Impact of health projects on peacebuilding

MAS Thesis

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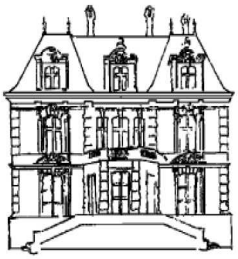

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Content

Illustration

List of abbreviations

CSPM	Conflict-Sensitive Programme Management CSPM
CMR	Case Mortality Rate
DRC	Democratic Republic of Congo
EU	European Union
FSPs	Fragile States Principles
HIV/AIDS	Human Immunodeficiency Virus Infection / Acquired Immunodeficiency Syndrome
ICN	International Council of Nurses
ICR	International Rescue Committee
MDGs	Millennium Development Goals
MSF	Médecins sans Frontières
NGO	Non Governmental Organisation
OECD	Organisation for Economic Development and Cooperation
SDC	Swiss Development Cooperation
MMI	Medicus Mundi International
PubMed	US National Library of Medicine - National Institutes of Health
STI	Sexually Transmissible Infection
WDR 2011	World Development Report 2011: Conflict, Security and Development

1 Introduction

Peace and health: Two conditions of fundamental importance to the wellbeing of individuals, communities and societies; peace and health share important elements, including social, mental and spiritual dimensions. The existence of armed conflicts is, alas, still a reality in modern times and frequently, in some ways, related to economic problems (WATERS et al., 2007). According to the World Bank (2011), fifteen of the twenty poorest countries in the world had conflicts in the last two decades of the twentieth century. Armed conflicts cause direct casualties and have many kinds of indirect negative effects on the health of individuals, communities and populations. The need for health care increases in the context of conflict and at the same time the effectiveness of health systems and health projects tends to be strongly affected (World Bank, 2011, PERCIVAL and SONDORP, 2010 p6).

In the early nineties of the last century a number of international initiatives and interventions with the objective to stop armed conflicts and to promote peace can be observed. Such peace enforcement or peace keeping operations, for example in Somalia, did not always have the expected effect (WENGER et. al, 2006 p23). The subsequent search for more effective ways to contribute to the creation of peace was expressed with the introduction of the concept of “Post Conflict Peacebuilding” by the Secretary General of the United Nations (UN) on June 7th 1992. He defined peacebuilding as “action to identify and support structures which will tend to strengthen and solidify peace in order to avoid relapse into conflict” (UN, 1992; BARNETT et al., 2007 p36). This new approach gained increasing attention and was further developed. Some of the recent approaches to peacebuilding and statebuilding are becoming more associated with development aid, including aspects of health.

2 Leading questions and research methods

This paper explores interventions in the health field in relation to peacebuilding. It looks at effects of conflict on people's health and health care. It further explores the evolution of peacebuilding and the relationship between concepts of peace (promotion) and health (promotion). An individual country's approach to international peacebuilding is presented with the example of Switzerland. Reverence is then made to the potential of health projects and health experts for peacebuilding. This thesis aims at finding conditions for health projects to have a positive effect on peacebuilding and at approaches to make health projects more effective in reaching their health objectives in situations of conflict. In this aspect the integration of health care projects into the wider peacebuilding policies and the systematic inclusion of elements of peacebuilding in health project in conflict situations will be discussed.

This thesis aligns both disciplines: international public health and peacebuilding. The research methodology includes the consultation of policy and evaluation documents in the fields of peace, development and health of multilateral and Swiss key stakeholders, including the United Nations (UN), the World Health Organisation (WHO), the Organisation for Economic Cooperation and Development (OECD), the World Bank, the Swiss Development Cooperation (SDC), Swiss Peace and Medicus Mundi International (MMI). The documentation of the Europainstitut Peacebuilding Seminar provided additional sources of information. A search in publications about peace and public health (including PubMed) and in the internet completed the collection of information. Key words used for the search are: "health systems and peacebuilding" (PubMed: 33 hits), "health policy and fragile states" (PubMed: 60 hits), "health sector reform and post conflict" (PubMed: 11 hits), "conflict transformation, and health professionals", (PubMed: 9 hits). The framework for analysis is based on the following concepts:

- BARNETTs' categories on peacebuilding (presented in chapter 9; p10)
- ABUELAISH Model of peace and health (presented in chapter 8.2; p 24)
- 10 OECD Fragile States Principles (presented in chapter 6.5; p 18)

Information concerning the impact of peacebuilding policies is available, however no sound evidence was found that would to allow demonstrating a causal effect of particular activities in the health field on peacebuilding outcomes. As a consequence the focus of this paper is limited to the examination of possible effects of health activities on peacebuilding and relations between the two fields. In order to keep complexity at a manageable level, the approach of the European Union (EU), with its high number of agencies and strategies involved, will not be discussed in this paper (TARDY, 2011). In the next chapter the term health project and the underlying concept of health chosen are presented in order to serve as reference for further discussions. Thereafter the evolution of the concept peacebuilding will be presented for the same purpose.

3 Health projects: The concept of health and health determinants

The term health projects stands in this paper for projects carried out or supported by international agencies and –ideally- integrated or harmonised with the national health strategy of the partner country. Health services influence people's health only to a limited extent, many more factors can have a major impact on the health status and well-being of individuals, communities and populations. In order to present this wider approach to health, this chapter describes the concepts of health and health determinants.

