a contribution to the conflict. NGOs often work on a local level, and therefore are better aware of the problems that exist in society. Because the staff of local NGOs are local as well, they better understand the situation. They can foresee problems that an outsider would not, and are trusted by the population since they are one of them. They will stay after the most intense violence is over and therefore want to make the peace to be sustainable. NGOs are often funded by international donor, and are thus acquainted with local and (inter)national situation. They can use this knowledge to see the bigger picture, and adjust programmes if necessary. Health professionals have many skills that help contribute to peace building. They are trained in identifying threats, have access to people and communities in need, but also to reliable information. They are associated with altruism, solidarity and credibility, making it easier to gain peoples trust.

Several tools can be used to see whether a health programme can contribute to peace building. Before entering in peace work, a conflict analysis should be done. This provide indispensable information about stakeholders, relationships and root causes. The role of the organisation in the conflict should not be forgotten. The Do No Harm tool can be used to minimize or avoid any negative consequences from the action taken by the organization. The Peace-building Filter can be used to analyse what specific problems are address, and if there are any problems that remain underexposed. This should be done before the programme is implement, otherwise more harm than good may be done. Finally, dialogue can be used to solve problems within society. There are several condition to take into account when using dialogue, like non-violent communication and active listening. This will provide the most constructive basis for peace-building.

Although health work may help conflict situations, there remain limitations to this approach. As health organisations try to be perceived as impartial and neutral, that may be hard when they become involved in peace work. Health intervention may be seen as political, winning the hearts and minds of the people. Since changing the situation in a conflict automatically means changing the power structures, their work is very political sensitive. A second problem is the misperception of health professionals engaging in peace work. The profession is to treat health problems and not peace problems, and health professionals should stick to that. By addressing underlying causes of a conflict, health workers may be seen as ideological, extreme or confrontational. People may argue that your activism distracts you from saving lives and improving health. Also, health professionals may lack certain skills, such as negotiation and diplomacy skills. The main shortcoming of the health-peace is the lack of evaluative standards. Without this, organisations cannot provide concrete evidence that their programme is making a contribution to peace. Results gained may be side effects from other actions. When their effectiveness cannot be proved, organisation may lose their funding.

Taken all information into account, in my opinion health organisation should still be very cautious to incorporate explicit peace building activities in their work. Even though they may have legitimate reasons to interfere, like addressing root causes, and may have a good position in society, it is not their area of expertise. The negative effects of a failed peace building activity can be very harmful for health organisations in the future. This may stop their ability to do health work at all. But the pure health work they are doing is already helping a lot, and this help is so important for victims of violence. Since there are organisations that are specialized in doing peace work and conflict transformation, my preference would be to let them do the peace work, so the health care is not jeopardized. There are however opportunities in which health care organisations are the only ones that can make a contribution to the peace, for example when it is the only organisation that all parties trust. But then still an organisation should think twice before saying yes, and establish clear conditions for their participation.

As far as implicit peace building is concerned, I think that health and peace are indeed interconnected, and that health work can (but not necessarily does) have an effect on peace work, depending on the work and situation. Addressing health issues in cooperation with different parties may be the closest that health organisation implicitly can contribute to creating sustainable peace, because parties are brought together and discuss a common problem. The problem discussion should in that case really be about health, so the facilitating health organisation has no hidden agenda.

In the end, it is up to the health organisation to decide what they think has the most positive impact on a society in need. There may be specific situations that justify taking the risks involved. But every engagement in the field should be considered extensively before made.

