Health as a Bridge for Peace: Theory, Practice and Prognosis — Reflections of a Practitioner

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Abstract

This article explores the nature of the relationship between Health as a Bridge for Peace (HBP) projects and the political contexts in which they are implemented. HBP projects derive from the intersections of the health and conflict fields, which may be formulated in one of two ways: the effect of the conflict on the practice of health care; and/or the use of the health field in the transformation of conflict. Projects carried out under the 'health as a bridge for peace' banner encompass a wide range of goals, target populations and project components, which vary based on factors such as local conditions and the initiating party. This paper offers two typologies for understanding HBP projects. It shows that while HBP projects are not a substitute for political processes, the relationships and the values they generate can serve as an important bridge during periods of conflict when the political processes are at their weakest point.

Introduction

One of the most frequent and challenging questions asked about Health as a Bridge for Peace (HBP) projects is: can humanitarian projects influence processes undertaken to end military/political conflicts and contribute to peacemaking and peacebuilding? This paper explores the nature of the relationship between HBP projects and the political contexts in which they are implemented, drawing on the international experience and my work as a practitioner and researcher of HBP.

In my experience in the Israeli-Palestinian context, HBP projects may be sustained even under adverse political circumstances, and may have positive impacts on individuals and organisations, though the projects themselves are not immune from the conflict and its political processes. How does this fit into the international experience? Answering this question required developing an analytical framework that would take into account the diverse types of HBP projects and the unique political contexts in which they are implemented. The framework for analysis presented in this paper looks at three areas relevant to HBP projects — the *background* to the conflict and health field, *project components*, and *outcomes* in health and conflict-related areas. It was developed based on an epidemiological model that outlines three factors that contribute to HBP projects — universal motives, international conditions and local conditions (Barnea, Abdeen *et al* 2000).

This paper begins with a review of *theoretical* issues underlying the HBP concept, as a basis for developing this framework. The *practice* of HBP is examined through an analysis of three documented HBP experiences, which test the framework and provide a context for reflecting on the broader implications of the relationship between HBP programmes and political contexts. These experiences are from conflicts in Haiti, the Middle East and the former Yugoslavia and were chosen because they represent diversity in both the political and health areas.

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The latest cycle of violence in the Israeli-Palestinian conflict erupted at the end of September 2000 and continues at the time of writing. These events reinforce the need to better understand the theory and practice of HBP initiatives, as well as compel one to reflect on the question 'What can health professionals contribute in a situation of long-standing conflict?' This question will be considered in the final *prognosis* section.

The ever-growing body of literature on the subject[1] indicates the interest of those involved to document and derive lessons from these experiences.[2]

Theory

'Health as a bridge for peace' as a catch-phrase first appeared in the 1980s in the Pan-American Health Organization (PAHO) initiative, the Plan for Priority Health Needs in Central America and Panama. The initiative was conceived 'in the belief that health, because of its unique value and universal acceptance, could serve as a bridge for peace, solidarity and understanding among the peoples of Central America and Panama' (Pan-American Health Organization [PAHO] 1991).

In the following decade, the World Health Organization — Division of Emergency and Humanitarian Action (WHO/EHA) — deliberated its role in what had come to be known as 'complex humanitarian emergencies' (CHEs). These are generally characterised by armed conflict, population displacements and food scarcities. WHO recognised the need to work along a continuum from relief to development in these situations (WHO 1997b, 1997c, 1998, 2000a). In addition, WHO initiated discussions on an additional response for conflict areas — Health as a Bridge for Peace.

> *The Spirit of Health as a Bridge for Peace* affirms commitment to Health for All and its Renewal. In achieving the primary goal of health for societies prone to and affected by war, we as health professionals recognize responsibilities to create opportunities for peace. For this we need new strategies, awareness, stance, skills and partners (WHO 1997a).

WHO defines the main purpose of its HBP programme as identifying and developing actions and strategies that can maximise the peacebuilding effects of health programmes before, during and after conflicts. Variations on the 'health as a bridge to peace' theme were also used for projects undertaken by other organisations such as the United States Institute of Peace (USIP), the Institute for Resource and Security Studies [IRSS] (Gutlove 1999), the partnership of the Economic Cooperation Foundation (ECF), and the Palestine Council of Health [PCH] (1999).

HBP efforts tend to reflect traditional health priorities in conflict areas — 'saving lives' and preventing the spread of infectious diseases. The relief to the development continuum, used by development agencies when working in complex humanitarian emergencies, allows for greater diversity in type and scope of projects dependent on local conditions and the ideologies of the professionals involved. With regard to post-conflict development, Saltman (2002:2) reminds us that,

> Despite the uniqueness of the health sector as against other realms of social and industrial policy — that health care is a social good, not a commodity, that it is investment in social capital, that it is a precondition to education and employment — the technical aspects of health care show a similar lack of respect for political boundaries.

