WHO/DFID
Peace Through Health Programme

A case study
prepared by the WHO Field Team
in Bosnia and Herzegovina
September 1998
EUROPEAN HEALTH21 TARGET 9

REDUCING INJURY FROM VIOLENCE AND ACCIDENTS

By the year 2020, there should be a significant and sustainable decrease in injuries, disability and death arising from accidents and violence in the Region

(Adopted by the WHO Regional Committee for Europe at its forty-eighth session, Copenhagen, September 1998)

Keywords

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BOSNIA AND HERZEGOVINA

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Summary

War is death but life without war is not the same as to live in peace.

The first principle of health is life. War is a direct and severe threat to life. For millions of people worldwide, surviving war is the predominant objective in their daily existence. Ending war would be the first step towards health and wellbeing in the any sense of these ideal conditions.

The war in Bosnia and Herzegovina (BH) was particularly brutal in its intensity and savage destruction of life and land. And although the fighting has been halted, life after war is not peace. Populations continue to be polarized, manipulated and scared. Opportunities for reconciliation are limited by the structures imposed by the Dayton Peace Agreement and the factional leaders who are supposed to implement it faithfully.

WHO/DFID Peace Through Health programme

The Peace Through Health (PTH) programme is a collaborative endeavour of the World Health Organization (WHO) and the Department for International Development (DFID) of the United Kingdom. Integrating WHO’s health sector development work and DFID’s conflict resolution mandate, PTH is a concerted and intensive attempt to address the fundamental obstacles to peace through health sector development.

Peace Through Health programme design and strategies

The PTH programme was designed to address key barriers to the formation of a democratic civil society: polarization, manipulation of information, discrimination, centralization of authority and power, isolation, and violence. Taken as the factors at the root of the Bosnian conflict, they will continue to predispose BH to renewed conflict unless addressed. They will continue to promote a systematic transfer and augmentation of prejudices to future generations. Consequently, these factors prevent or hinder the achievement of real health gains. Each of these issues is present in the health sector and/or has a severe influence on health and health care delivery.

The PTH strategy was integrated horizontally through all WHO BH programmes. Through a network of field offices, WHO has been able to implement a wide range of activities at various levels of the health system. Activities sought to address priorities in the health sector through strategies which contributed to peace-building processes. The principles and strategies of PTH are outlined in detail in this paper by Gregory Hess, Project Officer, PTH.

Outcomes

The success of the PTH programme will be told over time. However, it is fair to say that the health sector has been the most progressive in terms of reconciliation. The PTH programme has been the primary health sector catalyst in this process.

PTH directly addresses barriers to peace in order to create conditions conducive to health and wellbeing. In some senses, PTH is an imposition of ideals. However, no programme can impose peace, and in no sense does PTH try to do that. What PTH tries to do, and has successfully done, is to create opportunities for peace. It is empowering people who wish to live in and contribute to peaceful environments. It is giving people choices for peace which they otherwise would not have. And it promotes principles which are fundamental to a peace culture.
The direct outcomes of the PTH programme activities are outlined in this case study. They have occurred on all levels of the health sector and across many fields. To a large degree, the PTH programme has also become a model for programme implementation among a variety of international and local nongovernmental organizations (NGOs). The international health community has contributed to de facto division of Bosnia and Herzegovina by operating separate programmes in each politically controlled area. PTH broke this barrier and has enabled many NGOs to implement inter-ethnic programmes.

**Conclusions**

We are a long way from true peace in Bosnia and Herzegovina. Health is just one of many sectors and is subject to events at higher political levels. However, the challenges we are facing clearly highlight the advantages, and indeed the imperatives, of integrating peace-building concepts and strategies into post-war health sector reconstruction. For WHO, to view contributions to peace-building as extraneous to our technical role is at best myopic, at worst negligent. In a situation with such high levels of misinformation and polarization, health and wellbeing will forever be held prisoners to fear and insecurity until these obstacles are addressed. Each side has demonised the other to the point where it is not possible to feel secure. More than two million people are displaced from their homes and deserve the opportunity to return. Discrimination (in many forms) is rampant throughout health care services. The personal contact facilitated by PTH is crucial to dismantling negative and prejudiced stereotypes and therefore crucial to the creation of healthy environments. These outcomes are discussed throughout this case study and evaluated through the use of anecdotal evidence and statistical data.