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Annex A

Principles of Conflict Transformation as formulated by TransConflict (2012)

1. Conflict should not be regarded as an isolated event that can be resolved or managed, but as an integral part of society's on-going evolution and development;
2. Conflict should not be understood solely as an inherently negative and destructive occurrence, but rather as a potentially positive and productive force for change if harnessed constructively;
3. Conflict transformation goes beyond merely seeking to contain and manage conflict, instead seeking to transform the root causes themselves – or the perceptions of the root causes – of a particular conflict;
4. Conflict transformation is a long-term, gradual and complex process, requiring sustained engagement and interaction;
5. Conflict transformation is not just an approach and set of techniques, but a way of thinking about and understanding conflict itself;
6. Conflict transformation is particularly suited for intractable conflicts, where deep-rooted issues fuel protracted violence;
7. Conflict transformation adjusts to the ever changing nature of a conflict, particularly during pre- and post-violence phases and at any stage of the escalation cycle;
8. Conflict transformation is always a non-violent process, which is fundamentally opposed to violent expressions of conflict;
9. Conflict transformation addresses a range of dimensions – the micro-, meso- and macro-levels; local and global;
10. Conflict transformation is concerned with five specific types of transformation, focusing upon the structural, behavioural and attitudinal aspects of conflict:
 - a. Actors – modifying actors' goals and their approach to pursuing these goals, including by strengthening understanding as to the causes and consequences of their respective actions;
 - b. Contexts – challenging the meaning and perceptions of conflict itself, particularly the respective attitudes and understandings of specific actors towards one another;
 - c. Issues – redefining the issues that are central to the prevailing conflict, and reformulating the position of key actors on those very issues;
 - d. Rules – changing the norms and rules governing decision-making at all levels in order to ensure that conflicts are dealt with constructively through institutional channels;
 - e. Structures – adjusting the prevailing structure of relationships, power distributions and socio-economic conditions that are embedded in and inform the conflict, thereby affecting the very fabric of interaction between previously incompatible actors, issues and goals.
11. For conflict transformation to occur, tensions between parties to the conflict must be overcome – first, by ensuring all actors recognize that their respective interests are not served by resorting to violence; and second, by seeking consensus on what should be transformed and how;
12. Conflict transformation stresses the human dimension by reminding parties of the compatible nature of their needs, instead of emphasizing their opposing

- interests, and by rejecting unilateral decisions and action, particularly those representing a victory for one of the parties to the conflict;
13. Conflict transformation does not resort to a predetermined set of approaches and actions, but respects and adapts to the particularities of a given setting;
 14. Conflict transformation looks beyond visible issues and is characterized by creative problem-solving, incorporating the perspectives a broad array of actors, including those typically marginalized from such considerations;
 15. Conflict transformation invariably involves a third, impartial party, in order to help actors alter their cognitive and emotional views on the 'Other', thereby helping to break down divisions between 'Us' and 'Them';
 16. Conflict transformation represents an ambitious and demanding task, which is better equipped to contend with the asymmetric, complex and protracted nature of contemporary conflicts than prevailing techniques and approaches.

Annex B

Activity Matrix from Fischer 2004, adapted from Foreman, Patrick and Salomons, 2000

Sector/ Activities	Point of Onset of Activities			
	Crisis	Post-crisis (no settlement)	Post-settlement	Longer Term Reconstruction
1. Repatriation and Resettlement				
1.1 Transport assistance for return		■		
1.2 Shelter and reconstruction materials		■		
1.3 Community reconciliation and psychosocial counseling		■		
1.4 Family tracing and reunification			■	
1.5 Property claims arbitration				
2. Public Safety				
2.1 Mine clearance and awareness		■	■	
2.2 Demobilization: reintegration and alternate employment projects			■	
2.3 Small arms control/buy-backs			■	
2.4 Restructuring/retraining security forces (police, armed forces, paramilitary, intelligence)	■	■		
2.5 Human rights monitoring				
2.6 Conflict prevention and resolution training	■			
3. Infrastructure Recovery				
3.1 Water and sanitation		■		
3.2 Transportation		■	■	
3.3 Power generation		■		
3.4 Housing		■		
3.5 Solid waste disposal				
3.6 Telecommunications	■			
4. Food Security and Agricultural Rehabilitation				
4.1 Targeted food distribution		■	■	
4.2 Seeds and tools distribution		■		
4.3 Livestock/veterinary projects				
4.4 Land use planning	■	■		
4.5 Land tenure issues			■	
5. Health, Education and Social Welfare Needs	■			
5.1 Essential health services		■		
5.2 Medical facilities rehabilitation: reconstruction/material assistance			■	
5.3 Public health sector capacity building and priority programming			■	
5.4 Educational facilities rehabilitation (and reintegration)		■		
5.5 Employment and skills training, incl. food-for-work rehab. projects			■	
5.6 Microcredit			■	
5.7 Microenterprise development			■	
5.8 Essential production			■	
6. Governance and Civil Society				
6.1 Public administration and recurrent cost			■	■
6.2 Civil service rehabilitation/reform			■	
6.3 Non-governmental organizations capacity building			■	
6.4 Electoral process and institutions				■
6.5 Voter education and participation				■
6.6 Elections monitoring				■
6.7 Free media training and legal advocacy			■	■
6.8 Judicial reform				■
6.9 Civilian oversight and monitoring of security forces			■	■
7. Macroeconomic Stabilization				
7.1 National currency stabilization				
7.2 Financial institutions restoration				
7.3 Debt relief/arrears clearance				