HBP projects are implemented in real time — conflict/post-conflict situations — and in this sense are dynamic 'social' experiments. 'Health as a bridge to peace' projects derive from the intersection of the health and conflict fields and may be formulated in one of two concomitant ways: the effect of the conflict on the practice of health care; and/or the use of the health field as a tool in the transformation of the conflict. Humanitarian agendas are not necessarily compatible with political agendas and their intersection confronts those practising it with numerous dilemmas (Macrae 1998).

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The Effect of Conflict on the Practice of Health Care

'The 1990s will be remembered as the decade when regional wars were transformed in the popular Western consciousness and, to no small extent in the language of international relations, into 'humanitarian' emergencies' (Greenaway, 1999:1). The framing of conflicts as 'humanitarian' emergencies, complex or otherwise, may on the one hand reflect the increased involvement of health professionals who point out the continuously increasing 'humanitarian' toll conflicts are taking on the populations involved. On the other hand, they may serve as a stimulus for health professionals to be part of the 'cure'. Two issues to be considered in the practice of health care *vis-à-vis* conflict situations are the humanitarian ethos traditionally associated with health care and health care professionals, and the nature of armed conflict as a public health issue.

The Humanitarian Ethos of Health Care

'I see it all over the world. Health professionals and health promotion professionals are a breed of people who spread goodwill and humanitarianism wherever they go.' (project director interviewed in Barnea *et al* 2000:64) Since the Hippocratic Oath established professional codes of practice for physicians, health care has been associated with humanitarian values. Following the Crimean War (1864) and World War II (1949), the international community drafted the Geneva Conventions, an international standard and monitoring system (through the International Committee for the Red Cross — ICRC). The Geneva Conventions cover the treatment of those wounded in war and the treatment of the civilian population during times of combat, and provides for the protection of health care personnel involved in these activities. More recently, health professionals have initiated and developed service provision and advocacy organisations, such as Medicins Sans Frontieres (MSF), Medecin du Monde (MDM) Physician's for Human Rights (PHR), and International Physicians for the Prevention of Nuclear War (IPPNW), reconfirming their commitment to the underlying humanitarian ethos involved in health care and to carrying this ethos into conflict and conflict-related arenas. This commitment

was given international recognition with the awarding of the 1999 Nobel Peace Prize to Medicins Sans Frontieres.

The Nature of Armed Conflict as a Public Health Issue

The percentage of civilian casualties (out of total war casualties) has risen steadily in the 20th century, from 5-19% in WWI, rising to around 50% in WWII, and reaching over 90% in post WWII conflicts (Machel 1996). The public health consequences of armed conflict extend far beyond the mortality, morbidity and disability that are caused directly by the use of armaments. Parallel to the rising civilian casualty rate is the disintegration of health provision systems during times of conflict, especially preventive measures such as immunisations. This, combined with population conditions which include malnutrition, poverty and the displacement of people from their homes, are conducive to the rapid spread of infectious diseases. Vulnerable populations — children, women, the elderly, and people with disabilities — are especially at risk. Rape, carried out by combatants in conflicts, may lead to a rise in sexually transmitted diseases. In addition, conflict situations can cause short- and long-term trauma symptoms among soldier and civilian populations. The framing of conflict as a major public health threat leads to a broadening of the goals of public health to include the transformation of the conflict. This has opened the door for health professionals to become involved in this transformation. 'To the extent that this is a war on public health, it is impossible to protect public health without peace' (Mann *et al* 1994: 15, see also Macrae 1998).

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The Use of the Health Field as a Tool in the Transformation of Conflicts

The complex, deep-rooted, and often intractable nature of current conflicts is such that they do not lend themselves to straightforward resolutions — military victories may prove to be short-lived and diplomatic agreements are often difficult to enforce. This has led to the development of a multi-stage, multi-track approach in an effort to transform the conflict. The multi-stage approach is embodied in what is termed the post-conflict period — a transition phase between the formal cessation of hostilities and a formal peace agreement — and is derived from the need for time to heal deep-seated wounds and to learn new ways to co-exist with each other. In this context, it is not surprising that the term rehabilitation is being used to describe post-conflict processes as it may 'signify a generative forging of new life out of the ruins of the old' (Pugh 1998: 2).

The multi-track approach is derived from the intrastate and inter-communal nature of conflicts and takes into consideration the fact that these conflicts involve many layers of society. Therefore conflict resolution efforts can take place at any of these layers. The Institute for Multi-Track Diplomacy (IMTD) differentiates between nine tracks which operate as a system: Track 1 takes place at the official, governmental, diplomatic level; Track 2 involves conflict resolution professionals; and Tracks 3-9 engage different sectors of civil society (business, private citizens, research/training/education, activism, religious, funding, public opinion/communication).