PTH is not a model per se. It is a conceptual step forward in how we tackle the challenges of health development in politically complex situations. As the first sustained practical integration of peace-building and health development, PTH has clearly highlighted the need to clarify organizational mandates, principles and positions. It has also placed new demands upon field staff and identified specific staff support requirements. These issues are likely to be relevant to many organizations operating in complex political emergencies.
Acknowledgements

The Peace Through Health programme is a product of numerous individuals and contributions.

Through their dedication and principled humanitarian actions, WHO staff members working throughout the war placed WHO in the unique position to be able to take on the challenge of peace-building in the post-war.

The United Kingdom Department for International Development (DFID) and, in particular, Dr Mukesh Kapila have been invaluable supporters of WHO. Dr Kapila must be credited with encouraging WHO to tap the potential of the health sector as a viable contributor to sustainable peace.

Mrs Judith Large and Mr Robert Holden have made outstanding contributions as technical representatives of DFID. Their participation throughout the programme has been very much appreciated and enjoyed.

The entire WHO mission in Bosnia and Herzegovina would not be possible without the support of numerous donor countries. In particular to the PTH programme, the support of the United States Department of Population, Refugees and Migration to maintain WHO Field Offices has enabled PTH to operate on all levels throughout the country.

The Partnerships in Health and Emergency Assistance unit of the WHO Regional Office for Europe has the enormous responsibility of implementing humanitarian assistance programmes and, in spite of some difficult constraints, has appropriately adapted policies and strategies to the evolving demands of conflicts in the European region.

PTH is a strategy that cuts across all WHO programmes in Bosnia and Herzegovina. As such, the necessity for teamwork is extremely high. Perhaps serendipitously, the team in BIH was very close. The mutual respect and complementing personal and professional attributes produced an inspiring and fruitful synergy in a very challenging and often frustrating environment. We would all be so lucky if every team were as this one.

Finally, the “local staff”, although included in the aforementioned team, deserve special recognition. Their dedication to the objectives and principles of WHO is exemplar. Their patience and humour in dealing with the ways and attitudes of “internationals” were quite fortunately inexhaustible. It is the local staff who gave meaning to our work, for our work is their future.
**Acronyms**

BIH         Bosnia and Herzegovina
CDC         Centers for Disease Control, USA
DFID        Department for International Development, United Kingdom
DPA         Dayton Peace Agreement
ECHO        European Commission Humanitarian Office
EURO        World Health Organization, Regional Office for Europe
FBIH        Federation of Bosnia and Herzegovina, together with the Republika Srpska (RS), one of two political entities formulated in the Dayton Peace Agreement
FRY         Federal Republic of Yugoslavia (Serbia and Montenegro)
IEBL        Inter-Entity Boundary Line, the demarcation between the two constituent entities (FBIH and RS) of Bosnia and Herzegovina
IFOR        Implementation Forces (Multinational peace-keeping military led by NATO)
IGO         Intergovernmental organization
IMC         International Medical Corps
MoH         Ministry of Health
NATO        North Atlantic Treaty Organization
NGO         Nongovernmental organization
OHR         Office of the High Representative
PHC         Primary health care
PHI         Public health institute
RS          Republika Srpska, together with the Federation of Bosnia and Herzegovina (FBIH), one of two political entities formulated in the Dayton Peace Agreement
SFOR        Stabilization Forces, successor to IFOR.
STF         Sectoral Task Force
UNDP        United Nations Development Programme
UNESCO      United Nations Education, Scientific and Cultural Organization
UNHCR       United Nations High Commissioner for Refugees
UNMiBH      United Nations Mission in Bosnia and Herzegovina
WHO         World Health Organization
Introduction

In the midst of the most atrocious conflict on European soil since the Second World War, WHO embarked on a course of health diplomacy, initiating discussions with Bosniak, Bosnian Croat and Bosnian Serb health authorities on the possibility of a tripartite meeting to address common problems, an initiative finally realized in Copenhagen, April 1994. Further, covert meetings between public health professionals began at the UN-controlled Sarajevo airport under WHO auspices in early 1995 to discuss public health measures to protect civilian populations from further suffering. In the post-war period, WHO has continued to bring together health authorities and professionals to discuss common health issues. These efforts to address mutual health concerns are being developed into a unique strategy to strengthen peace processes: Peace Through Health.