Source: Foreman, Patrick and Salomons (2000, p64/65)

Annex C

Health and Peacebuilding Filter from Zwi *et al.*, 2006

Health and Peacebuilding Filter									
SA = Strongly Agree; A = Agree; B = Both Agree & Disagree; D = Disagree; SD = Strongly Disagree; DK = Don't Know; NA = Not Applicable									
Principle	Indicator	Responses							Comments
Cultural Sensitivity	1. Cultural sensitivity								
	1.1 The project promotes sensitivity to local cultures and to their differing approaches to health, wellbeing, illness, and death.	SA	A	B	D	SD	DK	NA	
	1.2 The project recognises the specific contributions to health that can be made by local and traditional practices and those of conventional medical and primary health care.	SA	A	B	D	SD	DK	NA	
	1.3 The project demonstrates knowledge and respect of cultural rituals and practices through how it organises its programs and activities.	SA	A	B	D	SD	DK	NA	
Conflict Sensitivity	2. Conflict awareness & responsiveness								
	2.1 The project provides training to assist staff to deal with issues related to the armed conflict.	SA	A	B	D	SD	DK	NA	
	2.2 The project is sensitive to the nature of previous and ongoing conflict as demonstrated in its own approaches to engaging with the community.	SA	A	B	D	SD	DK	NA	
	2.3 The project models non-violent resolution of local disputes.	SA	A	B	D	SD	DK	NA	
	2.4 The project incorporates positive elements of local cultural beliefs in relation to violence and conflict resolution.	SA	A	B	D	SD	DK	NA	
	3. Trust								
	3.1 The project is sensitive to health-related issues that have contributed to mistrust in this community.	SA	A	B	D	SD	DK	NA	
3.2 The project has processes in place which will help it gain the trust of different communities, NGOs and government agencies with which it works.	SA	A	B	D	SD	DK	NA		
3.3 The project promotes the building of trust among staff, individuals and community groups.	SA	A	B	D	SD	DK	NA		

Social Justice	4. Equity and non-discrimination							
	4.1 The project seeks to promote tolerance and reduce discrimination.	SA	A	B	D	SD	DK	NA
	4.2 The project contributes to addressing inequalities within the community.	SA	A	B	D	SD	DK	NA
	4.3 The project makes effective provisions for inclusion of specific vulnerable groups.	SA	A	B	D	SD	DK	NA
	4.4 The project ensures that access is not limited by economic or other barriers.	SA	A	B	D	SD	DK	NA
	5. Gender							
	5.1 The project demonstrates sensitivity to gender issues in its design and implementation.	SA	A	B	D	SD	DK	NA
	5.2 The project conducts gender sensitivity training with its staff.	SA	A	B	D	SD	DK	NA
Social Cohesion	6. Community cohesion							
	6.1 The project takes into account changes in community structures which have arisen during, or as a result of, the armed conflict.	SA	A	B	D	SD	DK	NA
	6.2 The project contributes to bridging the divide between different groups in the community.	SA	A	B	D	SD	DK	NA
	6.3 The project supports and reinforces community reconciliation efforts.	SA	A	B	D	SD	DK	NA
	7. Psychosocial well-being							
	7.1 The project is sensitive to key factors which affect the community's psychosocial health and well-being.	SA	A	B	D	SD	DK	NA
	7.2 The project is supportive of social recovery for individuals, families and communities.	SA	A	B	D	SD	DK	NA