'Each track has its own resources, values and approach, but since they are all linked, they can operate more powerfully when they are coordinated' (IMTD 2000). Current peace efforts endeavour to put multi-track diplomacy into practice and include clauses related to civil society activities in agreements and treaties negotiated between the sides to the conflict. Interestingly, the health field served both Track 1 diplomatic efforts — as a reason for a negotiated ceasefire in Central America (PAHO 1991) — and the civil society track — as a field for cooperation in the Israeli-Palestinian post-conflict era (Barnea *et al* 2000) .

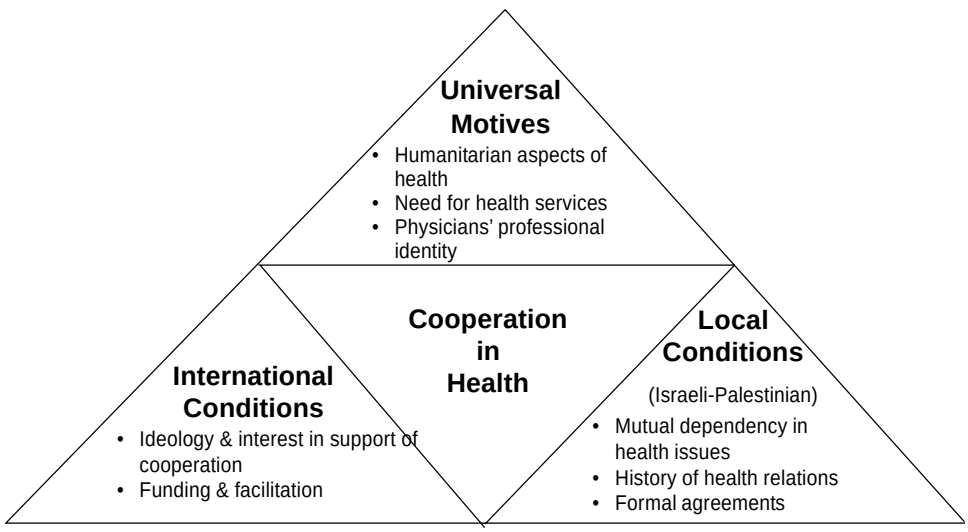
Parallel Processes or Conflicting Agendas: The Humanitarian-Political Dilemma

By their nature, HBP projects operate in highly political contexts. Traditionally the provision of humanitarian assistance — including health care — in conflict situations was considered disconnected from the political debate. However, both the ability and the desirability of humanitarian organisations remaining neutral and impartial have been called into question (Medicin du Monde 1999; Greenaway 1999, Macrae 1998, Tardiff 1998). Humanitarian programmes, including those in the health field, can be used and manipulated for political purposes thus pulling them into the political arena. In addition, there is often pressure on humanitarian assistance to become politically engaged — either through advocacy, rehabilitation or development work, or conflict resolution activities.

Practice

Barnea, Abdeen *et al* (2000) developed an epidemiological model to answer the question 'Why is the health field conducive to cooperation in conflict or post-conflict areas?'.

Figure 1: Factors Affecting Cooperation in Health



The model delineates three factors contributing to HBP projects:

— universal motives, such as the humanitarian aspects of health care, the need for health services and the physician's professional identity;

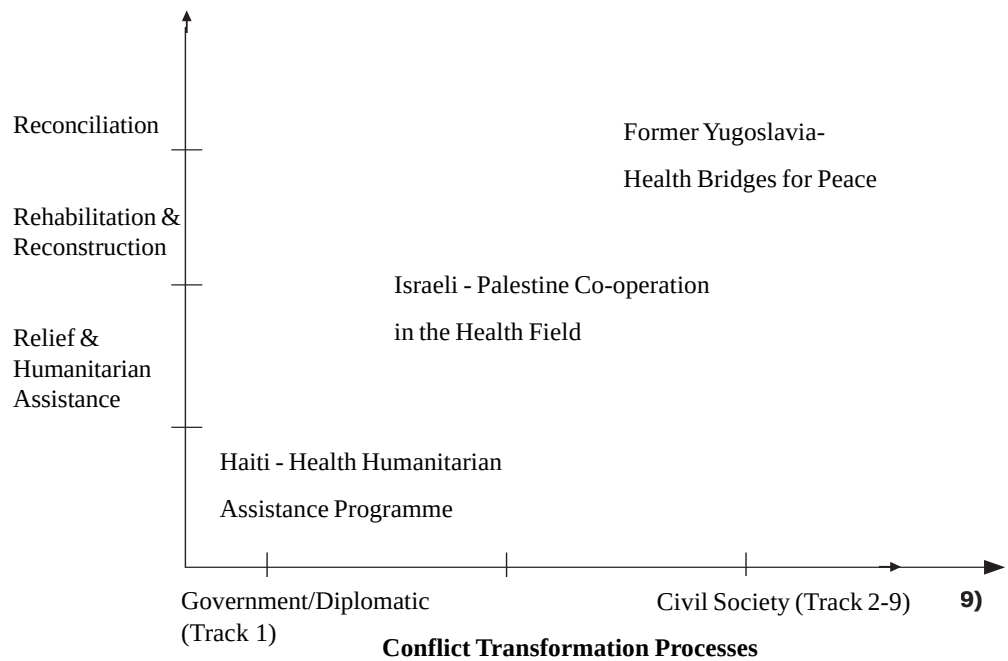
— international conditions, such as ideology and interests in support of cooperation and funding and facilitation by international organisations; and

— local conditions, such as mutual dependency in health issues, history of health relations and formal agreements.