The purpose of the WHO/DFID Peace Through Health programme is to catalyse and strengthen peace processes through the integration of peace-building and capacity for reconciliation into health development. The project is intended to address structural and social aspects of peace-building. Concrete activities implemented by WHO contribute to group and institution building for viable post-war reconstruction while relationship building fostered by the WHO staff facilitates renewal and healing.

This document is a case study of the PTH programme supported by DFID and implemented by the WHO team in Bosnia and Herzegovina. The aims and intentions of this document are manifold:

- to identify results and achievements of the WHO/DFID Peace Through Health programme;
- to highlight some of the principles and strategies which may be applicable by WHO in conflict situations around the globe;
- to stimulate partners in the health sector to think about how their programmes may be valuable contributors to peace processes;
- to identify organizational conditions and individual skills which are necessary for developing and implementing PTH approaches;
- to contribute to the growing debates and discussions surrounding conflict resolution and peace-building;
- to influence policy-makers in order that the tragedy that has befallen the Bosnian people strengthens global commitment to mitigate the impact of ongoing conflicts and to prevent future ones.

Due to the complexity and depth of the many issues which transcend PTH, discussions of many theoretical concepts raised in the case study are by necessity cursory. Reference documents listed in Appendix IV devote detailed attention to these issues. Emphasis in the case study is on experiences in BIH and lessons learned.
Historical and political background

The Socialistic Republic of Bosnia and Herzegovina was one of the six constituent republics of former Yugoslavia. The others were Croatia, Macedonia, Montenegro, Serbia (including the two autonomous provinces of Kosovo and Vojvodina) and Slovenia. The violent breakdown of Yugoslavia 1991 - 1995 has led to formation of five independent republics: Bosnia and Herzegovina (BIH), Croatia, Federal Republic of Yugoslavia (Serbia and Montenegro), the Former Yugoslav Republic of Macedonia and Slovenia.

Ethnically, the pre-war BIH population of 4.39 million people was more mixed than that of any other former Yugoslav republic. The proportion of mixed marriages was high, as was the number of people unable or unwilling to identify themselves in any of the three main ethnic/religious groups of Bosniaks (Muslims), Croats (Catholics) or Serbs (Eastern Orthodox). This was especially true in bigger cities like Sarajevo and Mostar, whereas the villages in countryside tended to be more clearly ethnically defined.

After Slovenia and Croatia declared themselves independent and gained international recognition in 1991, Bosnia and Herzegovina as a republic was left with two options: to declare independence or to remain a part of “rump-Yugoslavia”, now clearly dominated by Serbia and its President Slobodan Milosevic. During the subsequent referenda (one for Bosniaks/Bosnian Croats, one for Bosnian Serbs) in February 1992, roughly one-third of the BIH population, predominantly Bosnian Serbs, chose the latter option, while the majority (2/3) strongly favoured independence.

As the result of these referendum, BIH declared itself independent on 1 March 1992, gaining international recognition almost immediately. The war in BIH started in April 1992, as the Bosnian Serbs sought to carve out an ethnically homogenous state. By mid-1993 Bosnian Croat forces, supported by neighbouring Croatia, were fighting to define and control their own ethnically homogenous territory, leaving the Bosniaks to fend for themselves. Between the three armies and three political agendas, no areas of the country were untouched. The fighting lasted for 3.5 years until September 1995, interrupted only for short periods by countless cease-fires. A formal end to war in BIH was reached when all three sides (with the Bosnian Croats and Bosnian Serbs represented by the presidents of Croatia and Serbia, respectively) signed the Dayton Peace Agreement in November 1995 and the Paris Accords in December 1995.