Good Governance	8. Community capacity-building and empowerment							
	8.1 The project has established mechanisms for genuine community participation in all phases, including monitoring and evaluation.	SA	A	B	D	SD	DK	NA
	8.2 There is local ownership of the project.	SA	A	B	D	SD	DK	NA
	8.3 The project provides for the development of leadership and advocacy skills among staff and community members.	SA	A	B	D	SD	DK	NA
	9. Sustainability and coordination							
	9.1 The project includes mechanisms to coordinate with other groups in the community.	SA	A	B	D	SD	DK	NA
	9.2 The project participates actively in building networks with local groups, local and international NGOs, and donor organisations.	SA	A	B	D	SD	DK	NA
	9.3 Plans for long-term sustainability of project activities have been developed.	SA	A	B	D	SD	DK	NA
	10. Transparency and accountability							
	10.1 The project encourages transparency and accountability of decision-making to local communities.	SA	A	B	D	SD	DK	NA
10.2 The project strengthens the ability of community members to elicit greater accountability from central health service providers and government departments.	SA	A	B	D	SD	DK	NA	
Other Issues	Note here any other important health, peace and conflict issues associated with this project:							

After completing the full Filter, you can begin to create an Action Plan for the project here. Please note that the information supplied in the earlier parts of the Filter should be used as a contribution to the Action Plan, not as a fixed formula for developing one.

When responding, think about the following questions:

- What must the project do better? How can this be done? Who will do it?
- What is the project doing really well? How can this be extended?
- By when should these things be done?

Health and Peacebuilding Action Plan		
Principle	Indicator	Project Responses
Cultural Sensitivity	1. Cultural sensitivity	
Conflict Sensitivity	2. Conflict awareness & responsiveness	
	3. Trust	
Social Justice	4. Equity & non-discrimination	
	5. Gender	

Principle	Indicator	Project Responses
Social Cohesion	6. Community cohesion	
	7. Psychosocial well-being	
Good Governance	8. Community capacity-building & empowerment	
	9. Sustainability & coordination	
	10. Transparency & accountability	
Other		

Annex D

Guidelines for health work doing peace work

Health and Peace-building Filter Guidelines (Zwi et al., 2006)

Promoting Cultural Sensitivity

- Meet regularly with and/or access people associated with the different cultural, religious and language groups in the area
- Ensure the project demonstrates respect for local languages and facilitates their use in aspects of service delivery, information and education
- Recognise that different cultures have their own way of dealing with health problems: respect the choices they make in how to address an issue, and engage with them to find an appropriate solution
- Demonstrate awareness of the rituals and traditions of local cultures and religions
- Train staff to be sensitive to local cultures, religion and languages

Simple ways to promote conflict awareness & responsiveness:

- Recognise that the community has the capacity to resolve their own disputes: empower them to do so
- Recognise that conflict may produce winners and losers; this means that some people have an interest in seeing the conflict continue
- Be aware that health-related interventions, and other humanitarian inputs, may provide valuable resources over which disputes might arise
- Identify all parties to the conflict or dispute and the issues over which they are most concerned; establish communication with the key players
- Encourage negotiations and compromise where appropriate
- Develop effective mechanisms to communicate and respond to disputes, grievances, conflicts or other differences of opinion concerning the project
- Respond to grievances in a timely manner and state clearly the basis on which decisions are being made

Simple ways to promote trust:

- Take time to talk to people – and especially make sure you listen
- Meet face to face
- Be honest and realistic about what you can and cannot do; be open about the limitations of the project
- Communicate regularly with stakeholders; keep them informed; let people know about project changes early so that these are not a surprise
- Treat people fairly
- Be consistent, reliable and predictable
- Respect people's privacy and confidentiality; recognise that if people have told you things in confidence that these are not for sharing