Projects carried out under the 'health as a bridge for peace' banner encompass a wide range of goals, target populations and project components, which vary based on factors such as local conditions (history of the conflict, health needs) and the initiating party (local/international, health field/conflict field). It is important to try and understand this diversity in order to further the work in this field. Building on the theory presented thus far, the author offers two typologies, which may be used separately or jointly: the first is a classification of HBP projects by HBP goal and by conflict transformation process, and the second is a framework for analysis.

HBP projects may be classified by two parameters a) conflict transformation — from governmental/diplomatic initiatives (Track 1) to civil society initiatives (Tracks 2-9); and b) health/conflict goal — covering relief, rehabilitation (development), and reconciliation. These classifications are dynamic and not mutually exclusive and different projects lie at different intersections of the two parameters. The meeting points are not linear. Figure 2 illustrates the meeting points of the three HBP projects discussed in the next section.

Figure 2: Classification of HBP Projects by HBP Goal/Activity and by Conflict Transformation Process



Conflict Transformation Processes

The following presentation of three HBP programmes is based on published accounts of these projects. These projects were chosen because they represent aspects of both continuums and are not meant as an exhaustive review of HBP programmes, or as a comparison of the different programmes. Rather, they are intended to illustrate different types of projects carried out in varied conflict/post-conflict situations. Each programme will be presented through the framework for analysis developed which covers:

a) background and local conditions to the project in terms of the history of the conflict and health field;.
b) project characteristics — initiation, goals, components, partners and visibility; and
c) outcomes of the project in terms of health and conflict.

Case 1: Relief and Humanitarian Assistance — 'Haiti Health Humanitarian Assistance Programme (HAP)'

Relief and humanitarian assistance programmes (HAP) predate HBP programmes. The inclusion of HAPs in the framework of HBP is a step toward the politicisation of humanitarian programmes, a step not free of dilemmas. Francine Tardiff's account of the Health Humanitarian Assistance Programme implemented in Haiti in the years 1991-1994 clearly depicts the dilemmas facing humanitarian assistance and considers the potential of health humanitarian assistance in serving as a bridge to peace(Tardiff 1998).

Background and Local Conditions

a) *Conflict* — In 1990, following three decades of dictatorship and military rule, Jean-Bertrand Aristide was elected president of Haiti. Less than a year later, he was forced into exile by a military coup. The international community responded by imposing economic sanctions against the *de facto* government. However, the sanctions did not have an effect on the political *status quo* and in 1994 active international military intervention returned Aristide to office. 'The *de facto* years (1991-1994) are poorly represented by typologies of conflict in which two parties battle for control of power. However, the Haitian crisis is more illustrative of asymmetric conflict that pits groups of extremely unequal force: the military regime on one hand and, on the other, virtually the entire population, which gives its quasi-unanimous support to the overthrown constitutional authorities' (Tardiff 1998, Section 1:2).
b) *Health* — In 1991, Haiti was a poor country (GDP — $380) with a weak health infrastructure. Public expenditure on health was 1.2% of GDP. Population health indicators such as infant mortality rate (94 per 1,000 live births) and maternal mortality rate (350 per 100,000 live births) were gloomy.

HBP Programme

a) *Initiation* — The international community initiated the Health HAP in Haiti to protect the population from the impact of the international sanctions, though initially at least, it seemed that the population was not interested in this protection, since it was anxious that the sanctions should succeed. Tardiff (1998) frames the dilemmas in deciding on the provision of humanitarian assistance:

> Are major humanitarian assistance programs compatible with the imposition of severe political and economic sanctions? Is the very principle of economic sanctions against an entire country compatible with respect of the population's fundamental

> rights? Furthermore, can humanitarian assistance programs be imposed on a population who, for strategic political reasons, seems to refuse them? (Section 2:1).

b) *Goals and objectives* — The main objectives of the HAP were to meet the population's most urgent medical needs and to enable the weak health infrastructure to weather the crisis.

c) *Project components* — The focus was on the professional (technical) aspects and activities included: supply of essential medical and basic products (including vaccinations and AIDS prevention); provision of care; training of health personnel; and planning of services.

d) *Partners* — The programme was initiated and driven by international organisations [UN, OAS, PAHO/WHO] (which is why it was placed on the 'diplomatic/ government' end of the continuum). Local reactions were mixed with some local organisations against any activities that would reduce the impact of the sanctions. However, some local organisations saw a positive side to the HAPs and became involved in planning and implementation, which relied on local human resources (physicians and other health professionals). The international agencies partnered with local NGOs and attempted to share the risk by recruiting as many partners as possible.

e) *Visibility* — Due to the highly charged political atmosphere the program maintained a low profile.