The World Health Organisation (WHO) defined health in a holistic fashion as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (WHO, 1946). This definition has often been challenged for its broad and idealistic approach, far beyond a pathogenic perspective of health. The WHO definition is also being criticised because it does not fully include the different facets of individual and societal empowerment (ABUELAISH et al, 2013 p1). The "Ottawa Charter for Health Promotion" (WHO 1986) shows an evolution and includes a more salutogenetic approach and defines health as *"a positive concept emphasizing social and personal resources, as well as physical capacities"* (WHO, 1986). The term "Salutogenesis" was first used by Aaron ANOTNOVSKI, in contrast with pathogeneses and describes the process of healing, recovery and repair: "Salutogenesis stresses an understanding of how health is created and sustained and focuses on activities that seek to maximise the well-being of individuals, communities, and societies in general" (JUDD as cited by ABUELAISH et al. p2, 2013).

The major factors which have an effect on people's health are called "social determinants of health". They comprise "the social and economic environment, the physical environment, and the person's individual characteristics and behaviours" (WHO, 2012) and include more specifically "education and literacy (low educational levels are linked with poor health and more stress); the physical environment (safe water and clean air, healthy workplaces, safe houses, communities and roads); employment and working conditions; social support networks; culture; personal genetics and coping skills; gender and health services" (WHO, 2012).

In a conflict situation many of these factors deteriorate and a close relationship between peace and good health can in an intuitive manner be assumed. This is for example obvious for the destruction of infrastructure or houses due to armed conflict and the health determinant “deterioration of the physical environment”.

After this presentation of health concepts and determinants for health, the concept of peacebuilding and its development are presented in the following chapter, including some critical reflections on the concepts’ interpretation.

4 Peacebuilding: Introduction and critical overview

Since the introduction of the concept of “post conflict peacebuilding” by the UN in 1992, practitioners and scholars have attempted to identify factors which help to improve peace and to measure the impact of peacebuilding activities. BARNETT and his colleagues (2007 p42) found in a survey of 24 governmental and intergovernmental bodies active in peacebuilding, that nearly 50% of all countries receiving assistance slide back into conflict within five years and 72% of peacebuilding operations leave authoritarian regimes in place. They also identified that most of the programs “have focused on the immediate or underlying causes of conflict - to the relative neglect of state institutions” (BARNETT et al., 2007 p42). Conflict prevention and the elimination of the reasons for using violence were becoming more important. In the BRAHIMI Report (UN, 2000) peacebuilding was defined as: “Activities undertaken on the far side of conflict to reassemble the foundations of peace and provide the tools for building on those foundations something that is more than just the absence of war” (UN, 2000). With the 2005 World Summit, the UN Peacebuilding Commission was created, including a support office and funding. The concept of peacebuilding had evolved to something more than the elimination of armed conflict.

Different international and national agencies use different terms and different interpretations of peacebuilding which are usually well adapted to their proper organisational aims. For instance, conflict prevention and peacebuilding are sometimes used synonymously by different agencies. (BARNETT et al, 2007 p47). Growing criticism concerning the introduction of the market economy and the ideology of the (neo-) liberal state as important elements of many peacebuilding operations can be observed. This leads to the claim to concentrate activities more on the basic needs provision and the building up or rehabilitation of a functioning welfare system (LIDÉN et al., 2009 p591-593). In situations where poverty is the main reason for violence, the free market approach risks fuelling further conflicts. BARNETT and his colleagues expressed similar criticisms: “The liberal state approach might not promote peace, but create an effective ally in international antiterrorism efforts and is far from eliminating the root causes for conflict” (BARNETT et al., 2007 p56). Critically perceived is also an embedded imperialism in peace keeping and

peacebuilding operations (LIDÉN et al., 2009 p93). To increase the success of peacebuilding, modern approaches should focus more on local needs, partnership and local ownership (BARNETT et al., 2007 p56).

In order to present the potential scope of peacebuilding activities, four categories described by Barnett et al. (2007 p41) are presented below:

1) Security and military;

2) social, economic, developmental, humanitarian;

3) political and diplomatic;

4) justice and reconciliation.

With the aim to illustrate the importance of conflict for people's health, the subsequent chapter describes different relations between conflict and health: The effect of conflict on people's health; the effect of conflict on the health care system; and the difficulties for the provision of health care during conflict. The chapter will be concluded with the presentation of the effect of development aid on conflict.

5 Conflict and health

5.1 The effect of conflict on people's health

A clear deterioration of health conditions of populations during and following conflict can be assumed, although baseline data for post conflict situations are frequently unavailable. (WATERS et al., 2007 p6). In a situation of war and conflict we observe excess mortality and morbidity, displaced populations and an increased vulnerability to physical trauma, sexual violence, psychological distress and preventable communicable diseases such as Sexually Transmitted Infections (STIs, including HIV/AIDS), measles or malaria. Ruptures in the supply of clean water and breakdowns in sanitation systems result in an increase in preventable communicable diseases such as diarrhoea, malaria, and tuberculosis. During the 1998 – 2002 fighting in the Democratic Republic of Congo's (DRCs) five eastern provinces, the International Rescue Committee (IRC) conducted a mortality survey. The results indicate that the overall Case Mortality Rate (CMR) in eastern DRC is the highest in the world, with the majority of deaths caused by preventable infectious diseases. The report also suggests that the ongoing peace process has contributed to a decrease in mortality rates in eastern DRC (ROBERTS, 2002 p471). The worldwide fast increasing group of people suffering from chronic diseases, like diabetes, is especially vulnerable to the indirect effects of conflict. Some of these chronically ill persons are at risk of prolonged periods without their lifesaving treatment, with the consequence of suffering from severe complications or even of dying. (WATERS, 2007 p6). A functioning health system has the potential to provide remedies for a large number of health problems and therefore reduce suffering caused by conflict.