Simple ways to promote equity & non-discrimination:

- Identify and respond to inequalities which are unfair and unjust
- Collect data, for example by age, sex and people coming from different areas, to determine whether all people have equal access to services

- Make special efforts to direct your project to those in greatest need; these might be people most remote, most poor, or most ill – make sure you know about them and that your project is assisting them
- Make sure you know something about the human rights concerns in the area - talk to local human rights NGOs if they are present
- Agree with staff on appropriate action to be taken when human rights abuse is suspected or revealed.

Simple ways to promote gender sensitivity:

- Include women and children in all aspects of the project
- Promote gender awareness training for all staff members
- Be aware that projects may have unintended consequences: Some people, including women, may become worse off
- Establish working relationships with local women's groups, NGOs, and others who are engaged with issues of women, girls and disenfranchised men and boys
- Find ways of engaging men and young boys: stimulate discussion about roles and responsibilities

Simple ways to promote community cohesion:

- Remember that conflict is not just about social breakdown, it is also about social transformation and recovery
- Work to build links both within communities and between communities
- Provide opportunities for people to work together to address common needs
- Facilitate opportunities for employment and ensuring that the basic needs of all are met
- Develop mechanisms to facilitate communication in the community
- Work with women, children, disabled people, and the elderly
- Work together to unite families and communities that have been separated or affected by the conflict

Simple ways to promote psychosocial well-being:

- Note that people are not just victims and casualties of adversity – they have resilience, they cope, they adapt, and they take action to shape their futures
- Assist people to meet their basic needs
- Promote creative activities for children
- Create space for mutual learning through open dialogue
- Draw on local cultural and other resources to help individuals and the community to deal with difficult situations
- Do not over-emphasise professionally-led psychosocial interventions as community-led mutual support and assistance is often far more valuable

Simple ways to promote community capacity building and empowerment:

- Enable community members to make input to the strategies, direction, and design of projects
- Consult community members on major changes to the aims, objectives and processes of the project
- Ensure the project employs people from all communities in the area
- Contribute to building the resource base of the community

- Offer training workshops to build community capacity
- Foster the development of leadership skills for all, but especially for young people and for women

Simple ways to promote sustainability & coordination:

- Think early about the exit strategy for any donor funded or NGO projects; think about long-term sustainability and transfer of ownership right from the beginning
- Demonstrate a commitment to collaborating with others by meeting regularly with local groups, NGOs (local and international), and donor organisations working in the area to improve coordination and share information
- Share your resources with other organisations that may not have access to things they need
- Work together with other organisations and support local and national government to deliver services effectively

Simple ways to promote transparency & accountability:

- Establish a mechanism to deal with community complaints and ensure people know who they can talk to about the project; respond to community enquiries and needs in a thorough and timely manner
- Let people know who funds the project and where the money goes
- Keep community members informed about project activities, how decisions get made, and what is being discussed at all levels
- Base decision-making on whatever guidelines and documentation have already been agreed in the country, district or program
- Base action on agreed priorities to avoid suspicion concerning collusion or corruption

WHO Guidelines (WHO, 2012)

- Elaborate strategic planning based on a broad political understanding of the conflict, (addressing its root causes), a wide public health approach, a comprehensive perspective of victims and political actors, and a full consideration of Human Rights issues.
- Prevent side effects of humanitarian programs, which can foster dependency of beneficiaries on external aid.
- Involve local capacities for change.
- Create partnerships, with a strong presence of local civil society organizations.
- Develop Health as a Bridge for Peace training for lead staff in war-prone regions.
- Affirm the importance of field experience (bottom-up, instead of top-down approach) in the definitions, (re) adjustment and evaluation of HBP strategies.
- Promote Health Policy and Strategy inspired by "Health for All" with a commitment to equity, solidarity and social justice contributing to create conditions for stability, hope and peace.