During the war and “ethnic cleansing” in BIH, an estimated 200,000 people were killed or went missing, a similar number were injured, over one million people left the country, approximately one million were displaced internally, and widespread destruction of infrastructure and housing occurred, including about 35% of the health care facilities. The young and middle-aged, well educated population group was over-represented among those who left the country, leading to a significant and irretrievable brain drain.
Bosnia and Herzegovina in the post-Dayton period

One country, two entities, three ethnicities and the international community

The Dayton Peace Agreement (DPA) served two vital functions of peace in BIH: it stopped the fighting and it recognized complete sovereignty of BIH from Croatia and the Federal Republic of Yugoslavia (FRY). However, while the DPA maintained the territorial integrity of Bosnia and Herzegovina, it separated the country into two political entities. The Federation of Bosnia and Herzegovina (FBIH) is one entity, under the combined leadership of the Bosnian Croats and the Bosniaks. Republika Srpska (RS) is the second entity and is governed by the Bosnian Serbs. A tripartite presidency and Council of Ministers overarch the two entities. The Council of Ministers is comprised of three portfolios: Foreign Affairs, Civil Affairs, and Finance and Trade. All other governmental departments, including health, education, agriculture, and defence, are administered independently in each entity. Thus, for many domains (including health), BIH has two internationally recognized Ministries.

1996: no war, no peace

For the people of BIH, the signing of the DPA sparked a wave of euphoria which unfortunately would dissipate into fatigue within a few months as the realities of the reconstruction processes set in. The “return to normal” would be an extremely long process. Freedom of movement and communication between the entities was impossible. Security fears dominated a population which remained extremely vulnerable to manipulation and polarization strategies of the nationalists. Tensions were easily inflamed and practical implementation of aspects of the DPA, such as the transfer of Serb-held suburbs of Sarajevo to the FBIH in March 1996, resulted in widespread violence and destruction.

Politically, the general elections of 1996 created a façade of reintegration. The creation of parallel systems and mandated tripartite representation strengthened polarization around nationality and reinforced authoritarian control. Radovan Karadzic, although indicted as a war criminal, continued to control the political and economic machinations of the RS. Thus the Bosnian Serbs remained isolated by the international community and, through their leadership’s refusal to participate in structures created by the DPA, chose a path of isolation. FBIH on the other hand was extremely fragile. An evolution of a partnership forged to survive the war, the Bosniaks and Bosnian Croats were bound by the DPA to something akin to a forced marriage.

Although the DPA places the onus of implementation upon the signatories, two international bodies are assigned the arduous task of ensuring that the DPA is adequately implemented. The Implementation Forces (IFOR) and its successor the Stabilization Forces (SFOR), both led by the North Atlantic Treaty Organization (NATO), are responsible for overseeing military aspects of the DPA. The Office of the High Representative (OHR) is mandated to implement civilian aspects of the accords. Other agencies are designated lead agencies for specific elements of the DPA. For example the United Nations High Commissioner for Refugees (UNHCR) is responsible for Annex 7 of the DPA regarding refugee and displaced person returns. WHO leads the reform and reconstruction of the health system.

With the influx of scores of international agencies [ranging from small nongovernmental organizations (NGOs) to large intergovernmental organizations (IGOs) such as the United Nations Mission in Bosnia and Herzegovina (UNMiBH), the World Bank and the European Union], changes in the international community represent the biggest immediately perceivable changes heralded by the signing of the DPA. Throughout the war, UNHCR effectively led the
international relief agencies. Unfortunately, the transition from relief to development has been poorly coordinated and unhealthy competition within the international community has diluted the impact of international investments. This is in large part due to unclear mandates and poor pre-intervention communication between various agencies and international bodies.

**Recent developments**

The past year and a half (1997–1998) have seen political struggle continue between the two BIH entities. At the same time, the international community through its High Representative has taken a more pro-active role in pushing through initiatives essential for establishment of a modern state. These include a common flag, passports, vehicle registration plates, a Central Bank and a common currency. The replacement of the old vehicle registration plates (three different kind of plates showing national emblems) with the new, neutral ones is almost finalized. New, neutral and common vehicle registration plates carry a special significance in terms of freedom of safe movement for all citizens of BIH in all parts of the country.