5.2 The effect of conflict on the health care system

A health care system includes the necessary elements to provide health care. The WHO describes a good health care system as follows: "A good health system delivers quality services to all people, when and where they need them. The configuration [...] requires a robust financing mechanism; a well-trained and adequately paid workforce; reliable information on which to base decisions and policies; well maintained facilities and logistics to deliver quality medicines and technologies" (WHO, 2010).

Before, during and after conflict, the financing of the health system might be reduced (military spending!) or completely interrupted. Infrastructure and material such as hospitals, ambulances or stocks of medicines may be lacking or destroyed. Doctors, nurses, midwifes and other health professionals can be killed, have fled or stay away because of security hazards, because they have to look after their families or because they are not remunerated for their work. MÉDECINS sans FONTIÉRES (2008) report such a situation in Rwanda after the genocide. In 1996 the author of this paper worked in the hospitals of Butare and Kibuye and their surrounding regions. She observed the missing Rwandese health professionals and that basic health care was provided almost exclusively by international agencies. Most of the health professionals in the two regions had been reported killed and some others had fled.

A quote concerning the WHO statistics on maternal mortality illustrates the impact of insufficient health personnel and infrastructure: “In 2008, an estimated 358 000 women died from pregnancy. More than three-quarters of maternal deaths were concentrated in just two regions of the world: 53% in the African Region and 25% in South-East Asia. Most maternal deaths are avoidable, as the health-care solutions to prevent or manage complications are well known. All women need access to skilled care and emergency obstetric care during pregnancy, childbirth, and after childbirth, as timely management and treatment can make the difference between life and death” (WHO, 2013).

Given the fact that the presence or absence of a health care system makes a big difference to people’s lives, it appears as a logical consequence that many international agencies try to support a country in conflict with interventions in the health field. International agencies tend to concentrate their activities in areas where effects can be achieved, seen, understood and demonstrated to donors, or in case of state based agencies, to national parliaments. This is not per se negative, but bears the risk that funding gets deteriorated from other less illustratable i.e. more political agendas. Furthermore such well intended activities may have negative side effects, when they are carried out in a purely technical, “neutral” manner, without coordination with other stakeholders and without regard for the context of the conflict. A variation of approaches for health projects during and after conflict is presented in the next chapter.

5.3. Health projects during conflict and in post conflict situations

This chapter concentrates on the provision of health care and health systems during and after conflict in order to give an impression of the necessity of different approaches to substituting for or the rehabilitation of a health system, depending on the local situation and the stage of conflict.

During armed conflict, at first sight there is a special need for surgical capacities to care for persons wounded by weapons. This reduces the suffering of the injured persons, but it might have the externality that wounded fighters recover more quickly to rejoin the fighting again and, therefore, further fuel a conflict. In addition to surgical activities, the prevention of epidemics and basic health care should as far as possible be provided to the population. In situation where the health system has been disrupted -if the security situation allows it- international NGOs often provide basic primary health care and support the local structures and health workers in the affected zones as well as in refugee camps.

"Post-conflict rehabilitation of the health sector can be viewed in three parts:
(1) an initial response to immediate health needs;
(2) the restoration or establishment of a package of essential health services; and
(3) rehabilitation of the health system itself.
Where possible, the three parts should operate synergistically and as part of a continuum"(WATERS et al., 2007 p5).

The (1) initial response to immediate health needs includes basic and emergency curative health services; obstetric services; communicable disease control; immunizations; and supplementary feeding programmes. Depending on the pre-conflict situation and the degree of destruction, the second phase (2) restoration or establishment of a package of essential health services is carried out by international agencies, by national agencies with the support of the international agencies and donors or by both in a complementary way or conversely, in an uncoordinated manner. For (3) the post conflict rehabilitation of a health system we can see different challenges: one is the withdrawal of emergency relief by NGOs before a functioning system is in place. Another challenge relates to the issue of legitimacy and political decision-making: who has the authority to set priorities and make decisions? Who controls the resources, often generously provided by external donors? Coordinated

timing and allocation of available resources are important to both the long-term sustainability and political feasibility of rehabilitation efforts. Donors, international organisations like the World Bank or the WHO, foreign governments who are supporting a post-conflict country and post-conflict governments themselves can have varying agendas that require harmonisation for being effective. Furthermore health systems are heavily dependent on the broader macroeconomic picture in terms of revenue, sector expenditures, and the prioritization of policies (MACRAE, 1997 as cited by WATERS et al., 2007 p6).

There is no common framework to evaluate the rehabilitation of the health sector in post conflict situations, as each country and each conflict situation have their individual features. However, some case studies mentioned by WATERS et al. (2007) and a case study carried out in Kosovo (PERCIVAL, 2010 p7) suggest that the following elements are supporting a successful post conflict health system reform process:

1. Strong state capacity, leadership and national ownership.
2. A national health policy based on priority health needs including planning, prioritization, and integration of health services.
3. A generous timeframe and a strong focus on sustainability of the rehabilitation effort.
4. A strategy for the development of Human Resources—focusing on education and providing liveable wages and working conditions to government health workers.
5. Institutional development—including decentralisation, strengthening management capacities at local and national level, and development of information systems.
6. A decentralised and community based approach to the implementation of the national health policy. (WATERS, 2007, adapted by the author)

These elements demonstrate the necessity of ownership, stewardship and commitment by the post-conflict government. The importance of community involvement and the participation of a range of stakeholders can also be considered as essential.