Annex E

Aspects for sustainable dialogue (Gutlove, 2000 and Melf, 2012)

Dialogue

Dialogue can be helpful to bring parties together and help them understand each others problems. Gutlove (2000) states that parties are most willing to come together for shared actions when they share professional expertise, interests and needs, particularly in areas of social welfare, humanitarian aid and development. In this way, dialogue can be used to develop an integrated-action program. Even though humanitarian assistance and conflict management projects are temporary, they may offer fruitful opportunities for dialogue, followed by action. The shared, cooperative actions must be identified, regarding their appropriateness and feasibility of implementation. There are situations in which parties are not ready, logistically or psychologically, to cooperate. That should be respected by the health organisations, and not for the dialogue process on them.

To have constructive communication, all parties should feel safe, both psychologically and physically. This is the only way to create honest and effective communication. In violent conflict having a facilitator is of importance, to guide the dialogue. Often, when engaging in dialogue with people who do not share your opinion, people are inclined to convince or argue with the other. The goal of dialogue is to listen, learn and create new options. The dialogue should develop programmes for collaborative activities among parties where tense intergroup relations exist. The dialogue should be more structured than a conversation, but should not resemble a negotiation. It should be designed in such a way that it is integrating training and action with specific goals, and community ideas can spin off into concrete activities and reducing tensions of the relationship.

This is consistent with the Contact Theory. Contact Theory make the assumption that a conflict is ethnic, religious, racial, or driven by some other form of identity. The goals of Contact Theory is Identity conflict is about perceptions of the "other", perceptions are based on experience, prejudice remain because disconfirming events are few, contact between groups will disconfirm prejudice, better intergroup relationships will result. There are however conditions for Contact Theory to work. Allport has developed four conditions which are needed to make Contact work. First, equal group status within the situation is necessary. Second, there should be common goals. Third intergroup cooperation should be present, as well as authority support. There are however some limitations to this theory. In Allport's experiment people had to sign up for the program. This could mean that only people open to dialogue will participate, and that it is not necessarily the contact that enhances the situation. The people who are participating could have collaborated in other circumstances as well. The theory does also not explain how processes of change should look like. And finally, there are few studies that show contact to have generalizable affects.

Up till some level, the dialogue-action process does take into account. They take people with the same professional background (health workers). Those people are often more willing to talk to "the other".

There are five stage for the integrated action dialogue. The first step is to decide to engage in dialogue. Who should be involved, and what a good place is to meet needs to be determined. What should be the nature of the dialogue, who should facilitate the dialogue? Further, ground rules for the dialogue should be developed. Ground rules

could be to allow each participant the same time to make his point, everyone should listen respectfully to each other and to not verbally attack another person. The second stage is map out the public health situation. Identification of the problem that affect the situation, including relationships between the parties, and the causes of the problem is needed. Things that need to be done to change these problems, how that should be done and by who should be discussed constructively.

The third stage is about problem solving. One problem at a time should be probed in depth, to understand the dynamics of the problem and the potential for change. Who are the main groups involved in the problem, how is it affecting a group's interests, what does each group need from the other group and what changes are needed? Stage four is to build cooperative Health Bridge for Peace scenarios. Here the obstacles that stand in the way for change are identified. With the groups, is should be discussed how to overcome these obstacles and a list of steps can be created with the groups. Who can do what, and in what order should it be done? The last stage it to implement the projects designed in the dialogue. Important is to keep the projects practical to put the scenarios into action. Make clear agreements on what, how, who and when for each project.

Non-violent communication

Non-violent communication is an important tool for health and peace workers. It is also called empathic communication or compassionate communication. Through communication respect, trust and understanding can be expressed, but also the neglect of these issues. Different forms of violent communication are judgement, moralizing, denial of own responsibility, blaming, or demand. But also non-verbal communication can be hurtful. It is therefore important to be aware of your position and the way you bring your message.

