Lesson X.X: XXXXX

MPW Course 5: Peace through Health in violent conflict

General objectives
For centuries health professionals have had to respond to the death, sickness and injury that results from armed conflict. They do so in both the acute and post-conflict stages, and respond to the increased needs of different groups in various roles: as community, public or private health workers; as members of humanitarian organizations; and as part of the armed forces.

The historical relationship between war and medicine has changed over the centuries, into the sometimes still complex relations between them today, including the current debate about armed forces’ involvement in humanitarian assistance, much of which relates to health.

Health professionals have sought to promote peace, prevent conflict and mitigate its effects in various ways, and ensure that their own actions do no harm. They need to be aware of these concepts and the experience of their implementation, in order to analyse a particular situation and select appropriate interventions.

The need to promote peace and prevent a resurgence of conflict continues long after active fighting has finished. Psychosocial issues will need addressing, and issues of reconciliation and justice.

A greater awareness of these issues will encourage more effective peace-health interventions in armed conflict and its aftermath, and enable health workers to make a significant contribution to preventing conflict and promoting peace.

By the end of this course you will be able to:
• describe key aspects of the history of war and medicine and how they are interrelated in different contexts
• understand how health and health care are influenced by war
The Medical Peace Work textbook, 2nd edition

Course 5: Peace through Health in violent conflict

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Chapter 1: Medical assistance in violent conflict

Intermediate objectives

In this chapter you will learn about the history of war and medicine and that the relationship between them is mediated by context. You will also learn about how health and health care are influenced by war.
Lesson 1.1: Changing attitudes to health and illness during violent conflict

Author: Leo van Bergen

Health workers, war and illness

The history of medical treatment in times of war shows how attitudes to the concept of ‘health’ change. From the second half of the 19th century, the meaning of the word ‘health’ changed in Western Europe. When the First World War broke out in 1914, ideas about health were less determined by how people perceived their own health. ‘Health’ was seen as the physical and mental sanity of a bigger whole – the nation, the people and the ‘race’. This meant that, in the context of military service, the decisive factor in medical treatment was not an individual’s health but the strength of the armed forces, or even the strength of the nation. The individual’s health was secondary to the health of the bigger whole.

Let us explore these statements further as we consider the issues of health and medicine in wartime, focusing on the First and Second World War.

Medical examination

The medical examination of new military recruits was often seen as a measure of the nation’s health. The general level of the recruits’ health was considered a measure of the public’s physical and mental health. Recruits, so doctors said, had to be mentally and physically very fit to be able to wage a war, but...
often they were not. As a consequence doctors began to tackle issues like alcoholism and prostitution, blamed for the recruit’s poor condition and (therefore) the nation’s degeneration. It was even claimed that these recruits would become healthier through their participation in war: fighting not only required but also developed strength and spirit. The fact that a number of these ‘healthy specimens’ would be killed probably did not undermine the general effect; if so, it could be undone by a specific procreation programme after the war had ended. This mindset led some doctors to change their view of war from being ‘unhealthy’ to being ‘healing’.

Moreover, it was expected that very weak soldiers would not be able to endure (or live through) the war, so also in that sense conflict would have a cleansing effect on the state of the nation’s health. According to many doctors, war was not only a good place to work (because of the abundance of ill and wounded people), but war was a doctor itself; according to the German surgeon Sauerbruch, the ‘bloody teacher’.

**Illness in war and peace**

Illness in wartime was perceived very differently from illness in peacetime. People who would normally be declared ill were considered fighting fit in times of war. No one was at their best in the muddy trenches of the First World War, packed with lice, rats and corpses, or in the cold of the Russian winter (Figure 2), but reporting sick merely for the reason of ‘not feeling well’ was pointless. Often the soldiers did not even attempt to complain about being ill because they would run the risk of being branded a baby, a slacker or a malingering by the doctor. In other words, soldiers had to be extremely ill to be declared ill in wartime. There was hardly any other option for military planners: given the unhealthy conditions in which both world wars were fought, there would have been few soldiers left to fight.

As a German soldier wrote from Stalingrad in 1943: ‘My hands are done for, and have been ever since the beginning of December. The little finger of my left hand is missing and – what’s even worse – the three middle fingers of my right one are frozen. I can only hold my mug with my thumb and little finger. I’m pretty helpless; only when a man has lost any fingers does he see how much he needs then for the smallest jobs. The best thing I can do with the little finger is to shoot with it.’

*Source: www.historylearningsite.co.uk/battle_of_stalingrad.htm*
Illness and the soldier’s duties

Furthermore, illness was not considered in relation to the patient’s general wellbeing. Real illness made the soldier’s duties impossible. A severe cold rarely got in the way of performing those duties. As long as someone could move his legs, wave his arms or pull a trigger, there was no reason to declare him ill. Particularly in times of shortage of recruits, the criteria for determining who was ill were substantially raised, and doctors who were inclined to declare soldiers ill were overruled.

Typical examples of complaints and their classifications in the armies of the First World War include:

- cold, minor influenza, slightly raised temperature: not ill
- fatigue: not ill
- shell-shock (what the British called psychological and/or neurological problems): cowardice
- venereal disease: a criminal offence
- trench foot: a criminal offence, because it was said that if the soldier had followed hygiene regulations he would not have caught the disease.

Ill or injured?

Wartime also saw changes in the ascribed meanings of the terms ‘injury’ and ‘illness’. For instance, in the British army people were declared ‘wounded’ when ill or injured as a consequence of acts of war, and ‘ill’ when their injuries or illnesses were not caused by the war. In other words, a soldier was declared ‘injured’ when his illness, also in the eyes of often suspicious doctors, was clearly a result of the war, while a soldier who had been injured but not as a result of acts of war was declared ‘ill’.

These official definition changes (see the terms ‘shell shock-sick’ and ‘shell shock-wounded’) were driven by economics. Only those who had been ‘injured’ deserved retirement, so it the doctors’ task to declare as many soldiers as possible ‘ill’, in order to save the government paying pensions. As a result combatants did not always regard military doctors sympathetically: the abbreviation RAMC (Royal Army Medical Corps) also stood for Rob All My Comrades.
Combatants suffering from mental illness

<table>
<thead>
<tr>
<th>Armed forces</th>
<th>Numbers affected by mental illness</th>
</tr>
</thead>
</table>
| British      | Official figures: 80 000 ‘shell-shocked’ soldiers  
               Unofficial: numbers unknown, but much higher |
| German       | Approximately 600 000               |

Table 1: Men suffering from mental illness in the First World War (Ellis 1976:118, Binneveld 1995:81)

We have seen that for the treatment of combatants whose mental health was affected by war, it was important whether they were declared ‘ill’ or ‘injured’. But there was more. In Germany a soldier was seen as a ‘battlefield worker’. Soldiers were thought of in economic terms, so a psychologically healthy soldier was considered the paragon of a ‘man’ and therefore of a ‘worker’, which was considered the same thing. If a soldier was a battlefield worker, one who was psychologically damaged was therefore seen as a soldier on strike. He nevertheless could remain a man – be reinstalled as a worker – if his doctors could make him accept other tasks the government wished him to carry out, mostly in the weapons industry. In that case he still did his bit for the war-effort and was no longer a nuisance at the front.

In France and the UK, on the contrary, a mentally ill combatant was seen by the state and most psychiatrists as a man who had turned into a woman. Recovery therefore meant restoring the man in him, and this was considered done by returning him to the battlefield, enabling him to face battle again.

Military psychiatry

There were a number of debates during the First World War about the treatment of mentally ill combatants. Military psychiatric services were established at the outbreak of war for economic rather than humanitarian reasons, as the cost of providing the service was expected to be smaller than pension costs. The problem of mental illness turned out to be much bigger than expected. It therefore became essential that as many soldiers as possible were declared fit, so harsh treatments were invented such as ‘the electricity cure’ (Figure 4).
In a hospital like a military barracks, doctors such as the German Kaufmann and the Englishman Yealland placed an electric current on the arm, leg or, if the soldier was mute, the mouth. Combined with the repeated command ‘Thou shalt heal’, this continued until the desired effect had occurred, although in some cases the patient died first. Combatants became as frightened of the hospital as the front. After the return to the front (or as we saw, the weapons factory), the combatant could be declared ‘healthy’.

Figure 4: The electricity cure used by Kaufmann in Germany and Yealland in the UK (Binneveld 1995)

Mental health issues were dealt with differently during the Second World War because the problem was smaller – partly because it was a war of movement, the associated psychological problems were smaller in numbers than those in static and more stressful trench warfare. But it was also an ideological matter, especially for the Axis powers: a true German or Japanese combatant did not become neurotic or psychotic, and if he did he would probably be shot. This could be the reason why there was an epidemic of intestinal and stomach complaints in the German Army in 1939–1945. Some were probably psychological problems translated into physical – and therefore less dangerous – ones.

Understanding of mental health problems in conflict has grown since the First World War. It is now widely acknowledged that wartime experiences may lead to conditions such as depression, anxiety disorder and post-traumatic stress disorder that reflect unconscious psychological processes rather than moral failings. The armed forces of many nations now employ psychiatrists, including among front-line troops, to deal with the psychological stresses of warfare.

Most western countries have also introduced psychological screening programmes to assess the mental health of combatants. This is an attempt to ensure that those with severe mental health problems are not put in a situation that could cause their condition to deteriorate. Nevertheless, US soldiers with severe mental health problems triggered by previous conflict experiences have reportedly been sent back to fight in Iraq. They were said to be volunteers willing to return to action in spite of (or perhaps because of) their mental health problems (Rogers 2006).
Lesson 1.1: Changing attitudes to health and illness during violent conflict

References


Lesson 1.2: The relationship between war and medicine

Author: Leo van Bergen

Introduction

When discussing plastic surgery during the First World War, Rotterdam professor Van der Meulen said the irony of war was that where destruction is intended and attained, reconstruction is also inevitably the result. War was good for medicine, for ‘destruction brings people face to face with their insignificance and forces them to search for an alternative. The more ingenious the methods of destruction, the more salutary are the restoring alternatives,’ he said (Neelissen 2002: 9). However, is the relationship between war and medicine – translated by Cooter (1993) as ‘the goodness of war for medicine’ – really this simple? Is it not much more complicated than just lots of wounded, lots of practice, lots of ingenuity and therefore lots of medical evolution? (Van Bergen 2007).

War leads to medical inventions

Many doctors have continued to argue that, however terrible, war at least promotes medicine and medical science. They often point to innovations ascribed to the First and Second World Wars. A number of advances in clinical practice and research do indeed owe something to experience gained during warfare (Ponteva 2002).

They include:

- the proper treatment of infected wounds
- the external fixation of limb fractures
- methods of treating gangrene, trench foot, cold injuries and burns
- neurosurgery
- reconstructive surgery
- understanding stress reactions and disorders
- immediate support in critical situations
- catastrophe and disaster medicine.

Learning objectives

By the end of this lesson you should be able to:

- outline why war is often considered good for the development of medicine
- assess the relationship between war and medicine.
War: the bloody teacher

German surgeon Ferdinand Sauerbruch talked about war as ‘the bloody teacher’ (Sauerbruch 1951). Many doctors, especially surgeons, think that they can benefit from war, entering it with limited experience but emerging as accomplished professionals. Sauerbruch was speaking of the First World War and others shared this view of that war. Many doctors in 1914 thought war would be beneficial both for medical science and for the mental and physical condition of combatants. This notion did not disappear when the war turned out to be longer and more bloody than expected.

The idea also survived the Second World War, lingering into the second half of the 20th century. It is still current, although few would accept the idea in a 1960s NATO handbook that while a nuclear war might bring misery, it would increase knowledge of radiation sickness.

The basic idea behind these assertions is that war causes an abundance of diseases and injuries on which new treatments and interventions can be tested and old methods rejected. This benefits civilians in times of peace and combatants in times of war. There are current examples of medical technology and skill that have their origins in wartime. Yet we can question whether war is needed for the advancement of medicine:

- Could this knowledge have been gained without war?
- Have wars produced knowledge simply because every human activity and every period yields knowledge?
- Is a discovery in wartime valuable for other times – whether peace or another war?
- Does war provide the right environment for testing new methods and techniques?

First, the relationship between medical advance and armed conflict is not as direct as supposed by Sauerbruch, Van der Meulen and many others. For instance, Van der Meulen saw the Esser Inlay, which prevents necrosis of transplanted skin, as a direct consequence of the work of Dutch plastic surgeon Johannes Esser in Austro-Hungarian hospitals during 1914–1918. The inlay was first tested on deformed war victims, but there is no reason to assume Esser would never have tried it if he had dealt not with war victims but, say, victims of accidents. We can justifiably ask whether the connection of the invention to the war hospitals around Vienna and Budapest was coincidental rather than inevitable, and whether it was first tested on war victims simply because it was wartime and Esser worked in a war hospital.

Sometimes the evidence about the relationship between medicine and war is unreliable, for example the circumstances surrounding the industrial production of penicillin. Alexander Fleming published his discovery of the bacteria-destroying
nature of penicillin in 1929, but industrial production was not started until the 1940s. This was often assumed to be partly the result of its widespread use during the Second World War – but although its general application would have been slower without the war, it would have happened anyway. Penicillin was first used on a large scale after a big (not war-related) fire in Boston, USA in 1942, and it was placed at the disposal of military doctors only after it had showed its success there.

**Does war advance medical research?**

We can also ask questions from a scientific research viewpoint. The preconditions for scientific advancement were not favourable in wartime, although they are better in modern wars such as Iraq and Afghanistan than in the two world wars.

- Many medical experiments took place in terrible circumstances (which was why the experiments had to take place – higher chance of infection; bad or no medical instruments etc.)
- From time to time injured people were used without their consent to try out experimental treatment methods.
- These experiments were often no more than a test that would normally have been carried out on mice or rats, but for which humans were now available. There was no expectation of success, only a vague hope. Few were successful, many were not and often had disastrous consequences.
- Some tests were not conducted for the wellbeing of the patient, but to satisfy medical curiosity.
- These tests were not replicable in peacetime, for ethical reasons and because the circumstances leading to the experiments were absent for attaining real knowledge.
- The possibilities for exchange of knowledge at national and international level were limited, and long-term observation was practically non-existent.

**Is the absence of war better for medical science?**

The tranquillity and orderliness of peacetime were and are beneficial for medical science. Germany lost its rank in medical science because of the 1933–1945 Nazi period. If it had won the war, the relationship between smoking and cancer – proved in Germany in the 1930s – would have been common knowledge much sooner. Exchange of medical knowledge between East and West during the Cold War was also limited. Nevertheless, compared with wartime, the reduced animosity after 1918 and 1945 led to greater exchange of knowledge across national boundaries. This positive relationship between peace and medicine is rarely acknowledged. If peace is at least as good for medicine as war, then the statement ‘war is good for medicine’ carries no weight.
**War and clinical practice**

These remarks mainly touch on medical scientific research. The utility of war for the advancement of clinical practice is also questionable.

War medicine and civil medicine generally differ too much for solutions found in one situation to be transferable to the other. Problems that demand a solution in war, for example from exploding grenades or poison gas, rarely occur in peacetime. Secondly, many treatments performed by doctors in wartime were on wounds they would rarely see in war, let alone less violent times (Figures 1 and 2). This was why the Walter Reed Military Medical Hospital in Washington DC, US, published War Surgery in Afghanistan and Iraq in 2008. Even trauma surgeons in the most violent parts of New York and other American cities were astonished when they saw these injuries (Shawn et al. 2008), Van Bergen et al. 2010).

Thirdly, the acquired knowledge was of limited value even in frequently occurring cases. Gas gangrene was common in the First World War, but a cure was not found before the end of the war, and afterwards it became as rare as it had been before 1914.
In every major war, health workers face problems for which their civil education and experience do not prepare them. Similarly, the solutions they find in practice will rarely if ever be needed outside that particular war.

**Is war good for surgery?**

All this sheds a different light on the statement that war triggers the advancement of surgical procedures. Energies are directed towards faster recovery, not better recovery. Many injured in the two world wars lost limbs that would not have been amputated under less pressure of time. If the injured person was a civilian, especially a woman or child, the chance of being helped was even slimmer. The inevitable search for alternative treatments, seen as an advantage of war, was frequently not pursued and all too often interrupted to change to a familiar method.

At best, health workers learned how to treat the most common injuries quickly. This means that war medicine, generally speaking, and especially at the front, was essentially conservative.

**What is a 'good doctor'?**

Civilian doctors and nurses are supposed to act as the patient’s friend, but recovery of injured soldiers in wartime often meant returning to the front and was often tantamount to ‘sufficiently recovered to return to fighting’.

The patient did not always want to return to combat. There were many self-inflicted injuries; attempts to make an injury or illness appear worse than it really was; and attempts to feign an illness.

Health workers may burn out or lose their humanity when dealing with the vast number of wounded in a violent conflict, and the nature of their wounds. The possible effects of violating professional ethical codes during conflict may affect the health worker’s attitude and practice in peacetime.

Furthermore, there is an unwanted but sometimes inevitable – and in a certain sense even necessary – danger that doctors working in conflict zones become emotionally indifferent. When so many people are dying, one more or less is insignificant. Military doctors and nurses, and health workers in modern conflict settings such as Rwanda, experience this effect. Otherwise the work could become emotionally impossible to bear, but it can result in indifference to patients’ needs in peacetime. So even if surgeons return from war as accomplished technicians, they are not necessarily ‘better doctors’. In this sense too, war is not necessarily good for medicine.
Conclusion

During both world wars, military and Red Cross health care and indeed medicine in general was geared towards the availability of services rather than recovery of patients. It focused on treatment of conditions often so closely related to the circumstances of war that their value for other times can easily be overrated. Medical skills learned in times of war are not necessarily of much value in times of peace.

Furthermore, almost every precondition necessary for medical research is absent:

- rest and time
- the possibility of exchanging ideas, especially at international level
- the presence of control groups
- concern for the long-term effects of treatment
- the possibility of monitoring and repeating experiments.

The relationship between war and the advance of medicine is therefore not as straightforward as it might seem.

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Lesson 1.3: Military medicine in the 20th century

Authors: Leo van Bergen and Gideon Ertner

The role of military medicine

Military medicine is the care and treatment of sick and wounded combatants given by professional armed forces health services and auxiliary services under military command. From the standpoint of violence prevention, it always has and always will struggle with one dilemma: efficient military medical services save many lives, but also help armed forces to continue warfare, and therefore also indirectly endanger life.

Military medicine has no role in the primary prevention of war, because if primary prevention succeeded, it would not be needed. It has been successful in secondary prevention, dealing with war casualties (Figure 1).

Since the beginning of the 20th century, as a result of hygiene and bacteriology, disease is no longer the major cause of death for fighting armies. It remains the major cause of ‘non-effective’ person days – the total number of days a combatant was unable to participate in the fighting – because an ill survivor took longer to recover than a wounded one. Between the 1860s American Civil War and the 1960s Vietnam War, the number of American combatants dying from wounds fell from 20% to 2% of all wounded. However, changes in the correlation between site of wound and fatality have been negligible.

Figure 1: A neat picture of military medicine

Learning objectives

By the end of this lesson you will be able to:

- identify the attributes of military medicine
- describe the dilemmas of working in military medicine and some ways of dealing with them
During the American Civil War just over 40% of fatal wounds were in the head, face and neck, and this was still the case a century later. This small part of the body kept on causing many fatalities despite helmets and other protective devices.

The relationship between the number of instant deaths and the number of wounded has also remained roughly the same throughout the centuries, according to casualty figures (though these are not reliable). Despite changes in weaponry that have resulted in many more dead and wounded, and changes in health knowledge resulting in many more lives saved the ratio was and still is approximately one death to every four wounded.

**Divided loyalties**

Just like other health professionals, military health professionals are obliged to work in their patients’ interest, but they must also do what is best for the armed forces, maintaining morale and fighting strength. They thus have dual or divided loyalties, both to the patient and to the military organization.