5.3 The effect of development aid and conflict

Based on research carried out after the Rwanda conflict and genocide (UVIN, 1998) and in other conflicts (PAFFENHOLZ, 2006) it became apparent that “all aid, at all times, creates incentives and disincentives, for peace or for war, regardless of whether these effects are deliberate, recognised or not, before, during or after war” (UVIN, 1998). Aid, including support in the health field, can do harm without intention and negatively affect a conflict situation. Aid resource transfer can strengthen some actors in the conflict and fuel inter-group conflicts as in the case of Somalia. Therefore aid, including health care projects, must always be considered within the political context, especially in unstable countries and post conflict situations.

With the objective to further explore the relation between peace and health, the next chapter presents the effects of peacebuilding on development and health. At first some relevant elements of the “World Development Report WDR 2011: Conflict, Security and Development” (World Bank, 2011) will be presented; followed by a description of the concept of “Fragile States” and the presentation of two recent international initiatives on peacebuilding, statebuilding and development.

6 Peacebuilding, statebuilding, development and health

6.1 The World Development Report: Conflict, Security and Development

The World Development Report (WDR): Conflict, Security and Development (World Bank, 2011) is a voluminous documentation relating development to conflict and demonstrating the negative impact of persistent conflict on a country or a region's development prospects. In the report it is pointed out that not even one low-income and conflict-affected state has achieved a single Millennium Development Goal (MDG) to date.

The eight Millennium Development Goals were established by the General Assembly of the United Nations in the United Nations Millennium Declaration (UN Resolution 55/2, 2000). The states were called to take action and specify measurable steps for the achievement of each of the following goals: eradicating extreme poverty; achieving universal primary education; promoting gender equality and empowering women; reducing child mortality rates; improving maternal health; combating HIV/AIDS, malaria and other diseases; ensuring environmental sustainability; and developing a global partnership for development. (UNDP, 2000) Three of the MDGs are directly concerned with health, and the other five MDGs are about determinants of health. For example, extreme poverty during childhood negatively affects the health of people on the long term (GUPTA, 2007 p671). The WDR 2011 further demonstrates that development is very slow in countries affected by conflict. "The WDR 2011 states that criminal and political violence need to be taken into consideration when talking about creating an environment for sustainable peace and development. The causes for the violence might be different; the impact on the affected population is similar" (Swiss Peace, 2012).

Different states with limited capacities to carry out basic functions of governing a population, due to conflict situations or other reasons, have comparable risks and problems. As a consequence the denomination of "Fragile States" was introduced. In the following chapter the concept of "Fragile States" is presented, followed by the discussion of two initiatives recent initiatives, both aiming at better understanding and more effective management of such fragile situations.

6.2. Fragile States

The OECD (2011) defines a Fragile State as follows: “A fragile State has a weak capacity to carry out basic functions of governing a population and its territory, and lacks the ability to develop mutually constructive and reinforcing relations with society. As a consequence, trust and mutual obligations between the state and its citizens have become weak.”

Not every fragile situation has a conflict involved. But often “fragility is either the reason or a symptom of violent political conflict, insecurity and / or violence. This usually results in injustice, exclusion of some groups of people from public goods or basic services” (Swiss Peace, 2012). Fragile contexts are characterised by high dynamic and quickly changing situations. Today Fragile States have moved from the periphery to the centre of the international aid. Until recently, donors tended to stay absent from fragile situations, as they were expecting no or very limited effect from their “invested” resources (Chandy, 2011). Between 2005 and 2011 the share of the world’s poor living in fragile states has doubled from 20% to 40% (Chandy, 2011). Besides new Fragile States centred initiatives, there is also growing evidence that well designed and context adapted aid programs can have a positive effect on peacebuilding and the well-being of populations (Chandy, 2011). Two major international initiatives aim at encouraging the useful support for Fragile States: One, “The New Deal for Engagement in Fragile States” has been initiated by fragile countries themselves, the other, the “10 OECD Fragile States Principles” is an OECD initiative.

6.3 The New Deal for Engagement in Fragile States

Out of a global population of 7 billion, 1.5 billion people live in countries affected by violent conflict. International aid to fragile and conflict-affected states accounts for 30 percent of global official development assistance flows. However, no low-income fragile or conflict-affected country has yet achieved a single Millennium Development Goal (International Dialogue on Peacebuilding and Statebuilding, 2011).

Faced with these challenges, a group of nineteen fragile states calling themselves the g7+ came together with their international partners in Busan, South Korea, to endorse the "New Deal for Engagement in Fragile States" on November 30, 2011 (International Dialogue on Peacebuilding and Statebuilding, 2011). The New Deal

outlines an ambitious agenda for more effective aid to fragile states, based upon five peacebuilding and statebuilding goals (PSGs): legitimate politics, security, justice, economic foundations, revenues and services. These five peacebuilding and statebuilding goals are intended to enable the countries concerned to transition out of their state of fragility and focus more on development. The New Deal also aims at the involvement of civil society in this process (Krienbühl, 2013). The OECD has already started an initiative for fragile states in 2007, formulated 10 principles and developed a framework for evaluating progress.

