

Background Paper I

Health and Peace-building: Securing the Future

**The University of New South Wales
Health and Conflict Project**

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Prologue

In September 2003, AusAID funded the Australia-Canada Consortium on Health and Conflict to draw on the experience of academics and practitioners from Australia and Canada at the interface between health systems and conflict prevention and peace-building, conflict management and reduction, and support for post-conflict recovery. The study aims to contribute to the knowledge of, and evidence around, the interface between health and conflict by documenting experience and identifying good practice.

The initial year of the project was largely devoted to exploring the vast area of health and conflict, types of conflict situations, and specific country situations. The countries forming part of this study are East Timor, Sri Lanka, Solomon Islands, Bougainville/PNG, and Cambodia. A two-phase approach has been adopted to drive the project forward. The first phase predominantly involved secondary research and concentrated largely on framing the research questions. The two initial papers cover what the team deems essential to introduce the area of health, conflict and peace-building:

I. Health and Peace-building: Securing the Future

II. The Challenge of Human Resource Management in Conflict-Prone Situations

Issues Paper I: *Health and Peace-building: Securing the Future* sets the scene for contemplating the relationship between health and peace-building in humanitarian crises and development, specifically focusing on the long-term health and social impact of violence.

Issues Paper II: *The Challenge of Human Resource Management in Conflict-Prone Situations* explores the characteristics of post-conflict and transition periods, and challenges they present to the health workforce.

Comments on these materials would be appreciated: please submit these to the Project Coordinator, Anne Bunde-Birouste (ab.birouste@unsw.edu.au) or to the Project Leader, Anthony Zwi (a.zwi@unsw.edu.au). For information on related projects, please check the project website at <http://healthandconflict.sphcm.med.unsw.edu.au/>

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Preamble

The growing number of states in crisis internationally has created the need for new approaches to global governance to address the effects of political violence, to prevent conflict, and to build more peaceful societies. The international consensus is that earlier strategies of national development have not realised their goals and that growing levels of poverty are a major cause of political violence and social insecurity. Moreover it is now realised that any response to humanitarian emergencies must go beyond relief to address the longer term well-being of populations in distress. Humanitarian responses have become integrated with development strategies in order to improve human security by addressing the root causes of conflict.

The complexity of current conflicts makes a simple analysis of them hazardous. Too often conflicts are approached as if they were between clearly identifiable protagonists when in fact they are dynamic and reflect shifting and competing interests both within and between groups.

Conflict is not just about social breakdown but it is also about social transformation. The requirement that humanitarian assistance and development projects need to be conflict sensitive is recognition of this reality. The ‘do no harm’ imperative warns us that current conflicts become symbiotically connected to the social and economic resources introduced into conflict areas. On both sides there are state and non-state actors as well as legal and illegal business interests that can overlap producing patterns of ‘cooperative conflict’.

The reality that any intervention becomes part of the dynamic of a conflict means we should be modest in evaluating the conflict prevention and peace building potential of any particular initiative. Projects will usually have local and wider potential benefits. At a minimum we should ensure that there is a local benefit which will endure for the individuals and communities directly affected. Wider peace building gains may be more difficult to measure especially in situations where the overall conflict persists.

Abstract

In this paper, we explore the relationship between health and peace-building in conflict prevention, humanitarian crises and post-conflict development. We focus specifically on the long-term health and social impact of violence. We examine the link between humanitarian relief and development cooperation. The two concepts are often regarded as having different sets of priorities. We contend that they are related, both aiming to reduce vulnerabilities. They differ, however, in that the former aims to reduce *acute* vulnerability - to disaster and conflict – whereas the latter aims to reduce *chronic* vulnerability.

Within the context of relief and development, we review frameworks of assessment as integral steps for effective aid interventions in conflict-prone societies. Conflict vulnerability assessment aims to identify the risks and drivers of violence, and health assessment intends to identify needs and propose interventions to alleviate human suffering. The inter-relationship between humanitarian relief and development cooperation, and conflict assessments and health assessments, is explored in relation to the objective of enhancing human security.

Coupled with conflict sensitivity and cultural competence, the health initiatives outlined seek to contribute to the promotion of equity, social cohesion and health conditions and systems. A health and human security framework for assessment and intervention is proposed for doing so.

Assumptions:

1. Structural violence is the indirect use of economic, political and social power to disempower others. This takes place through systems and institutions, causing disadvantage and harm. Structural violence may be evident in a number of different but interlinked ways (e.g. unequal access to resources, political power, education, or health care). Inequities in health status (i.e. Inequalities which are unjust and unfair) are an important indicator of structural violence within a community. Violent conflict may be a visible manifestation or response to underlying structural violence.
2. The human ethic to save life and alleviate suffering as the core of health interventions is a powerful imperative on all sides.
3. Health provides an avenue through which to address important needs in a context where longer term political resolution will take significantly more time.
4. Adding a health dimension to conflict vulnerability assessments adds value to intervention and programming initiatives, thereby helping to integrate humanitarian relief and development perspectives.
5. Conflict-sensitive health interventions can produce lasting benefits even when the general political situation generating conflict is not easily resolved.

Introduction

The majority of Australia's aid resources in conflict-prone countries of the Asia-Pacific region, specifically Bougainville, Cambodia, East Timor, Solomon Islands and Sri Lanka, are targeted towards addressing security and governance issues. However, many of the issues underpinning the root causes of conflict can also be addressed from a health perspective. Such approaches can thus add value to assessment and intervention programming.

In conflict-prone settings, the rationale for investing in health is based on the immediacy of preventing death, and treating illnesses and violence-related injuries. Health programs and health professionals have historically played a key role in humanitarian responses to complex emergencies and have contributed to protecting life and alleviating suffering. While health interventions should first attend to these pertinent areas, the scope for health is more far-reaching and includes building trust and supporting reconciliation, promoting social cohesion, addressing psychosocial responses to conflict and creating healthier environments.

1. The Perspective of Health and Conflict

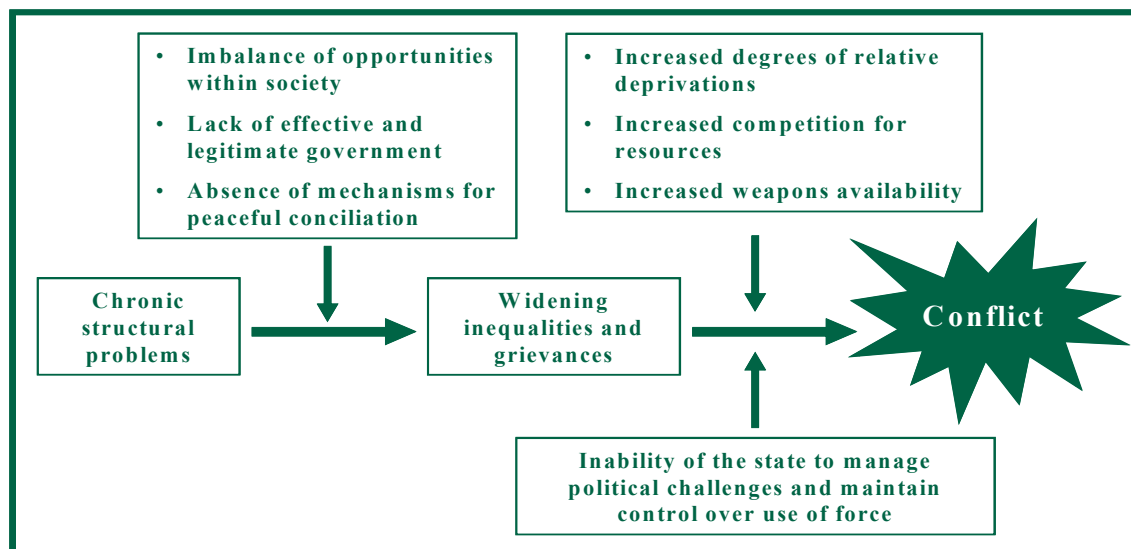
Recent attention to peace, conflict and development has focused on the roles that humanitarian relief and development cooperation can play in preventing and responding to conflict. Within the humanitarian relief and development fields, the health sector provides an additional track through which to prevent violence and build a more sustainable peace. While expectations as to what aid may achieve in these highly contested areas often exceed the reality, investing in effective and coherent health programming is an important avenue through which contribute to building peace and security.

Armed conflict results in serious negative consequences for the health of entire populations, exacerbating disease and disability. More women and children die from preventable diseases, malnutrition, and childbirth complications in conflict zones than from direct violence or brutality. Additionally,

the disruption of health services due to destroyed medical facilities and other public infrastructure, facilitate the spread of ill-health. Beyond deteriorating physical health, conflict creates wider secondary health effects that may remain for many years after a conflict ends. These effects include but are not limited to:

- increased disease and illness as a consequence of the breakdown in health systems and unavailability of drugs;
- displacement and homelessness;
- increased malnutrition;
- long-term detrimental impacts on social cohesion, some stemming from psychosocial difficulties and;
- human rights violations, including: sexual violence, torture and disappearances.