This dual loyalty may from time to time lead to conflict, or at least tension. What is good for the individual patient is not necessarily best for the army. For instance, from a military point of view it is better to take care of the mildly wounded before the severely wounded, because the latter will be unable to play a part in war again, at least in the short term.

Dual loyalty is not limited to military health professionals. Civilian health professionals also have loyalty to both their employers and their patients, and to their professional codes and to the law of the land which may influence the cost and type of care offered. They also have a duty to society in general, which may require disclosing otherwise confidential information, for example when the patient presents a danger to others (Carter 2007). Nevertheless, military medicine presents some specific ethical dilemmas that we will look at here. You can learn more about dual loyalty in Course 2, Lesson 1.2.

**Dilemmas faced by military doctors**

Though it is the doctor’s job to heal his or her patients, getting wounded combatants back on their feet means they will have to face danger again, and therefore the chance of further physical and/or mental damage. There is also a risk that military doctors and psychologists could face pressure from military command in need of manpower to declare wounded and sick soldiers mentally or physically healthy so that they can remain in or return to the fighting forces.

A conflict of loyalty may also arise if a soldier disclosed to a military health professional that he had been drinking alcohol on duty or using illegal substances.
(Pearce & Saul 2006). Even though he has broken military rules, he is still entitled to confidentiality just as a civilian patient is. As always, however, the rule of confidentiality may be waived if a patient presents a danger to others.

When health staff of foreign occupying or peacekeeping forces treat local civilians, the responsible course of action might be to keep the patients in their care for as long as possible, but pressure may be exerted to transfer them to an inadequate civilian facility in order to make hospital beds available for combatants (Henning 2009). There may be questions about using supplies intended for combatants. As will be made clear in Lesson 1.6, however, the Additional Protocols to the Geneva Conventions demand that all sick and injured persons should, as far as possible, be given the care they need; treatment should not be differentiated on anything other than health grounds. These rules of war are not always followed.

It may at times be medically necessary to evacuate the patient to a higher-grade facility, for example in the homeland of a Western occupying or peacekeeping force. Military superiors may agree to transport the patient. However, the doctor must consider whether he or she is serving a patient’s needs by transferring them to a foreign country. Local authorities may refuse to allow the transfer (Pearce & Saul 2006).

Military health services may also be competing with local health facilities. If they become the main source of health care for the local population, they may undermine the local health system (Tobin 2005; Henning 2009). They may also exacerbate local tensions if they, even unintentionally, provide health services preferentially to some parties to the conflict (Tobin 2005). These issues are covered more extensively in the context of humanitarian agencies in Chapter 2.

**Medical aid as military strategy**

Military medicine is always a military necessity, but is sometimes used as a deliberate part of military strategy. It is the carrot in the ‘carrot and stick’-strategy, often used in guerrilla warfare. Health care is scarce in times of war and therefore a weapon in the hands of warring parties. It can make populations trust the aid-giving party by winning their ‘hearts and minds’, in the hope that they will give information about the enemy. Medical aid was used in this way in Indonesia after the Second World War and in Vietnam in the 1960s, when Howard Levy, an American doctor was sentenced to jail for refusing to work in the medical units used for this tactic. In recent wars such as Afghanistan and Iraq, providing health services to local civilians has been part of a ‘winning hearts and minds’ approach (Van Bergen 2004).

There are two major problems with this approach. First, health care is not just considered as the good end it is in itself, but also in utilitarian terms as a means to
win wars. Among other things, this may have the effect of blurring the distinction between military and humanitarian aid, and make health workers legitimate targets of war (this issue is discussed in further detail in Lesson 1.5). Second, military health workers are neither specifically trained nor equipped to treat many conditions found in civilians, especially relating to women and children (Von Bertele 2006, Pearce & Saul 2006).

On the other hand, military health workers have a duty to treat sick and injured people who present to them for treatment, and to refuse to do so is not in accord with either professional ethical standards or international law (see Lesson 1.6). In fact, there is often pressure from the military health community itself to provide more care for civilians on assignments (von Bertele 2006; personal correspondence with Dr Jens Tingleff).

A related issue is that of health workers carrying arms in self-defence or as part of military patrols, or avoiding marking their facilities so they will not present a target to the enemy. This may compromise the status of health workers as non-combatants under the Geneva Conventions (Pearce & Saul 2006).

**Norms and regulations**

Military health professionals are generally taught and obey international regulations, such as the Geneva Conventions, but they also have to obey national regulations and military orders that may conflict with international law. It has been said that they should not have to obey ‘unlawful orders’, but it is not always clear what ‘unlawful’ means, and it may jeopardize their future career if they protest against orders that endanger their patients.

Impartiality, for instance, is a medical ground-rule. However, imagine that you are a military doctor deployed with the army of your home country and that one evening you are the only surgeon available in the theatre. Now, two badly wounded soldiers arrive at the same time, one from your own unit and the other an enemy, and you have to choose which one to operate. It could be tempting to make this choice on other than strictly health grounds. Most people will instinctively feel a loyalty to one’s comrades. Moreover, choosing to treat the ‘hostile’ wounded will not strengthen your own forces and may endanger the mission.

Nevertheless, this area is regulated by the Geneva Conventions, which state that ‘members of the armed forces and other persons mentioned in the following Article, who are wounded or sick, shall be respected and protected in all circumstances’ (First Convention, Article 12). ‘They shall be treated humanely and cared for by the Party to the conflict in whose power they may be, without any adverse distinction founded on sex, race, nationality, religion, political opinions, or any other similar criteria. Any attempts upon their lives, or violence to their persons, shall be strictly prohibited; in particular, they shall not be murdered or
exterminated, subjected to torture or to biological experiments; they shall not wilfully be left without medical assistance and care, nor shall conditions exposing them to contagion or infection be created. Only urgent medical reasons will authorize priority in the order of treatment to be administered.’

Thus it is laid down in international law that when caring for enemy combatants, military health workers should apply the same ethical code as civilian colleagues. This is mostly respected in Western armed forces, although there have been examples of the contrary happening too, for instance in Iraq and in the role of doctors during the ‘war on terror’. Nevertheless, there is some evidence that the degree of democratization and the amount of free press in a country has some positive effect on upholding the Geneva regulations. Doctors and nurses in autocratic states in general may find it harder to uphold the Convention in the face of opposition from military superiors.

Alleged complicity of doctors in mistreatment of so-called ‘unlawful combatants’ by US authorities is a notable recent example of doctors being implicated in human rights abuses in a Western context. The US claims that terror suspects do not enjoy the status and privileges of prisoners of war – but whatever their legal status, they should not be deprived of the protections in Article 3 of the Geneva Conventions. This states that torture and cruel, humiliating and degrading treatment are forbidden at any time and in any place whatsoever (Singh 2003).

Guidelines for military medicine

To help handle the difficult dilemmas faced by military health workers, an International Dual Loyalty Working Group proposed the following guidelines (IDLWG 2002):

1 | The military health professional’s first and overruling identity and priority is that of a health professional.
2 | Civilian medical ethics apply to military health professionals as they do to civilian practitioners.
3 | The military health professional should adhere to the principle of confidentiality in a manner consistent with practice in civil society.
4 | The military health professional is a member of the national and international health professionals’ community.
5 | The military health professional should treat the sick and wounded according to the rules of medical needs and triage.
6 | Military health professionals should not participate in research or development of chemical or biological weapons that could be used for purposes of killing, disabling, torturing or in any way harming human life.
7 | The military health professional should refrain from direct, indirect and administrative forms of cooperation in torture and cruel, inhuman and degrading treatment and punishment at all times, including in wartime and during interrogation of prisoners.

8 | The military health professional should refrain from direct, indirect, preparatory and administrative participation in capital punishment, both within the military court martial system and elsewhere.

9 | Military health professionals should report violations of human rights that interfere with their ability to comply with their duty of loyalty to patients to appropriate authorities and report human rights violations (especially of the Geneva conventions) perpetrated by their own troops as well as by others.

10 | The health professional should not engage or participate in any form of human experimentation among members of military services unless the research will provide significant health and other benefits for military personnel and facilitate promotion of their human rights.

**Conclusion**

Can a military health worker acting strictly according to the above guidelines actually work in a military setting? As we have seen, most of the content of the guidelines is already covered by the Geneva Conventions, which demand that military medicine must follow established medical ethics. In contemporary warfare, where technologically superior Western forces fight much worse equipped ones, international law is usually – though as said certainly not always – respected by Western forces (also because these rules are based on Western norms and values). That others apparently break or bend the rules more often has therefore not only to do with the absence of free press and democracy, but also because, being technologically inferior, it is the only way they can win.

Furthermore, Western forces often have an added incentive to ensure that the local population’s health needs are met; having well-disposed local people may be crucial to the war effort (personal correspondence with Tingleff). In this setting (though not necessarily in others) military health workers will usually be allowed to adhere to their professional ethics. Should a conflict nevertheless arise between ethical values and the orders of superiors, the health worker must of course take a decision according to conscience, and is obliged to respect international law.
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Lesson 1.4: Humanitarian health aid

Author: Marion Birch

Health care is health care – why humanitarian?

To understand the role of humanitarian agencies in relation to medicine, it is important to consider the word ‘humanitarian’. At its heart is the concept of being ‘concerned with or seeking to promote human welfare’ (New Oxford English Dictionary). The International Committee of the Red Cross (ICRC) is often considered the first humanitarian agency of modern times: its mission statement describes it as ‘an impartial, neutral and independent organization whose exclusively humanitarian mission is to protect the lives and dignity of victims of war and internal violence and to provide them with assistance’ (ICRC 2007). In practice this means it works in such a way that it takes no side in any conflict.

The mandates and mission statements of other humanitarian organizations often say they are impartial, neutral and independent, although many no longer claim to be neutral. These words have important implications for maintaining a humanitarian position. Let us examine them more closely.

Impartiality is often defined in this context as being assistance that is ‘guided solely’ by the needs of individuals (ICRC 2005:10).

Take two minutes to think about why the idea of impartiality is important. Think about a complex disaster such as that in Darfur in the west of Sudan, or in Helmand province in Afghanistan. Write down your answers.

You might have thought of the key point that if a medical organization has a humanitarian mandate its duty is to all human beings, not just those associated with one side of a conflict. Individual humanitarian workers may have sympathy with one side or another, but in their professional conduct it is important they do all they can not let their personal inclinations influence what they do.

Learning objectives

By the end of this lesson you will be able to:

- understand the character, strengths and limitations of humanitarian medical aid
- assess its potential for contributing to conflict prevention
- describe current debates about impartiality, neutrality and independence.
If humanitarian workers care only for civilians in an area controlled by one side in a conflict, but have access to civilians on both sides with similar needs, they are not responding according to need. They are not being impartial. This is the key role of humanitarian agencies: they care for everyone according to need, regardless of who they are, provided they are not active combatants. You can see how different this is from the health care provided by armed forces, whose health personnel are expected to give priority to maintaining the strength of their own fighting forces. In this sense they are clearly not impartial.

In the above example it is clear that some humanitarian workers do not act in a neutral way.

Neutrality is often defined as ‘not tak[ing] sides in hostilities’ (ICRC 2005:10). By being impartial it might be expected that humanitarian organizations are also neutral, but many organizations have either dropped this claim or never made it.

**Take two minutes to think about why being neutral might be difficult in a conflict situation.**

Being neutral in the provision of assistance would mean providing equal assistance to all sides in a conflict. However, this may clash with the mandate of some organizations if they are mandated to work in a particular country or with a particular group of people. It may also be difficult for small organizations because of the resources involved, especially if there is no movement across the ‘front line’ and assistance to each side needs two geographically separate operations. It may also be potentially dangerous for organizations that are particularly associated with one side or another. If there is one organization that can claim to be neutral it is the ICRC, which maintains its neutrality through strict adherence to its code of conduct. It is also very well resourced.

**Take a few minutes to look at the article ‘Does it still make sense to be neutral?’ by ICRC deputy director for international law and cooperation, Marion Harroff-Tavel, in which she explains the importance of neutrality for the organization.**

Again you can see how different this is to the role of the military in a conflict situation, who – unless they have a peacekeeping or peace enforcement mandate – are inevitably involved on one side of the conflict. When they are involved as peacekeepers or peace enforcers the situation gets more complicated.

**Independence** has been defined as the ‘endeavour not to act as instruments of government foreign policy’ (Macrae et al. 2004:1). To see how difficult it can be to remain independent, read the article ‘Independent aid in Iraq virtually impossible’
(Younis 2004). You will see that lack of independence is one of the factors that can blur what should be a clear distinction between military and humanitarian actors. As this blurring has become more frequent, humanitarian organizations have developed strategies to reduce their visibility: a less visible and ‘hands off’ approach has in some cases enabled them to continue their activities without compromising their principles.

In 2008 the ICRC drew attention to the ‘commitment and courage of its Iraqi staff’ as a ‘fundamental element in ensuring’ that it could continue its operations. This meant it could develop ‘innovative remote-control mechanisms to ensure a continuation of its humanitarian activities’ while remaining ‘committed to its traditional principles of neutral, impartial and independent action’.

Is humanitarian health aid always good?

Humanitarian health aid can be less effective than it should be – or even harmful. Common reasons include lack of preparation or qualifications of humanitarian health workers; teams that are insufficiently supported and equipped; and workers who are insufficiently aware of the local context. Each conflict brings new challenges for health workers, and sometimes problems arise even with the best preparation. It is important to be sensitive to what is happening locally, and to have good support from those you are working with and the organization you work for.

The purpose of this course is to promote peace, so here we will focus on claims that the diversion of humanitarian medical aid can help prepare for, or exacerbate, armed conflict.

Example 1

During the severe famine in Ethiopia in the 1980s, the government resettled large numbers of people from the affected areas in the north to the southern part of the country. Approximately 600,000 people were moved in 1985–6 away from their home villages and farms and transported to various regions in the south, many forcibly by the military. While conditions there were definitely better in terms of water and agricultural land, many did not want to leave their home areas. They were also moved from higher ground where they had not been exposed to malaria, and many died of malaria in the south.
Humanitarian organizations were distributing food in the north of the country. People were often picked up for resettlement when they came to the food distribution centres.

**Example 2**

During the 26-year conflict between the government of Sri Lanka and the Liberation Tigers of Tamil Eelam (LTTE), which ended in 2009, humanitarian organizations had to obtain permits for many items if they were going to take them to areas controlled by the LTTE. These included antibiotics, prostheses for landmine victims and bandages. The Sri Lankan authorities said these items could fall into the hands of the LTTE and be used to maintain the fitness of their combatants.

**Example 3**

In Somalia in 2009, UNICEF (UN Children’s Fund) estimated that 3.6 million people were in ‘a state of humanitarian emergency’: 1.3 million were displaced, and 19% of children under five were acutely malnourished, with acute malnutrition rates in some areas reaching 27%. In early 2010 there were media claims of a UN report that 50% of food aid to Somalia was being ‘diverted to corrupt contractors, radical Islamic militants and local UN workers’. The World Food Programme, in charge of food distribution, previously said that between 2% and 10% of aid was being sold. Whatever the exact figures, it would be very surprising, given the years of conflict and breakdown of governance in Somalia, if some food aid was not diverted, and that a proportion of it would go to actors in the conflict.
Some responses

These examples show the difficulty of both deciding not to act and trying to prevent medical or food aid contributing to the conflict.

In the first example, Ethiopia, it could be argued that:

- innocent people were also dying
- denying medical assistance would have been an inappropriate way to try and bring the perpetrators of genocide to justice.

In the second case, Sri Lanka, it could be argued that:

- the civilian population would also be affected by shortages of these items
- combatants needing these items would be injured or sick and were therefore non-combatants.

In the third case, Somalia, it could be argued that:

- in a situation of extreme poverty and lack of governance, food aid had become a part of the local economy; stopping it would hurt everyone
- in a situation where are so few resources, the families of those diverting the food aid may also be in desperate need.

You have considered some examples where aid might exacerbate conflict. The other main question is the significance of health aid in relation to other powerful factors that fuel conflict.

Box 1 describes an initiative called Do No Harm, started by Mary Anderson, to ensure that humanitarian assistance does not worsen conflict. DNH is discussed in detail in Lesson 2.2.
Box 1: Do No Harm (Overseas Development Institute 1998)

The dictum that humanitarian agencies should ‘do no harm’ originated in the US in 1996 and borrows deliberately from the Hippocratic oath of Western medicine. Whilst there have been many instances where humanitarian aid has been hijacked and diverted to the benefit of warring factions, the empirical evidence is simply not available to warrant a focus upon humanitarian aid ‘doing no harm’ as against the harm done by, say, other states, business interests, illegal and semi-legal trading activities (tropical hardwoods, drugs, precious stones, etc.) and arms traders. The manipulation and occasional diversion of relief aid have wrongly been equated with an analysis of the war economy. In most, if not all, conflicts the role of humanitarian aid as a source of support for warring factions has probably been slight.

Many of the resources brought into a conflict-affected and resource-poor situation will inevitably become part of the war economy, and it has been argued that this has exacerbated and even prolonged conflict. However it is likely that any sustaining effect of medical assistance on the conflict is relatively minor compared to the health benefits this assistance brings to the civilian population. There is also something morally uncomfortable about not assisting people to maintain their health when any evidence that this course of action will bring a specific conflict to a rapid end is likely to be extremely weak.

Can humanitarian medical assistance prevent violent conflict?

Medical humanitarian assistance may help prevent conflict in three ways:

1. The availability of accessible and effective health services means that people have one less source of stress in their lives, and one more reason to feel that essential services are being delivered in an equitable way (a just environment).

2. The act of caring in itself brings people together. Keeping health as neutral ground – we all want our children to be healthy – will maintain better communication and dialogue between people on different sides of a conflict.

3. Health-related actions may be taken specifically to reduce the likelihood of conflict.

The UN Commission on Human Security, linking general security and health, says ‘health security is at the vital core of human security – and illness, disability and avoidable death are “critical pervasive threats” to human security’ (UN 2003:96).
The implication is that access to effective and equitable health services will remove some of the triggers of conflict, as suggested by points one and two above.

Specific health actions (point three above) have tended to focus more on peace-building than conflict prevention. For example, ‘days of tranquillity’ and ‘corridors of peace’ are ceasefires held to enable vaccinations to take place in rebel or opposition-held areas – such as those held in Afghanistan in 2001 for polio national immunization days. While valuable as reminders of core humanitarian values, these exercises require massive financial and human resources. A more sustained – but slower – investment in the functioning of existing services may, in the long run, be more effective.

References


Lesson 1.5: Armed forces as humanitarian actors

Author: Marion Birch

There are many historical examples of when armed forces have supplied medical and humanitarian aid, for example during the Berlin airlift in 1948, but discussion only began in the early 1990s about expanding their role more formally. In this lesson we will consider the history, advantages and disadvantages of their involvement, and key aspects of the present debate. We will concentrate on assistance that relates directly to health; however, as much if not all humanitarian assistance relates to health, at times we will simply refer to humanitarian assistance.

When it was suggested in the early 1990s that armed force could be used to deliver humanitarian assistance, it was asked: ‘What will it be like, a sort of Oxfam with guns?’ In the course of this lesson we will see this is definitely not what it should be like.

Military involvement

Remember that all armed forces are organized in different ways, so the nature of cooperation will depend on the country context.

The military traditionally helps out in large-scale ‘natural’ disasters, in their own countries and, when asked, in other nations. While this seems a straightforward role, it still needs some clarification.