6.4 The 10 OECD Fragile States Principles

The "Fragile States Principles" or "Principles for Good International Engagement in Fragile States and Situations" (FSPs) provide a set of guidelines for actors involved in development co-operation, peacebuilding, statebuilding and security in fragile and conflict-affected states. The following reasons for the establishment of the 10 principles were formulated: Fragile States face severe development challenges such as a lack of security, weak governance, limited administrative capacity, chronic humanitarian crises, persistent social tensions, violence or the legacy of civil war (OECD, 2007). Widely accepted as a point of reference, the FSPs were adopted by the OECD ministers in 2007 (OECD, 2007).

The 10 Principles for "Good International Engagement in Fragile States and Situations" (FSPs) are:

1. "Take context as the starting point
2. Ensure all activities do no harm
3. Focus on statebuilding as the central objective
4. Prioritise prevention
5. Recognise the links between political, security and development objectives
6. Promote non discrimination as a basis for inclusive and stable societies
7. Align with local priorities in different ways and in different contexts
8. Agree on practical coordination mechanisms between international actors
9. Act fast... but stay engaged long enough to give success a chance
10. Avoid creating pockets of exclusion ("aid orphans")" (OECD, 2007)

A common OECD-framework for the evaluation of country case studies has been formulated for the regular evaluation of the effects of the “OECD Fragile States Principles” in individual countries. The “OECD 2009 Fragile State Survey” presented some positive results on the principles 5, 6, 7, 8, 9. The most problematic outcomes were found concerning principle 10 (avoid creating pockets of exclusion); and in some of the countries just moderate performance was found on principles 1 (take context as starting point), 2 (do no harm), 3 (statebuilding as central issue).

The “New Deal” and the “10 Fragile States Principles” inform multilateral as well as national development and peacebuilding policies. The example of Switzerland in the next chapter demonstrates how an individual country is integrating these approaches.

7 The Swiss approach to peacebuilding, development and health projects

The Swiss Development Cooperation (SDC) started in the 1990s with constructive crises prevention and initial peacebuilding activities. One earmark in the peacebuilding history of SDC is the experience in Nepal (PAFFENHOLZ, 2006; SDC Asia Brief, 2011). Nepal had been a priority of Swiss Development for many years. When the war broke out in 1996, SDC decided to stay on and developed the expertise to include a conflict sensitive project approach in formerly purely development oriented projects. The Swiss development approaches were combined with diplomatic peacebuilding and human rights strategies. This work was thoroughly evaluated in 2006 (PAFFENHOLZ, 2006), and in the same year SDC published the guidelines on Conflict-Sensitive Programme Management (SDC, 2006) to integrate conflict sensitivity and prevention of violence into SDC programs. The objective was to have a conflict sensitive approach in all development projects implemented in a fragile or post conflict context and to look at every context with a "conflict lens". Adapted to the objectives of a project and the degree of fragility of a situation, three approaches to CSPM are proposed in the document:

7.1 SDC Conflict-Sensitive Programme Management CSPM

SDC CSPM (2006) has the following three levels:

- All SDC programmes must answer to the minimum requirement: **do no harm** and look at conflict factors that **separate** people and factors that **connect** them, with the objective to strengthen the connectors and avoid separators in relation to a programme.

- **CSPM Basic** must be applied to programmes and individual projects which are working **in** conflict situations. The open or hidden conflict must be observed to reduce active conflict relevant risks and to avoid negative conflict aggravating effects.

- **CSPM Comprehensive** is applied in programmes working **on** conflict who seek to transform (positively influence) a conflict. In such a situation, the dynamics of a conflict must be observed and analysed on a regular basis.

Such a program requires important political and mediation competencies and can create room for dialogue, reinforce alliances for peace and support the development of competencies for the transformation of conflict (SDC, 2006**)**

7.2 Further developments

Since 2006, peacebuilding has gained increasing importance in the Swiss approach to development cooperation. In the main legal and financial instrument governing Swiss foreign aid, the "Message (Botschaft) on Switzerland's International Cooperation in 2013 – 2016" (Bundesrat, 2012), the tasks of humanitarian aid, development cooperation, economic and trade policy measures are all described within the framework of development cooperation. The principal objective of development cooperation remains poverty reduction, additionally Switzerland wants to work more closely in fragile contexts (a fragile context can be a fragile state, but also a fragile region).

In 2012, the SDC adopted a package of measures for working in fragile and conflict affected contexts. Conflict sensitive programme management and a focus on the five Peacebuilding and Statebuilding Goals as set out in the New Deal are seen as absolutely essential in this regard. "In local statebuilding in particular, development cooperation and humanitarian aid projects combine direct aid for the population with the long-term impact on statebuilding and democratisation. In this regard, partnerships between foreign NGOs, local civil society organisations and the relevant authorities are essential for achieving results" (Heiniger, 2013).

7.3 Swiss Peace includes new findings

The 2012 "Fact Sheet: conflict Sensitive Programme Management" developed by Swiss Peace (2012), includes the results of the six years experience since the publication of the SDC CSMP document, in particular the "10 Principles for Good Engagement in Fragile states" (OECD, 2007), the World Development Report (World Bank, 2011), and the New Deal (International Dialogue on Statebuilding and Peacebuilding, 2011).