At a societal level, violent conflict disrupts social networks and destabilises the political, social and economic life of a community. Fear breaks down social cohesion and leads to a contraction of social relationships such that individuals and communities narrow their interaction with others to the closest and most important relationships, usually family.

Figure 1: Contributions to instability

Threats of violence undermine the ability to exercise basic rights such as the right to food, shelter and livelihood. Displacement resulting from violent conflict removes villagers from the source of their livelihoods (e.g. land, livestock) and from financial supports (e.g. those who you can borrow from, barter with make partial payments for services).

1.1 Health, inequalities and conflict

Political conflict and war are often the products of long-term structural inequalities. Conflict may lead to opportunists seeking to benefit from the ‘voids’ created between the various elements that normally protect societal relations. In the ensuing mayhem, the weakest are most vulnerable to the type of atrocities and war crimes that have characterised many of the conflicts of the late twentieth and early twenty-first centuries.

The Development Assistance Committee of the Organisation for Economic Cooperation and Development (OECD) has identified three key factors that contribute to instability: these include imbalance of opportunities within society, lack of effective and legitimate government, and the absence of mechanisms for peaceful conciliation (Figure 1). When layered on chronic structural problems, these characteristics predispose to widening inequity and grievance, which in turn may lead to conflict in the presence of: heightened degrees of relative deprivation, increased competition

for scarce resources, and greater availability of weapons.

Where the state is unable or unwilling to manage political challenges and maintain control over the use of force, violence erupts. In some instances, an authoritarian State may be able to control the violence, such as in North Korea where gross structural inequalities have not yet manifest in violence.

The increase in social disorganization and conflict resulting from longer-term structural inequalities invariably are associated with worsening population health indicators. As such, monitoring of health indicators can provide a litmus test of the overall *health* of a society including the level of risk for growing social grievances that may predispose a community to descend into mass violent conflict. Intervening to improve declining health and social conditions as a result of chronic structural inequalities may provide a platform to alleviate some of the tensions. Table 1 identifies a range of underlying processes and characteristics which predispose states to risk of internal conflict or collapse.

Alongside the delivery of public services, these indicators reveal the importance of political and social factors, in predicting an escalation of violent conflict. In particular, they highlight the importance of inequity in access to resources and services and inability to exercise political power, as important contributors to violence and instability.

Table 1: Indicators of states at risk of conflict

Indicator	Sign
Inequality	<ul style="list-style-type: none"> • Widening social and economic inequalities – especially those between, rather than within, distinct population groups
Rapidly changing demographic characteristics	<ul style="list-style-type: none"> • High rates of infant mortality • Rapid changes in population structure, including large-scale movements of refugees • Excessively high population densities • High levels of unemployment, particularly among large numbers young people • An inefficient supply of food or access to safe water • Disputes over territory or environmental resources that are claimed by distinct ethnic groups
Lack of democratic processes	<ul style="list-style-type: none"> • Violations of human rights • Criminal behaviour by the state • Corrupt governments
Political instability	<ul style="list-style-type: none"> • Rapid changes in regimes
Ethnic composition of the ruling group sharply different from that of the population at large	<ul style="list-style-type: none"> • Political and economic power exercised – and differentially applied – according to ethnic or religious identity • Desecration of ethnic or religious symbols
Deterioration in public service	<ul style="list-style-type: none"> • A significant decline in the scope and effectiveness of social safety nets designed to ensure minimum universal standards of service
Severe economic decline	<ul style="list-style-type: none"> • Uneven economic development • Grossly unequal gains or losses between different population groups or geographical areas resulting from large economic changes • Massive economic transfers or losses over short periods of time
Cycles of violent revenge	<ul style="list-style-type: none"> • A continued cycle of violence between groups

Source: WHO World Report on Violence and Health, 2002.

1.2 Politics and humanitarian relief

The question of whether or not aid agencies can remain neutral and non-political is emerging as a key point of debate. Health, its distribution, the response to need, the organisation of services, and the health sector, are all political. Health workers in particular are part of their community, and therefore part of the conflict dynamics, both as victims and as service providers. Field staff face difficult political decisions every day. Using health ‘neutrality’ as justification to avoid difficult policy decisions can do great harm to the mission of the field operation and ultimately to the health of the population.

Increasingly, non-governmental agencies are tied to bilateral or multilateral donors and their agendas, thus diminishing their independence.

They are drawn into serving political and foreign policy objectives and may find difficulty preserving their neutrality, or, if they do maintain it, may find difficulty mobilizing funds for their activities. The increasing politicisation of humanitarian intervention brings threats and dangers, undermining key humanitarian principles of neutrality and independence.

1.3 Relationship between health in humanitarian crises and development

Health and the role of health professionals have historically played a key role in humanitarian responses to complex emergencies with the aim of protecting life and alleviating suffering. Health work provides one mechanism to help reduce the impact of violence through its immediate health benefits for individuals and communities. In doing so, it may offer an avenue to repair fractured social relations and construct new ones, providing a basis for long-term development and peace-building.

The health impact of violence can be addressed either through health sector oriented actions or health promotion actions. The former include actions most likely implemented in emergency situations, in an attempt to address immediate morbidity and mortality due to violent conflict, such as:

- delivery of basic services and supplies,
- capacity building through training programs,
- primary health care delivery,
- rebuilding health infrastructure

During humanitarian relief efforts, diverse public health effects can be addressed through a range of health promotion and psycho-social actions that include:

- reproductive health programs
- youth health
- violence prevention
- mental health counselling
- post-trauma rehabilitation of both individuals and communities
- resettlement of internally displaced persons and refugees
- rebuilding trust.

Many of the health interventions from the humanitarian relief stage should be carried through to the development stage. Activities should include exploring the creation of stronger partnerships to bridge the work between the relief and development sector. Additionally, the health sector can promote a concerted effort to help overcome enduring trauma, encourage reconciliation and help prevent renewed outbreaks of violent conflict. Considerations for development should begin early, even during the humanitarian relief stage. As a development objective, the health sector provides an advantageous opportunity for systems and structure reform where structural inequalities have existed.

The legitimacy of humanitarian intervention is based on neutrality to provide immediate relief and individual healing. It also constitutes an important foundation for social healing and the recovery of social relationships ruptured by political violence. It can be suggested that the humanitarian ethic at the basis of health and the work of health professionals provides the platform for reconstructing moral communities, fostering long-term development and promoting peace.

2. Phases of Conflict

Some sources of international literature indicate that defining cycles of violence can be problematic and over-simplistic. While it is agreed that cycles of violence are complex and often blurred, for the purposes of aid interventions, it may be useful to consider the following four time-frames for interventions: prevention, humanitarian relief, transitional phase and development cooperation.

Conflict is not necessarily negative or destructive. Problems arise when non-violent conflict(s) turn (or re-turn) violent. The 'surprise' about violent conflict is not that it occurs, but that we watch it develop for so long, and do nothing about it — e.g. the disintegration of governments and rule of law, increasing abuses of human rights, the imposition of conflict-creating terms of trade or economic conditionalities, the acceptance of (or participation in) corrupt business practices, the selling of weapons to illegitimate and violent regimes.

Source: UNDP report: Peace and Conflict Development Analysis, Solomon Islands, 2004.

2.1 Prevention

Health can assist in the prevention of violent conflict in two ways. First, as an early warning mechanism where regularly collecting and reviewing health indicators may help identify risk of conflict. Health information may be derived from:

- monitoring mortality and morbidity rates and other health data;
- conducting regular surveys;
- interviewing focus groups;
- reviewing records by population group for density, income and unemployment levels and;
- monitoring expenditures on health and other social services.

Secondly, health can contribute to violence prevention by providing effective, equitable health services and psychosocial health promotion.

No single sector can prevent violent conflict. Health programs can, however, contribute to identifying and alleviating stressors that indicate potential to provoke violent conflict. Many underlying factors, including poverty, social inequalities and gross inequity in the distribution of services and resources, may be addressed from a prevention perspective through effective, equitable health service provision and psycho-social health promotion programs.

The challenge to donor groups in working to prevent potential escalation of tensions is to provide sufficient and appropriate investment well before acute conflict erupts.

2.2 Linking humanitarian relief and development cooperation

The transition from humanitarian relief to development cooperation often proves difficult. Historically, humanitarian relief and development cooperation have been handled as separate and unrelated activities. Humanitarian interventions may occur with or without the host government's approval or support. Its relatively short-term objectives focus on responding to acute vulnerabilities by saving lives and livelihoods. In contrast,

development programs typically occur with the involvement of host governments and include longer-term goals of building sustainable systems, promoting equity, supporting systems of governance, and eradicating poverty.