Learning objectives

By the end of this lesson you will be able to:

- describe the different mandates of military and humanitarian actors, and the implications for providing assistance in conflict situations
- understand what has driven the increased military involvement in humanitarian assistance
- know how military and humanitarian roles differ, and understand the dangers of increased military involvement in conflict situations
- list examples of good understanding between military and humanitarian actors
The definition of a ‘natural’ disaster is that the disaster is not man-made. There is much debate about which disasters are truly ‘natural’. With natural disasters there is also an assumption that conflict is not involved, but the definition refers only to the cause of the disaster. Natural disasters may take place in areas of conflict, and the presence of the military may then become more complicated. This was illustrated by the response to the 2004 tsunami in Banda Aceh, Indonesia, and in the north and east of Sri Lanka. In both places armed parties to the conflicts participated in relief efforts. In Banda Aceh the disaster appeared to help the peace process, but in Sri Lanka it appears to have contributed to the resumption of fighting, as pointed out by the then UN Secretary-General Kofi Annan on the second anniversary of the tsunami (UN 2006).

In general, though, military involvement in humanitarian assistance after natural disasters in their own countries or at the invitation of another government is relatively straightforward.

The military, and particularly their medical corps, have traditionally helped in conflict situations through such actions as treating wounded civilians and removing unaccompanied children from the battlefield, as they did in Mozambique in the mid-1980s. This is very different, however, from having a humanitarian mandate and planning to deliver health services.

**Different mandates**

As you will remember from Lesson 1.4, humanitarian actors working in conflict situations try hard to preserve their impartiality.

You may have remembered that:

- humanitarian actors need to be trusted by the communities they serve; this will be difficult if they are seen to be associated with one or other of the warring parties;
- the security of the humanitarian actors themselves could be affected if they are perceived to be collaborating with one side in a conflict.

**Take a moment to remember why.**

Now think about the military. Why might American army doctors trying to set up a health centre for civilians in Afghanistan in 2006 have problems?

If military forces are engaged in the conflict, or even just associated with one side or the other, the health centre – including its health workers and civilian users – may become a target for attack. It could also be risky for civilians to use the health centre, as they may be accused of being collaborators or come under suspicion because of their closeness to the fighting forces of either side.
There has nevertheless been a recent increase in military involvement in humanitarian work. For example, there were only 13 UN peacekeeping operations before the late 1980s, but 29 new operations were established between 1988 and 1996 (UN Department of Peacekeeping Operations 2007).

Involvement of private military and security companies (PMSCs) in a range of activities, many involving humanitarian assistance, has also increased, a trend that accelerated sharply as a result of the Iraq war. The annual revenue of UK PMSCs alone rose from £230 million (€300 million) in 2003 to £1.8 billion (€2.4 billion) in 2004 (War on Want 2006).

In some cases the role of the military may be non-combative. For example, if they have a peace-keeping rather than peace enforcement mandate they can usually only use arms in self defence. Mandates may also be adjusted for specific situations. For example, Resolution 1590 established the UN Mission to Sudan in 2005 to support the Comprehensive Peace Agreement; this was adjusted in 2006 and gave rise to Resolution 1706, which included support to the Darfur Peace Agreement (UN Security Council 2006).

Note that in paragraph 12a, the forces are mandated to ‘seize and collect as appropriate arms or materials [possessed] in violation of the agreement’, as well as protecting humanitarian workers. Even in a peace-keeping role the difference between what troops and humanitarian workers are formally involved in is very different.

**Health professionals in the armed forces**

Members of the armed forces medical corps may officially be non-combatants, as is the case in the UK armed forces, but there is still a big difference between them and humanitarian organizations. The main objective of health workers belonging to humanitarian organizations is to provide the health component of humanitarian aid. The primary responsibility of the medical corps is to preserve the health of the military, although there is growing official recognition of their role in the care of civilians.
The military doctor’s dilemma

Trying to treat civilians as well as military personnel can lead to very difficult situations.

Yesterday five severely wounded Afghan civilians were admitted following an explosion. Eighteen beds were already occupied by military personnel, some waiting to be flown back to the UK but you do not know exactly when. You have just been informed on the radio that two more soldiers injured on foot patrol are being brought to the hospital. Then you get an urgent message that a planned offensive has been brought forward for tactical reasons. It will be launched tomorrow and all beds possible need to be cleared for the expected casualties. You are thinking not just about ‘beds’ but about how many acute care nurses, ventilators and oxygen cylinders are available.

Your answer may be clear: discharge only those who are in a fit state to be discharged, and take additional patients into the beds available. This is the ethical answer. But think how difficult it would be to turn away a fellow soldier who needed ventilation.

It is virtually impossible for the military, including its medical corps, to be impartial, as they are effectively the armed wing of their government, and they do what they are told by their political masters.

Pros and cons

What has driven the increased involvement of the military in humanitarian assistance, and what are the advantages and disadvantages?

A consideration of the driving factors behind this increased involvement can clarify motives and complicated issues. It also raises the question – for whom there are potential benefits and for whom there are dangers in such a strategy.

1 Protection of humanitarian supplies

Think about this scenario. You have been working as a humanitarian worker overseas for a year and your relief supplies – including drugs and food for health posts, general rations and feeding centres – are increasingly being high-jacked.
and looted. You can do nothing as it would put you and your drivers at risk if you resisted, and the provisional government’s control over the situation is too limited. Your project coordinator suggests that the only way you can get more than half your supplies to their destination is with an armed escort. What would you do?

Use of the military in areas of difficult security to help humanitarian actors gain access to civilians is on the rise. There are some difficulties with this that you may have identified:

• it will inevitably affect the perceived impartiality of the humanitarian actor;

• people are more likely to get killed and injured if the militias still attack the convoys;

• the military only protects the supplies while they are in convoy – what happens when the goods have been delivered to the civilians, and does it put them at greater risk?

Very difficult decisions have to be made. This was clearly illustrated in Somalia in 1992, when some agencies called for UN military escorts for humanitarian convoys and others did not. In summary, it is felt that there is a lack of consistency about the approach of humanitarian actors to using military escorts, and a tendency to do so too soon.

2 A humanitarian cloak for political and military ends

There is a danger that the ‘humanitarian’ argument may be used to:

• justify an intervention that is desired politically but may be more acceptable if described as humanitarian;

• carry out activities that are designed to support one side in the conflict.

An example of the first point is the bombing of Kosovo in 1999, described by NATO at the time as a ‘humanitarian war’. Whatever might be thought about the justification for the bombing, there was strong reaction to this use of the word ‘humanitarian’, particularly given the number of civilian casualties and the suffering. The then UN Secretary-General Kofi Annan said, ‘Let’s get right away from using the term humanitarian to describe military operations’ (VOICE 2000).

An example of the second point is ‘hearts and minds’ operations. The military have traditionally carried out short-term actions, such as supplying basic drugs, which appear to give immediate benefit to civilians in the name of winning hearts and minds. These actions may have a humanitarian aspect but are primarily designed to secure the goodwill of the population for military and political ends. There is no guarantee that they are planned for the greater and longer-term good of the population, and the dangers for civilians of associating in this way with the military
are rarely taken into account. Today these activities are frequently called Quick Impact Projects – a term used by humanitarian actors and first used by the United Nations High Commissioner for Refugees (UNHCR).

Inappropriate promises can also be made. The American air force dropped leaflets in Afghanistan in 2002 suggesting they would stop men beating their wives. Efforts to reduce domestic violence may be part of a humanitarian programme, particularly in camps established for some time, but this was an offensive and crude attempt to influence hearts and minds by promising something they could not fulfil, and that showed ignorance of good practice in gender advocacy.

Other dangers arise when the military tries to take on a humanitarian role for which they are not properly prepared. In Afghanistan at about the same time the American military were providing food parcels that looked very similar to the cluster munitions they were also using, some of which remained unexploded and were likely to be mistaken for food parcels by civilians.

3 Relative strengths

The military may be able to access places which humanitarian organizations cannot, because of the security situation. There may then be humanitarian needs that no one else can meet. Military and humanitarian actors have shared humanitarian supplies such as medicines in some circumstances to ensure they reach civilians.

The military may also have unique logistical capabilities, particularly at short notice, that can be vital for the humanitarian effort – as helicopters were in the 2000 floods in Mozambique. The military has traditionally taken the lead in these situations so this is not new; what perhaps is new is that these relative strengths are being used as a justification for playing a greater role.

On the other hand, and as has been mentioned above, the military may not have the necessary humanitarian skills, for example, in general ration distribution. They also tend to operate on a much shorter time-frame than is necessary for humanitarian work, and do not engage in local participation and decision-making as much as other actors. Crucially they represent the national interests of their governments, which can raise difficult conflicts of interest – particularly if they are involved in the conflict during which they are also trying to supply humanitarian assistance.

4 The rise of the responsibility to protect

Since the Rwandan genocide in 1994 in particular, debates about human security have led to an increasingly interventionist attitude to crises taking place within the borders of a state. The 2001 report of the International Commission on Intervention...
and State Sovereignty says intervention should only be undertaken in extreme cases (ICISS 2001). In the sections covering ‘the decision to intervene’ and the ‘six criteria for military intervention’, the word ‘humanitarian’ does not appear once – the term ‘human protection’ is used. Yet as we saw earlier, the word ‘humanitarian’ was used in relation to the bombing of Kosovo, perhaps hoping it would give a more acceptable image to a military intervention.

Human security and human protection are vital. The danger, as we have seen above, is that trying to achieve them using the military in a humanitarian role can be counter-productive in conflict situations.

**A positive example**

Our examples above are of interventions that have not worked well, as generally occurs when the role of the military is expanded to meet a political agenda.

Good cooperation between humanitarian and military actors does not necessarily mean working closely together; it can come about through an understanding of different roles, and through maintaining a distance.

If you were a humanitarian worker with a convoy of food and medical supplies to take through a disputed and volatile area, what would you want from each side of the conflict? Think about this before you consider the following example.

During the long conflict in Sri Lanka, the Liberation Tigers of Tamil Eelam (LTTE) controlled large areas of the north and east. Humanitarian supplies for these areas came from the rest of the country, controlled by the government of Sri Lanka. Humanitarian actors agreed convoy routes and times of travel in LTTE-controlled areas with the Sri Lankan military; these were clearly written on permits. Quantities and other details of a wide range of ‘sensitive’ items – including medicines – were also negotiated and written on permits, which once issued were mostly respected at checkpoints. The LTTE did not interfere with the transport of humanitarian goods at its checkpoints. All these measures meant that humanitarian actors could operate in what was otherwise a highly charged and sometimes very violent situation.

**Conclusion**

Clarity of agendas and mandates is essential. Governments who use their armed forces to implement foreign policy in the guise of humanitarian action undermine humanitarian action, and may put at risk those they are trying to assist.
References


Lesson 1.6: Medical neutrality

Authors: Leo van Bergen, Karoline Kragelund Nielsen and Cæcilie Buhmann

‘He took my arm and very smoothly said: “You know, Jacobo, that we doctors have many secrets. You see here: this blue line is one of your arteries and I can inject here. You know that we have some substances that make you talk but it is always so painful because it affects your brain; so why can’t you just talk and we can be friends.”’ His presence was terrible because he was the symbol that a scientific instrument is with you when you are tortured by the beasts’ – writer Jacobo Timerman describes his torture during the military dictatorship of Argentina (BMA 1992:1).

The rules of medical neutrality

The Geneva Conventions of 1949 and the Additional Protocols of 1977 refer to the rights and duties of health workers in situations where humanitarian law is endangered or violations of humanitarian law are taking place. They clearly state that health workers and combatants are obliged to respect medical neutrality in times of armed conflict, understood as the right to (access to) health care and respect of the neutral position of health workers and facilities.

This means health professionals, when carrying out their work, should not take sides in hostilities, but as the story of Jacobo Timerman shows, they do not always obey.

Article 3 of the First Geneva Convention and Articles 7 and 9 of Protocol II are relevant here.

First Geneva Convention, Article 3

In the case of armed conflict not of an international character occurring in the territory of one of the High Contracting Parties, each Party to the conflict shall be bound to apply, as a minimum, the following provisions.
1 | **Persons taking no active part** in the hostilities, including members of armed forces who have laid down their arms and those placed hors de combat by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely, without any adverse distinction founded on race, colour, religion or faith, sex, birth or wealth, or any other similar criteria.

To this end, the following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons:

- violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture
- taking of hostages
- outrages upon personal dignity, in particular humiliating and degrading treatment
- the passing of sentences and the carrying out of executions without previous judgement pronounced by a regularly constituted court, affording all the judicial guarantees which are recognised as indispensable by civilised peoples.

2 | **The wounded and sick** shall be collected and cared for.

Article 12 of the same convention deals specifically with injured combatants’ right to medical care. This is covered in more detail in **Lesson 1.3**.

**Protocol I, article 10 and Protocol II, article 7**

(Protocol I refers to international, and Protocol II to national armed conflicts. There is a slight variation in wording in the two articles but the meaning is the same. Not all nations have signed these additional protocols.)

**Protection and care:**

1 | All the wounded, sick and shipwrecked, whether or not they have taken part in the armed conflict, shall be respected and protected.

2 | In all circumstances they shall be treated humanely and shall receive to the fullest extent practicable and with the least possible delay, the medical care and attention required by their condition. There shall be no distinction among them founded on any grounds other than medical ones.
From the text of the article and the commentary to the Protocol it can be deduced that peacetime medical ethics also apply in times of conflict: sick people must be treated on the basis of need, as far as circumstances allow. Allocation of resources for treatment of individual patients is, however, at the doctor’s discretion. Under international humanitarian law there is criminal liability on the part of the doctor only in the case of intentional unnecessary treatment, removal of organs or medical experiments performed without the patient’s consent, all of which are considered war crimes (this interpretation is based on personal correspondence with Simon Mark O’Connor). This is also the stance taken by the World Medical Association in the Declaration of Havana and subsequent amendments (World Medical Association 2006b).

The commentary to the Protocol states that people who are not ‘ill’ in the usual sense of the word but are vulnerable to illness, such as newborn babies, are also eligible for protection. However, health workers are not obliged to care for combatants who do not lay down their arms.

**Protocol II, Article 9**

**Protection of medical and religious personnel**

1 | Medical and religious personnel shall be respected and protected and shall be granted all available help for the performance of their duties. They shall not be compelled to carry out tasks which are not compatible with their humanitarian mission.

International human rights law that applies in both conflict and peacetime protects individual rights. Thus, according to the UN Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the use of torture is a criminal offence. Countries that have signed and ratified the convention are obliged to prevent such acts and investigate any allegation of such treatment within their jurisdiction.

**Other relevant declarations and resolutions**

The World Medical Association has issued a number of declarations, including the 1975 Tokyo Declaration which says doctors should not participate in, condone, or give permission to torture or other forms of cruel, inhuman or degrading procedures (World Medical Association 2006a). The 1997 Hamburg Declaration emphasises the responsibility of the organized medical profession to support doctors who experience difficulties as a result of their refusal to participate in torture or similar procedures, or as a result of their attempts to speak out or to act against such inhuman procedures (World Medical Association 1997). However, the World Medical Association cannot ensure the declarations are complied with (Yudkin 2009).
The Istanbul Protocol, which became an official UN document in 1999, is another important set of guidelines on torture for health workers. The protocol establishes a framework for assessing people who allege torture and ill treatment, for investigating cases of alleged torture, and for reporting such findings to the judiciary and other investigative bodies.

In 2009, the UN Human Rights Council passed a resolution on torture and other cruel, inhuman or degrading treatment of punishment, The role and responsibility of medical and other health personnel (UN Human Rights Council 2009). This draws heavily on the principles in the Tokyo and Hamburg declarations. The resolution establishes the duty of health workers to report acts of torture, and affirms that ‘states must never request or require anyone, including medical or other health personnel, to commit any act of torture or other cruel, inhuman or degrading treatment or punishment’. Moreover, it calls for the UN Special Rapporteur on Torture to help enforce these obligations of health professionals.

**Violations of medical neutrality**

Despite these and other rules governing health professional behaviour, health workers have been involved directly or indirectly in many violations of humanitarian law, human rights and medical neutrality.

These include:

- neglect and maltreatment of the sick and wounded;
- torture of prisoners, including medical screening or treatment to ensure that torture may continue without causing severe morbidity or mortality;
- imprisonment of the sick and wounded;
- discrimination in the treatment of sick and wounded;
- playing an active part in the use of medical units to reach military objectives, such as using medical vehicles for transporting weapons;
- use of the Red Cross, Red Crescent and other medical emblems for non-medical objectives;
- unethical use of medical expertise, such as experiments on humans without consent.

As with prison health professionals, military health professionals run a higher risk of being involved in human rights violations. The risk of human rights violations in times of extreme violence is greater than normal, and there are also issues of dual loyalty.
In some situations, practising medicine can come to be regarded as a technical skill and the moral implications are ignored, perhaps as a psychological defence mechanism. In a 1990 hearing on bodies found in a mass grave near Sao Paulo, a Brazilian forensic doctor was asked why during the military dictatorship none of the autopsy reports from his medico-legal institute mentioned torture. He replied: ‘Our function was purely technical. First thing in the morning we received bodies [...] and we performed autopsies to establish the cause of death. [...] Our task was only to establish the medical cause of death and not the judicial cause of death. [...] It is purely descriptive. [...] All that is on the body is observed and recorded. Now, the interpretation of these lesions is something we cannot give. A haematoma could be a spontaneous haematoma or a traumatic haematoma. But we just describe the haematoma’ (BMA 1992:39).

The risk that a health worker might encounter violations of human rights and international humanitarian law is high when working in government institutions, or in military and relief organizations. This may place the health worker in a dilemma between maintaining neutrality and speaking out about the violations. For instance, medical organizations giving aid under difficult circumstances may come under pressure not to report violations of human rights, because that can jeopardize or conflict with their obligation to help ill and wounded people. In the case of military medical organizations, reporting violations – and protecting human beings from future harm – may endanger not only health assistance in the present, but also the military operation. Reporting violations or refusing to cooperate in interrogations can be seen as contradictory to the military task of military health workers.

Examples of medical violations of international humanitarian law and human rights

Notorious war-related medical violations of human rights include medical experiments in German concentration camps in the Second World War; Japanese doctors also violated humanitarian rules during this time. But in World War I as well doctors from all sides conducted medical experiments without patient consent (some even were prosecuted). Colonial wars are infamous for their breaches of medical neutrality, as are civil wars and military dictatorships. Military health staff work in armed forces that are a party in war, unless they are in a peace-keeping role, and they face particular challenges to maintain their neutrality.

The chances of being convicted after committing human rights violations are small. After the fall of the Greek junta in 1973 only one doctor was put on trial; similarly after the collapse of the Videla military dictatorship in Argentina in 1981. In both situations medical violations of human rights were ‘all in a day’s work’. Only 23 of at
least 350 German doctors involved in abuses stood trial at Nuremburg (and some were soon allowed to return to practice) (Figure 1). ‘Prosecutions, therefore, can be regarded as a poor indicator of the scale of the phenomenon, seriously underestimating its occurrence’ (BMA 1992:25–26).

According to international humanitarian and human rights law, countries that ratify treaties like the 2009 UN resolution commit themselves to respecting those rights and ensuring that those who violate them within their jurisdiction are prosecuted. If the country is unwilling or unable to do so, the violations can be investigated and prosecuted at regional or international level.

Figure 1: The Nuremburg trial of German doctors, 1946

Not all doctors comply with violations of human rights abuses, even in the most extreme circumstances. An ex-military doctor, who was supposed to treat tortured prisoners during the military dictatorship in Chile, said: ‘We knew of others in the military, including physicians, who were involved [in torture]. Some of them collaborated because they were ordered to and because they were afraid of what might happen if they refused. In my case, I was sent on two occasions to a detention camp to treat prisoners who had been tortured. The experience troubled me so much, I began planning a way out of service’ (BMA 1992:38).

Health workers and weapons production

Assisting in the manufacture and development of weapons can also be seen as a violation of medical neutrality. Many health workers have cooperated and still cooperate in weapons production, although some have refused to do so and others have later expressed regret for doing so. They indirectly cause physical and/or psychological harm, and trade medical neutrality for a nationalistic or commercial goal.