Outcomes

a) *Health* — The health outcomes of the Haiti Health HAPs were mixed. Two successful outcomes of the Health HAPs were the continued access of the population to medical assistance and the preservation of some achievements of the country's health sector in spite of the collapse of the public sector. Health indicators were mixed with a stagnation of the juvenile (3-5 years) mortality rate and an increase in malnutrition and a decrease in fertility and infant (0-2 years) mortality rates. One main disappointment of the Health HAPs was the unintended consequences it had on the transition/post-conflict stage when the new government tried to assert its authority in the health field and was faced with an NGO sector reluctant to relinquish their activities.

b) *Conflict/Peace* — In the final analysis Tardiff (1998) states: 'Health HAPs, as they were planned and carried out in Haiti, did not contribute to the peacemaking or peacebuilding process in the country, either directly or indirectly.' (Section 5:3). First, they did not foster conditions necessary for social peacebuilding and second, the legacy which pitted the new government against the NGO sector was not conducive to the reconciliation needed between the State and the population.

In addition, the view of the outcome is coloured by the in-born dilemma of providing humanitarian assistance to a population whose government is being pressured through international sanctions. On the one hand, the Health HAPs in Haiti enabled the population to survive where 'simple survival already represented a form of victory over the *de facto* government which was associated with the forces of death and destruction.' (Tardiff 1998, Section 4:1). On the other hand, there were many who felt that humanitarian assistance "helped normalize the *de facto* regime and, in doing so, directly or indirectly contributed to the weakening of civil society, the loss of momentum of the popular movement, and, consequently, to slowing the democratisation process in the country' (Tardiff 1998, Section 5:1).

Case 2: Rehabilitation (Reconstruction and Development) — 'Israeli-Palestinian Cooperation in the Health Field, 1994-1998'

'Between war and peace there is a complicated transition with great challenges for relief and development organizations' (van der Heijden 1997:1) One of the challenges is whether post-conflict reconstruction and development can also serve as a vehicle for the transformation of the conflict. One area where reconstruction and transformation may meet is in fostering the development of civil society. Another meeting place is cooperation — projects in which both sides work together. *The Study of Israeli-Palestinian Cooperation in Health Care, 1994-1998* (Barnea *et al* 2000) documents and analyses this phenomenon. The renewed outbreak of armed conflict between the two societies in September 2000 is a reminder that the ability of these activities to influence the overall political situation is limited.

Background and Local Conditions

a) *Conflict* — The root of the conflict stems from the claim of two national movements, Zionist and Palestinian, to the same piece of land. Most of the 20th century was marked by ongoing conflict, which numerous times led to outright war (1948, 1967, 1973). The 1967 war led to Israeli rule of the Palestinian population in the West Bank and Gaza Strip. Diplomatic efforts to find a solution to the conflict finally led to the 1993 Oslo accords, and to the establishment of the Palestinian Authority, which heralded a new era in Israeli-Palestinian relations.

   In spite of the ongoing conflict, living side-by-side in the same piece of land forced Israelis and Palestinians to interact with one another. Often it was as antagonists, as Israeli rule of the West Bank and Gaza (following the 1967 war) led to asymmetry in the relations — occupier/occupied, patron/client. However, elements of cooperation were also evident. Barnea *et al* (2000) review the history of cooperation in the health field from 1967 and identify four periods:

   1967-1976: Stabilisation and reorganisation of the Palestinian health system in the West Bank and Gaza Strip

   1977-1987: Build up of local capacity of Palestinians

   1988-1993: Shift in power structure

   1994-1999: Change in authority and relationship

   In summary, they note: 'Cooperative activities in the health field between Israeli and Palestinian professionals took place within the context of the overall process occurring between the two sides, which in hindsight was a process of separating into two national units (sometimes through military conflict, sometimes through diplomatic efforts — R.G.) rather than integrating into one' (p. 8).

b) *Health* — For 27 years (1967-1994), Israel was responsible for the health of Palestinians in the West Bank and Gaza Strip. Its overall policy was to provide the necessary health services within existing resources and a fixed budget and to allow the Palestinians to administer the health sector as much as possible. In practical terms, this meant an emphasis on aspects of primary care (mother and child health, immunisations, etc.), with secondary and tertiary care provided mainly in Israel, and the management of the health sector done by a few Israelis, together with Palestinian health officials [employed by the Israel Civil Administration] (Barnea and Husseini 2002).

In 1994, the Palestinian Authority assumed responsibility for the health field and began implementing the first Palestinian National Health Plan developed between 1990 and 1992. Funding from donor countries enabled wide-scale investment in physical infrastructure at all levels. Palestinian health professionals who had trained and practised abroad returned, expanding the pool of health professionals. A national health insurance scheme was implemented (Barnea and Husseini 2002).