The transitional phase linking relief and development can be messy and unclear. International literature has neither sufficiently addressed the challenge of defining objectives in the transitional phase nor how to best facilitate the complex shifts from relief to development. From a health perspective, the transition phase poses a severe problem of *aid dependency* common in post-conflict settings. The influx of humanitarian relief, arriving to address acute vulnerabilities may raise standards of health care and resources to unsustainable levels. The elevated level of assistance raises local expectations for higher standardised care. Local groups may even aggravate the conflict so as to maintain such level of care, raising the question as to how aid agencies may be fuelling the persistence of conflict.¹

Transition Phase: high expectations, low morale

Initial country visits to both Bougainville and East Timor have highlighted the difficulties aid agencies face when programming in the transition phase between humanitarian relief and development cooperation.

In Bougainville, representatives cited widespread depression surrounding this 'let down' phase when the reality at present indicates the level of prosperity and standards of services the province enjoyed during the mine operation will not be achieved. Bougainvilleans have expressed dissatisfaction with the on-going subsistence living and have been questioning what has been achieved from the conflict.

In East Timor, a typical reaction to conflict – gratitude, resentment and acceptance – was pervasive. The year 2002 was characterised by resentment and miscommunication; however, a psychological shift occurred when movement towards longer-term development became discernible.

¹ See Tulloch et al. 2003. *Initial Steps in Rebuilding the Health Sector in East Timor*. The National Academies Press: Washington, D.C., p31. and Le Billon et al. 2000. *The Political Economy of War: What relief agencies need to know*.

In each phase, there are different actors, funding patterns, assessment of outcomes, mechanisms for accountability, strategies and approaches (see Section 1.3). International NGOs, for example, particularly international ones, may be more active in the relief phase. Local NGOs may be particularly active during development cooperation, in which government to government activity is also prioritised.²

The balance between humanitarian relief and development will vary over time and place; getting the balance right and adequately resourcing the transition warrants careful research, documentation, reflection and the commitment of appropriate longer-term funding. Some aid agencies have recently promoted greater flexibility of funding during the period of transition. This increases opportunities to better bridge the relief and development divides. It is notable that despite a developing evidence-base for health-related humanitarian action, evaluations of humanitarian activities have found ongoing problems. These include poor standards of delivery, duplication of efforts by different agencies, lack of coordination and failing to learn from prior experience.

3. Conflict and Health Assessments

Operating at the interface of humanitarian relief and development cooperation requires careful assessment as to the context of conflict, intervention options, and the implications of acting, or not acting, in a particular way at a particular time.

In the past decade, most political violence has been internal strife and civil war rather than external wars between states. The major exceptions have been the Gulf War in 1991, Kosovo in the 1990s, Afghanistan in 2002 and the Iraq War in 2003. Conflicts have occurred in weak states over issues such as social exclusion, land distribution, resources and the inequitable exercise of social and political powers. Many of these are post-colonial states

² See Tulloch et al. 2003, p26.

in which the project of national citizenship was never fully inclusive.

Consequently, communities in conflict zones carry legacies of different kinds of violence: ethnic, tribal and/or religious differences which have provided lines for ongoing or exacerbated political cleavage and social fragmentation. In some cases communities are destroyed and displaced. In others, they remain in situ and community structures and culture persist. The impact of conflicts on communities is geographically and socially specific; understanding their local and differential impact thus warrants careful analysis.

Caution with assessment tools and frameworks

‘There is a danger however, that the a priori identification of indicators may obscure as much as it reveals by highlighting (and thus legitimating) some features of a project, while simultaneously burying (and thus delegitimizing) other... At the risk of appearing trite, it needs to be said: Sri Lanka is not Bosnia; it is not Rwanda; it is not Nicaragua. Sri Lanka is Sri Lanka. And this is what must drive the parameters, the possibilities and the limits on development programming on the island.’

Source: K. Bush, 2003

3.1 Conflict vulnerability analysis

Conflict vulnerability analysis seeks to map the sources of conflict by identifying the actors and their agendas. Incorporating this knowledge in the planning process may reveal entry points for preventive and/or peace-building interventions. Given the potential for aid to become a source of competition that may exacerbate tensions, conflict vulnerability analysis identifies barriers and scope for peaceful cooperation between key stakeholders at the local level as well as between the local and national level.

Peace and Conflict Impact Assessment (PCIA) identifies the potential for aid interventions to aggravate tensions by introducing sources of competition into conflict-prone societies. This enables practitioners to minimise harmful peace-conflict impacts of development and humanitarian assistance. Wherever feasible it

also enables practitioners to identify opportunities to support capacities for peace.

Some donor agencies have adopted a conflict vulnerability lens which focuses on poverty as an underlying cause of violent conflict, and inversely, violent conflict as an inhibitor of poverty reduction programs. The application of conflict risk assessment methodologies as the basis for diverse humanitarian and ‘development’ interventions enables donors to incorporate considerations necessary for rebuilding health and the social fabric within development cooperation programs. An example of model conflict analysis questions is included in Appendix 1.

Experts in the field of peace and conflict advise that assessment tools and frameworks should be used to guide a process, not be applied as a blueprint. Most importantly, the indicators need to be determined by those concerned, starting at the local level. Local participation in the assessment process is crucial for promoting empowerment and building the peace. This proposal offers a model to donor policy makers of large donor makers who are searching for practical tools to improve programs.

Key Points on conflict assessment:

- Political violence has been primarily internal not external.
- Conflicts are multi-dimensional and multi-layered. They should not be over-simplified.
- There are no ‘blueprints’ for reducing conflict. Conflicts must be addressed from the specificity of a particular location and therefore peace-conflict dynamics of each context must be thoroughly analysed and understood
- Internal conflicts require some form of reconciliation between populations that are going to have to continue living together.

3.2 Health assessment

Generally health assessments have been undertaken separately from the process of peace and conflict impact assessments. Health assessments have focused on:

- identifying health burdens;
- assessing the distribution of those burdens within the community and;
- determining the most appropriate interventions.

Health assessments need to be comprehensive, taking into account both physical and psychosocial impacts in order to provide information relevant to health policy and priority setting, as well as rebuilding the health system and promoting social cohesion.

Ideally, health assessments in conflict-prone settings should consider concepts of both conflict sensitivity and cultural competence. A culturally competent approach strives to attain a diagnosis and clinical management specific to a certain culture and integrates, as far as possible, traditional, local and Western interventions for health. These insights are also relevant to community development and participation, training and supervision, and the use of community resources. Such interventions will sustain viable health initiatives without having to rely on extensive external support in the long term.

Appendix 2 presents a summary of three such frameworks. These focus on a specific dimension of health common to conflict-prone settings:

- psychosocial
- reproductive health
- health sector services and systems

They offer not only a process for assessment, but also include intervention planning and

Golden rules for effective health assessments and intervention planning:

- Identify immediate medical/health problems, including changes from pre-conflict and intra-conflict situations.
- Establish who are the most vulnerable groups.
- Identify imminent health problems from those above.
- Identify war related legacies on population.
- Undertake a thorough appraisal of the challenges people face and the resources they need.
- Involve community throughout assessment, planning and implementation.

guidance. While the above frameworks are particularly useful to further assess impact in these health specific areas and effectively build programs to address them, we propose that an overall conflict and health impact assessment model is necessary. A combined conflict and health assessment may yield more effective and appropriate health interventions.

3.3 Combined conflict and health assessment

A combined conflict and health assessment helps to better understand both the conflict and health context in stressed environments. In particular, a combined assessment highlights potential benefits or drawbacks likely to be associated with different interventions. Assessment of health interventions outcomes during humanitarian relief stage needs to continue into the subsequent community development stage. Such evaluation allows for adjustment of program activities and objectives in line with changing community needs over time.

3.4 Health – Conflict Cube

An ideal model addresses the multiple dimensions within the health sphere, the various stages within the conflict cycles and the range of actors involved. The proposed *Health - Conflict Cube* (Figure 2) suggests assessments across three dimensions: actors, timeframe and influences on health outcomes. The *Health – Conflict Cube* is of value in identifying the intersection between different aspects of assessment, analysis and proposed interventions. In addition to the *Health – Conflict Cube* described below, Appendix 3 proposes a matrix, derived from the cube, and which may be of value in assessment and planning.