Health workers were involved in the manufacture of poison gas during the world wars, and of atomic weapons. American health workers were involved in testing atomic weapons on humans in the 1950s and 1960s. More recently health workers have been involved in research on biological agents. The line between research on prevention and research on weapons production is blurred.
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Chapter 2: Offering support during violent conflict

In this chapter you will learn about how health workers attempt to stop combatants fighting and other violent events, and how they engage in peace building.
Lesson 2.1: How health initiatives bring people together

Author: Klaus Melf

This lesson will describe how health can create ‘bridges’ that connect people at different levels of society, and the qualities, potential and dangers of such connections.

Health as a superordinate goal

Health is highly valued by most people; it has a dominant position in different societies and cultural traditions. You can observe this in the wishes people share in form of greetings, toasts and birthday congratulations. We all know that even mild illness can affect our work and family life, interests and wellbeing. Health is therefore a superordinate goal for many, meaning it has higher status than other needs and wishes.

The Peace-through-Health programme at McMaster University explores the idea of health as a superordinate goal that can build bridges across the divides created by violent conflict, and contribute to the establishment of peaceful relationships (MacQueen et al. 1997). For a presentation of the 10 Peace-through-Health mechanisms, see Course 1, Lesson 2.3.

This is also the basic assumption of the WHO framework Health as a Bridge to Peace (HPB), as stated by Guerra de Macedo in 1994: ‘Health issues transcend political, economic, social, and ethnic divisions among peoples and provide a nexus for dialogue at multiple levels’ (Rodriguez-Garcia et al. 2001: 11). The WHO framework is a multidimensional policy and planning framework that supports health workers in delivering health programmes in conflict and post-conflict situations and at the same time contributes to peace-building.

In this lesson we will look at three levels at which health can connect people: the grass roots, the health professions, and decision-makers. We can visualize these bridges (Figure 1) by modifying Lederach’s pyramid model of multilevel peacebuilding, presented in more detail in Course 1, Lesson 3.1 (Lederach 1997: 39):

Learning objectives

By the end of this lesson you will be able to:

- describe how health initiatives can be used to connect people in conflict situations
- describe the different aspects of these ‘health bridges’
- explain how health bridges can be established
- highlight the limitations of and challenges for health bridges.
Connecting civil society

The desire for health for ourselves and for our children, relatives, and friends is characteristic of all human beings. Health is a universal basic need. Many people care for the health and wellbeing of people they do not know, a humanitarian impulse which shows that people empathize with the pain and suffering of those less fortunate. In civil society, an enormous feeling of solidarity and involvement is directed at saving life and health.

The provision of health care and the promotion of health for all can help people to survive. At the same time, such support and solidarity from outside can give a sense of respect and hope. It can end a feeling of neglect, and reduce marginalization and other forms of structural violence. Health initiatives can connect people in need to the international community or the human family. Imagine what it means for those living in an isolated or beleaguered place, for instance Gaza, to receive international humanitarian aid. Other examples from the micro level include care for stigmatized and isolated groups such as asylum seekers or for people living with HIV/AIDS. Non-profit civil society groups with humanistic, social or spiritual goals often provide these health bridges.

Shared professional concern

Health workers are, by definition, concerned about health. They share a professional field of interest, common goals, and to a certain extent values, language and understanding – at least in the Western tradition. These unite millions of health workers in a global health community whose members have a long tradition of international exchange and collaboration in teaching, research and practice.
Many public health challenges (for example, infectious diseases and environmental degradation) do not respect national borders and require regional and international cooperation. It would not have been possible to eliminate smallpox or control poliomyelitis without concerted international action, nor will we be able to reach the health-specific goals 4, 5 and 6 of the Millennium Development Goals (United Nations General Assembly 2000).

Even across political, cultural and ethnic divisions health workers can unite in the service of humanity. They do so to fight all kinds of health problems, including harmful marginalization, hatred and direct violence. For example, Israeli-Palestinian cooperation in the health field includes 148 projects involving health professionals from both groups (Dajani and Carel 2002). About half of those interviewed in this study said their main motive for collaboration was a desire to contribute to conflict resolution.

Health professional associations, too, can contribute to unite health workers in the service of peace. A good example is the Norwegian Medical Association’s initiative to bring together the newly formed medical associations of the former Yugoslav republics in 1993–1997. Despite the ongoing Balkans war, the representatives developed joint educational programmes on human rights, medical ethics and medical conduct (Steenfeldt-Foss et al. 1998).

The founding principle for the medical disarmament organization IPPNW (International Physicians for the Prevention of Nuclear War) in 1980 was the need to unite against the biggest threat to health and life on earth. Shared health concerns built bridges between the American cardiologist Bernard Lown and his Russian colleague Eugeny Chasov, and between many other doctors from East and West. Politicians and diplomats from East and West could not talk to each other during the coldest period of the Cold War, but doctors met in order to prevent ‘the last epidemic’ – a nuclear war.

**Health as a political priority**

Government ministers and other decision-makers, even those responsible for activities outside the health sector, are concerned about health. Shared concerns around fundamental health issues can connect political and military decision-makers, and even end wars.

High-level health bridges established during armed conflict include ‘humanitarian ceasefires’ or ‘days of peace’, a principle first applied in the civil war in El Salvador in the 1980s. Facilitated by UNICEF and the Roman Catholic Church, the fighting parties agreed to suspend hostilities in order to vaccinate all the country’s children. This not only had a crucial impact on children’s health – the underlying superordinate goal, it also developed new channels of communication, brought confidence and hope for a peaceful conflict settlement, and created an environment that enabled negotiations leading to a lasting peace agreement (Peters 1996).
Similar initiatives have been used since in many violent conflicts. They are often
time- and space-limited, and carry names like Days of Tranquillity, Corridors of
Peace, Safe Havens, Sanctuaries of Peace, Children as Zones of Peace and Conflict-
free Zones. WHO has catalogued humanitarian ceasefires and assessed their
effectiveness (WHO 2001).

**Characteristics of health bridges**

We have seen that health bridges may exist at different societal levels. All may help to reduce violence and promote peace. To have a sustainable impact, not just the level of connection is important, but also the characteristics of the bridge. As described in Galtung’s ABC triangle in Course 1, Lesson 1.2, conflict consists of attitude, behaviour and contradiction (Galtung 1996). It is necessary to modify each of the three elements in a conflict to achieve sustainable peace.

Health activities can contribute to changes in all three elements. Let us look more closely at three aspects of health bridges during violent conflict: technical cooperation, empathic connections and transformative connections.

![Figure 2: Three characteristics of health bridges linked to the ABC conflict triangle](image)

**Technical cooperation**

Most health collaboration between conflicting parties, or between conflicting parties and the international community, comprises joint actions in a technical realm – the health realm. Such actions can take many forms including service delivery, data collection and research, training health workers and health policy advice (Manenti and Cassabalian 2003).
Technical collaborations bring health professionals together within or from outside a violent conflict zone to solve health problems. People become busy with health work and do not fight. Joint health initiatives, for instance vaccination of children, can influence the fighting behaviour of conflict parties and bring about a reduction of direct violence. Underlying causes of conflict, or violent attitudes are not necessarily challenged in these initiatives.

Nevertheless, there may often be the wish and intention of health workers that the collaboration could indirectly also have a positive impact on the conflict through better communication, building trust or disrupting the fighting agenda.

**Empathic connections**

Technical cooperation alone, however, is not sustainable or useful without empathic connection and transformational leadership. Professional cooperation requires a certain level of communication and relationship but does not automatically mean that people meet at a deeper personal level. If, however, there is willingness to listen to each others’ feelings and needs, there is also an opportunity to connect on a personal level and to (re)establish friendly relationships. Health initiatives that start as technical cooperation can personalize ‘the other’ and humanize the enemy (MacQueen et al. 1997).

A healing connection can take place when people meet on equal terms and their pain and suffering is mutually acknowledged. For example, the Medical Network for Social Reconstruction in the Former Yugoslavia tried to integrate the delivery of health care into the process of community reconciliation (Gutlove 1998). The example from Bosnia and Herzegovina in Box 1 also illustrates how technical collaboration can create empathic connection.

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**Box 1: From technical collaboration to empathic connection (Salvage 2006)**

‘I worked with nursing leaders in Bosnia and Herzegovina in 2004–6, after the war, to help them develop a national action plan for nursing. This was the nursing component of a European Union project to support health care reform, funded by the EU and implemented by WHO,’ says British nurse consultant Jane Salvage.

‘These nurses and midwives came from all sides of the conflict – whether Bosniak, Croat, Serb, Muslim, Orthodox or Catholic. They had never sat in the same room together until our first workshop. The process of describing their visions for the future of nursing, and working on the national action plan, helped them realise that people they saw only as enemies actually shared many of their own goals, experiences and ideals.

Creating a nursing leadership group for the whole country and helping it to function well was an important step forward in itself, since there had been no sustained nursing initiative of this type for many years. By the end of the two-year programme the nurses began to be able to relate to each other genuinely across their religious and ethnic divides. On reflection, I felt that this very small contribution to reconciliation was probably more valuable and sustainable than our overt short-term aim of writing a nursing strategy and sharing leadership skills.’
Transformative connections

Conflict contradictions are more explicitly addressed by health initiatives that focus on and try to change violence structures and the root causes of conflict. IPPNW, for instance, has done this successfully by bridging the East-West divide and emphasizing the futility of nuclear weapons. Physicians for Human Rights (PHR) targets violations of human rights in the Occupied Territories, among many other initiatives. Other initiatives promote the development of civil society and social welfare systems, and build equally accessible health services. Health bridges can thus address underlying root causes of conflicts, challenge structures that perpetuate hostilities, and establish peaceful alternatives.

Limitations and challenges

Sometimes, however, health bridges to peace can have a negative effect. Humanitarian ceasefires, the best documented examples of health bridges, may have other unintended effects. Let’s take a closer look.

The value of humanitarian ceasefires is limited if they are not integrated in a peace process which addresses the underlying causes of the conflict (Peters 1996). Conflicting parties may even abuse them for propaganda purposes, repositioning forces or shipping in new weapons.

Technical cooperation in health often has no clear peace-building goal. Its impact on a violent conflict may be marginal (only changing behaviour temporarily) or accidental (resulting also in changes of attitude and contradictions). It may also worsen a situation, especially if one side does not perceive the connection to be taking place on equal terms.

Palestinian health workers criticized Palestinian-Israeli health cooperation schemes (Palestinian Health Organizations 2005), which they saw as:

- imposed from outside
- not mindful of the unequal relationship between the two parties
- failing to respect the academic boycott of Israel
- politicized despite claiming to be apolitical
- useless when promising peace without addressing justice.

This example also demonstrates that health does not always function as a superordinate goal or shared concern. There may be conditions, such as long-lasting humiliation, when needs for acknowledgment, justice and integrity are more prominent than the wish for health access, or even survival.
Another example is the unwanted humanitarian assistance given to the people of Haiti during the years of economic sanctions after a military regime had driven out the first elected president, Jean-Bertrand Aristide. The majority of civil society was in favour of the sanctions and considered the humanitarian interventions, made on the pretext of guaranteeing the ‘right to health’, as imposed from outside, and as a betrayal of their fight for political and civil rights (Tardif 1998).

What factors make humanitarian ceasefires work? Peters (1996) says the necessary ingredients for successful outcomes of humanitarian ceasefires include:

• common ground (a superordinate goal)
• a considerable level of communication and trust
• interventions based on the principles of impartiality and transparency
• understanding and respect for local cultures
• unbiased facilitators
• participation of local peace capacities
• existing international pressure on the conflict parties
• reference to international agreements and laws
• a clear monitoring procedure
• an accompanying educational campaign to create awareness and knowledge about the goals and context of the initiative.

Conclusion

This lesson has looked at how health bridges differ in terms of the level of society at which the connection takes place and of their characteristics. We discussed how health as a superordinate goal has the potential to unite conflict parties in the fight for common health and wellbeing. However, these bridges may not have a substantial impact on peace if they do not address underlying violent attitudes, and the contradictions and root causes of conflict.
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Lesson 2.2: Do no harm? – the impact of aid

Author: Sam Engelstad; with acknowledgements to the Collaborative for Development Action, Cambridge MA, USA.

What is Do No Harm?

The end of the Cold War altered the circumstances in which aid agencies work. Many poor countries, and their illegitimate regimes, saw their artificial support from the superpowers evaporate. The resulting power vacuum caused violent conflicts to surface.

The new circumstances propelled aid workers into situations of increasing danger that affected them, their projects, and their beneficiaries. It became increasingly apparent that aid provided in conflict areas could itself become a part of those conflicts. Further, it was clear that the aid often exacerbated the conflict itself.

Members of the aid community were therefore eager to learn how to minimize any negative effects that aid might produce, and to provide aid in a way that mitigated violence and permitted those involved in conflict with space to build peace. This wish provided the impetus for the development of the Do No Harm (DNH) framework and helped guide aid workers working in conflict situations towards these goals.

Violent conflicts are never simple. The DNH framework described here will not make it easier to work in conflict areas. Rather, it might help us get a better understanding of the complexities of the conflict environments in which we work. Done well, it might demonstrate how the decisions we make affect inter-group relationships and help us to think of different ways of doing things to have better effects. The aim is to help aid workers deal with the real complexities of providing assistance in conflict areas with less frustration and more clarity and, it is hoped, with better outcomes for the societies where aid is provided.

Learning objectives

By the end of this lesson, you will be able to:

- identify connectors and dividers in conflict situations
- demonstrate your understanding of how resource transfers and implicit ethical messages can affect a conflict situation
- describe how humanitarian interventions in violent conflict situations can strengthen connectors
- use the Do No Harm framework to analyse an aid programme.
What if aid is found to support war and violence; should agencies and practitioners continue to provide aid? The resounding answer given by aid workers all over the world is that the needs of suffering people are too important to ignore. However, there are always ways to modify an aid program.

Some fundamental DNH findings

- It is both possible, and useful, to apply DNH in conflict-prone areas, in ongoing war, and in post-war situations.
- DNH prompts us to identify the negative impacts of aid much sooner than is typical without such an analysis.
- DNH increases our awareness of inter-group relations in project sites and enables us to play a conscious role in helping people come together.
- DNH clarifies the connections among programming decisions, including where, and with whom, to work, how to set the criteria for assistance, who to hire locally, how to relate to local authorities.
- DNH provides a common reference point for considering the impact of our aid on conflict. This brings a new cohesiveness to staff interactions, and to our work with local counterparts.
- Most importantly, it enables us to identify programming options when things are beginning to go wrong. Many people using DNH say that, while they have been aware of the negative impact of their programs, they believed these to be inevitable and unavoidable. DNH is useful precisely because it gives us a tool to find better ways – we call them programming options – to provide aid.

Use in a development context, or in situations with little history of conflict

The original emphasis of DNH was as a tool to be used in aid settings where serious violent conflict was endemic. Yet Mary Anderson, who organized the DNH process, says experience has taught us the wisdom of analysing the impact of any assistance programs on the relationships among groups in recipient societies. Sadly, conflict beyond normal societal tensions has demonstrated a frightening potential to spin out of control. And even if death and destruction are not imminent, people’s awareness of negative impact can be positive and help to change their personal styles of interaction to permit, even encourage, more involvement of societal subgroups.
The framework for understanding how aid and conflict interact

The DNH analytical framework was developed from the programming experience of many aid workers. It provides a tool for mapping the interactions of aid and conflict and can be used to plan, monitor, and evaluate both humanitarian and development assistance programmes. The framework is not prescriptive. It is a descriptive tool that first and foremost identifies the categories of information that have been found through experience to be important for understanding how aid affects conflict. Next, it organizes these categories in a way that highlights their actual and potential relationships. Finally, using a tool called Options, DNH helps us predict the impacts of different programming decisions.

The framework has six steps:

**Step one – analysing the conflict context**

The conflict context underpins the very essence of DNH. Without a good understanding of the conflict context, DNH analysis is useless. So what is conflict context?

It simply refers to the circumstances under which people in the conflict area live and work – what divides and connects them, their socio-economic status or gender, their languages, school systems, religions, the quality of their public services, etc. Different tools for conflict analysis can help us to understand the conflict context (as we have seen in previous lessons).

To practice DNH, and to be a good project manager or donor, you must understand the conflict context of the region in which you work. Without this knowledge the aid may unintentionally help to exacerbate the conflict. Conversely, with this knowledge, your aid may help to reduce the conflict.

As we have previously said, understanding the conflict context is critical to be able to analyze a project using DNH. There are some practical tools we can use to operationalize this understanding, as the next steps demonstrate.

**Step two – analysing the connectors**

Most societies contain moderating influences that prevent disagreements from breaking into violence. Although they may be divided by conflict, people also may remain tied together across sub-group lines. In DNH terminology, these ties are called connectors, and you want your project to strengthen them (or, at the very least, avoid weakening them). Connectors may include trade, irrigation systems, churches, mosques, or education. Say, for instance, that the school system remains integrated in a conflict area. It doesn’t take a rocket scientist to realize that this is a good thing; when young people interact every day, have the same teachers,
and use identical teaching tools and books, they are likely to have a common value platform. This is a classic connector, and even if your project doesn’t directly touch on education, you may still want to make sure that it does not in any way undermine it.

Remember that every conflict has connectors. They can be hard to spot, so take the time, and use your imagination, to identify them. Also remember that not all connectors are genuine. Learn to be skeptical. Women’s groups, for example, simply by virtue of being made up by women, sometimes claim to be connectors. Yet we know that women are as capable as men are of being members of violent groups. For this reason, as an aid worker, the more you learn about the conflict context, the more effective you will be.

**Step three – analysing dividers**

Dividers are just that: sources of tension that help to divide individuals, groups, and communities. Some may be rooted in deep-seated, historical injustice, while others may be recent, short-lived. Subgroup leaders often manipulate dividers, which may arise from many sources, including economic relations, geography, demography, politics or religion. Some may be entirely internal to a society; others may be promoted by outside powers. More specifically, they may include militias, which may favor one group over another, legal systems that discriminate, police stopping one group but not others at checkpoints, agriculturalists and pastoralists using land differently, religious laws being imposed on people not of that religion, and so on. Understanding what divides people is critical to understanding how aid programmes may feed into divisions and social tension.

Fortunately dividers are usually easy to spot, unlike many connectors. In a conflict situation, many groups exploit dividers for personal or clan gain and may wish to uphold the status quo. When you design a project, it is critical that you understand what divides people so that your programmes do not feed into these forces. Only a thorough knowledge of the conflict context can help you to do this.

Finally, not all dividers are bad. They can represent healthy pluralism. These are generally not the dividers DNH is concerned with.

**Step four – analysing the aid programme**

Step four of the framework involves a thorough review of all aspects of the aid programme. Where and why is aid offered, who are the staff (external and internal), how were they hired, who are the intended recipients of the aid, by what criteria are they chosen, what is the aid provided, and who decides how the aid is delivered, warehoused and distributed? You will find an example of such programme analysis in the end of this lesson.
**Step five – analysing the aid program’s impact on dividers and connectors**

Step five is an analysis of the interactions of each aspect of the aid programme with the existing dividers and connectors. In doing this analysis, we ask – who gains and who loses from our aid? Do these groups overlap with the dividers we identified as potentially or actually destructive? Are we supporting military activities or civilian structures? Are we missing or ignoring opportunities to reinforce the connectors? Are we inadvertently undermining or weakening any connectors? Each aspect of programming should be reviewed for its actual and potential impacts on the connectors and dividers.

**Step six – choosing programming options**

Finally, if our analysis of the conflict context, the dividers and connectors, and the programme itself shows that aid exacerbates inter-group dividers, we must consider how to provide the same aid in a way that eliminates the negative, conflict-worsening impacts. If we find that we have overlooked any connectors, then we must redesign our programme so we do not miss this opportunity to support peace.