In the Swiss Peace Fact Sheet is pointed out that: "Fragile states are a big challenge for global security, because development is very slow, they have the potential to destabilise their region and they can be platforms for drug trafficking, and all kinds of

illegal activities due to dysfunctional judiciary and law enforcement systems"(Swiss Peace, 2012) (e.g. dumping of dangerous waste or piracy in Somalia). The document emphasises the following points for the application of CSPM in practice:

- "Analyse the key elements of conflict, fragility and security risks and potentials for peace
- Have a strategic orientation and work with an explicit theory of change
- Have a "conflict lens" integrated into all programme work at every stage of the programme management and the internal organisation, including staff and security management" (Swiss Peace, 2012)

Swiss Peace also addresses the need for high administrative flexibility and high decision making power at the country level because unexpected changes of situations occur frequently in a fragile context. This is an issue also raised in a evaluation report of SDC work in a fragile context. (Swiss Peace, 2012; SIDA et al., 2012).

After a description of different relations between conflict, peacebuilding, development and health, the following chapter addresses the input of health projects and health personnel on peacebuilding with an overview over current expert discussions, followed by the presentation of a model illustrating the closeness of the determinants of health and the determinants for peace.

8 Roles of health projects and health experts in peacebuilding

8.1 Recent expert discussions and evidence base

In recent years experts in international health have taken up the subject of “health system strengthening” in the context of Fragile States (SONDORP et al, 2012 p3). In the academic world, the relation between peacebuilding / statebuilding and health system strengthening is a newly emerging theme (FUSTUKIAN, 2012 p9). Additionally, there is a need for developing a deeper understanding of health as an instrument for change (VAN EEGHEN, 2012 p16). In line with the WDR 2011, evaluations indicate that health system rehabilitation in post conflict situations or in Fragile States are often of limited effectiveness if their focus is purely technical, with the exclusive aim to deliver services. Some experts see “intuitive” evidence that health system strengthening can contribute to state building and that delivering basic services can contribute to enhancing the legitimacy of the state (SONDROP et al, 2012 p3).

Rachel SLATER, a researcher from the Secure Livelihoods Research Consortium (SLATER as quoted by SONDORP et al., 2012 p.6) shares this view and also sees a strong intuitive logic. She also points out that an increasing number of international agencies started to base their programming on this assumption. However, a review of the evidence base through consultants and a literature review process show a very thin evidence base. SLATER (as quoted by SONDORP et al., 2012 p.6) sees a number of causes for this lack of evidence: the agenda is relatively new; it is complex to show the casual chain between perceptions, legitimacy and state building; the settings are very heterogenic; and it is difficult to do research and impact evaluation in fragile states. In SLATER`s view, projects in the health field should not lose focus on the main priority of a health system: curing sick people and preventing disease. In addition, she points out the importance to look at the wider project context and to respect the principle “to do no harm”. There are worries that when health is placed in the political, peacebuilding sphere, health projects could be instrumentalised.

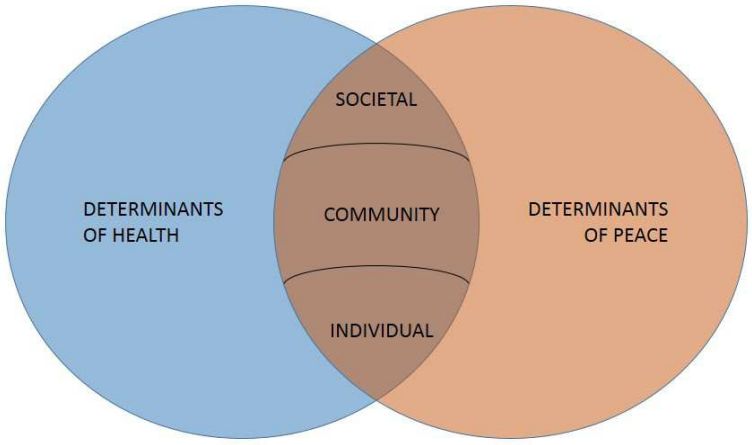
Or as Egbert SONDORP (2012) puts it, “the politisation of health, that we have seen in more recent conflicts, whereby the relation between health and peace is being increasingly used by the military in their efforts to win hearts and minds” (SONDORP,

(2012 p6). He also warns of implementing health system building blocks (WHO WPR, no date) in a fragile state without looking at the context and social determinants of health. He sees fragility and poor governance as very relevant determinants which should be included in efforts to strengthen health systems.