Actors

As the scope of health can often be far-reaching beyond clinical models to include a broad range of social, economic and political factors, it is advantageous to view health interventions as collaborations across various sectors of society. The horizontal dimension on the diagram indicates the range of actors

who may be involved; inclusive programming must ensure participation, ownership and cooperation. Tensions often arise or are perpetuated if one or more of these key sectors are excluded:

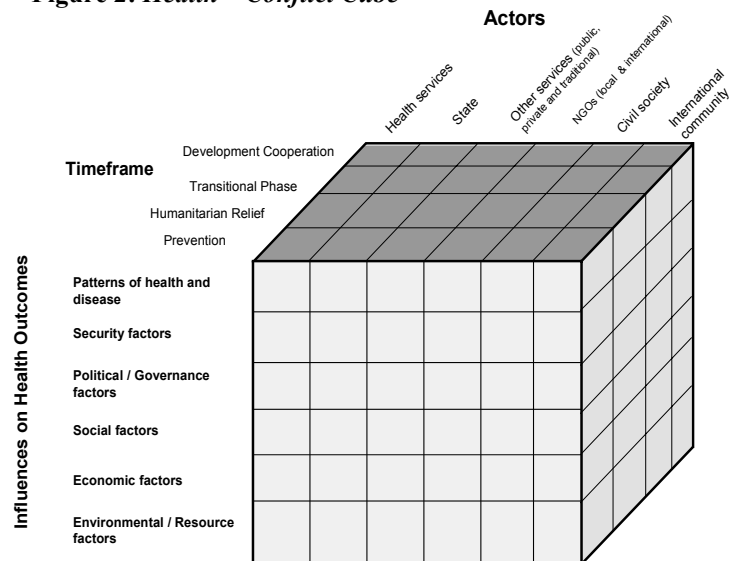
- *State* (e.g. Ministries of Health, Education, Labour, Finance, Defence)
- *Health sector* (health service delivery)
- *Other services* (public, private, traditional)
- *Non-government organisations* (local, international)
- *Civil society* (e.g. media, church, women's groups, professional associations)
- *International community* (e.g. United Nations, donor organisations)

Timeframe

Communities affected by protracted conflict rarely fall simply into the categories of conflict or post-conflict; upheavals may be episodic and recurrent and low-grade conflict often persists in some areas during periods of relative peace. The oblique dimension identifies these phases simply to alert planners of the need to consider elements of these phases. Most often, aspects of all four 'phases' coexist.

- *Pre-conflict*
The pre-conflict phase occurs before full-scale violence. Applying special attention to indicators of growing instability, civil disturbances and deteriorating economic and social conditions may lead to prevention of violence.
- *Humanitarian Relief*
During the intermittent phases of intense violence and relative instability characterising conflict, emergency relief aims to reduce the acute vulnerability of the affected population by providing secure environments in which basic needs such as food, shelter, water, and health services, can be met.
- *Transitional Phase*
The transitional phase occurs when relative stability returns. Typical features during this phase may include an exodus of humanitarian relief agencies,

Figure 2: Health – Conflict Cube



sometimes followed by an influx of development agencies. Problems arise when there is a mismatch between needs and support in developing effective responses.

- *Development Cooperation*
The development cooperation phase is characterised by reconstruction or new development, reintegration of returned displaced populations, building social cohesion and reorganising state structures to alleviate chronic vulnerabilities within the post-conflict society. Development cooperation is usually heralded when a new government, with a degree of local and international legitimacy, is in place.

Influences on Health Outcomes

The vertical dimension indicates the need to consider core health indices and patterns within a context of human security, and the broader political, social and economic framework. Environmental factors and availability of resources (including human, social, cultural and material) need to be considered.

- *Patterns of health and disease*
- *Security factors*
- *Political and governance factors*
- *Social factors*
- *Economic factors*
- *Environmental / resource factors*

In deciding what health and peace-building strategies are possible, a combined conflict and health assessment allows for the consideration of potential benefits or drawbacks in a particular situation. Additionally, a combined assessment highlights the important principle that all health initiatives in conflict-prone countries, even the seemingly most technical, should be subjected to a broader peace-building analysis. Such an analysis is relevant even in relation to basic issues such as management of supplies, choice of priorities, employment strategy, developing communications systems and the rebuilding of infrastructure such as clinics and hospitals.

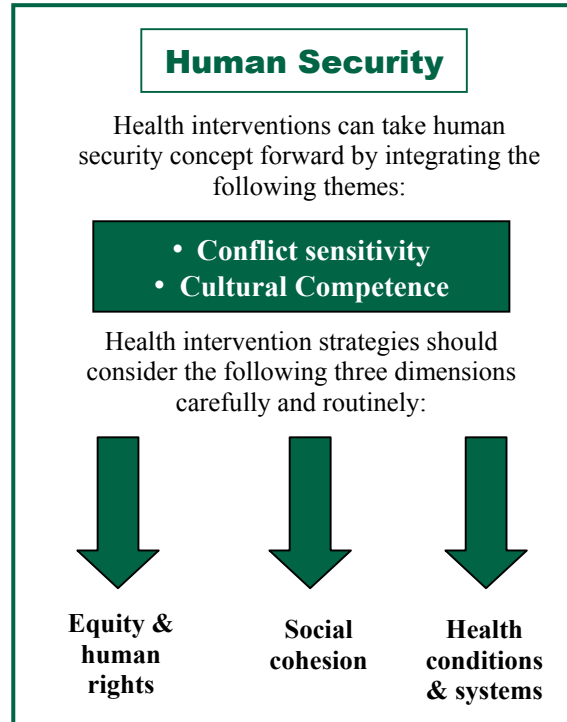
4. Ways Forward

4.1 Minimising the risk of conflict and building the peace

There always will be some tensions between ‘getting things done’ to reduce immediate morbidity and mortality in emergency settings and the imperative to undertake a comprehensive contextual and historical assessment that includes a peace-building focus. Even in acute humanitarian settings, basic knowledge about the history, politics, culture, social relationships and economics of a country provides a foundation for applying a peace-building lens. This lens allows for planning interventions to be conducted in a manner that promotes equity, dignity, and social justice. Accurate analyses can lead to interventions that support culturally-appropriate solutions, local leadership and a sense of empowerment rather than inadvertently creating dependency, passivity and unrealistic expectations.

To begin reflecting on how peace-building can be consolidated in health interventions, we propose an integrated framework for examining health contributions as one avenue for promoting longer-term regional stability and building peace. The *Health and Peace-building Framework* (Figure 3) adopts the overarching concept of human security as the major objective, followed by five core themes that must be addressed in conflict settings: conflict sensitivity, cultural competence,

Figure 3: *Health and Peace-building Framework*



equity and human rights, social cohesion and health conditions and systems.

4.2 Health and Peace-building Framework

The *Health and Peace-building Framework* gives priority to *human security* as a lens through which to promote peace-related health initiatives, sustainable socio-political communities and eventually contribute to regional stability and security.

Human Security

Governments typically approach conflict analysis from a law and order perspective. Many would argue a more appropriate premise for a health perspective on conflict is human security. *Human security is defined as the safety for individuals and groups from violent threats (such as violent crime, gross violations of human rights and terrorism) and non-violent threats (such as environmental degradation, illicit drugs, economic crises, infectious diseases and natural disasters).*

Health provides a platform through which these commitments may be addressed. Health and conflict-sensitivity, along with cultural competence, provide an opportunity to take the human security framework forward.

Conflict sensitivity

Inadequate sensitivity to the relationship between health, conflict and peace-building, may inadvertently lead to health interventions being a focus of additional enmity, grievance and conflict. If services are re-established in some areas and not others, this may heighten sense of grievance, for example.

Cultural competence

A culturally competent approach not only acknowledges local culture, traditions, and resources, but also strives to involve local communities in all aspects of assessment, program and policy planning and implementation. Adopting a framework of cultural competence integrates local and western interventions for health and community development as far as possible. Key considerations include: institutionalising cultural knowledge, valuing diversity, responding to cultural differences and efforts to bridge the gap between local/indigenous approaches to health care and imported approaches.

These approaches need to be applied to a number of important dimensions for both assessment and planning purposes. The combination of these concepts needs to be considered prior to a conflict, as well as in both emergency relief and development

Women, Conflict and Peace

During the recent crisis in the Solomon Islands gender-related violence, occurred throughout Guadalcanal and other provinces impacted by the crisis...that is not to say, however, that women's experiences of conflict in the Solomon Islands were entirely negative or disempowering. On the contrary, through their work to bring the warring factions together and to build a culture of peace, women report gaining a sense of individual and collective empowerment. Nevertheless, despite the efforts of this group and others, Solomon Island women were excluded from participating in the official peace process in Townsville and appear to remain excluded from political decision-making at the national level in the post-conflict context. For many women these events represent a step backwards and an explicit message on the part of government that their efforts and needs are not seen as a contribution or a priority.

H. Leslie, S. Boso, Asia Pacific Viewpoint, Vol. 44, No. 3, December 2003, ISSN: 1360-7456, pp325-333

cooperation settings and the transitional period which bridges them. The balance of attention to different dimensions, and the amount of resources directed to them, will necessarily vary, but they nevertheless should be considered as part of a more comprehensive picture.

Following the overarching framework of human security and the concepts of conflict sensitivity and cultural competence, the following three pillars should also be considered during assessment, planning, implementation and evaluation stages: equity and human rights, social cohesion and the implications for health conditions and systems.

Equity and human rights

Health programs have the opportunity to support human rights and social justice by promoting dignity and respect for patients and health service users, responding to ethnic and gender inequities (in service delivery and staffing), and providing transparent and fair grievance procedures for personnel, patients and the community.