So what does DNH say about options? First of all, if the analysis is to be useful, it must lead to action. However, several things can limit our scope of action. These include the mandates and demands of organization headquarters and donors. Project managers find their hands tied because the mandate under which the project was funded (specifically or by chance) excludes certain actions that might have strengthened a connector. This does not necessarily mean a lack of goodwill on anyone’s part: headquarters’ hands may be tied by a donor agency, whose own hands, in turn, are tied by politicians or civic donor groups. The situation on the ground, in a territory rife with violent conflict, may also move far too quickly for aid policy, however well-intentioned, to adapt.

Remember it is always possible to make changes in projects along the way. Even minor adjustments may have a great effect. It can therefore be helpful to ask what level of ambition to aim for: Do no harm at all? Do less harm? Do nothing? There is no perfect answer to these questions; DNH argues simply that it is critical to focus on dividers or connectors, and to keep looking for better programming options. Once a better option has been identified, make sure to check and recalibrate the expected impacts of the new approach on the dividers and connectors.

Aid projects typically influence connectors and dividers in two ways, through resource transfers and through implicit ethical messages.
Lesson 2.2: Do no harm? – the impact of aid

1 Resource transfers

Aid is a vehicle for providing resources to people who need them. Its most direct impact on conflict happens when aid (food, health care, training, shelter, improved water systems, etc.) is provided to areas which may be very poor and where there is an ongoing inter-group struggle. The degree of inter-group competition or collaboration will depend on the amount of resources provided, how it is being distributed, and who makes the decisions. How these are made can determine whether war or peace will prevail. DNH generally refers to resource transfers as:

- Theft: Warring factions often steal food to support the war efforts. This usually happens in one of two ways: directly, when food is stolen to feed fighters, or indirectly, when food is stolen, and then sold, in order to raise money to buy weapons.

- Market effects: Aid affects local prices, wages, and profits. It can either reinforce the war economy (activities that are war-related) or the peace economy, including normal civilian production, consumption, and exchange. The market effect on the civilian economy can be very hard to determine and need not always be positive: purchasing local trucking capacity, for example, may cause warring factions to hijack the transportation system, driving up the prices, and ultimately decide on who gets aid and who does not. The effect on the conflict can obviously be very negative indeed. On the other hand, by bringing your own trucks, you can doom a vital sector of the local commerce by putting people out of work. Either way, you are likely to exacerbate public resentment and cynicism. The DNH framework can help you to analyse this dilemma and negate some of its worst effects.

- Distributional effects: When aid is targeted to some groups and not to others, assistance can reinforce and exacerbate conflict. On the positive side, the way aid is distributed, if done well, can also reinforce connectors by linking groups that otherwise would not be linked.

- Substitution effects: Aid can substitute for local resources that would have been used to meet civilian needs and, thus, free these up to be used in support of war. There is a political substitution effect that is equally important. This occurs when international agencies assume responsibility for civilian survival to the extent that local leaders and warriors are permitted to define their roles solely in terms of warfare and control through violence. As aid agencies take on support of non-war aspects of life, local leaders may be tempted to abdicate responsibility for these activities.

- Legitimization effects: Finally, just as every intervention creates losers and winners, the aid process is no different: it legitimizes some people while undermining others. It can support people who pursue war, or those who work to maintain peace. Make sure you know enough about the conflict context to support the right people.
### 2 Implicit ethical messages

The delivery of aid also affects conflict environments through something we call implicit ethical messages. An implicit ethical message is the impact that an aid worker’s attitudes and actions may have on any given conflict. While they can be subtle, such attitudes are perfectly capable of exacerbating, even upending, inter-group tensions. Implicit ethical messages include:

- **Arms and power**: When international agencies hire armed guards to protect aid material from theft, or their workers from harm, the implicit ethical message is to legitimize arms and permit, in effect, their use to determine who gets access to food, shelter, and medical supplies. (‘If they can use arms to achieve their goals, why can’t we?’)

- **Disrespect, mistrust, and competition among aid agencies**: When agencies refuse to cooperate, or badmouth each other, a common perception among the public is that it is unnecessary to cooperate with anyone with whom one does not agree. Further, it suggests that you don’t have to work with, or respect, people you don’t like.

- **Aid workers and impunity**: When aid workers use their aid and support systems (vehicles, etc) for their own pleasure, they send a message that it is permissible to use them for personal benefit and not be accountable.

- **Different value of different lives**: Agencies send an unacceptable message when they adopt different policies for two groups of people (e.g. expatriate and local staff), or act in ways that suggest that some lives (and even some goods) are more valuable than other lives.

- **Powerlessness**: When field-based staff disclaims responsibility for the (usually negative) impacts of their assistance programmes, the message is that no one working in complex circumstances are required to take responsibility.

- **Belligerence, tension, and suspicion**: When aid workers are nervous and worried for their own safety, they often approach difficult situations with suspicions and belligerence. By doing so, they may reinforce a sense of warfare, thus exacerbating tensions. The message sent is that it is all right to approach people you meet with suspicion and belligerence.

### Analysing the impacts of an aid programme on conflict

Any aid programme embodies a series of decisions answering a fundamental set of questions. Why have we chosen this activity, with these resources, in this place, with these people? How did we select these beneficiaries, these resources, and these staff? Who made these decisions, and how?
Every organization has a programme planning process that outlines how such decisions should be made. However, the reasons behind such choices often remain unspoken or implicit. This is not helpful, as each of the choices will likely have an impact on the conflict. It will help if the decision-making process is explicit and transparent.

Few programmes are likely to have only negative impact but may, in fact, be doing much of the good they set out to do. As a result, they do not necessarily have to be scrapped simply because one, or two, or three pieces do not work. Instead, they must be modified and adapted.

The DNH framework captures the decision-making process by asking seven basic questions. Please remember, though, that it is not enough, when analysing a programme, to ask these questions once. It is necessary to ask them again and again, until the whole structure of the programme has been made explicit and clear.

Some basic questions, taken from a case study of a health training centre in Somalia, include:

**Why?** (Why has the aid worker chosen to focus on this particular project? What does s/he expect to achieve?)

**Where?** (Where is the project located, and what criteria does the aid worker use for placing it in that location?)

**When?** (When does the aid worker expect to implement the project, and why?)

**What?** (What are the aims of the project?)

**For whom?** (Who is the intended target group? What are the criteria for choosing some beneficiaries over others? Who would not benefit and why were some left out? What may happen as a result of such an exclusionary policy?)

**By whom?** (Who are the aid worker’s partners and employees? Are they locals or expatriates? Which clan do they belong to? What are the criteria for hiring these people? Who does the criteria exclude, and why? What may happen as a result of such an exclusionary policy?)

**How?** (How does the aid worker implement the project? Is s/he bringing in food, shelter, money, training, experts, vehicles, radios, tools, etc – or are they supplied locally? Should s/he rent or build, and why?)

At the beginning of this lesson, we emphasised that the DNH framework is an analytical tool, grounded in the concept of connectors and dividers – intended to help provide aid in a way that does not exacerbate the existing conflict. The above text will help you to do that. The grid below will help you to review some of the issues underpinning the framework (Table 1).
Objectives

- Systematically study the impact of humanitarian and development intervention (relief and development) by outside agencies on destructive conflict situations
- Identify patterns in how aid interacts with conflict
- Facilitate a process of programming options

The approach

- Promotes collaborative learning
- Rests on aid workers own experience
- Is solidly anchored in field evidence

The process is generated by

- 15 case studies in 14 conflict settings (using different types of conflict, intervention, and actors)
- 25 feedback workshops (including more than 400 persons with experience of working in conflict settings)
- 12 cases with up to three-year implementation periods (practical testing phase 1997–2000)
- Mainstreaming phase 2001–Present

Lessons learned

1 | In a violent conflict setting, aid almost always becomes part of the conflict

2 | The conflict context is always characterized by the following two factors:
   - Dividers
   - Connectors

3 | Aid interacts with Connectors and Dividers in negative or positive ways

4 | Resource transfers is one way in which aid impacts the conflict

5 | Implicit ethical messages are another set of mechanisms through which aid interacts with conflict

6 | What determines the projects impact on conflict lies in its details

7 | There are always options!
Other things to remember

DNH is not a peace-building tool, but is intended to help relief and development agencies improve what they are mandated to do. Neither is it a static tool. To quote Mary Anderson, ‘aid workers […] accept and work under muddled circumstances without exaggerated or naive expectations about our power. At the same time, we urge ourselves on to greater effectiveness and higher goals and more comprehensive programming to achieve better results for the people with whom we work. The work of humanitarianism and of development support poses many dilemmas, but among the most important is the necessary balancing of hardheaded realism and programmatic modesty.’

Created by pragmatic aid workers with long experience in the field, DNH is a living process that will continue to evolve as aid workers’ circumstances change. It is critical to record their experiences and ensure that the lessons learned are shared with, and debated among, colleagues everywhere. Whether you use straight-up DNH, or a new and improved version, always remember to step back and do ongoing analysis. The DNH framework reminds us again and again that some analysis always is better than none. Indeed, many valuable programme decisions have been made by a couple of aid providers back at the field office working off the back of an envelope, using nothing but connectors and dividers to guide them.

References

For information on DNH, newsletters, updates, and case studies, visit: http://www.cdainc.com/cdawww/project_profile.php?pid=DNH&pname=Do%20No%20Harm, accessed 14 December 2011

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Lesson 2.3: Protecting civilians during violent conflict

Author: Hanna Mollan

Introduction

Humanitarian agencies specialise in offering medical services and material assistance to civilians affected by armed conflict. However, we increasingly see that aggression against civilians is used as a tactic of war. Where civilians are subjected to sexual violence, forceful displacement, and killing, humanitarian assistance is not enough. People need protection from intentional harm.

The protection of civilians during violent conflict is the responsibility of the conflicting parties, not humanitarian agencies. However, to reach those in need of life-saving assistance humanitarian agencies enter into ever more violent environments. As a result, humanitarian workers are likely to work in a militarized environment, to witness acts of aggression to those they are helping, and to experience threats or violence against their own person.

We will see that humanitarian agencies have responded by refining their assistance activities, and developed new strategies to protect their beneficiaries. This is known as humanitarian protection, and is based on ensuring respect for the legal provision that protect civilians and humanitarian action in war.

Legal protection

Civilians affected by armed conflict have the right to be assisted and protected. These rights are established in human rights law, refugee law, and international humanitarian law. For a good overview of these three bodies of law, see: http://www.icrc.org/Web/eng/siteeng0.nsf/html/6T7G86

Human rights law outlines the basic rights and freedoms to which all people are entitled, and apply in times of peace and during armed conflict. Refugee law determines who is a refugee, and establishes the right of refugees to seek asylum,
and to be protected from involuntary return to a country where they could face prosecution. International humanitarian law regulates warfare, and applies only during armed conflict.

The core of international humanitarian law is the Geneva Conventions, signed by every single state in the world (194 states as of 2009). For an excellent presentation of the Geneva Conventions and international humanitarian law see: http://www.icrc.org.

The purpose of the Geneva Conventions is not to end war, but to protect the life, health and dignity of human beings once hostilities have broken out.

The Geneva Conventions oblige the conflicting parties to distinguish between civilians and combatants, and not to attack civilians. Any deliberate attack on civilians or civilian targets, such as schools or hospitals, goes against the very essence of the Geneva Conventions. Conflicting parties are required to treat civilians and wounded or captured enemy combatants humanely at all times. Killing, torture, cruel and degrading treatment, arbitrary arrest and hostage taking are prohibited under all circumstances. These minimum standards apply to state actors (regular armies), and to non-state actors (irregular armed groups, rebel movements).

We recognize that international humanitarian law is frequently violated with impunity. It is the collective responsibility of states to inform and teach their army and population about their rights and obligations, to monitor compliance, to investigate violations, and to punish the perpetrators. For this reason, the legal protection of civilians is only as effective as the willingness and ability of states to monitor each other and to intervene to enforce the laws they have signed.

In 1998, the International Criminal Court (ICC), was set up to try grave crimes of international concern, such as genocide, war crimes and crimes against humanity. The ICC was established by the Rome Statute, an international treaty signed by 111 states at March 2010. This manifests a will of the international community to enforce international law.

To sum up, it is the concerned states and conflicting parties that bear the primary and legal responsibility for assisting and protecting civilians during conflict. While the Geneva Conventions give neutral and impartial humanitarian agencies a right to provide relief assistance, humanitarian agencies are not parties to international law, and can only play a secondary, supportive role in providing humanitarian assistance and protection.

**Mandated protection agencies**

Mandated protection agencies are those whose protection roles and responsibilities are enshrined in international law agreed upon by states. There are four main such agencies.
Lesson 2.3: Protecting civilians during violent conflict

1 | The International Committee of the Red Cross (ICRC) is an impartial, neutral and independent humanitarian institution. It has been given a mandate by state signatories to the Geneva Conventions (1864, 1949) to monitor the implementation and development of international humanitarian law, and to offer humanitarian assistance. The ICRC works closely with all parties to a conflict to protect and assist civilians, especially prisoners of war, children separated from their families, and the wounded. To fulfil its mandate, the ICRC must enjoy the confidence of all parties to the conflict as it depends on safe access to all areas of a conflict zone. Therefore, the ICRC is the most rigorous of all humanitarian entities in working according to the principles of neutrality and impartiality. Neutrality means not taking sides in the conflict, and not engaging in any political, racial, religious or ideological controversies. Impartiality means relieving the suffering of individuals solely guided by need, making no discrimination on the basis of political opinions, race, nationality, or religious belief.

2 | The United Nations High Commissioner for Refugees (UNHCR) leads and co-ordinates international action to protect refugees worldwide, based on the Refugee Convention (1951). The UNHCR promotes the basic human rights of refugees, works to ensure that everyone can exercise the right to seek asylum and find safe refuge in another state, and strives to prevent the involuntary return of refugees to a country where they face persecution.

3 | The United Nations Children’s Fund (UNICEF) works for the protection of children, in peacetime and during conflict. UNICEF bases its work on the UN Convention on the Rights of the Child (1989) which establishes the fundamental rights of children, including the right to be protected from economic exploitation and harmful work, from all forms of sexual exploitation and abuse, from physical or mental violence, and the right not to be separated from their family against their will.

4 | The Office of the United Nations High Commissioner for Human Rights (OHCHR) is a department of the UN Secretariat, led by a High Commissioner for Human Rights. The OHCHR works to ensure respect for human rights and the rule of law by providing technical training, and assisting governments to ratify new and existing human rights treaties. The International Covenant on Civil and Political Rights and the International Covenant on Social, Economic and Cultural Rights (1966) are the two main bodies of international human rights law.
Non-mandated protection agencies

Non-mandated (sometimes called self-mandated) protection agencies are national and international non-governmental organizations (NGOs) that engage in protection activities not based on an international mandate from states, but by their own decision.

Due to their legal status endorsed by states, mandated protection agencies may be in a better position than NGOs to make public statements or representations directly to the authorities or armed groups regarding rights violations. For the same reason, mandated protection agencies may also be in a better position to withstand pressure and deter possible retributions from political or armed group that have been exposed or criticised.

UN agencies, for example, report regularly to the UN General Assembly and the Security Council, and have privileged access to leaders of states who can intervene to influence a critical situation.

On the other hand, smaller NGOs can find it easier to gain the access to vulnerable groups that for whatever reason are suspicious of authorities and the mandated agencies that collaborate with them. They have more freedom to change and adapt their activities to changing circumstances, and can be more flexible and respond more rapidly to a crisis than the larger, mandated organizations.

The work of mandated and non-mandated protection agencies is complementary. They exchange information, refer tasks between each other depending on expertise and resources. Recently, humanitarian coordination has been strengthened through an ongoing humanitarian reform process.

Humanitarian coordination

In large-scale emergency operations hundreds of humanitarian agencies are present, and proper coordination mechanisms are vital to avoid a duplication of efforts and to make sure no need or group is neglected.

In 2005, the UN system, the Red Cross/Red Crescent Movement, and various NGOs launched a humanitarian reform process aimed at improving the coordination and effectiveness of humanitarian assistance. As a result, agencies are now organized in sectoral groups known as clusters, whose purpose is to clarify the roles and improve coordination between the numerous humanitarian actors in large-scale humanitarian operations. (for further information on Humanitarian reform and clusters, see: http://ochaonline.un.org/roap/WhatWeDo/HumanitarianReform/tabid/4487/Default.aspx).

There are clusters for health, education, nutrition, agriculture, protection and so on, each with a lead agency. The UNHCR is the cluster lead for protection activities during armed conflict, and is responsible for coordination efforts, and ensuring that
humanitarian agencies build on local capacities and develop links with government and local authorities, state institutions, and local civil society. As with the legal obligations, the focus is on states.

Humanitarian protection

Humanitarian protection is defined as ‘encompassing all activities aimed at ensuring full respect for the rights of the individual in accordance with the letter and the spirit of the relevant bodies of law, i.e. human rights law, international humanitarian law and refugee law’.

Humanitarian agencies strive to meet the humanitarian needs of people affected by providing health care, food, water and shelter. They also work to ensure full respect for the rights of individuals.

As we shall see, humanitarian protection can comprise a range of activities and analysis, such as:

- assistance
- appropriate types of assistance
- presence
- training
- documentation and reporting
- advocacy

Assistance

The provision of medical care, clean water, nutritious food, adequate shelter, and proper clothing protect people from poor health, disease, distress and allows them to maintain their dignity in difficult and dangerous circumstances.

The way in which assistance is delivered also matters. For example, it could be that by distributing food to a community, they become vulnerable to attack and looting from armed groups who also need food, or who will sell it to buy weapons, or whose aim it is to destroy or forcefully move that community from their land.

Think back to the Do No Harm framework in Lesson 2.2. A proper analysis prior to distribution could prevent a catastrophe. Perhaps an organization could be stationed there to deter attacks. Someone could contact and negotiate with the leader of the armed group threatening this community, and dissuade them to attack. Perhaps the community could temporarily be moved to a safer place. Members of the armed group may have a grievance that humanitarians can solve, or bring to the attention of someone else who can help (broken well, sick children, lack of medical facilities).
Because it has proven effective, donor institutions now often ask agencies to use the Do No Harm framework to plan, implement, monitor and evaluate humanitarian programmes.

Humanitarian agencies involve communities in assessing the situation and the humanitarian needs. Agencies must be open to feedback, and have regular meetings with those they are assisting. In this way, they are alert to possible problems and can make changes if necessary.

The quality of the food must be thoroughly checked before any food distribution. If rotten or inappropriate food is distributed it can be very humiliating for the recipient, even though there are no ill intentions from the agency.

Water pumps in refugee camps, for example, should not be located in isolated areas that may put women or children in danger if they go there alone. Male and female toilets should not be located too near each other, and have lights to allow safer use at night.

In a field hospital, the wards must be properly guarded. Sometimes journalists, human rights workers or the police want to interview survivors of rape or assault, and find their way to a patient without the latter’s consent.

**Presence**

The presence of humanitarian staff can in itself dissuade armed groups from exploiting or attacking civilians, at least in the immediate vicinity of humanitarian staff and activities. Staff can document the humanitarian and security situation in their area, report on and advocate for responses to assistance shortfalls, rights violations and other concerns to mandated protection agencies, responsible authorities, their own donors, and governments.

**Training**

Agencies also work to prevent and deter violations by conducting training to disseminate information about legal rights and duties to conflict-affected civilians, civil government authorities, and armed actors.

**Documentation and reporting**

Agencies increasingly seek to understand the root causes and dynamics of conflicts, and some spend considerable time and effort to document and disseminate their findings. Reports can for example focus on links between a lack of resources, environmental degradation and disease and conflict, or provide details of discrimination, incidents of violence, and rights violations. The standards that behaviour is measured by are outlined in the relevant international law applicable in the context.
Each agency has a particular perspective and understanding of the situation, depending on the sectors and geographical areas they work. With joint efforts, new needs or threats can be identified, and collective action and advocacy strategies can be devised to meet them.