HBP Programme

This example presents a spectrum of projects as discussed in *The Study of Israeli-Palestinian Cooperation in the Health Field, 1994-1998* (Barnea, Abdeen *et al* 2000). The study identified 148 cooperative projects involving 67 Palestinian and Israeli organisations and over 4,000 participants.[3] One hundred and twelve Israeli and Palestinian health professionals were interviewed (among them key entrepreneurs, project directors and project team members) to learn how it worked (Barnea *et al* 2000).

a) *Initiation* — The initiation of Israeli-Palestinian cooperative projects in health span the continuum from the governmental/diplomatic to the civil society tracks. On the diplomatic track, a 'People-to-People' programme was included in Annex VI of the Interim Agreement between Israel and the Palestinian Authority (September 1995). The health field was specifically mentioned in another section of the agreement: 'The health systems of the Israeli and Palestinian sides will maintain good working relations in all matters, including mutual assistance in providing first aid in cases of emergency, medical instruction, professional training and exchange of information' (Interim Agreement 1995, Annex III, Appendix 1, Article 17, Item 7). Palestinian and Israeli health officials created five joint committees on pharmaceuticals, epidemiology, food control, training of health professionals, and ambulatory care.

   On the civil society track, over half the projects were initiated by individuals, either project directors or heads of organisations.

b) *Goals and objectives* — The projects all had health-related goals. In addition, some had organisational goals, and a significant number had goals related to cooperation.

c) *Project components* — Analysis of the 148 projects by primary type of activity revealed that most of the projects were in the areas of training (46%), followed by research (23%), and service development (14%). Four smaller areas included: conferences, seminars, dialogues and youth activities (7%), service provision (5%) and policy planning (5%).

d) *Partners* — Israeli-Palestinian cooperative projects involved organisations such as: governmental policy making and service organisations; NGOs involved in service development and/or service provision; universities and research institutions; NGOs engaged in peace-oriented or human rights activities; and private institutions engaged in non-profit cooperative activities. The study showed that many of the key entrepreneurs and heads of organisations had had contact with their colleagues from the other side, prior to 1994, during the conflict period.

e) *Visibility* — The assumption that due to the political atmosphere, the projects would maintain a very low profile was not fully borne out by the study. Rather it seemed that organisations took a pragmatic approach to publicizing the activities. The findings of the study indicate that the activities were more widely publicised among the professional community than among the general public: Eighty percent of all respondents reported that the projects were presented within their organisations. Both Palestinian (72%) and Israeli (53%) respondents reported that their projects

had been publicised through external, professional forums, and about half of all respondents reported that their project had been publicised to the general public through the media. "However, a number of respondents noted that the media is often not interested in publishing stories on successful cooperation, because they are not sensational enough" (Barnea *et al* 2000:30).

Outcomes

a) *Health* — Positive outcomes were found in two areas: professional development, and health services improvement. The main benefits to professional development found were increased professional knowledge and skills, gaining cross-cultural knowledge, and professional networking. With regard to health services improvement, over three-fourths of the project directors said that the health-related goals of their project were achieved. Specific examples of health-related outcomes were noted for nine projects. These include:
   - *Training of health personnel* — specialist training of 23 Palestinian physicians; accredited training in family medicine for four Palestinian physicians; training of 380 teachers as health educators.
   - *Development of infrastructure* — contributing to the establishment of the Health Promotion and Education Directorate in the Palestinian Ministry of Health; establishment of a state of the art laboratory at a Palestinian university.
   - *Direct provision of service* to over 20,000 Palestinians in rural areas and 80,000 students in elementary schools.
   - *Generation of data* — to assist policy planning and development of intervention programmes in both the Palestinian Authority and Israel in the fields of adolescent health behaviours, leischmaniasis and beta-thelassemia.

b) *Conflict* — Outcomes measured related to the conflict include:
   - *Opportunities to meet and learn about each other* — Israeli respondents said they were able to learn first-hand about Palestinian people, their needs and their culture (as opposed to second-hand reports in the media), and Palestinian respondents said they learned about Israeli professionalism.
   - *Changing attitudes* — the work on a cooperative project showed the participants that cooperation is possible, enhanced the desire to live in co-existence and moderated views on the conflict.
   - *Spreading the word* — ninety percent of health professionals involved in cooperative activities shared their experiences with colleagues or friends.

   Neither the infrastructure development nor the cooperation could completely withstand the outbreak of violence in the years 2000-2002, which has led to severe health consequences for both populations. However, the relationships and projects developed in the years 1994-1998 and in the years that followed, offer the vision of a different way. Even at the height of the violence, with official channels closed down, this vision enables a small core of professionals and organisations committed to the HBP concept to continue working together.