Social cohesion

Social cohesion is the quality of social relationships and the existence of trust, mutual obligations and respect in communities and the wider society. Programs should promote bridging social capital, between groups, in an effort to enhance scope for social cohesion to be built and consolidated.

Health conditions and systems

Data on the distribution of health and ill-health should feed into health interventions. So too should information on health services, in particular the extent to which they offer quality services and are accessible to all groups. Promoting access and equity, and reducing inequalities in health and health care, remain key underlying issues which must underpin health and health system interventions.

The framework suggests that more sensitive assessment and planning will lead to more effective post-conflict health outcomes. Not only would health outcomes benefit, but so too would a range of other areas necessary for the promotion both of health and of regional stability and security. These include good governance, the role of other sectors in

Dr Judson Leafasi, the Under Secretary Health Care, Solomon Islands, has encouraged his own village of approximately 800 people to build their own health clinic, feeling that it helps build unity within villages that may be divided by religion. In his village there are four different denominations and this is a potential cause of division. He feels that the only progress will be made by working with communities.

Such initiatives have occurred elsewhere on the islands; however, without proper planning these community-induced health centres may remain idle as there are no appropriate staff nor are drugs and equipment available – scarce resources that are typically reserved for established health centres. Poor, adhoc planning may lead to the inability of the Ministry of Health to properly plan and provide necessary resources.

promoting basic needs and addressing human security concerns, and the more equitable distribution of resources at the societal level. Health needs to be addressed both in relation to individual and social wellbeing. Improved health contributes to the ability of individuals and communities to claim their other entitlements and benefits from development and other opportunities. Violence prevention requires creating a community that has its basic needs effectively addressed and which shares in the resources available at societal level. Such societies are less liable to be driven by divisions and grievance, and violence.

The framework presented is a starting point and not an endpoint. It suggests avenues that require further development and elaboration. It highlights gaps in current assessment and programming approaches. Appendix 4 offers a model to begin thinking about how a health and peace-building filter may be applied to health interventions. The filter will be able to first highlight if the intervention is serving a peace-building function. Secondly, it will offer recommended action to strengthen its peace-building role or incorporate peace-building elements into the intervention.

4.3 Addressing major issues

This paper explores the relationship between health in humanitarian crises and post-conflict development, specifically focusing on the long-term health and social impact of violence.

As such we have considered it essential to address the issues of assessment and propose effective approaches to accomplish them. We recognise the major health-related priorities in humanitarian emergencies and post conflict development cooperation. Listed below are health issues that continuously reappear in recent literature on violent conflict, indicating they merit further exploration:

- mental and psychosocial health;
- reproductive health;
- gender issues;
- trust and reconciliation and;
- health and human resources.

5. Case Studies

The following four case studies present health and peace-building initiatives in conflict-prone settings. The first case study highlights the importance of psychosocial programming. The second addresses health worker training in highly contested areas. The third illustrates the significance of creating culturally competent health settings. Finally, the fourth is a reflection on the role of the military in a whole of government approach to health and peace-building.

5.1 Case Study: The Butterfly Garden³: Psychosocial healing in Sri Lanka

Building on research from multi-country studies on psychological distress in war-affected children, the Butterfly Garden in Sri Lanka is an innovative program of accompaniment and healing for war-affected children, and reconciliation at community level.

A combined health and peace approach:

The project aimed to promote psychosocial resilience in children affected by experiences

³ See <http://www.thestupidschool.ca/bpg/index.htm>

of violence and support community development approaches to building peace in conflict affected areas. Guided by principles of cultural competence, the Health Reach Project team collaborated with local organizations and researchers to plan and conduct initial surveys. Capitalising on the opportunity provided by the 100-day cease fire in 1995, the team conducted an extensive survey of school children aged 9-11 years in Sinhalese, Tamil and Muslim communities in the Eastern Province. This provided context-specific information on the direct and indirect effects of war on children and provided a platform for building the activities of the program.

To date the Butterfly Garden has provided after-school and weekend creative play programming to over 600 schoolchildren from 20 communities representing local ethnic groups (Tamil and Muslim). The program offers a rich choice of play and art activities (claywork, drama, storytelling, music, arts and crafts) facilitated by staff animators; local men and women from different ethnic groups. Training is by apprenticeship and skills development enhanced through hands on experience, attention to one's own personal healing work, on-site mentoring, and workshops drawing on specialist Sri Lankan and international practitioners.

Five years on, the program is demonstrating a range of positive effects on the participating children, with more incremental signs of success as a peace-building and reconciliation measure at the community level.

Lessons learned:

- The culturally appropriate, creative approaches fostered community healing and reconciliation.
- Neutrality and transparency were vital; association of respected members of the community contributed to the program's acceptance.
- In using a child-centred, non-violent and creative approach to health, the program was perceived to be politically neutral and has thus been an entry point to wider peace-building, encouraging dialogue between local security forces and militants.
- Participation across religious, ethnic and political groups has been

identified as one of the keys to success.

- Healing potential for staff as well as children is needed (and possible) within program.
- Short-term, small grant programs can allow communities to mobilize quickly, and take advantage of changes in the conflict environment; however longer-term commitment is necessary to build and sustain the project. A mix of funding is required.

5.2 Case Study: Health as a Bridge for Peace⁴: Training in Indonesia.

The WHO Health as a Bridge for Peace (HBP) initiative attempted to improve health workers' skills to deliver services in conflict-prone environments and to identify opportunities for peace-building in their practice.

A combined health and peace approach:

In October 2000, Indonesia held a national workshop for health professionals working in provinces affected by conflict to introduce them to the HPB training curriculum. The national focus was followed by a series of provincial level HPB workshops in the Maluku, North Maluku and Aceh provinces.

Across the three provinces, the workshops were felt to have helped maintain or re-establish communication *within* the health system, facilitate some practical planning efforts and provide a safe environment for health workers to voice concerns, frustrations, and problems.

Overall, however, the programmes met varied levels of success at the different sites. Two reasons were cited for the varying outcomes. The first involves the level of commitment by local health authorities. The second explanation revolves around the conflict context in each setting, such as in Aceh where the entrenched dynamics of conflict contributed to less outcomes. The HBP – Indonesia experience highlights the need for programmes to be tailored to local context, as

⁴ See <http://www.who.int/disasters/bridge.cfm>

well as the need for experienced health professionals to be familiar with peace and conflict skills.

Maluku Following the national workshop, the resources available in this province both catalysed the operational thinking and motivation of health workers. Three operations directly promoted within the HBP program succeeded in opening operational space. A range of positive activities and concrete outcomes have ensued, such as: providing a safe environment to vocalise opinions, influencing health policy, passing on HBP planning to NGO workers, as well training a pool of core health workers to continue seeking opportunities for linking health and peace-building.

Aceh. Due to ongoing tensions in Aceh, there are no joint projects, only government health workers that are under pressure from both sides of the conflict. Aceh's HBP program was therefore appropriately titled 'Health Workers and Conflict', as the word *peace* was not deemed suitable. The title change, in fact, gave a very different light to the overall approach, focusing on the needs of the actual health workers conducting health services.

The program aimed at providing peer support for health workers, developing a communication or network amongst health workers, providing a forum to isolated health workers. A week-long workshop was introduced which included conflict analysis, effects of conflict on health workers, the community and health systems.

The result from this program was increased motivation, good information about the realities of the field, a better understanding of the conflict and health dynamics. The planned projects were to lead to regular staff development program managed by local health authorities which would become a regular training for all staff. Although the program faced funding constraints, coupled with increased military operations, it was a useful exercise in helping health personnel prepare for conflict situations.

North Maluku The intra-religious conflict in North Maluku in 1999 meant health systems were fragile during the HPB workshop. Weak

health systems coupled with a lack of local health authority commitment, meant the initial HBP workshop remained an isolated attempt at joint health development work. However, the workshop did facilitate the reunification of health workers who were segregated from the conflict.

Lessons learned:

- Practical and technical support is a necessary accompaniment to any HPB strategy. The provision of quality health services must be central to the health and peace initiative.
- Action to rehabilitate the health system, build health worker capacity, and improve service delivery through local ownership and involvement is critical.
- In highly contested environments some health workers may be reluctant to engage in peace building initiatives; there may be a perception that these activities politicise an otherwise 'neutral' space of health service delivery.
- Health and peace links can be made into operational planning tools that inform recovery of health services and build in equity at a time when it may not be seen as a priority or people may not have technical experience to build this into the recovery of health systems.

5.3 Case Study: Cultural sensitivity in health service provision: Kafurumu Clinic Health Program, Solomon Islands⁵

Solomon Islands are emerging from a five year period of 'tensions' marked by widespread insecurity and violent conflict largely carried out along ethnic lines. Access to services and clash of traditional versus non-traditional authority has been identified as being among the root causes of the conflict (along with land ownership, economic opportunity and law and justice concerns).