In addition to the political struggle between the two entities, internal divisions restrict the pace of progress. In FBIH, a strong power-game continues between the constituent parties (Bosnian Croats and Bosniaks). In RS the political division between the Pale-based hardliners in eastern RS and more moderate powers in Banja Luka in western RS intensified during the past year, leading finally to the nomination of a new government, based in Banja Luka and a new Prime Minister, Milorad Dodik. This move has been met with great enthusiasm from the international community, giving promise to more adherence to the obligations outlined in the DPA and, in return, a more equitable division between the entities of international support for reconstruction in the near future. (International aid distribution in 1996 was estimated by some to have been 98% to the FBIH and only 2% to the RS.) Unfortunately, elections held at the time of writing this report seem to indicate a shift back towards nationalist policies in Bosnian Serb and Bosnian Croat areas but the short- and long-term implications of the results are not yet clear.

Security remains a central concern. On the national level, military strengthening on the FBIH side under the US-sponsored ‘Equip and Train’ programme fuels speculations of a Muslim attack. From the other side, recent history, continued influence from Croatia and FRY, the lack of external borders, and possession of a very difficult territory to defend leave the Bosniak leadership with no alternative other than to be prepared for the worst-case scenario.

At the community level, minority returns have been deterred through violence and destruction. Police, particularly in rural RS and Croat parts of FBIH, represent the interests of the ruling parties and have consistently failed to prevent or respond to violence against returning minorities. The implementation of common licence plates and continued work with the UN International Police Task Force, whose role is to help train the police forces according to international policing standards, will hopefully alleviate some of these security concerns.

One of the most promising developments in the past year has been the progress towards justice. Without even symbolic justice, significant strides in reconciliation are not possible. However, the tenacity of the International Criminal Tribunal for the Former Yugoslavia and the support it has received from SFOR have led to the arrests of a significant number of indicted war criminals. While the “biggest” of these are not yet in custody, international vigilance has forced indicted war criminals into hiding, reassuring the public that at least a measure of justice will be served.

**The health sector**

Throughout the war, WHO served as the public health adviser to UNHCR and as the lead health agency responsible for coordinating international humanitarian health assistance. Following the
war, WHO was asked by the World Bank to chair the Sectoral Task Force on Health and Social Reconstruction. Numerous partners (United Nations agencies, IGOs, NGOs) played large roles in continued humanitarian assistance throughout the transition phase and in the reconstruction of health and social services.

In broad terms, WHO and its health sector partners faced two enormous challenges following the Dayton Peace Agreement. The first and most obvious challenge was restoring a health system following nearly four years of war. In addition to widespread destruction and disrepair, obsolete equipment and the loss of large numbers of health professionals, the BIH health system also faced the need for substantial reforms given the as-yet-unaddressed challenges of transition from a socialist to free-market economy.

The second principal challenge faced by WHO was the ethnic divides in the health sector. Two formal systems had been created by the DPA, each with its own Ministry of Health. Furthermore, in practice, the FBIH health system was divided between the Bosniak and Bosnian Croat populations under a cantonal system. These divides extended very clearly through all aspects of health care delivery, including health system financing, service provision, and professional training.
WHO in Bosnia and Herzegovina

All of the WHO BIH programmes are coordinated by the central office in Sarajevo and implemented through a network of field offices. Currently, WHO field offices are located in Banja Luka, Bihac, Mostar, and Tuzla-Brcko. PTH activities are horizontally implemented through all WHO programme areas. A cursory overview of the main WHO programme areas and principal objectives is given below.

National strategic health planning
1. To assist the Ministries of Health in the development of strategic plans for health system reform and reconstruction.
2. To help the Ministries of Health in the implementation of reforms.

Health care services

Primary health care
1. To reorient hospital-based and specialist-delivered services inherited from the former socialist system into a community-based primary health care approach.
2. To train and equip Family Medicine teams.
3. To promote a fundamental philosophical shift among health care providers and receivers alike.