Case 3: Reconciliation (and Peacebuilding) — Health Bridges for Peace in the Former Yugoslavia

The ultimate goal in conflict resolution is ending the conflict and reconciliation. The nature of current conflicts often make this goal appear unattainable, or something for the distant future — suggesting the multi-stage approach. However, there are people and groups willing to undertake the challenge of tackling the issues at the core of the conflict and bringing together people from both sides with the goal of reconciliation. Gutlove (1999) describes a HBP project in the former Yugoslavia whose aim is conflict prevention and community reconciliation.

Background and Local Conditions

a) *Conflict* — The Federal People's Republic of Yugoslavia was composed of six republics — Serbia, Croatia, Bosnia and Herzegovina, Macedonia, Slovenia and Montenegro — and two provinces — Kosovo and Vojvodina. Serbs, Croats, Muslims, Albanians make up just a few of the ethnic and nationalistic groups living in this region. Prime Minister Tito who ruled Yugoslavia from WW II to his death in 1980 imposed a pan-Slavic regime, which held all the various ethnic and nationalistic groups together. With his death, ethnic and nationalistic differences began to flare. In 1991, Slovenia and Croatia declared independence. Slovenia managed to break away with minor fighting, while four years of fighting resulted from the Croatian declaration of independence. In 1992, Bosnia-Herzegovina, the most ethnically diverse of the Yugoslav republics, declared independence, beginning a war that lasted almost three years. Conflict erupted in Kosovo in 1996, and by 1998 a full-scale war was under way. At the time of writing this article, Macedonia, which had previously been untouched directly by the violence, was feeling the 'winds of war' (Macedonia was touched indirectly by the violence, through the many refugees who fled the fighting in Kosovo).

b) *Health* — Saric and Rodwin (1993) debunk the myth of the unique 'socialistic' nature of the Yugoslav health care system and point out that the rhetorical commitment to primary care was not necessarily reflected in resource allocation. This notwithstanding, the socialist Yugoslav system can be credited with major advances in the health care system. By 1978, they had tripled the number of hospital beds, increased the number of physicians five-fold and extended health insurance coverage to 82% of the population. This trend changed in the 1980s, when Yugoslavia was hit by a severe economic crisis that affected health care providers and access to care. Following the break-up of Yugoslavia, the newly formed republics were left to build their health systems based on the legacy of the former Yugoslavia — both in terms of the health infrastructure that was left and the ethnic divides in which health professionals found themselves functioning. The active conflict placed a heavy toll on public health and health care delivery in those areas directly affected and in some instances the health system was drawn directly into the conflict. For example, hospitals could find themselves under attack, and were also sometimes used as military outposts.

HBP Programme

a) *Initiation* — The project was initiated in 1991, by local physicians in Slovenia, Serbia and Croatia who turned to an international organisation, the Institute for Resource

and Security Studies (IRSS), to learn skills of conflict management in response to the violent course the region was heading for. The IRSS had worked with a range of professionals throughout the region on dialogue and training workshops.

Gradually the work came to focus on the unique and crucial role that health care professionals, primarily physicians, can play, not only in mending the physical and psychological wounds of individuals but also in rebuilding structures for public health care and in creating bridges for community reconciliation (Gutlove 1999:11).

In 1996, IRSS launched the Health Bridges for Peace project.

b) *Goals and objectives* — The project aims to integrate conflict management techniques with other humanitarian efforts.

c) *Project components* — The project provides training for health care professionals in conflict management and community reconciliation techniques. It subsequently helps these professionals to design and implement community-based activities that integrate community reconciliation and conflict prevention strategies into health care delivery. The project evolved into a Medical Network for Social Reconstruction, bringing together health professionals from all parts of the former Yugoslavia.

d) *Project partners* — At the local level, it appears that individuals choose to participate. However, they bring back what they learn to the organisations they work with. The Network established a Contact Group, with members from all former Yugoslav states, to implement decisions and plan activities. The IRSS provided the 'know-how' and training in the conflict management field.

e) *Visibility* — This issue is not specifically discussed in the article. However, the conflict management orientation of the activities would seem to dictate some level of visibility.

Outcomes

a) *Health* — Concrete health programmes were a direct outcome of the project. They include: specialised surgical technique training of Muslim, Croat and Serb opthalmologists who now serve as a mixed-ethnic team in Bosnia-Herzegovina, and offering long-term care to child war victims from the Muslim-Croat Federation and Republic of Srpska at a pediatric facility in Montenegro. In addition, participants in the project are involved in integrating war-affected people, resettling refugees and displaced persons, and reconstructing health care delivery systems.

b) *Conflict* — Since 1996, the Network and the IRSS have convened five large meetings and numerous smaller ones, held in different parts of the region and bringing together hundreds of professionals from all areas of the former Yugoslavia. The Network itself has a membership of 100 professionals. Members of the Network maintain contact through e-mail and fax enabling them to ride out the political storms surrounding them. Projects include promoting sustainable processes for managing community conflict. In addition, the Network tries to influence the larger political climate. "When violence erupted in Kosovo in mid-1998, the Network issued a nonpartisan declaration. The declaration urgently asked all the parties to the conflict and the international community to 'recognize that the situation must not proceed to war, which would devastate the public health interests of all parties and be a crime against humanity.' Sadly, this statement of sanity and solidarity went unheeded" (Gutlove 1999:13).