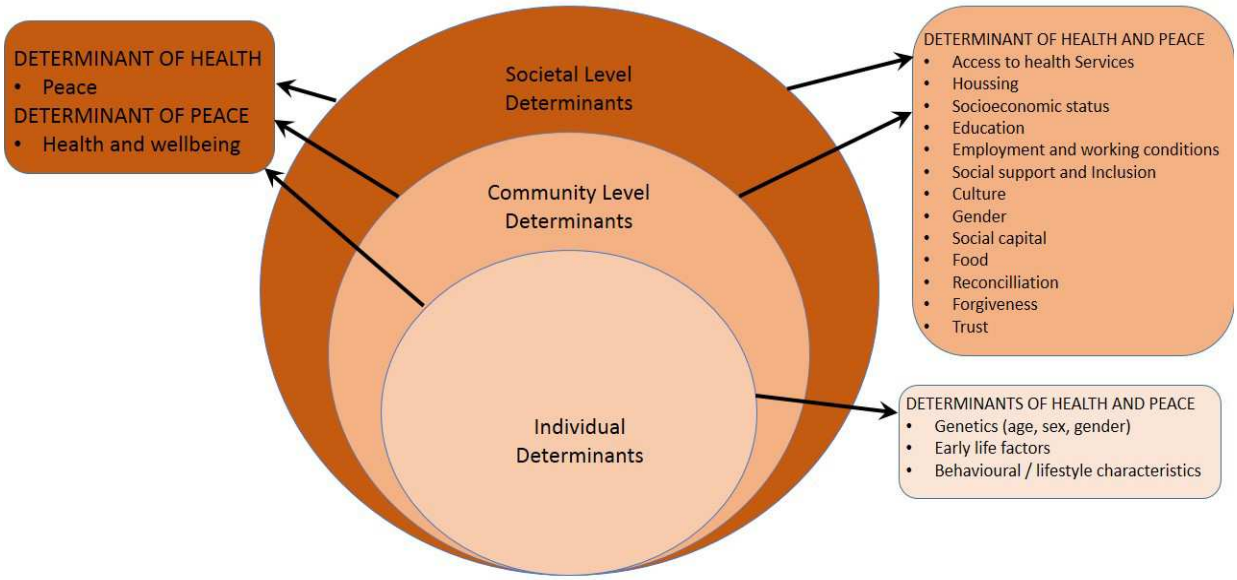
8.2 A model to present the relation between peace and health

The information presented above suggests that peace and health are both central to the quality of life of persons and communities. Looking at the determinants of health (WHO) and at the fragile states principles (OECD), they appear interrelated. ABUELAISH et al. use an approach that implies "that peace leads to health and health leads to peace" (ABUELAISH et al., 2013 p4). They propose a multi-sectoral and multi-level "Peace and Health" approach and developed a model presenting the overlap between determinants of health and determinants of peace at the societal, community and individual level.

Graph 1 (ABUELAISH): Model of individual, community, and societal determinants of health and peace



(a) The overlap between the individual, community, and societal determinants of health and peace by Abuelaish et al (2013) International Journal of Peace and Development Studies Vol. 4(1), pp. 1-7, February 2013



(b) the mutual determinants of health and peace
by Abuelaish et al (2013) International Journal of Peace and Development Studies Vol. 4(1), pp. 1-7, February 2013

The interrelated factors promoting health and peace touch many areas of human organisation, including the traditional silos of governance, management and research. Social, economic and political conditions all influence health and peace of individuals and communities. Poverty, including the absence of adequate housing, employment and income, leads to social exclusion and can contribute to stress, mental and physical illness and violence. Thus education, jobs, adequate housing, trust and respect at the individual, community and societal level are positive for peace and health of persons, communities and societies (ABUELAISH, 2013 p4).

As a consequence, one can assume that collaboration and exchange between experts in the fields of peacebuilding and public health, as well as the good utilisation of their complementary aspects, has beneficial effect on the effectiveness of peacebuilding as well as on the effectiveness of health projects in Fragile States (ABUELAISH et al., 2013 p6). At the community level decentralised and community based health projects have a potential for community involvement and empowerment. At the national level a well functioning health system can contribute to the increase of trust in the state and its institutions. Additionally peacebuilding can be supported by health programs through the reduction of individual suffering after trauma and the reduction of individual violence, in particular through mental health

programs. The professionals working in the health system are essential for providing health care. They care for people, they earn their livelihood in the health system and they are sometimes physically at risk during conflict or they can experience stress when they are not in the position to provide health care according to their professional and ethical standards.

8.3 Health professionals and peacebuilding

Physicians, nurses, midwifes and other health professionals have the potential to play a very particular role as peacebuilding agents at the relational and personal dimension. Health professionals are usually valued and trusted by society; they work with an evidence base, value science and critical thinking and can therefore critically reflect on war making in a conflict promoting environment where myth, propaganda and lies flourish. The international health community is strongly integrated with shared values, it is a powerful learning community and information is shared quickly at a global level (ARYA et SANTA BARBARA, 2008 p107). Health professionals in direct contact with patients and the population are often overloaded with work, especially in fragile situations. Additionally they have no special expertise in peacebuilding, such as political or mediation skills, thus their potential for peacebuilding lies mainly in the way they carry out their work and relate with people at the individual and at the community level.

The nursing profession for example is present in all settings, and has a particular potential in remote areas of poor and fragile countries, where the provision of health care is mainly secured by nurses (WHO, 2011). Nurses are part of the ones who cure and care for people, they can involve the community in health activities, and with their personal attitude and behaviour they are examples of respectful and ethical conduct. The “Global Code of Ethics for Nurses” (ICN, 2012) represents a global set of values and rules of ethics, to which over 130 national nurses associations, and their millions of members, adhere.

The following examples of paragraphs of the ICN Code of Ethics can be useful the light of peacbuilding:

- “In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected.”

- “The nurse shares with society the responsibility for initiating and supporting action to meet the health and social needs of the public, in particular those of vulnerable populations. The nurse advocates for equity and social justice in resource allocation, access to health care and other social and economic services. The nurse demonstrates professional values such as respectfulness, responsiveness, compassion, trustworthiness and integrity.” (ICN, 2012)

Usually ethics is part of the education of health professionals, and professional associations have their ethics committees. Nurith WAGNER (no date) for example, a nurse and the chair of the Israeli Nurses Association Ethics Bureau, uses the instruments of nursing ethics to describe her dilemmas as mother of an Israeli soldier and a volunteer of “Machsomwatch”. “Machsomwatch” is a movement of Israeli women who are observing the human rights situation at some 40 checkpoints at a daily bases. They are following media reports of violations of human rights of Palestinians transiting border police checkpoints in the West Bank and Jerusalem (Wagner, no date).