Mental health and vulnerable groups
1. To improve the wellbeing of vulnerable groups through the modernization of approaches to mental and social health.
2. To integrate mental health services with community-based primary health care provision.
3. To reduce discrimination against and social exclusion of vulnerable groups.

Community-based rehabilitation
1. To develop and adapt physical, mental and social rehabilitation programmes into an integrated approach which emphasizes community involvement.

Public health
1. To strengthen disease surveillance and control programmes.
2. To improve the skills of Bosnian public health workers.
3. To introduce and strengthen health promotion strategies.
Inception of the Peace Through Health programme

The concept of formulating a specific PTH programme in BIH evolved during discussions with DFID, then called the Overseas Development Administration (ODA), in late 1996. Throughout the war, WHO established working relations with health professionals and officials on all sides of the conflict. In 1993 WHO began discussions with Bosniak, Bosnian Croat and Bosnian Serb health authorities on the possibility of a tripartite meeting to address common problems, an initiative finally realized in Copenhagen, April 1994. Further, meetings between various health representatives began in Sarajevo under WHO auspices in early 1995, nearly a full year before the end of the war.

DFID has been working in Bosnia and Herzegovina since the beginning of the war and has in-depth knowledge and documentation of the complexity involved in post-war reconstruction. The DFID mandate for conflict reduction takes into account the cycles of recurrent violence possible in the absence of conflict preparedness, prevention measures, and mitigation. The reconciliation of groups within divided societies is an essential element in any sustainable peace.

In this vein, DFID was keen to help WHO to build upon its well-established relations and to promote the health sector as a catalyst for peace. DFID supported WHO in its first post-Dayton year as it moved from a war-time relief delivery role to an effective presence in the gradual normalizing of health policy and service development. Thus the PTH initiative was spawned from DFID’s commitment to conflict reduction and WHO’s well established position in BIH.

The PTH programme aims to integrate health development and conflict resolution. The programme was developed and periodically reviewed by the entire WHO field staff together with a conflict resolution specialist from DFID. The conceptual framework in the form of a project proposal was developed in March 1997 (attached as Appendix III) and the project effectively began in September. A reflective “taking-stock” workshop was held in March 1998. DFID review missions took place in December 1997 and again in April 1998. The content of this case study is largely derived from these team planning and evaluation sessions.

The value of the innovative, professional, and technically interactive manner in which DFID operated cannot be overstated. In this regard, it is the opinion of the WHO BIH field team that this type and quality of cooperation created better working conditions for WHO field staff, improved feedback to and involvement of the donor agency and, ultimately, produced stronger results for the people of BIH.

Intent and design of the Peace Through Health programme

Much literature and discussion has been produced in recent years surrounding the notion of “civil society”, the social and legal parameters which shape and curb interaction between individuals and between groups. These parameters dictate social norms and form the criteria for making distinctions between acceptable and unacceptable behaviour. In a democratic civil society, peace is ensured by a common respect for individual human rights, by governments which protect these rights for all citizens, and by institutions (e.g. media, education, economic) which independently affirm and reinforce these rights. In a war-torn region such as the former Yugoslavia, fundamental aspects of a democratic civil society are deficient and/or entirely absent.
The WHO/DFID team took this as the conceptual starting point for developing the PTH programme. In the initial workshop in March 1997, six conditions were identified which together prevent the development of a democratic civil society in BIH:

**Polarization** – forcing people to identify with one of the groups in conflict where discussion, middle ground, or alternative choices are generally not viable options. In BIH, polarization has occurred on the bases of religion, political ideology, ethnicity and urban/rural residency.

**Discrimination** – lack of tolerance/acceptance of people with one or several characteristics differing from those of the group which holds the power (in various forms). In BIH, “traditional” vulnerable groups have been augmented by discrimination following (and resulting from) the war.

**Manipulation of information** – changing, falsifying or misrepresenting information to polarize groups, stigmatize opponents, and strengthen positions of power. For example, in the education sector, each side is actively re-writing history, language and cultural heritage. The media is also a critical institution in this determinant of peace.

**Centralization of power and authority** – the over-reliance on hierarchical structures and central authorities, particularly characteristic of formerly socialist countries, whereby the active participation and contributions of individuals are restricted or discounted.