⁵ Reflections by David Maclaren, PhD candidate, School of Public Health, Griffith University, Australia

Examining access and equity issues in health services are a key component of the rebuilding stage. The following is a brief description of the situation at Atoifi hospital in East Kwaio Malaita. It highlights the importance of centralising cultural understanding in health services.

Atoifi hospital, one of the most respected health care institutions in the Solomon Islands, was constructed by the Seventh Day Adventist Church in the 1960's with no incorporation of Kwaio cultural beliefs and traditions. The traditionalist Kwaio are a group of approximately ten thousand people, one of 12 language groups living on the Island of Malaita in the Solomon Islands. Approximately half of this group have chosen to maintain their traditional ways of life and uphold traditional beliefs. A significant belief affected by not recognising Kwaio customs is the specific roles of men and women. Much of Kwaio custom involves men and women becoming 'tabu' during specific times of their lives. For Kwaio 'tabu' governs social interactions and relationships and is a basis of social behaviour. An example of how these beliefs affect health services is evident in the hospital's maternity services.

The maternity ward is located within the main Atoifi hospital building. It is situated on the higher side of the building as the building follows the slope of the ridge it is built on. The male ward is on the lower side of the building. Two cultural principles are thus affected:

- 1) Kwaio custom dictates women should be physically separated during childbirth.
- 2) Kwaio custom dictates that men's area should be above the women's area. This is particularly significant when men and women become 'tabu,' as is the case during childbirth.

The physical layout of the hospital means those entering any part of the hospital are seen as entering a childbirth area and breaching the social relationships governed by 'tabu.' This essentially excludes members of the Kwaio traditionalist community from entering the hospital or accessing health services based there. A further barrier to accessing maternity services for traditionalist women is the cultural

need for a process of de-sacralisation (purification). The de-sacralisation process occurs when a woman comes from her tabu state during child birth to a normal state again to resume normal social interactions. As the hospital does not provide such a facility as a part of its maternity services, most Kwaio traditionalist women do not use maternity services at Atoifi.

To access health services at Atoifi hospital Kwaio traditionalists are forced to repudiate Kwaio custom. This means they must pay massive amounts of compensation to the community or leave their customary land in the mountains and settle in villages on the coastal fringe that they have no ownership over. The resultant inequality, exclusion and injustice create an environment of potential (and at times actual) conflict and confrontation. The lack of a culturally competent health care system means Atoifi hospital is *in* Kwaio, but not *of* Kwaio.

Key elements for effective cultural competent processes:

Interventions should engaging indigenous populations by using:

- Assessment processes that explore local experiences through use and understanding of indigenous terms, classification, explanations;
- Engagement should begin with bottom-up approach using local resources and active participation and influence of stakeholders, drawing from the less urbanised – and urbane – sectors of the community as well as from those more likely to engage with the international community;
- Carry out train the trainer and write manuals in local language and using local as well as Western idioms;
- Ensure that local trainers/workers are themselves helped to overcome cultural ethnocentrism through which they may judge their compatriots;
- Engage communities, and involve key opinion leaders such as traditional healers and religious leaders of a range of persuasions. Interventions must be founded on a deep understanding and respect for indigenous cultures, in order that they do not aggravate situation through ignorance.

Source: Eisenbruch et al. 1997. *Community Mental Health in Cambodia*. Transcultural Psycho-social Organization (TPO)

A combined health and peace approach:

As a result of this health provision gap, a Kwaio village health worker set up a health clinic at Kafurumu, in the heart of the traditionalist area. Health programs there incorporate Kwaio values, liaising with chiefs and community leaders, ensuring Kwaio voices are heard. Programs organised by the clinic recognise the Kwaio concept of *to'oru leanga* (Kwaio language – state of well-being). The programs incorporate traditional treatments and western medications and recognise the importance of custom, and social connectedness to the land and to each other in its approach to health. Kafurumu is able to provide equitable access to services for the traditionalist community that do not access services at Atoifi Hospital. As Kafurumu clinic is *in* and *of* Kwaio, the traditionalist community have more ownership and participate in ongoing management issues. They are able to access services while upholding their cultural identity and maintaining their community life, creating an environment that mitigates against conflict and confrontation.

5.4 Case Study: Whole of Government approach to health and peace-building: A military perspective

*Whole of government: contributions but not without dilemmas*⁶

Military resources can be offered by nations as a component of whole-of-government support to humanitarian aid operations. The primary focus of such forces is generally to deter armed conflict or inter-sectoral violence. Other objectives may be more directly aligned to humanitarian operations such as rapidly providing assistance with transportation, governmental coordination or communications capacities for disrupted communities.

The health capacity of the military in the form of health personnel, facilities, medical resources and transportation are generally deployed in support of the troops tasked with peace monitoring or similar operations. If conditions are stable and the threat to troop safety is low, health resources may be under-utilised and offered to the civil authority to assist in community support.

Fundamental dilemmas present themselves when military commanders and their political masters weight up the necessary guidelines and limits on the nature, scale and duration of support that can be offered when faced with human suffering. Considerations when setting these guidelines and instructions include the:

- quantum of available resources that can be offered to community aid without impinging on first line or prudent reserve stocks required to support the ongoing military mission;
- extent to which aid assistance and community support efforts can reinforce military goals and objectives, thereby contributing to mission success;
- extent that providing community assistance through military capacity may actually hinder the rapid development of independent local capacity or the operations of other agencies;
- ethical dilemmas posed by having to balance short-term but high value assistance over longer term but more fundamental development options; and
- possibility that assistance offered may provide either tacit or implicit support to one community sector or group over others, thereby worsening inter-sectoral tensions.

Effective public health planning traditionally involves multi-sectoral engagement in order to maximise impact. Such comprehensive engagement provides a sound platform from which to operationalise a whole of government approach to peace-building and humanitarian assistance, including the role that military capacity as one element of many possible modes of assistance in such crises.

⁶ Reflections by Major Kerry Clifford, Royal Australian Army Nursing Corps, Master of Health Administration Candidate, School of Public Health and Community Medicine, The University of New South Wales, Australia

In 1999, the Australian-led coalition forces took over control of security in East Timor whilst the occupying Indonesian authorities withdrew. Health support was critical as there were large numbers of displaced, injured and ill East Timorese requiring help. Medical personnel from the forces of contributing nations worked independently and in consort with the United Nations High Commissioner for Refugees (UNHCR) to conduct much needed health clinics around the new nation. By way of comparison, forces remaining twelve months later provided much less direct health care, but provided valuable assistance to international and local health agencies through providing assistance with transport to remote communities and other types of practical support to civilian agency activities.

Good practice of military and civil cooperation

Therefore, the question arises as to whether or not the military can be included in a whole of government approach to peace-building in highly contested areas. As discussed earlier in this paper, the increasing politicisation of humanitarian intervention brings threats and dangers, undermining key humanitarian principles of neutrality and independence. Involving the military in a whole of government approach to peace-building may blur the separation from humanitarian relief work and the ensuing development. Emerging evidence in regards to good practice of military and civil cooperation indicates the following:

- responding to health needs must be free of discrimination;
- humanitarian relief work must make distinctions among civil and military action;
- humanitarian relief work must be carried out free of political pressures and;
- security of humanitarian relief workers must be a priority.

Conclusion

Clearly, as a major public sector, health can play a key role in peace-building but only as part of a whole of government and multi-sectoral approach. The present paper attempts to provide a conceptual overview of the important components of a peace-building framework for health without offering a prescriptive set of actions or activities, a design task that should always be undertaken at the local level to avoid the risk of applying formulaic solutions.

Realism is important in attempting to incorporate a peace-building perspective into health initiatives in conflict-affected societies. It is not practical or feasible to incorporate all the considerations in all contexts. There may be extreme contexts in which it is impossible for health to do more than save lives and reduce morbidity, simply because the humanitarian space has been constrained by warring parties and other interests to the point that the pursuit of peace, or the implementation of a peace-building framework in health, is not feasible. Difficult questions then arise as to whether, at a particular point in the conflict, any humanitarian intervention can be effective and whether the risks involved in acting outweigh those of inaction. The medical maxim, *primum non nocere* (first, do no harm) should always be kept in mind in such settings.

One risk is that the imperative to act to save lives and treat the sick may seem so compelling that it becomes a blanket rationale for ignoring the larger responsibility to ensure that health initiatives are shaped in ways that reduce conflict and promote peace. By requiring all program planners and implementers to consider a peace-building framework, a greater level of awareness can be maintained about its salience, assisting program teams to seize opportunities to introduce peace-building strategies when conditions allow.