Non-violent communication works under five basic assumptions. The first one is that all human being have similar basic needs. These include not only physical needs, like food, water and warmth, but also mental, social and spiritual needs. Often, the physical needs are seen as more important, as dissatisfaction of these needs may lead to ill health and even death. However, if people want to live their lives in a fulfilling way, all the basic needs have to be met. Non-violent communication can help satisfy these needs.

The second basic assumption is that everything we do has the goal of fulfilling some of the needs. The ways or strategies to accomplish this are very divers and may seem ineffective or stupid to other people. The underlying needs of certain actions are sometimes not very clear, because people have not learned to articulate their needs. According to Rosenberg (2003) people even have developed traditions, ritual and habits so they do not have to think about their needs. Non-violent communication focuses on identifying the needs that underlie an action, and distinguish between needs and strategies, and developing a needs vocabulary.

One of our strongest needs is to contribute to the life and well-being of others. This assumption works in two ways. First, we would not like to receive help from others because it is their duty, but prefer help that is given from the heart. Also if we did not have the need to help others, we would not be doing that, but only fulfil our own needs. Non-violent communication can offer a way to connect to other persons, and help see the reasons behind someone's actions. When the person and the reason for their action is known, it is easier to connect to and help this person (Melf and Molho, 2004).

The fourth assumption is that our feelings depend on whether or not our needs are met. The satisfied needs are depending how a person deals with certain stimuli. Consider a crying baby. When a person's needs are not met he may be frustrated, and therefore

react in an angry way to the crying baby. On the other hand, when the needs are met the person may react in a relax and caring manner. The last assumption is that everybody is responsible for their own feelings and needs. It is up to every person individually to identify the underlying needs and ways to get them fulfilled. Help can be asked at any time, as long as help is given willingly and with joy (Rosenberg, 2003).

Non-violent communication is a four staged process. It is centred around observations, feelings, needs and requests. To express observations may be difficult for people, since we are trained to immediately transform observations in evaluations. When describing observations one should only describe what happened for a fact, not what may or not may have been implied. The second step is to describe how that observation made one feel and why. This needs to be done honestly and should only describe feelings and not thoughts. By doing this it is possible to find the underlying needs of a person, especially the needs we need right now. The difficulties of identifying needs is to avoid naming the strategies. The feelings help identify the need. For example, when a person feels oppressed, he needs freedom. How that freedom is reached is important in the next stage. A person can make a request as to how he would like to see his need fulfilled. It is important that the other person is given a choice in the request, otherwise it would be a demand.

Active Listening

In violent conflict people have suffered loss and trauma. They have a need to tell stories to of their experiences, to help them make sense of the past. This restores a sense of identity, making it possible for them to create a future. Also, being listened to reduces the sense of being alone with their thoughts and feelings. In this way people are given the understanding that others are with them. The storytelling should happen in a safe environment, so not to revive past disagreements(Gutlove, 2000).

In Active Listening the listener has the responsibility to actively grasp the facts and feelings and help the teller to understand himself better. This can bring changes to people's attitude towards themselves and others. Key point is here the understanding. It is not about evaluating or changing person, only to understand why people act in a certain way and why they have these feelings. The listener needs to have a honest interest in the thoughts of the speaker, and a willingness to see things from another point of view. Since listening to each other reduces the threat of being criticised, people will be better able to present their ideas. In this way they will feel more respected by others (*ibid.*).

When engaging in Active Listening, the setting must be safe enough to allow speaker and listener to incorporate the new values to his self concept. This can be accomplished by setting ground rules, and by appointing an (outside) facilitator to ensure that the ground rules are respected. The listener should try to capture the total meaning of the speaker's message. This can be done by asking questions. In this way the underlying feelings to the content will become more clear. After the speaker is done, the listener should reflect back what he has heard. In emotionally charged situation or when misunderstanding is great, the speaker should reflect his own words.

The emotions of the listener can form barriers to active listening. The more a person is involved in a situation, the harder it will be to put aside his feelings. The listener should try to sense when he is becoming angry, resentful, threatened or hostile. Listener and speaker should also change role, so that both have the opportunity to share feelings and problems (*ibid.*).