**Advocacy**

Advocating on behalf of groups under threat or in need of protection is increasingly common. When providing assistance is not sufficient, humanitarian agencies can use their knowledge of the context to create advocacy plans and join forces with other organizations to influence governments and powerful actors that can intervene, isolate, stop, and punish perpetrators of violence.

They can opt for public advocacy, by using the media to sway public opinion, or more targeted advocacy aimed at specific and relevant persons, institutions, corporations known to exercise influence over those who can stop abuse.

Advocacy can involve the denunciation of groups or individuals who perpetrate violations, by publicly exposing their shortfall and pressuring them to change behaviour. To safeguard their activities, and avoid possible reprisals, humanitarian agencies in the field rarely resort to denunciation. However, as humanitarian become more vocal about rights violations they gradually go beyond the cornerstone principles of neutrality and impartiality, and become more vulnerable.

**Humanitarian challenges**

In a clinic or hospital, data on patients’ identities, addresses, and medical records are kept. If patients have been victims of abuse, the documentation of injuries and their statements are invaluable for the police or human rights investigators who seek to collect evidence to identify and charge offenders, and ultimately to prosecute and punish them. The question is, should humanitarian staff share these records or not? Who is in a position to decide? What could the consequences be for the humanitarian operation and for the patient?

If the conflicting parties begin to see humanitarian agencies as a source of information on rights violations, humanitarian staff and beneficiaries of aid may suffer reprisals. How much can humanitarian staff disclose publicly about what they know? If sharing information puts the lives of staff and beneficiaries at risk, is it still worth speaking out if it means a perpetrator will be arrested and tried? This is a constant dilemma for agency staff. Decisions are guided by the best interest of those they are striving to protect.

The ICRC, for example, operates on the premeditated understanding that what they see and the information they collect will not be made public (known as the principle of
confidentiality). Access to victims of war through ongoing dialogue with the conflicting parties takes precedence over trying to improve the situation through public advocacy.

Different NGOs have different policies with regard to confidentiality, sometimes making it difficult for them to collaborate on advocacy interventions. The conflicting parties are seldom able or willing to distinguish between different NGOs, meaning that if one organization decides to go public with compromising information about perpetrators (such as naming names, or saying figures of authority are responsible and must be held accountable) it could be perceived as if all NGOs agreed to the decision.

To avoid confusion, it is important to be very clear about the policy of your agency and spend enough time and effort to make sure your patients, colleagues, armed and civil authorities understand what your role is, and what it is not.

Important information about incidents and allegations of human rights or humanitarian law violations could be discreetly referred to protection mandated agencies that have sufficient expertise and procedures to deal with sensitive information, or directly to authorities, if possible.

Example from Darfur

On 4 March 2009, the ICC issued an arrest warrant for Sudan’s President Omar al Bashir for war crimes and crimes against humanity in the country’s western region of Darfur. The next day, President Bashir announced a decision to expel 10 international and three national humanitarian agencies from the country. The agencies had been providing food, water, and medical care for one million people in Darfur. Sudan is not a party to the Rome Statute and is opposed to the ICC. However, Sudan is a signatory of the Geneva Conventions, and depends on international assistance to fulfil its obligations to assist and protect conflict-affected civilians in Darfur.

The 13 agencies had to leave immediately, and the remaining humanitarian agencies faced a dilemma.

If they immediately tried to fill the gap left behind by the exiting agencies, it would be a sign to the Sudanese authorities that they can expel humanitarian agencies with no consequence. If they decided to protest and hold the government accountable for the humanitarian catastrophic consequences of its decision, people would suffer. The humanitarian priority is to save and protect lives, and that is what the remaining agencies proceeded to do.

President Bashir blamed humanitarian agencies in Darfur for collaborating with ICC, and for providing it with evidence to build a case against him. He did not consider, or did not want to consider, these agencies as neutral and impartial humanitarian entities. Some agencies do not adhere strictly to neutrality, but try to combine delivering humanitarian assistance while at the same time sharing the information they get with human rights groups and others who conduct investigations to bring justice to victims of abuse, and uphold the rule of law.
The case of Darfur is extreme. The state behaves as an enemy of its own citizens, killing its own population. But this pattern is repeated to a lesser degree in many armed conflicts. It is the responsibility of other states to intervene to stop states that allow or participate in grave violations, such as war crimes, crimes against humanity and genocide.

Humanitarian agencies must deal with whichever authority in charge of an area to negotiate access to people in need of assistance and protection. Their role is not to judge the behaviour of the conflicting parties. Humanitarian contact with illegitimate or abusive groups does not give them legitimacy, and provides opportunities to influence their behaviour. Experience shows that some rebel groups see it in their interest to learn and comply with basic provisions of the Geneva Conventions (for example, allow the ICRC to visit their prisoners of war, to allow humanitarian convoys to pass through their areas, and allow agencies access to treat the wounded and sick), as it can give them credibility and future political advantages.

Conclusion

We have noted that humanitarian assistance is not always sufficient to assist and protect victims of war, especially where civilians are targets of direct aggression. Legal instruments aimed at protecting civilians in armed conflict oblige states to assist and protect, and give humanitarian agencies a right to contribute. In addition to providing material assistance, mandated and non-mandated protection agencies also work to ensure respect for the legal provisions that protect civilians and humanitarian action in war, the sum of these activities is known as humanitarian protection.

References


Lesson 2.4: Conflict resolution and mediation

Author: Nick Lewer

Health professionals may find special opportunities for conflict resolution and mediation in their own communities and other places which conflict is possible or occurring. This lesson describes the process of mediation, and considers applications of conflict resolution, mediation, and conflict sensitivity from the perspective of public health professionals. Conflict resolution and mediation, two important tools in the peacemaker’s toolkit, must be used to complement other initiatives, some of which will be described in this lesson.

The context

Health workers working in conflict zones and engaging in peace-making and peace-building activities should also learn about the political and security context. This will enable them to engage more meaningfully and pragmatically with key stakeholders. Stepping out of a professional role and into that of a peacemaker is a serious undertaking. Intervening non-violently in other people’s violent personal and political conflicts carries great moral and ethical responsibilities and obligations, and dangers to personal safety. It should not be undertaken without serious consideration of the consequences, motives and commitment.

Conflict resolvers and mediators face ethical dilemmas and must ask themselves important questions. Their interventions must be appropriate and sensitive to the needs of local people. They can offer support in the form of skills training workshops, mine clearance, negotiation, human rights protection, medical and food aid and other assistance, but those working at local level to resolve and manage violent conflict must also address their own psychological preparation.

Learning objectives

By the end of this lesson you will be able to:

- describe mediation by health professionals;
- distinguish between official (T1) and non-official (T2) conflict interventions;
- discuss the key skills needed by health professionals undertaking mediation and conflict resolution;
- understand the contexts and situations in which health professionals may engage in mediation and peacemaking activities;
- adopt a conflict-sensitive approach to medical interventions.
This includes developing their inner resources of wisdom, courage and compassionate nonviolence. Otherwise they will be worn down by those who are more interested in violence than peace (Curle 1986).

**Principles of conflict mediation**

At its simplest, mediation is the ability to form significant interpersonal relationships with the parties in conflict in an even-handed manner. The terms ‘mediation’ and ‘mediator’ can best be embodied by the phrase ‘in the middle’: a mediator is between conflicting parties and in the middle of the conflict itself. To be effective a mediator must be nonjudgemental, committed and impartial. He or she must assure confidentiality – without media publicity or the publication of research articles exposing shared confidences. The many desired personal qualities include patience, stamina, persistence, imagination, energy, and the ability to listen.

**Active mediation**

Active mediation is described as ‘the diplomatic activity of mediators, which involves direct mediation between the political and/or military leaderships of conflicting parties’ (Curle 1986). It is shuttle diplomacy, involving traveling between the disputants, perhaps carrying messages and information, finding common ground, and attempting to identify common issues. Mediators undertake active mediation with the specific purpose of removing obstacles on the path to peace, while arguing strongly against the misunderstandings and preconceptions that strengthen these obstacles.

**Track 1 – Track 2 levels**

There is a distinction between track one (T1) – official diplomacy, and track two (T2) – non-official approaches to conflict resolution and mediation. T2 is also known as citizen diplomacy, supplemental diplomacy, and complementary diplomacy. Whereas T2 diplomacy represents a form of conflict resolution that is nongovernmental, non-directive and informal, T1 continues the government-to-government, power-based, formal and official traditional approaches to international interactions.

**Implications for health professionals**

Non-violent conflict resolution and mediation work has three main strands:

- training, preparation and networking
- creating mediation contexts
- active mediation.
Training, preparation and networking

Health professionals who want to become engaged in mediation and conflict-resolution work should undertake thorough training and preparation to:

- develop and refine interpersonal communication skills;
- acquire knowledge of the dynamics and processes of conflict at intrapersonal, interpersonal, intragroup, intercommunity, and international levels of conflict;
- understand the causes of conflict and conflict resolution theories;
- acquire knowledge of the history and causes of the conflict for which the intervention is intended;
- deepen personal humanitarian commitment to the pursuit of peace with justice.

A working knowledge of and practice in good communication skills is essential, not only for effective coping, management, and resolution strategies, but also for caring and empathetic relationships between health professional and patient, and between the public health worker and the community.

Conflict resolution skills and methods are therefore important for health professionals who wish to improve their clinical and public health practice and also contribute positively to the peace of their communities. When opportunity arises, they may wish to use peacemaking skills to promote international conflict resolution, communication and dialogue-building projects, and reconciliation initiatives. In many cases, these skills and strategies are called on when conflict and violence has already broken out – but the greatest potential lies in using them to prevent conflicts from becoming destructive and violent.

Preparation is a continuous process that includes the study of other mediation attempts, keeping up to date with the current literature, tracking existing and potential conflicts, meeting experienced mediators, gaining experience at community and international levels, and attending conferences and seminars (see Box 1 for an example).

Box 1: Training in mediation

International Physicians for the Prevention of Nuclear War (IPPNW) is an international nongovernmental organization (INGO) that has been active, through its national affiliates, in organizing training workshops. Over the years it has facilitated training in Croatia, Hungary, Macedonia, Malaysia, the Netherlands, Sri Lanka, Uganda, and the UK.

(cont.).
Box 1: Training in mediation (continued)

The workshops blend theoretical input and experiential techniques such as role-play and simulation. They operate at many levels:

- providing basic exposure to mediation and other nonviolent conflict resolution methods and training;
- promoting a greater awareness of such methods;
- fostering relationships and building up trust between representatives from conflicting communities, thus making contacts for possible future mediation initiatives;
- enabling facilitators to become known as people who are concerned with mediation work, in local communities and government institutions.

The intention is not only to introduce Western-style methods and thinking about conflict resolution to other cultures, but also to facilitate the adaptation of such concepts to each cultural setting. A common language or understanding is an important starting point for conflict resolution and mediation work.

Creating mediation contexts

International opportunities for conflict mediation are most likely to arise in the context of other projects. Such contexts include:

- conflict resolution training;
- facilitating professional conferences and seminars on ‘neutral’ territory;
- organizing humanitarian ceasefires, corridors of tranquility and bubbles of peace;
- delivering humanitarian aid;
- remaining in contact with colleagues on all sides of a conflict.

The following examples illustrate some of these mediation contexts.

Example 1 | Cyprus

In 1991, a mediation team from the Medical Association for the Prevention of War (now known as Medact), the IPPNW affiliate in the UK, visited Cyprus in an initiative to promote rapprochement and bicommmunal relations between Turkish and Greek
Cypriot health professionals. The group organized a seminar to benefit both medical communities in the neutral territory of the UN buffer zone. Over nine months the team managed to meet the political and medical leadership of both communities and obtain clearance for the seminar to take place. Talks were also held with doctors from both communities and with senior personnel of the UN agencies in Cyprus. A programme was designed and agreed by all parties that reflected a wide range of medical interests.

In October 1991, 50 doctors met in a conducive and professional atmosphere, and an equal number of Greek and Turkish Cypriot doctors presented case studies. For some participants, friendships almost 20 years old were rekindled. It was hoped that this initiative, while not overtly a mediation attempt, would act as a communication channel between the two communities by creating a mediation context (Craig 1993).

**Example 2 | The former Yugoslavia**

The wars in former Yugoslavia brought requests from health colleagues on all sides. In 1991, at the beginning of the Serb-Croat war, health professionals in Zagreb and Belgrade formed Physicians for the Prevention of War (PPW) in an attempt to keep lines of communication and dialogue open; to work for human rights and justice; and to maintain support for, and adherence to, the Geneva Conventions – particularly those pertaining to the rights and duties of medical personnel (Baccino-Astrada 1982).

Until the war became too intense, members of IPPNW affiliates attended PPW meetings to support and show solidarity with these efforts to work for peace. As the war spread to Bosnia-Herzegovina, the activities of IPPNW and many other health organizations intensified. IPPNW in Europe organized a series of seminars and conferences in Austria and Hungary to which colleagues from all over the Balkans were invited. These meetings provided a neutral forum to keep communication open, at a professional and humanitarian level, between health professionals from the various belligerent parties and others related to the conflict. Representatives from Western European IPPNW affiliates were in a position to moderate and mediate.

The topics included the care of refugees, trauma and rape counselling, the special needs of children, mediation and conflict resolution, humanitarian aid delivery, and medical ‘corridors of peace.’ The value of keeping alive personal contacts was recognized not only by outsiders, but also those engaged in conflict, to develop understanding of the situation and hasten the process of mediation and peacemaking.
Conflictsensitivity

Opportunities for active mediation at international (T1) level may be rare, but health professionals can use conflict resolution and mediation skills, particularly when working in humanitarian disasters. This enables them to be more ‘conflict-sensitive’. Conflict sensitivity is developed through using conflict analysis tools to understand the complexities of the operational context, and then doing health work in such a way that potential negative impacts are minimized and the positive impacts of interventions are maximized. This supports the Do No Harm approach described in Lesson 2.2.

Here are just a few situations in which a conflict sensitive approach is important and can save lives.

The process of triage, selecting patients for emergency treatment based on the severity of their condition and the capacities of the health unit involved, is an emotive issue that requires a sensitive approach to prevent conflict and violence erupting at the hospital or in the wider community. This is particularly problematic when combatants and civilian patients from conflicting communities present themselves for treatment at the same time. In such cases accompanying relatives or local military and political groups may demand preferential treatment or accuse the emergency teams of being biased in setting their priorities.

When health teams are sent by governments or organizations perceived to be biased (such as via ethnic or religious markers), misunderstandings may arise about motives relating to how patients are accepted for treatment. During violent conflict, armed groups may locate military units in or in close to health facilities, attack enemy wounded in hospitals, demand that patients from opposing sides are handed over, and accuse aid agencies of complicity with rival armed groups.

Cultural or religious norms and taboos over certain forms of treatment are also potential sources of conflict. These include issues related to blood transfusion, gender, and patients’ refusal to be treated by health workers from a rival ethnic group, or health workers refusing to treat patients from a rival community. Disregard for or failure to recognize these considerations could lead to interpersonal conflict at the health facility, which could spread. During conflict there may also be restrictions on access to health services by civilians, imposed by armed groups or occupying powers.

Such situations require considerable mediation and negotiation skills on the part of health professionals, who should also have an understanding of the wider security and political context.
Conclusion

Health professionals, who have a long and rich tradition in peacemaking, can play an important role in international conflict resolution and mediation – not usually as major political players, but at grass-roots levels in areas where their health knowledge, expertise and connections can be maximized. By using extensive global networks, communicating with organizations of other professionals, and speaking up loudly for respect and adherence to international humanitarian law and the Geneva Conventions, they can add a powerful voice to calls for peace, reconciliation and justice.

References


Chapter 3: Improving mental health after violent conflict

In this chapter you will learn about the role of health professionals in rehabilitating and reconciling individuals and communities in post-war situations.
Lesson 3.1: Mental health and violence: individual problems and solutions

Author: Kerstin Stellermann

This lesson examines the concept of war-related trauma, and interventions to deal with it at the individual level.

Violence and mental health

Mental health disorders comprise four of the 10 leading causes of disability worldwide (Lopez 2006). The baseline proportion of people with severe mental health problems such as psychosis or severely disabling moods, anxiety, and stress related disorders is an estimated 2–3%. In emergencies and violent conflicts, the proportion is projected to be about 1% higher. People with pre-existing mental health disorders are particularly vulnerable (Silove 2004, Silove 2005). In post-war situations this can amount to many thousands of vulnerable people (Van Ommeren 2005).

The major effect of violence is the destruction of people’s social and physical worlds, with a resulting sense of collective and individual loss. It engenders a wide range of feelings including fear, anger and grief. These are normal responses to abnormal circumstances.

In a traumatic experience, the person experiences a dissonance between the threatening situation and their own coping resources. This is associated with feelings of helplessness and unprotected surrender, causing a permanent shock to one’s self and understanding of the world (Riedesser 1999).

Incidents and events that can act as a precursor to traumatic stress reactions include:

- personal trauma – incidents that threaten a particular person (sexual violence, domestic violence, bereavement, being a victim of crime, accidents)
- war and terrorism – threaten soldiers and civilians
- major disasters – earthquakes, train and plane crashes.

Learning objectives

By the end of this lesson you will be able to:

- describe the impact of violence on mental health
- describe the symptoms of psychological trauma
- outline the theory and practice of mental health programmes and trauma healing
This list is by no means exhaustive, and the trigger event will vary from person to person. Not everyone who witnesses a potentially traumatic event goes on to develop a stress disorder. Conversely, people who have not actually witnessed the event but were indirectly involved, for example health workers, may go on to develop some kind of traumatic response (Tehrani 2002).

**War and the diagnosis of trauma**

The concept of ‘war trauma’ originated during the First World War. Some psychologically traumatized soldiers were shot as deserters, while others were described as suffering from ‘shell shock’. Treatment varied, but was often based on removing them from active duty for extended rest. Military doctors and mental health professionals started to realize, however, that shell shock could manifest without any physical trauma. The psychological aspects of the syndrome were well recognized by the time of the Second World War (Yule 1999).

The concept of post-traumatic stress disorder (PTSD) gained momentum during the Vietnam War in the 1960s. Veterans’ personalities and ability to readjust were affected for years afterwards (Yule 2002). The evidence of trauma-related reactions in the veterans was compelling, and influenced the American Psychiatric Association (APA) to include PTSD in the third edition of the Diagnostic and Statistical Manual of Mental Disorders in 1980.

It said three symptoms form the basis of the diagnosis: re-experiencing the event, numbing and avoidance, and hyper-arousal. These diagnostic criteria have been revised several times. In 1993, in the tenth version of the International Statistical Classification of Disease and Related Health Problems (ICD 10), PTSD was acknowledged as an internationally recognized and defined set of symptoms and diagnoses.