Resources and Appendices

Resources and References

Interesting Resources

Berghoff Handbook on Conflict Transformation:
<http://www.berghof-handbook.net/index.htm>

Deadly Connections: the War/Disease Nexus; Human Security Report,
<http://www.humansecurityreport.info/deadlyconnections.htm>

The Psychosocial Working Group: www.forcedmigration.org/psychosocial and
www.qmuc.ac.uk/cihs

A Health-to-Peace Handbook: <http://www.jha.ac/Ref/r005.htm>

WHO Health as a Bridge to Peace and other significant conflict research:
<http://www.who.int/disasters/hbp/general/Documents.htm>

Gender Issues: <http://www.womenwarpeace.org>

Reproductive Health: [http://www.who.int/reproductivehealth/
publications/RHR_00_13_RH_conflict_and_displacement/](http://www.who.int/reproductivehealth/publications/RHR_00_13_RH_conflict_and_displacement/)

Conflict Prevention and Resolution: <http://www.c-r.org>

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Appendix 1: An example of model conflict analysis

Model conflict vulnerability analysis requires an understanding of:

Profile: (the setting of the conflict)

1. Intensity of conflict: high or low?
2. Who are the most vulnerable groups and what is their predicament?
3. Geographic considerations: urban, rural, concentrated, dispersed?
4. What are the main economic resources?

Causes: (the structural, proximate and trigger causes of the conflict)

5. Who controls the main economic resources of the area (eg. land, commodities, trade) and how are these distributed between groups?
6. Are there longstanding grievances held by particular groups?
7. What particular events have sparked political violence?

Actors: (interest, goals, capacities)

8. What are the main social groups in the area?
9. What are the key political and military actors in the area?
10. What is the international presence in the area?
11. What are the differing interests, goals and capacities of these groups?

Impact: (social, economic and political change produced by the conflict)

12. What is the political economy of the conflict in the area (e.g. competition over control of land, commerce, natural resources, selling protection)?
13. What is the specific history of violence in the area and how did it affect individuals, families and communities?
14. Has the conflict generated particular ethnic/tribal/sectarian cleavages?

Dynamics: (trends, opportunities, scenarios)

15. How stable is the conflict in this area?
16. To what extent has a war economy become self-sustaining in this area?
17. What is the relationship between community level and higher level conflicts (eg. district, national, international)?

Adapted from Gaigals, 2001.

Resources

A variety of conflict analysis tools have been developed and are differentiated by their focus. The study 'Conflict-sensitive approaches to development, humanitarian assistance and peace building: tools for peace and conflict impact assessment' provides a detailed outline of different methodologies which have been applied by development practitioners to sensitise aid programs to peace-conflict dynamics.

The most up to date list of "tools" can be found in the CPRN compendium which is hosted at the CIDA website - <http://www.acdi-cida.gc.ca/peace>.

Appendix 2: Health Impact Assessment Frameworks

The following frameworks offer both impact assessments and response planning information for approaching specific conflict-induced health problems in humanitarian relief through development cooperation settings

Analysing Disrupted Health Sector's – A Toolkit

Written by professionals with lengthy experience in conflict and post-conflict situations, the 'toolkit' is designed to provide guidance for analysis of troubled health sectors in :

- countries on the verge of an economic, political and/or military catastrophe,
- protracted crises situations
- situations of transition from disaster to recovery.

Further information : Dr D. Nabarro : nabarrod@who.int. or Dr A. Loretta : lorettia@who.int.

ADAPT (Adaptation and Development After Persecution and Trauma) Framework

ADAPT is a heuristic model for designing, implementing, monitoring and evaluating psychosocial and mental health programs in post conflict countries. The ADAPT framework was developed through concrete experiences with East Timorese populations, initially with refugees in Sydney and then in East Timor. The model proposes an important new direction for donors through a shift from a micro-management model of designing, implementing, monitoring and evaluation of projects to one that incorporates a focus on broader issues of individual, family and community adaptation and development.

Further information : Prof. D Silove : d.silove@unsw.edu.au

Reproductive health during conflict and displacement: a guide for programme – an Inter-agency initiative

Incorporating culturally competent practices throughout, this useful tool includes :

- situation and needs assessments for different phases of conflict and displacement;
- guiding principles for provision of reproductive health care services;
- guiding principles for related community empowerment practices;
- addresses emergency services as well as integrating development approaches;
- addresses programme planning, implementation, assessment
- framework highlights psychosocial responses and supporting community-based groups

Further information : www.who.int/reproductivehealth/publications/

RHR_00_13_RH_conflict_and_displacement/reproductivehealth@who.int

Appendix 3: Health – Conflict Cube Matrix

As each conflict situation is unique given the different context, so too are various analyses used by humanitarian relief and development organisations. Therefore, the following matrix presents a framework for applying a combined assessment using the Health – Conflict Cube. The purpose of the matrix is to reflect on how various stages of conflict may require different action and a range of actors to address specific conflict-related health problems.

Influence on Health Outcomes	Problem (examples listed below)	Priority (immediate, short-term, medium-term, long-term)	Actors (e.g. health services, state, NGOs, civil society, international community)	Recommended Action
Pre-Conflict				
1. Patterns of health and disease	1.1 Rising morbidity and mortality 1.2 Increase substance use / abuse 1.3 Communicable diseases 1.4 Infectious disease (vector-borne, water-related / HIV/AIDS) 1.5 Malnutrition / deficiency disorders 1.6 Food insecurity 1.7 Women's health / reproductive health 1.8 Sexually transmitted infections 1.9 Mental health illness 1.10 Violence-related health issues (injuries) 1.11 Deteriorating health service delivery 1.12 Unavailability of drugs / medical supplies 1.13 Flight of health personnel			
2. Security factors	2.1 Rising inequalities 2.2 Large expenditures on military 2.3 Proliferation of small arms 2.4 Volatility of electoral processes 2.5 Endemic police corruption 2.6 Displacement of large populations			
3. Political / Governance factors	3.1 Human rights violations 3.2 Processes of policy development, participation, and implementation			

	<p>3.3 Poor transparency / accountability</p> <p>3.4 Constitutional exclusivity</p> <p>3.5 Intra-group rivalry</p> <p>3.6 Weak and fractured institutional framework</p> <p>3.7 Ethno-centric voting patterns</p> <p>3.8 Media bias, inaccurate information</p> <p>3.9 Restrictions on civil and political liberties</p> <p>3.10 Marginalised or ineffectual civil society</p>			
4. Social factors	<p>4.1 Multiple conflict cleavages – ethnic, religion, caste</p> <p>4.2 Rising inequalities</p> <p>4.3 Cultural degradation</p> <p>4.4 Social justice issues</p> <p>4.5 Linguistic discrimination</p> <p>4.6 Gender-based violence and discrimination</p> <p>4.7 Youth disaffection</p>			
5. Economic factors	<p>5.1 Rising Poverty</p> <p>5.2 Landlessness</p> <p>5.3 Unemployment</p> <p>5.4 Poor record of economic grievances</p> <p>5.5 Economic stagnation</p> <p>5.6 Skewed income</p> <p>5.7 Employment generation strategy</p> <p>5.8 Indebted labour and debt bondage systems in plantation sector</p>			
6. Environmental / Resource factors	<p>6.1 Land ownership</p> <p>6.2 Environmental degradation</p> <p>6.3 Depletion of mineral and natural resources</p>			

Humanitarian Relief

7. Patterns of health and disease	<p>7.1 Rising morbidity and mortality</p> <p>7.2 Communicable diseases</p> <p>7.3 Infectious disease (vector-borne, water-related / HIV/AIDS)</p> <p>7.4 Malnutrition / deficiency disorders</p> <p>7.5 Food insecurity</p> <p>7.6 Women's health / reproductive health</p> <p>7.7 Sexually transmitted infections</p> <p>7.8 Mental health</p> <p>7.9 Violence-related health issues (injuries)</p> <p>7.10 Deteriorating health service delivery</p>			
8. Security factors	<p>8.1 Forced migration</p>			

	<p>8.2 High security zones prevent civilians from accessing the means of livelihoods</p> <p>8.3 Proliferation of small arms</p> <p>8.4 Landmines</p> <p>8.5 Child abductions</p> <p>8.6 Endemic police corruption</p> <p>8.7 Widespread violence (e.g. against women and children)</p>			
9. Political / Governance factors	<p>9.1 Human rights violations</p> <p>9.2 Poor transparency / accountability</p> <p>9.3 Decision-making process</p> <p>9.4 Intra-group rivalry</p> <p>9.5 Weak and fractured institutional framework</p> <p>9.6 Poor service delivery capacity</p> <p>9.7 Media bias, inaccurate information</p> <p>9.8 Integrity of judiciary</p> <p>9.9 Restrictions on civil and political liberties</p> <p>9.10 Marginalised or ineffectual civil society</p> <p>9.11 Aid conditionality</p>			
10. Social factors	<p>10.1 Multiple conflict cleavages – ethnic, religion, caste</p> <p>10.2 Trust (individuals, service providers, communities, state)</p> <p>10.3 Relationships (peers, intimate partners, family members)</p> <p>10.4 Social / family cohesion (mental health, psychosocial)</p> <p>10.5 Forced migration / migration patterns</p> <p>10.6 Cultural degradation</p> <p>10.7 Social justice issues</p> <p>10.8 Gender-based violence and discrimination</p> <p>10.9 Youth disaffection</p>			
11. Economic factors	<p>11.1 Rising Poverty</p> <p>11.2 Landlessness</p> <p>11.3 Unemployment</p> <p>11.4 Lost of livelihoods</p> <p>11.5 Skewed income</p>			
12. Environmental / Resource factors	<p>12.1 Water and sanitation</p> <p>12.2 Infrastructure damage – transport, etc.</p> <p>12.3 Land ownership</p> <p>12.4 Environmental degradation</p> <p>12.5 Depletion of mineral and natural resources</p> <p>12.6 Rapid demographic changes</p>			