Prognosis

Is the HBP concept naive? What can health professionals contribute in a situation of long-standing conflict? Gutlove (1999) appears to be optimistic, stressing the potential of the bridge. 'Health care providers can create a bridge of peace between conflicting communities, whereby delivery of health care can become a common objective and a binding commitment for continued cooperation' (p. 14) Tardiff (1998) is more cautionary, stressing the political realities in which these projects operate.

> Health humanitarian action does not necessarily promote peace by the simple virtue of approaching common concern and building consensus on health intervention among antagonistic parties. Rather, political revendications (demands) and the quest for justice and democracy sometimes appear more vital than defending the right to health (Tardiff 1998, Section 2:3).

The projects presented here show that HBP projects exist even in difficult political circumstances, have positive impacts in the health field, on the conflict at individual and local levels, but are very much at the whim of the political processes surrounding them.

While writing this article, a new cycle of violence erupted between Israelis and Palestinians. The subtitle of the article is 'reflections of a practitioner' and I cannot end the article without reflecting specifically on my work in HBP and how this crisis in the Israeli-Palestinian conflict has affected it.

Barnea *et al* (2000) conclude their report with the statement that "Peace is not merely the absence of war, but the opportunity to contribute to the health and welfare of all the people in the region' (p. 53). For the four years studied (1994-1998) and the two years following, in the absence of war and in the presence of a violent environment, Israeli and Palestinian health professionals worked together to contribute to the health and welfare of the people in the region.

For four years I have been directly involved in this cooperative process. It seemed that these efforts were an important part of building a new future — or at least a concept or a model for a new future — in the region, one based on shared work, mutual interests and mutual respect. The current hostilities are testing the boundaries and the essence of cooperation and the relationships it has forged; with the potential to be either the political straw that breaks the camel's back or an opportunity to raise the levels of commitment to cooperation, of the quality of the work, and of the interpersonal relationships.

Since the onset of the hostilities in September 2000 — which have taken a high toll in lives and living conditions — there has been dwindling cooperation. It has not, however, ceased. Organisations committed to life-saving and humanitarian efforts, such as the Palestinian Red Crescent Society and the Israeli Red Magen David, continued to look for ways to work together towards these goals, with the assistance of international bodies, such as the International Committee of the Red Cross (ICRC 2000). Personal relationships have also been maintained and sometimes even deepened. At the same time another trend is evident. As the conflict continues to escalate and the health sector becomes drawn directly into the conflict (as in the former Yugoslavia), cooperation is tapering off. This is characterized by the lack of new initiatives and the presence of strained relationships. However, as one professional still involved in cooperation put it: "For me today, cooperation is my island of sanity" (*Ha'aretz Magazine*, 9 August 2002).

As all three case studies show, health professionals in conflict areas are not immune to the political events surrounding them. However, in both the Israeli-Palestinian and Yugoslavian examples health professionals came together on their own initiative to work

on a shared professional agenda. It is the relationships they develop that have the potential to serve the future. The study of Israeli-Palestinian cooperation (Barnea, Abdeen *et al* 2000) found that the seeds of cooperation were sown during the conflict era in relationships developed among health professionals who worked together because of, or in spite of, the conflict.

When Israelis and Palestinians cooperate on an issue that is not at the heart of the political conflict, the political other is not at the heart of their cooperation, and this allows for interaction on a human level. At times when the political conflict heats up, the political other re-enters the cooperation, moving other issues aside. Whether the political conflict completely overtakes the issues at the heart of the cooperation depends both on the will to continue of those involved, and on the macro-political environment. (Garber, Mashal & Sugarman 2002: 25).

HBP projects are not a substitute for political processes. The relationships and values HBP projects generate can serve as important bridges between communities, especially during periods of conflict when political processes are at their weakest point.

RANDI GARBER, Senior Programme Manager, JDC-Middle East Programme in Jerusalem, develops and implements cooperative projects between Israeli and Palestinian professionals in the fields of health and rehabilitation.

Endnotes

1. Much of the material for this paper was collected for a literature review (Garber, Mannor and Barnea 2000, 1998) undertaken as part of the Study of Israeli-Palestinian Cooperation in the Health Field, 1994-1998 (Barnea *et al* 2000).
2. I am indebted to all those on whose work this paper is based. I am particularly indebted to Tardiff (1998) and Gutlove (1999) whose documentation of their work in Haiti and the former Yugoslavia are the basis for the examples presented here.
3. A detailed project desciption can be found in the final project report of the Child Development Programme in Idna Village (Garber, Mashal & Sugarman 2002), which brought together 40 Palestinian and Israeli professionals to provide services to 134 children and their families.

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