8.4 Negative effects of health projects on peacebuilding

There is also a possibility for health projects to negatively affect peace-building, when they are not adapted to their fragile environment, or when health projects and their material and financial resources are used as an instrument to strengthen one particular group of a conflict. At a structural level, the lack of equitable access to health is one more symptom of injustice and one more element, likely to increase tension. Negative examples of health professionals who have acted in an unethical manner exist. They may have abused their position, peoples trust and the special knowledge about their patients and the communities they are supposed to care for - to neglect, denounce or even kill persons, as it has been reported during the genocide in Rwanda (MAYER, 2013 p52).

RUBENSTEIN (2010) describes a more political and subtle example, which concerns the long history of cross-border cooperation between Palestinian and Israeli health professionals in health; including collaboration in disease surveillance, training and advocacy for health. RUBENSTEIN (2010) describes this cooperation as becoming increasingly difficult because of ongoing travel restrictions on Palestinians in the West Bank. The cooperation is also more and more perceived by Palestinians as

having a political aim and even as a tactic to endorse the Israeli occupation of their territory. This leads the Palestinian health professionals to renounce the collaboration with their Israeli colleagues despite its effectiveness and benefits for both sides, in order to invest their energy in creating an effective and independent health system in the West Bank.

9 Conclusion

A high number of related factors and a set of common determinants concerning the promotion of peace and the promotion of health exist at the levels of society, community and individuals. Generally speaking, social, economic and political conditions all influence the health and peace of individuals, communities and societies. Poverty, for example, and its effects, such as the absence of adequate housing or the absence of employment and income, leads to social exclusion and can contribute to stress, mental and physical illness and violence. On the other side education, jobs, adequate housing, trust and respect at the individual, community and societal level are positive for peace and health.

The main purpose of health projects, carried out or supported by international agencies in a fragile context, should not be the one of a political instrument; the main focus of health projects must be the reduction of suffering through the provision of good quality health care and the sustainable rehabilitation of the health system. Further effects of health projects are the creation of jobs and income for health professionals and some technical collaboration and thus communication between health professionals on different sides of a conflict may develop.

Given a context of fragility, the information presented in this paper indicates the necessity of collaboration between experts in peacebuilding and experts in public health. According to BARNETT's categories (chapter 4), the major potential lies in the second sector (social, economic, developmental, humanitarian). Only limited or no potential can be seen concerning the sectors one (security, military), three (political and diplomatic) and four (justice and reconciliation).

Health projects in a fragile state are more likely to be effective and to contribute to peacebuilding, when they include a fragility assessment and an objective on fragility. In a fragile context health experts working at a strategic level, as well as individual doctors and nurses, will have to leave their silos and consult with political experts. Health projects are not neutral, they are an intervention in an existing system and are part of it, and therefore they must, in any case, consider political, security and development issues. In a fragile context more time needs to be invested in practical co-ordination mechanisms with national and international actors. In some contexts, it

can be useful to integrate health and other aid projects into a whole peacebuilding strategy and work under the umbrella of a general peacebuilding approach. In a fragile context the “10 OECD Fragile States Principles”, which are closely related to some of the WHO determinants of health, should always be integrated in project planning, implementation and evaluation.

The community based public health project approach usually takes the local context as a starting point and is alienated with local priorities, aims at being inclusive and giving access to health, wellbeing and health services to the vulnerable. If health projects are conceived in a conflict sensitive way, they can directly contribute to the reduction of suffering. Furthermore health professionals have unique qualities and positions to act as change agents for peace in their daily contact with people, at individual and at community level. In their daily work they create trust and wellbeing among individuals and the community. At the level of the society or state, a functioning health system can improve general health and wellbeing and create trust for a government and its agencies.

10 Summary

Peace and health are both complex concepts, central to human life. In the field of peacebuilding, practice and research have advanced significantly, especially since UN peace missions have not always had the expected effects. Today we observe a growing interest in peacebuilding and conflict prevention. Two major initiatives, the "New Deal for Engagement in Fragile States" and the "10 OECD Fragile State Principles" are included in an increasing number of international and national policies.

Also in the health field an emerging interest in peacebuilding and the "Fragile States Approach" can be observed. The health system and supporting health projects have always had an important role in reducing peoples suffering during and after a conflict. Furthermore health projects in Fragile States are often of limited effectiveness. Some experts suggest that projects in the health field have the potential to support peacebuilding. The "World Development Report 2011" makes the link between development aid (including health) and peacebuilding more explicit.

This paper explores the relationship between peace (promotion) and health (promotion) and aligns both disciplines peacebuilding and public health. A model, including determinants of peace and determinants of health, developed by Izzeldin ABUELAISH and his colleagues (2013), is presented and used as a framework for answering the following questions: Could it be useful to integrate health care projects into the wider peacebuilding activities? Are there ways to systematically include aspects of peacebuilding in any health project in conflict or post conflict situations?

The findings suggest that in fragile situations it is often useful to integrate health and other aid projects into a whole peacebuilding strategy. Health projects conceived in a conflict sensitive way reduce peoples suffering and have the potential to contribute to peacebuilding. In particular health professionals have unique qualities and positions to act as change agents for peace in their daily contact with people, especially at the levels of individuals and communities.

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Erklärung

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