Transitional Phase

<p>13. Patterns of health and disease</p>	<p>13.1 Increase substance use / abuse 13.2 Communicable diseases 13.3 Infectious disease (vector-borne, water-related / HIV/AIDS) 13.4 Malnutrition / deficiency disorders 13.5 Food insecurity 13.6 Women's health / reproductive health 13.7 Sexually transmitted infections 13.8 Mental health 13.9 Violence-related health issues (injuries) 13.10 Deteriorating health service delivery</p>		
<p>14. Security factors</p>	<p>14.1 Forced migration 14.2 Legacy of violence / atrocities 14.3 High security zones prevent civilians from accessing the means of livelihoods 14.4 Landmines 14.5 Demilitarisation</p>		
<p>15. Political / Governance factors</p>	<p>15.1 Human rights violations 15.2 Processes of policy development, participation, implementation 15.3 Poor transparency / accountability 15.4 Decision-making process 15.5 Intra-group rivalry 15.6 Weak and fractured institutional framework 15.7 Poor service delivery capacity 15.8 Integrity of judiciary 15.9 Restrictions on civil and political liberties 15.10 Marginalised or ineffectual civil society</p>		
<p>16. Social factors</p>	<p>16.1 Multiple conflict cleavages – ethnic, religion, caste 16.2 Trust (individuals, service providers, communities, state) 16.3 Relationships (peers, intimate partners, family members) 16.4 Social / family cohesion (mental health, psychosocial) 16.5 Forced migration / migration patterns 16.6 Social justice issues 16.7 Community participation 16.8 Gender-based violence and discrimination 16.9 Youth disaffection</p>		

17. Economic factors	17.1 Rising Poverty 17.2 Landlessness 17.3 Unemployment 17.4 Loss of livelihoods 17.5 HIV/AIDS leading to lost economic opportunities 17.6 Economic stagnation 17.7 Skewed income 17.8 Employment generation strategy 17.9 Indebted labour and debt bondage systems in plantation sector		
18. Environmental / Resource factors	18.1 Water and sanitation 18.2 Infrastructure damage – transport, etc. 18.3 Land ownership 18.4 Environmental degradation 18.5 Depletion of mineral and natural resources 18.6 Rapid demographic changes		

Development Cooperation

19. Patterns of health and disease	19.1 Increase substance use / abuse 19.2 Communicable diseases 19.3 Infectious disease (vector-borne, water-related / HIV/AIDS) 19.4 Malnutrition / deficiency disorders 19.5 Food insecurity 19.6 Women's health / reproductive health 19.7 Sexually transmitted infections 19.8 Mental health 19.9 Violence-related health issues (injuries) 19.10 Deteriorating health service delivery		
20. Security factors	20.1 Legacy of violence / atrocities 20.2 Landmines 20.3 Demilitarisation 20.4 Endemic police corruption		
21. Political / Governance factors	21.1 Human rights violations 21.2 Processes of policy development, participation, implementation 21.3 Decision-making process 21.4 Intra-group rivalry 21.5 Weak and fractured institutional framework 21.6 Poor service delivery capacity 21.7 Political posturing		

	<p>21.8 Ethno-centric voting patterns</p> <p>21.9 Media bias, inaccurate information</p> <p>21.10 Integrity of judiciary</p> <p>21.11 Restrictions on civil and political liberties</p> <p>21.12 Marginalised or ineffectual civil society</p> <p>21.13 Aid conditionality</p>			
22. Social factors	<p>22.1 Multiple conflict cleavages – ethnic, religion, caste</p> <p>22.2 Trust (individuals, service providers, communities, state)</p> <p>22.3 Relationships (peers, intimate partners, family members)</p> <p>22.4 Social / family cohesion (mental health, psychosocial)</p> <p>22.5 Social justice issues</p> <p>22.6 Community participation</p> <p>22.7 Gender-based violence and discrimination</p> <p>22.8 Youth disaffection</p> <p>22.9 HIV/AIDS leading to demographic imbalances</p>			
23. Economic factors	<p>23.1 Rising Poverty</p> <p>23.2 Landlessness</p> <p>23.3 Unemployment</p> <p>23.4 Rising inequalities</p> <p>23.5 Lost of livelihoods</p> <p>23.6 HIV/AIDS leading to lost economic opportunities</p> <p>23.7 Economic stagnation</p> <p>23.8 Skewed income</p> <p>23.9 Employment generation strategy</p> <p>23.10 Indebted labour and debt bondage systems in plantation sector</p>			
24. Environmental / Resource- factors	<p>24.1 Water and sanitation</p> <p>24.2 Infrastructure damage – transport, etc.</p> <p>24.3 Land ownership</p> <p>24.4 Fisheries stock management</p> <p>24.5 Environmental degradation</p> <p>24.6 Depletion of mineral and natural resources</p> <p>24.7 Rapid demographic changes</p>			

Appendix 4: Health and Peace-building Filters

Specific issues to consider in the design, monitoring and evaluation of programs

Guiding Principles	Issues	Questions	Descriptive Response	Recommended action
Conflict Sensitivity	Conflict Management	<ul style="list-style-type: none"> How does the program include training in conflict management? How does the program support conflict management, resolution and negotiations skills? 	•	•
	Trust	<ul style="list-style-type: none"> How does the program focus specifically on building institutions and practices that promote trust between providers and patients? More specifically, is there a place within the programs for inclusion of peace training initiatives that promote conflict resolution, negotiation and compromise skills)? How does the program contribute to fostering trust and reconciliation within an institutional setting and across society as a whole? 	•	•
Cultural Competence	Non-violence	<ul style="list-style-type: none"> How does the program make explicit provisions for protecting vulnerable groups in collaboration with other sectors? How does the program explicitly include provisions for reducing violence both within the institution and in the wider community? 	•	•
	Cultural competence	<ul style="list-style-type: none"> How does the program bridge the gap between local / indigenous approaches to health care and imported approaches to ensure coherence and respect for tradition? How does the program stimulate wider cultural competence and ability to work and manage environments in which multiple groups are present? 	•	•
Equity and Human Rights	Equity	<ul style="list-style-type: none"> How does the program increase equitable access to health services and/or opportunities for health promotion? How does the program increase equity in the distribution of health resources (e.g. people, materials, money)? How does the program address charged / politicised environments in which people are operating may worsen equity? 	•	•
	Non-discrimination	<ul style="list-style-type: none"> How does the program make provisions for relevant vulnerable groups (e.g. single mothers, unaccompanied minors, survivors of rape and domestic violence, ex-combatants, child soldiers, torture survivors)? How does the program ensure that non-discriminatory practices are adopted both in recruitment of staff of health projects and the delivery of services in the community? 	•	•

	Human rights and Social justice	<ul style="list-style-type: none"> • How does the program explicitly aim to promote dignity and respect for patients, community members and all social subgroups? • Have human rights and social justice considerations been considered not only in principle but in the actual implementation of the program? • Have issues of gender equity been integrated in all areas of program development? • Are there explicit and fair grievance procedures for staff, patients and the community? 	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> •
Social Cohesion	Social cohesion	<ul style="list-style-type: none"> • How does the program strengthen social ties with the aim of explicitly bridging the divide amongst groups while respecting cultural diversity and political pluralism? • How does the program build community responsibility and capacity (e.g. were community members involved in all areas of assessment, planning, implementation, monitoring?) • How does the program empower women and children? 	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> •
	Psycho-social	<ul style="list-style-type: none"> • How does the program recognize the close nexus between physical, psychological and social health and the conflict-related risks that involve all of these aspects? • How does the program recognize the impact of human rights violations in all its manifestations and how such problems should be addressed in developing new health frameworks? • How does the program reinforce and build upon positive coping mechanisms, adaptations and community resilience? 	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> •
Health Conditions and Systems	Transparency and Good governance	<ul style="list-style-type: none"> • Are the procedures followed transparent and open to auditing? • How does the program enhance good governance at an institutional level? • Are all stakeholders kept informed of developments and able to feel part of the process? 	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> •
	Capacity building and community empowerment	<ul style="list-style-type: none"> • How does the program build community responsibility, inclusiveness and capacity: were community members involved in all areas of assessment, planning, implementation, and monitoring? • How does the program strengthen the ability of communities to influence and elicit greater accountability from central service providers and government departments? 	<ul style="list-style-type: none"> • 	<ul style="list-style-type: none"> •

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