**Isolation** – the exclusion of individuals, vulnerable groups, or communities from social networks, information, and the “outside world”. Isolation makes communities susceptible to manipulation and polarization, prohibits freedom of individuals, and feeds into a cycle of competitive victimhood whereby no side can overcome their grievances and move forward to a peaceful co-existence.

**Violence** – an outcome of the absence of peaceful conflict resolution methods. Four years of war have legitimized violence as a means of problem solving.

Taken as the factors at the root of the Bosnian conflict, these conditions will continue to predispose BIH to renewed conflict unless addressed. They will continue to promote a systematic transfer and augmentation of prejudices to future generations. Consequently, these factors prevent or hinder the achievement of real health gains. Each of these issues is present in the health sector and/or has a severe influence on health and health care delivery. Thus the WHO/DFID Peace Through Health programme is an attempt to improve health and wellbeing by addressing these issues through health sector activities.

**Peace Through Health is as much about processes as outcomes.** The principal process is the transformation of a conflict-ravaged and communist society into a democratic civil society. In this process, there is no perfect end-state; determinant variables such as those listed above never evolve into flawless and static conditions. Furthermore, the process of implementing the PTH programme in itself initiated several other processes. For WHO, PTH has been a very healthy learning process, expanding traditional conceptions of health development, forcing intense scrutiny of principles, positions and strategies. For the donor community it may provide lessons in how to optimize relations with implementing partners and how investments of today can, with conceptual innovation, produce stronger returns for tomorrow.
An overview of Peace Through Health

The intersection of health development and conflict resolution is both broad and deep. Accordingly, WHO’s PTH initiatives work on many levels and through many channels. Fig. 1, created during one of the team PTH evaluation sessions, is a very good visual depiction of the aims and challenges of PTH. Although it may appear complicated, it is a concise visual representation of an extremely complex situation.

The large outer circle is a graphic representation of BIH. The three transversal lines depict the physical separation of Bosniaks, Bosnian Croats, and Bosnian Serbs. The area of intersection in the centre signifies remaining areas of the country where ethnic heterogeneity remains. The three intersections on the sides represent areas where two ethnicities are integrated. The areas encompassed by each transversal line are approximate representations of population proportions.

The large ovular spheres represent the nationalistic forces within each ethnicity. These forces vary in the amount of the population they encompass and, within each sphere, in the unanimity of objectives. As indicated by their positioning, the nationalistic spheres of Bosnian Croats and Bosnian Serbs have an obvious and significant overlap with neighbouring Croatia and FRY, respectively.

Within a simplified conceptualisation of the health sector exist “health authorities” and “health professionals”. “Health authorities” are considered to be those who administer the health sector and define health policy. “Health professionals” encompasses a wide range of practitioners. The
health authorities of each faction vary in their adherence to nationalist aspirations, although the health authorities in all parts of BIH have proven largely to be obstructionist in regard to inter-factional cooperation. However, on an individual basis, health professionals tend to be willing to collaborate in cross-community activities.

A principal PTH objective has been to create opportunities and environments where both health professionals and health authorities can interact and can recognize their potentials and obligations to create healthy, peaceful environments. A summary of principal achievements of the PTH programme is presented in the next section. This is followed by an outline of the principles and strategies by which WHO has been attempting to promote the health sector as a catalyst for peace.
Summary of principal Peace Through Health achievements

Peace-building is the creation of “tangible and intangible conditions to enable a conflict-habituated system to become a peace system”. (Institute of Multi-track Diplomacy, 1996) The achievements which constitute WHO’s principal peace-building efforts (although not exclusively PTH programme activities) are listed below under the three types of peace-building approaches which are necessary for the successful transformation to a peace system: political, structural and social. Some of these achievements preceded the inception of the PTH programme while others, which were not funded by PTH, were made possible by the organizational positioning and policies stimulated by the PTH programme.

Political peace-building

Political peace-building is the formation of agreements and political arrangements that provide the overall context within which to understand the relationships of the various parties and their resources. It is about building a legal infrastructure that can address the political needs and manage the boundaries of a peace system.