ICD 10 describes a spectrum of post-traumatic stress responses (PTSR). These vary from person to person and differ in severity, but can be categorized under four main headings: emotional, cognitive, physical and interpersonal responses (Table 1).
Table 1: Signs and symptoms of common traumatic stress responses, based on ICD 10 and DSM IV

<table>
<thead>
<tr>
<th>Emotional</th>
<th>Cognitive</th>
<th>Physical</th>
<th>Interpersonal</th>
</tr>
</thead>
<tbody>
<tr>
<td>• SHOCK</td>
<td>• IMPAIRED CONCENTRATION</td>
<td>• FATIGUE/EXHAUSTION</td>
<td>• INCREASED RELATIONAL</td>
</tr>
<tr>
<td>• TERROR</td>
<td>• IMPAIRED DECISION-MAKING</td>
<td>• INSOMNIA</td>
<td>CONFLICT</td>
</tr>
<tr>
<td>• IRRITABILITY</td>
<td>• MEMORY IMPAIRMENT</td>
<td>• CARDIOVASCULAR STRAIN</td>
<td>• SOCIAL WITHDRAWAL</td>
</tr>
<tr>
<td>• BLAME</td>
<td>• DISBELIEF</td>
<td>• HYPER-AROUSAL</td>
<td>• REDUCED INTIMACY</td>
</tr>
<tr>
<td>• ANGER</td>
<td>• CONFUSION</td>
<td>• PHYSICAL PAIN</td>
<td>• ALIENATION</td>
</tr>
<tr>
<td>• GUILT</td>
<td>• NIGHTMARES</td>
<td>• DECREASED SELF-ESTEEM</td>
<td>• IMPAIRED WORK/SCHOOL</td>
</tr>
<tr>
<td>• GRIEF</td>
<td>• WORRY</td>
<td>• DECREASED APPETITE</td>
<td>PERFORMANCE</td>
</tr>
<tr>
<td>• SADNESS</td>
<td>• DISSOCIATION</td>
<td>• DECREASED LIBIDO</td>
<td>• DECREASED SATISFACTION</td>
</tr>
<tr>
<td>• NUMBING</td>
<td></td>
<td>• SUSCEPTIBILITY TO ILLNESS</td>
<td>• DistrUST</td>
</tr>
<tr>
<td>• LOSS OF PLEASURE</td>
<td></td>
<td>• HEADACHES</td>
<td>• EXTERNALIZATION OF BLAME</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• FEELING OF ABANDONMENT / REJECTION</td>
</tr>
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<td></td>
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<td>• OVER-PROTECTIVENESS</td>
</tr>
</tbody>
</table>

Children’s responses to trauma are often related to those of their caregivers and significant others. An adult may perceive an event that is traumatic for a child as very insignificant, for example, falling off a chair, losing mother for a minute in the street, being bitten by a dog. Children’s reactions to trauma include regressing to an earlier stage of development, for example bed-wetting, sucking their thumb or using baby talk. Small children sometimes try to cope with trauma by re-enacting the traumatic situation repeatedly, or asking for the story to be retold.

Traumatic stress responses are now understood as a normal reaction to abnormal events. However, as mentioned above many of the signs and symptoms could indicate other mental health problems, such as depression or psychosomatic disorders. For further reading on traumatic stress see Perry and Szalavitz (2008) and Herman (1994).
Criticism and responses

The methods used to diagnose post-traumatic stress responses have been criticized because they do not take account of exogenous factors such as situations of violent conflict or other complex emergencies, when mental health problems, and by extension PTSR, inevitably increase because of experiences like rape and torture.

There is also growing awareness of the need to consider cultural and social beliefs and practices. These influence how people react to events, and include understandings of health and illness, causes of misfortune, gender and social position. ICD-10 is seen as more sensitive to these variables but many countries do not yet use it as standard.

In response to some of these criticisms, WHO developed the International Classification of Functioning, Disability and Health (ICF) as a companion to ICD-10. ICF moves away from imputing problems to the specific impairment, and includes consideration of the individual, social and environmental context.

In addition to these diagnostic manuals, more specific tools are available to help health professionals assess the risk of PTSR following what may be considered a traumatic event. Some are self-administered and based on signs and symptoms checklists. The most widely used include the Harvard Trauma Questionnaire and the Hopkins Symptom Checklist.

Therapeutic approaches

There is disagreement about PTSD and the appropriateness of providing services focused on trauma. There is an emerging consensus, however, about good practice in mental health and standards on minimal responses in emergencies (Sphere 1998, 2000). A range of social and mental health intervention strategies and principles is broadly supported by expert opinion.

Exposure to extreme stressors is generally agreed to be a risk factor for social and mental health problems. Social interventions, and mental health interventions with social interventions that have secondary mental health effects, are both needed and should work in close partnership. Services should be community-based to be accessible and minimize stigma (see also Lesson 3.2).

Trauma-focused services are helpful if they are integrated in a general mental health care system (van Ommeren et al. 2005a). A review of studies showed that seven factors prevent the development of PTSD (Wilson and Raphael 1993, Wilson 1985). These are locus of control; self-disclosure; sense of group, feeling a survivor; coping strategies and resources; pre-social behaviour and altruism; seeing meaning in the trauma and the future; and social interactions.

Those factors should be addressed in social interventions.
In practice this means:

- Safety first!
- Attend to basic needs first (water, food).
- Encourage the person to talk about the traumatic event and to other survivors.
- Reassure them that their emotional reactions are normal.
- Encourage them not to avoid situations that remind them of the event.
- Activate resources: people, skills, beliefs.
- If there are severe difficulties, a short course of medication may help.

Treatment, like diagnosis, should depend on context. It is also time-dependent – after any traumatic event, the period of adjustment and recovery can range from days to years. It is those people who are unable to adjust or recover that are of concern.

In this lesson we focus on Western biomedically-led understanding of mental health problems and interventions. There has been much debate about their appropriateness in other contexts. In most developed nations, treatment is usually offered through mental health teams, particularly psychologists, on an out-patient basis. Treatments include cognitive behavioural therapy, family therapy, treatment of specific symptoms and the short-term administration of sedatives.

In poorer countries, where people have limited access to health services, there is often little or no treatment for mental health problems and very few psychologists, psychiatrists or mental health nurses. Mental health problems may not be recognized in local understandings of health and illness. People with psychological problems may therefore have no treatment, which can result in exclusion from families and communities. Stigmatization and discrimination against people with mental health problems is rife across the world (Silove et al. 2000).

People and cultures have a wide range of coping mechanisms and strategies to deal with traumatic events. For example, many cultures and communities that have undergone a disastrous event hold healing or cleansing rituals as an essential part of recovery and rehabilitation. For example, they have been used when demobilized child soldiers are returned to villages and families in parts of Africa, and when children have been affected by community violence.

A holistic approach is important to help children live and deal with the impact of the survived trauma, which may trigger reactions at many different levels, including the physical, psychological and spiritual. See Box 1 for a successful example.
Box 1: Holistic help for traumatized children (www.children-for-tomorrow.de)

Children for Tomorrow South Africa is a project of the German Children for Tomorrow foundation. It offers free psychological and psychotherapeutic services to children affected by violence. In Langa, the oldest township of Cape Town – an area of deprivation and frequent community violence – staff often meet children and young people who have survived rape, gang shootings, and/or have lost parents, siblings and peers to AIDS, TB or murder. Most adults in Langa have been traumatized themselves, making it more difficult for them to contain the child’s trauma. The child is often overwhelmed by their experiences, their physical and emotional responses, and feelings of loss of meaning and lack of safety.

Many families in Langa use both Western medicine and traditional healing, and staff have found ways to create an approach that gives space to both. One example is the case of an 11-year-old girl who saw her brother dying in their home after he had been mugged and severely injured by gunfire. After six months she still showed symptoms of trauma, including recurrent nightmares. The therapeutic setting of Children for Tomorrow South Africa allowed her to grieve about the violent loss of her brother, but she continued to have difficulties sleeping as she believed her brother’s spirit was still in the room where he had died. A ritual celebrated by the family’s traditional healer enabled his spirit to leave the room, and traditional medicine allowed her to sleep through the night with no nightmares (Stellermann et al. 2006).

Traumatic experiences stay with people, and may be transmitted through the generations at individual and also communal level (see Lesson 3.3). Recent research on the first, second and third generations of Holocaust survivors and on the children of the survivors of 9/11 suggests that the transmission of trauma symptoms can take place at emotional, behavioural and epigenetic levels, and affect people’s physical and psychological development and interactions.

Furthermore, traumatic experiences are not left behind when people leave their homes and countries. The growth of research on the mental health of migrants is linked to the rise in numbers of refugees, displaced people and forced migrants, particularly following wars and violent conflicts (Drozdek et al. 2003).

Conclusions

This lesson has demonstrated the impact of violence on mental health, especially stress-related illnesses. ‘Much of the violence that plagues humanity is a direct or indirect result of unresolved trauma that is acted out in repeated unsuccessful attempts to re-establish a sense of empowerment’ (Gilligan 1997).
In medical peace work it is important to recognize violence as a threat to mental health, and mental health problems as a threat to peace – surviving a violent event often causes a feeling of loss followed by a desire for justice and revenge. The ability to forgive may be affected when suffering from depression and PTSD or feeling a strong desire for revenge. Promoting mental health and treating mental illness is a crucial factor in peace-building, as we will see in Lesson 3.3. It involves engaging with the coping mechanisms and strategies people use to deal with traumatic events, including local understandings, as well as engaging with them at community and national levels.

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Lesson 3.2: Community interventions and psychosocial trauma programmes

Authors: Maria Kett and Esa Palosaari

Mental health is increasingly recognized as ‘a core public health area in complex emergencies’ (Mollica et al. 2004:2058). More mental health programmes are now being offered to people and communities after disasters and emergencies, including violence and war. In this lesson we will discuss reasons for and evaluations of this development.

Introduction

Conflict has a devastating effect on public health in general and mental health in particular. People affected by violent conflict and/or displaced from their homes are especially vulnerable to traumatic stress responses. Civilians are often deliberately targeted: for example, during the wars in Rwanda and Sierra Leone, militia groups killed or amputated the limbs of hundreds of thousands of men, women and children. Civilians of all ages are at risk of rape, torture and mutilation, as well as injury or death from landmines and other ordnance.

Modern war results in population displacement, death and separation of families, loss of homes and other assets. It destroys not only these assets and the means to renew them, but also the social structures and networks necessary for individual and community recovery. All this affects mental health: the rate of post-traumatic stress disorder (PTSD) among victims of war is 15–50% and of depression 15–70%, and most have additional psychiatric disorders (de Jong 2002:12).

Learning objectives

By the end of this lesson, you will be able to:

• describe the factors that may protect people and populations against mental health problems in and after violent conflict;
• debate the value of psychosocial programmes in tackling mental health problems in post-conflict countries.
Protecting mental health

In a stressful situation such as war, some factors may protect against the development of mental health problems. Research has identified the following factors:

- being physically healthy (Bonanno et al. 2007)
- having little recent and previous stress (Bonanno et al. 2007)
- having sufficient autonomy to exercise some control in response to severe events (Cortes and Buchanan 2007, Punamaki et al. 2001)
- creativity and intelligence (Punamäki et al. 2001)
- coping skills appropriate for the situation (Punamäki & Suleiman 1990, Sutker et al. 1995, Weisenberg et al. 1993)
- ability to regulate feelings – thinking and getting a grip on emotions before making decisions under stress (Cortes and Buchanan 2007)
- having a sense of the future (Cortes and Buchanan 2007)
- having material resources (Bonanno et al. 2007)
- the wellbeing of significant others (especially the mother, for a child) (Ajdukovic and Ajdukovic 1993)

These research findings are correlations, which means there may sometimes be uncertainty about causation. For example, one longitudinal study found that while trauma-related mental health problems predicted loss of resources such as support from one’s family, loss of resources also predicted poor mental health (Benotsch et al. 2000). Many of these protective factors are disrupted in wartime as people often have no control over events, material resources are lost or destroyed, and support networks are damaged.

What are psychosocial trauma programmes?

Psychosocial trauma programmes range from trauma counselling and therapy to non-violent conflict resolution. They may include initiatives to build life skills and self-esteem. Partly because of this diversity, they have been criticised for a lack of clearly defined interventions or evaluation, despite their popularity with donors. Some interventions are backed by empirical evidence but many are not. We will return to these criticisms later.
The programmes are usually implemented by a small number of (often expatriate) professionals who spend a relatively short time in the host country working with affected populations. Some are implemented through national health structures, and many train local staff to continue the programmes when the trainers leave.

The implementation processes vary, but can be divided into three phases: emergency, transitional and long-term.

**Emergency phase:** Provision of ‘psychological first aid’ is recommended (CSTS undated). This is not the same as rapid debriefing (a single conversation about the traumatic event and the thoughts and feelings it aroused), which has little proven benefit (van Emmerik et al. 2002) and may even cause harm (Lilienfeld 2007). In the emergency phase, it is important to establish a sense of normality. This means providing protection (for example, from violence and other threats) and family reunification, as well as re-establishing everyday activities such as education and work, and providing health care. Coping factors such as social cohesion should be redeveloped and maintained.

**Transition phase:** Donors and governments should move on to support the repair of existing mental health care systems, including working with traditional healers, training local health workers and establishing assessment and monitoring procedures. In the long term, programmes should work with national health systems to ensure that mental health issues are not marginalized. This requires careful negotiation: human rights abuses of people with mental health problems are widespread, and can be used as a tool of political oppression. For example, people who oppose totalitarian regimes may be imprisoned in psychiatric hospitals. When planning and giving psychosocial assistance, attention to mental health should not lead to neglect of other needs such as nutrition, housing and justice.

We will now turn to the growing debate on these issues.

**The debate about psychosocial input**

The ongoing debate on psychosocial interventions in communities affected by war and disasters centres on the universalistic approach versus the constructivist approach. To what degree are human beings the same from one culture to another? The universalistic approach sees humanity as sharing basically the same psychology and therefore experiencing similar problems, so that post-traumatic stress and other related mental health problems may be treated with similar methods worldwide. The constructivist approach regards human psychology as socially and culturally constructed, and thus different from one culture to the next, so there is no universal experience of mental health problems.

This conceptual divide creates a difference in how mental health problems are tackled: between those who call for interventions based on Western science to
reduce the mental health problems caused by war, and those who suggest that such responses diminish the importance of people’s own, locally more appropriate, ways of healing.

This may oversimplify the debate but nevertheless highlights the tensions in the field. Summerfield has led criticisms of what he calls ‘bread and counselling’ approaches to humanitarian aid, which do not address survivors’ needs for physical protection or reparative justice. He says that for most people, post-traumatic stress is a pseudo-condition, ‘a label that not only pathologises but may dehumanise survivors by stripping them of the complexity of their living realities and associations’ (Summerfield 1998:31).

He argues that the meaning attached to signs of PTSD varies in different cultures and contexts (Summerfield 1999:1454). Although PTSD probably has a universal neurobiological basis (Georgopoulos et al. 2010), some people and peoples may regard the symptoms as unimportant. Summerfield (1999) says daily functioning is not strongly related to PTSD and interventions that ignore the social world will fail (Summerfield 2008:261). There is some evidence for the claim that, for many people, PTSD symptoms do not lead to significant impairment in familial, occupational or social functioning (Jones and Kafetsios 2002, Kinzie et al. 1986, Sack et al. 1993, Summerfield and Toser 1991). However, not everybody is as fortunate (Momartin et al. 2004, Zatzick et al. 1997).

Those who oppose psychosocial programmes argue that interventions may prove counterproductive and create passivity and disempowerment in war-affected populations. They may lessen the community bonds and resilience that constitute social capital (Summerfield 1999), and may ultimately be used to justify external military interventions and social control (Pupavac 2004).

There is no conclusive evidence of these counterproductive effects, however. Current scientific literature suggests that certain psychosocial trauma interventions may reduce symptoms of PTSD and other mental health problems such as depression and anxiety, including among people from non-Western cultures (Crumlish and O’Rourke 2010, Gotthardt 2006, Schauer 2008, Shooshtary et al. 2008; for some statistically non-significant results, see Peltonen and Punamäki 2010).

Measures of overall functioning have also been found to improve in these interventions. For example, a study of a large-scale school-based intervention among children after war in Sri Lanka found that narrative exposure therapy based on scientific notions (it includes reconstructing the person’s life history and re-experiencing the emotions while describing the traumatic events) was as good or better on most measures as locally practised within-culture coping by meditation and relaxation. The major difference in the outcomes of these two approaches was that certain school grades worsened in the meditation group and improved in the narrative exposure therapy group (Schauer 2008).
More research is needed on the interaction between culture, mental health and especially traumatic stress. There are indications that cultural variability makes psychiatric problems harder to detect and underreported. It may also be possible that people from non-Western cultures are more resilient and experience more positive psychological growth after violent conflict than people from Western cultures (see Box 1).

**Box 1: Current research on the interaction between culture and mental health**

- How culture-specific is psychiatry? Are mental disorders the same around the world? Cultural variation in mental disorders has been debated, for example, in the British Journal of Psychiatry ([http://bjp.rcpsych.org/cgi/content/full/179/1/1; http://bjp.rcpsych.org/cgi/reprint/179/5/460.pdf](http://bjp.rcpsych.org/cgi/content/full/179/1/1; http://bjp.rcpsych.org/cgi/reprint/179/5/460.pdf))
- One argument in the debate is that the symptoms of mental disorders are similar across cultures but their expression and interpretation can vary. Reporting of mental disorders may also be different because of differences in social stigma associated with them (de Jong 2002:62).
- Refugees moving from one culture to another can experience complex interactions between culture and mental health. For example, the more acculturated to the new culture and language immigrants are, the greater is their tendency to report similar levels of mental health problems as others in the new society do (Parker, Chan, Tully, & Eisenbruch, 2005).

Some of these dichotomies are less clear-cut than they may appear. In non-Western societies, local, traditional concepts of mental health problems and healing practices have been found to include important components also used in Western diagnoses (PTSD, dissociation, somatization) and interventions (relaxation, social support, exposure and cognitive reframing) (Harlacher 2009). Few cultures are isolated and most instead have a mix of influences, including Western ones. People looking for help – some of whom may otherwise not obtain any healing – may access many kinds of interventions, including psychosocial ones (Harlacher 2009).

**Conclusions**

There is an acknowledged role for appropriate psychosocial interventions and programmes that are sensitive to cultural diversity and use integrated treatments (Van Ommeren et al. 2005a). It may be particularly difficult to help populations returning home after violence and war who are fearful of their safety and security. It is vital to coordinate with others working in the area, and with what is already available locally, to re-establish autonomy, access to material resources and support networks that may include traditional healing and other local practices aimed at restoring communities (Stamm and Friedman 2000). This also raises questions about issues of reconciliation, which will be discussed in the next lesson.
References


Lesson 3.3: Justice, truth and reconciliation

Authors: Maria Kett and Kerstin Stellermann

In this lesson we will examine the issue of restorative and reparative justice, assessing the efficacy of truth commissions and international criminal tribunals in restoring social harmony, with special reference to South Africa. Then we will examine how building an equitable health system might also help the cause of social stability, with special reference to the countries of the former Yugoslavia.

Definitions

‘Restorative justice’ is a term used to describe a wide range of practices that aim to address violations of legal and human rights through peaceful processes. It is based on a number of key principles: inclusivity; balance of interests; non-coerciveness; and a problem-solving approach. It ranges from mechanisms at international and national level, such as truth and reconciliation commissions, to local attempts at restitution between communities and individuals. ‘Rather than privileging the law, professionals and the state, restorative resolutions engage those who are harmed, wrongdoers and their affected communities in search of solutions that promote repair, reconciliation and the rebuilding of relationships’ (Centre for Restorative Justice undated).

One element of restorative justice is reparative – that is, a way of making amends. This may be financial recompense, but could be other practical means such as giving time or services. The aim is to benefit both victim and perpetrator; to gain insight and acceptance of responsibility; and to create opportunities to make amends to individuals and/or communities as a whole (Criminal Justice Review Group Northern Ireland 2004).

National legal systems around the world tend to be based on principle of punishment for wrongdoing through prosecutions and trials – known as ‘retributive justice’. The International Criminal Court (ICC) is also based on principles of retributive justice (Maiese 2003).

Learning objectives

By the end of this lesson you will be able to:

- describe and evaluate some mechanisms of restorative justice
- consider whether rebuilding health systems helps to promote social stability
Social healing – the case of South Africa

After the traumatic events of war or violent conflict, attempts are needed to re-establish peace and reconciliation between affected societies and groups as much as individuals. Social healing requires efforts to guarantee justice and reconciliation. If those intervening in areas affected by war can deliver these twin objectives, the potential to prevent future conflict and maintain peace is enormous.

The South African Truth and Reconciliation Commission (TRC) is one of the best known and documented examples of restorative justice. Truth commissions have become a popular way of pursuing reconciliation after violent conflict, but it is still questionable how far they can address the enormous issues the conflict has raised, as we will see when we look at the TRC.

The TRC was set up to deal with the effects of apartheid on society, and to redress violence and human rights abuses carried out during the apartheid regime. It did this through an amnesty for perpetrators of actions carried out during the regime, to advance reconciliation and reconstruction. This amnesty was granted on condition of ‘full disclosure’ by perpetrators, with the understanding that the actions disclosed were undertaken as a ‘political act’ (Hamber 2003).

Here we will focus on the specific question of the TRC’s impact on psychological and social healing (see also Hamber 2007).

The TRC’s main intention was not to produce a direct psychological benefit for the population of South Africa, but to engage people in the social and political processes of reconciliation. Hamber, a psychologist with many years experience in South Africa and Northern Ireland, argued that ‘on the psychological front, the process may have helped some with healing, but was hardly sufficient and the impact not necessarily psychologically beneficial’ (Hamber 2003:6).

Nevertheless, a study by a group of psychologists in South Africa found that survivors of human rights abuses who had not forgiven their perpetrators had more psychiatric problems (Kaminer et al. 2001). It concluded that while truth commissions may benefit social healing to some extent, they are not sufficient in themselves for the recovery of individual survivors. Culturally appropriate therapeutic interventions that address the specific needs of survivors are needed to supplement truth commission processes.

In the transitional period from violent conflict to peace, both restorative and retributive mechanisms of justice are needed to ensure balance, according to these studies. ‘Truth commissions are best at telling the story of the past from the perspective of victims, allowing victims to tell their stories in an uninhibited fashion, explaining war in broad causal terms, and assigning responsibility and accountability while leaving justice to the courts’ (Hamber 2003:12).
Reconciliation is a complex process that requires a number of interconnected strands to be effective, otherwise it may be ineffective or counter-productive. Hamber and Kelly outline five essential elements (cited in Becker 2005):

- developing a shared vision of an interdependent and fair society
- acknowledging and dealing with the past
- building positive relationships
- significant cultural and attitudinal change
- substantial social, economic and political change.

These optimum conditions for recovery and reconciliation echo the three protective mechanisms against individual mental health problems that you studied in Lesson 3.1, namely the extent to which people have:

- a degree of autonomy and control
- access to material resources
- a network of psychological support.

We will now look at the role of health system reconstruction in providing security and wellbeing.

**Health and peace-building in the Balkans**

In the early 1990s, the break-up of the former republic of Yugoslavia triggered violent conflicts that erupted across the Balkans. In Bosnia and Herzegovina, one of the worst affected countries, the 1995 Dayton peace agreement was concerned to redress some of the worst atrocities, in particular the ethnic cleansing of thousands of people from the three main ethno-religious groups – Muslims (Bosniaks), Catholics (Croats) and Orthodox Christians (Serbs). As part of the agreement, Bosnia was divided into two separate entities under the international jurisdiction of the Office of the Higher Representative: the Serb-administered Republika Srpska and the Muslim/Croat-administered Federation of Bosnia and Herzegovina.

In 1993, the UN Security Council passed Resolution 827 establishing the International Criminal Tribunal for the former Yugoslavia (ICTY). It was set up in response to the ‘serious violations of international humanitarian law committed in the territory of the former Yugoslavia since 1991, and as a response to the threat to international peace and security posed by those serious violations’ (See ICTY website www.un.org/icty/glance-e/index.htm). It has four main functions:

- to bring to justice those allegedly responsible for serious violations of international humanitarian law;
- to render justice to the victims;
• to deter further crimes;
• to contribute to the restoration of peace by holding accountable persons responsible for serious violations of international humanitarian law.

It is above all a legal entity. There has been no truth commission in Bosnia or any other part of former Yugoslavia. There have, however, been many attempts to rebuild divided communities across Bosnia.

These have included health-related initiatives. As WHO notes, ‘health initiatives may have a positive impact on peacebuilding, when they are based on wide perspective and strategic planning, this implies taking into consideration both short-term and medium/long-term concerns, addressing both basic needs and human rights, involving local capacities for change, and promoting international partnerships and networking’ (WHO undated:1).

One such initiative was the joint UK Department for International Development (DFID) and WHO collaboration in 1997–1998. The key elements of the programme were to reduce violence, discrimination and polarization; decentralize power; and promote inter-community reconciliation (Rushton and McInnes 2006:97). The success of the Bosnian Peace Through Health programme began a momentum that culminated in the 1998 World Health Assembly resolution to accept Health as a Bridge for Peace as part of the strategy for Health for All in the 21st century (ibid:97). (For more on health bridges see Lesson 2.1).

Research on post-war reconstruction suggests that a key factor in enabling a successful transition is to avoid recreating the conditions that led to conflict. This often means equitable access to welfare structures such as schools, hospitals and primary health care. Provision of health care can be costly, and in the transition phase international organizations and other stakeholders can help the government to deliver public services. This is ‘an important step towards building a long-term environment of peace and stability in which the government is recognised as legitimate and as a provider of security, economic opportunity and public services’ (Rushton 2005:452).

Let us consider an example of an attempt to deliver equitable health care, from Eastern Slavonia, a region of the former Yugoslavia.

**Case study**

Following the conflict in the 1990s, Eastern Slavonia was removed from Serb control and reincorporated in Croatian territory. The UN Transitional Administration for Eastern Slavonia (UNTAES) was responsible for overseeing this, with 5000 peacekeepers and 20 civilian staff. UNTAES was part of moves to create ‘international administrations [that] aimed to prevent the re-emergence of violence
by dealing with the underlying economic, social, cultural and humanitarian factors that could further perpetuate conflict’ (Bloom and Sondorp 2006:117). The civilian staff established a number of Joint Implementation Committees to facilitate a peaceful process of transition in sectors including the police, civil administration and public services. Of these, education and health became ‘[the] most emotive and difficult sectors for negotiated transition’ (Large 1999:571). Why was this so?

Croatia declared independence in 1991. Dr Bosanac, a Croat, became senior hospital manager at Vukovar General Hospital in Eastern Slavonia, a civilian facility, until the town was besieged in November. The hospital was bombed and around 265 patients, staff, friends and relatives were massacred by the Yugoslav National Army (Bloom and Sondorp 2006). Between 1991 and the 1995 peace agreement the hospital was under Serb administration, with the previous administration exiled – reflecting the region’s wider ethnic divisions. During this time, doctors from the hospital were seen as representing political factions: ‘[the] politics of health were highly personalised, and epidemiological data became acutely sensitive in the light of propaganda and ideological usage’ (Large 1999:572).

After UNTAES arrived in October 1995, hospital staff of all ethnic groups began returning to work, but cooperation was slow and difficult. UNTAES requested assistance from WHO to help the Joint Implementation Committee reintegrate the divided health sector. Eventually agreement to cooperate was made in a number of areas, including community-based mental health; physical rehabilitation; health information systems; the negotiation of terms of employment of existing health sector employees; and population rights to health care.

The negotiation of the terms of employment of existing health sector employees proved to be particularly challenging, as there were big differences in salaries and job allocations between Serb and Croat staff. This threatened the fragile peace. Vukovar General Hospital underwent a process of downsizing, losing many employees in the process. This increased tension due to the already high unemployment, low economic activity and discrimination against the Serb population in the region.

Despite all these problems, some regard the reintegration of Eastern Slavonia’s health sector as a success, at least from the viewpoint of ethnic reintegration. ‘Even with its limitations and still ongoing disputes, the overwhelming perceptions and reviews of the UNTAES-led reintegration process are generally very positive’ (Bloom and Sondorp 2006:126).

Discussion

Dealing with the psychological and psychosocial wounds of war is important and complex. Volkan, describing the influence of the 1389 Battle of Kosovo on events in the Balkans in the 1990s, says that knowing about psychological
processes, especially unconscious ones, can help us understand how they may become the fuel that ignites horrible human dramas and feeds the fire of hostilities (Volkan 2002:97). ‘Psychoanalytic research into the transgenerational transmission of shared trauma, its activation in leader-follower relationships, and the associated phenomenon of “time collapse” can illuminate many hidden aspects of ethnic or other large-group conflicts and show us how internal and external world issues become intertwined’, he says.

According to this theory, once the flame of nationalism was ignited time could be collapsed and the flames fanned to devastating effect by keeping old myths alive. There is a conundrum: if ‘those who forget the past are condemned to repeat it’, how can we maintain the balance between keeping memories alive ‘lest we forget’, but not fanning flames of hatred?

‘If there is not to be an effective hierarchy of victims, all of the bereaved and maimed have to be given the same chance to give their accounts and receive whatever accountability is possible,’ writes O’Toole on reconciliation following the conflict in Northern Ireland (O’Toole 2007:36). ‘Finding a way to do this is hard for the same reasons that it is necessary – it demands an approach to the past that is not exclusive; and it requires a belief that truth is a value in itself, rather than a form of tribal vindication. A process that could meet these needs would not merely honour the dead, but disarm the habits of thought that helped to kill them.’

**Conclusion**

“Consequences of violence are broader than death and injury and include serious harm to the physical and mental health and development of victims, particularly children. The Consequences contribute to costly adverse health outcomes.”

(WHO Guidelines to implementing the recommendations of the Worlds Report on Violence and Health, page 63)

The three lessons in Chapter 3 have highlighted the personal, community and state responses to violence and mental health and how they are interlinked. Health workers in the field, especially in countries affected by violence and conflict, must be aware of these issues. Psychosocial programmes must be inclusive, advocating the accumulation of both material and social capital in a secure environment. We must promote reconciliation in ways that are understandable and acceptable to local people; and we must support the rebuilding of trust and confidence, working in a context of community regeneration and investments in infrastructure development.
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Glossary Course 5

**Altruism:**
Unselfish concern for the welfare of others.

**American civil war:**
The American civil war lasted from 1861 to 1865 and was fought between the northern, more industrialised states of the United States of America and the southern, more rural states. One of the issues fought over was the abolition of slavery. With the victory of the northern states, led by President Abraham Lincoln, slavery, at least officially and judicially, ceased to exist.

**Assets:**
Tangible and intangible goods, states of being and relationships on which people depend for survival.

**Civil society:**
The United Nations defines civil society as “associations of citizens (outside their families, friends and businesses) entered into voluntarily to advance their interests, ideas and ideologies. The term does not include profit-making activity (the private sector) or governing (the public sector)”. Civil society might therefore include labour unions, faith-based groups, business and professional associations, academic and research institutions, human rights networks, consumer rights coalitions, social movements, social and sports clubs, philanthropic foundations, and other forms of ‘associational life’.

**Community violence:**
Violence between individuals who are unrelated, and who may or may not know each other, generally taking place outside the home.

**Conflict:**
Perception of incompatible goals in a goal-seeking system. Conflict is not necessarily violent. In fact, parties who have incompatible goals may deal with them in productive and non-violent ways.

**Democracy:**
Form of government characterised by elections, majority rule, representation in parliamentary bodies, the rule of law.

**Development:**
Alan Thomas says that the term development is commonly used in three ways: as a vision of how we would like the world to be; to describe a process of historical change; and to mean the actual interventions of governments, international agencies and others make to bring development about.

**Direct violence:**
A deliberate act or omission, acute or chronic, causing a reduction in the physical, mental or social potential of beings (J. Galtung).
Medical Peace Work: Glossary Course 5

First world war:
Armed conflict lasting from August 1914 to November 1918, which cost the lives of around nine million soldiers. The main warring parties were Germany, Austria-Hungary and the Ottoman Empire on the one hand and Great Britain, France and Belgium on the other. The United States entered the war in 1917 on the side of the latter. The war is nowadays particularly remembered because of its countless cases of war neurosis and because it saw the first use of poison gas (at Ypres, April 1915). The vast majority of deaths, however, were the result of the use of ‘conventional’ weaponry.

Gender:
Gender refers to the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women (World Health Organisation).

Geneva Conventions:
The Geneva Conventions were established by governments under the auspices of the International Committee of the Red Cross to regulate the conduct of war. The first Convention (1864) focused on the rights of the armed sick and wounded as well as medical personnel. The second (1906) included those fighting at sea. The third (1929) set up rules for the treatment of prisoners of war and the fourth (1949) protected civilian populations. Two additional protocols were formulated in 1977 to protect victims of international and non-international conflicts.

Health:
The World Health Organisation defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.

Health system:
The World Health Organisation defines a health system as “all the activities whose primary purpose is to promote, restore or maintain health”. The functions of a health system have been defined in a more detailed way by Maureen Mackintosh and Meri Koivusalo. At the core are health services, but these are complemented by public health functions (surveillance, prevention, cross-sectoral action and emergency preparedness); systems for training the people needed to staff the system (medical and nursing schools etc); and policy, ethical and regulatory decision-making bodies which direct the health systems and the people in them.

Human Security:
The Canadian government defines human security as “freedom from pervasive threats to people’s rights, safety and lives.” Human security includes economic security, food security, health security, environmental security, personal (physical) security, community security, and political security.

Humanitarian aid:
Aid which is concerned with or seeking to promote human welfare.

Humanitarian emergency:
A humanitarian emergency is said to exist if the crude mortality rate (CMR) exceeds one death per 10,000 people per day; and the daily under-5 mortality rate (U5MR) exceeds twice the CMR.
Impartial:  
In the context of humanitarian aid, this refers to assistance that is ‘guided solely’ by the needs of individuals.

Independence:  
In the context of humanitarian aid this has been defined by Joanna Macrae as the ‘endeavour not to act as instruments of government foreign policy’.

International Committee of the Red Cross:  
An organisation set up in 1863 by five Swiss citizens from Geneva: Henry Dunant was the leading figure. It strives to regulate the conduct of war firstly, by taking care of the sick and wounded and secondly, by establishing rules for the conduct of violent conflict.

International Human Rights Law:  
International Human Rights Law lays down obligations which states are bound to respect. The Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (plus their optional protocols) form the so-called International Bill of Human Rights. These core instruments are supplemented by a battery of other treaties adopted to guarantee human rights (such as the Covenant on the Elimination of all forms of Discrimination Against Women).

International Humanitarian Law:  
See the Geneva Conventions

Landmine:  
Landmines are conventional weapons used in wars to stop military opponents from encroaching into territory. There are between 600 and 700 different types of landmines that are produced in 60 countries. Examples include blast mines and fragmentation mines.

In terms of their effects two types of landmines can be distinguished. Anti-personnel mines are directed against persons and are activated by contact, proximity or presence of a victim. Anti-vehicle-mines, on the other hand, are directed against any kind of vehicle.

Millennium Development Goals:  
The eight Millennium Development Goals (MDGs) were agreed at the United Nations Millennium Summit in September 2000 and nearly 190 countries have subsequently signed up to them. They set targets related to poverty, health, education, hunger and other key development issues that countries – assisted by international aid agencies – should achieve by 2015.

Morbidity:  
Morbidity means illness or disease. Measures of morbidity such as the prevalence of chronic diseases can be used, among other measures, to help understand the health of a population.

Mortality:  
Mortality means death. Measures of rates of mortality such as life expectancy and infant mortality can be used, among other measures, to help understand the health of a population.
Nuclear weapons:
A weapon whose explosive power results from a nuclear reaction. This reaction results in the release of an immense amount of energy in the form of an explosion, many times greater than that of conventional explosives.

Peace:
Not merely the absence of violence, but a state of mutual beneficial relationships, fair structures, and a culture of peace. Peace is also a capacity to handle conflicts with empathy, creativity and by non-violent means (J. Galtung).

Poverty:
Poverty has many dimensions. It can include lack of income and material goods, as well as lack of the things that we all have reason to value, such as the ability to lead a healthy life, be educated, to have political or spiritual liberty. The World Bank has set an international poverty line at about US$1 per day. The 1.2 billion people who live below this line are said to be in a state of “absolute poverty”, in other words “a condition of life so characterised by malnutrition, illiteracy and disease as to be beneath any reasonable definition of human decency” (World Bank). But poverty is also a relative concept: all societies – at different levels of economic and social development – have different standards for what constitutes living in poverty.

Protection:
In the context of humanitarian aid this refers to the protection efforts of humanitarian agencies in conflict areas (but not including physical armed protection).

For humanitarian agencies, protection refers to “all activities aimed at obtaining full respect for the rights of the individual in accordance with the letter and the spirit of the relevant bodies of law (i.e. human rights law, international humanitarian law and refugee law)” (Inter-agency Standing Committee 1999).

Psychosocial:
A programme or way of thinking that puts the psychological development of individuals in the context of their social environment.

Reconciliation:
Repair of broken relationships and the restoration of peaceful relationships.

Refugee:
A person who, owing to well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.

Right to health:
The right to health or – more precisely – the right to the highest attainable standard of physical and mental health is established in Article 12 of the International Covenant on Economic, Social and Cultural Rights. Measures states should take to fulfill the right are laid down in Article 12 and have been further elaborated in General Comments by the treaty’s monitoring committee. The right to health is subject to the principle of progressive realisation outlined in the Covenant.
Second world war:
Armed conflict beginning in September 1939 with the invasion of Poland by Nazi Germany (although Japan had invaded China in 1937). It became a ‘world war’ in a truer sense in 1941 after the bombardment of Pearl Harbour by the Japanese and the consequent declaration of war by the US on Japan and Germany. Although in terms of the percentage of soldiers killed it was a less bloody war than the first world war, the total sum of the dead – approximately 40 million – was devastating. For the first time in history in a major war the civilian dead outnumbered those within the fighting forces. The war is also infamous for Nazi Germany’s medical experiments on human beings, and its sterilisation and so-called ‘euthanasia’ programmes.

Sex:
Sex refers to the biological and physiological characteristics that define men and women. (World Health Organisation).

Special Rapporteur:
An independent UN expert employed to examine questions relevant to a particular UN Convention. There is a Special Rapporteur on the right to health.

Structural violence:
Structural violence refers to socio-economic and political processes which violate basic human needs (J. Galtung).

UN Security Council:
The UN Security Council has primary responsibility, under the UN Charter, for the maintenance of international peace and security. The Council is composed of five permanent members – China, France, Russian Federation, the United Kingdom and the United States – and ten non-permanent members that are elected for two-year terms.

UNICEF is mandated by UN Member States to work for the protection of children, in peacetime and during conflict. UNICEF is the lead UN agency in child protection.

United Nations General Assembly:
From the UN website: established in 1945 under the Charter of the United Nations, the General Assembly occupies a central position as the chief deliberative, policy-making and representative organ of the United Nations. Comprising all 192 Members of the United Nations, it provides a forum for multilateral discussion of the full spectrum of international issues covered by the Charter. It also plays a significant role in the process of standard-setting and the codification of international law. The Assembly meets in regular session intensively from September to December each year, and thereafter as required.

United Nations High Commissioner for Refugees (UNHCR):
The UNHCR is mandated by UN member states to lead and co-ordinate international action to protect refugees worldwide.
Vietnam war:
The Vietnam war might best be seen as part of the cold war and anti-colonial battles which convulsed south-east Asia in the period after second world war. After the defeat of Vietnam’s French colonisers by the Viet Minh forces at the battle of Dien Bien Phu in 1954, the country was split into a communist-ruled North and a capitalist south. The south was supported by the United States. The Americans feared that – in the wake of the Chinese revolution – the fall of south Vietnam would lead to a communist takeover of all countries in south-east Asia (the ‘domino theory’).

American interference in Vietnam led to armed conflict with the communist-ruled North throughout the 1960s and 1970s. The war extended to neighbouring countries. The war ended in 1975 when American troops were expelled from the southern Vietnamese city of Saigon. Around 50,000 American soldiers had died; Vietnamese dead are estimated at one million.

Violence:
Unnecessary insult of basic human needs (J. Galtung).

War:
Extreme form of violence. Used as a means to solve conflicts between nation states, or between groups within a nation state (civil war).