- **Regular meetings of the Ministers of Health.** In the immediate post-war period, prior to the formal inception of PTH programme, WHO brought together the Ministers of Health from both entities in the World Bank Sectoral Task Force (STF) meetings, a forum for governments, international agencies, and donors to discuss reform and reconstruction of the health sector. Bringing together the Ministers only three months after the DPA was unprecedented in the post-war reconstruction of BIH. The STF meetings promoted at least four fundamental aspects of peace-building: they fostered direct communication in non-threatening environments; they promoted a neutral transfer of information; they addressed issues of mutual concern; and they provided incentives for cooperation and collaboration. The precedent established by the STF enabled “informal” ministerial meetings as needs required in WHO offices.

- **Joint statement to the international community.** With WHO as a mediator, the Ministers of Health outlined the common foundations of their health care systems in a joint statement signed in September 1996. At a time in which the peace was still extremely fragile, no other sector had made such a significant public gesture.

- **Strategic plans for health system reform and reconstruction.** With the guidance of WHO, both MoH have completed the legal frameworks for their health care systems. In principle, both entities have adopted a primary health care approach which ensures equity, equality, efficiency, affordability and accountability in health care delivery.

- **Communication and collaboration between public health directors.** In 1997, WHO served as an intermediary between RS and FBIH public health directors, delivering messages by hand. (The first was a request for employee records of two elderly women seeking their pensions.) Now communication is constant between the two directors and has led to collaboration on many public health issues.

- **Health for all national conference.** With WHO, the public health directors and MoH representatives convened a three-day seminar with presentations from both sides on how to achieve Health For All targets for Bosnia and Herzegovina.
WHO/DFID Peace Through Health case study  Summary of principle Peace Through Health achievements

- **Common mental health services reformation plans.** Mental health services are in need of drastic reforms. Both entity representatives have been working together through WHO to develop common mental health care systems.

- **Joint statement on mental health.** The mental health coordinators have drafted a joint statement to highlight progress in their reforms and the need for continued support. The statement has yet to be signed by the Ministers of Health.

- **Common pharmaceutical guidelines and draft legislation.** Prescribing practices and pharmaceutical dispensation systems are also in need of substantial reforms. Under WHO auspices, the pharmaceutical experts have been harmonizing reforms, especially in areas which require consensus, for example import regulations.

**Structural peace-building**

Structural peace-building encompasses activities which create structures – systems of behaviour, institutions, concerted actions – that support the embodiment or implementation of a peace culture.

- **Inter-entity advanced epidemiology workshop.** Implemented with CDC USA, this two-week course set the precedent for inter-entity seminars. In spite of obstruction from FBIH authorities, the course was completed with participation from both entities, including the first overnight stays of health professionals in the other entity.

- **Advanced Cardiac Life Support instructor certification course.** Participants were brought together for a week-long instructor certification in emergency services and then supported to train other health professionals in their home community. Implemented with International Medical Corps (IMC).

- **Mostar Continuing Education Centre and lecture series.** With the support of WHO and ECHO, the Mostar Continuing Education Centre was set up in the same building as the WHO offices. Professionals from both sides could access the centre on their own time and a weekly lecture series, arranged alternatively by the two sides, brought professionals together for information sharing and discussion.

- **Freedom of movement agreements between Ribnik (RS) and Kljuc (FBIH).** In an area where the roads of the two entities are intertwined, WHO negotiated with municipal authorities to allow freedom of movement for ambulances and reciprocal treatment of emergency cases.

- **Polio national immunization days.** WHO together with Rotary International, UNICEF and SFOR, assisted the health authorities to implement national immunization days to halt the possible spread of poliomyelitis.

- **National tuberculosis programme.** TB coordinators from both entities have been selected and trained by WHO. Data is collected within each entity and sent together to WHO EURO. The coordinators have worked together on TB control plans and public awareness campaigns.

- **HIV/AIDS awareness campaign.** Using communication materials developed by local NGOs, a common public awareness campaign was implemented across BIH.
WHO/DFID Peace Through Health case study  Summary of principle Peace Through Health achievements

- **Countrywide no-tobacco network.** No-tobacco focal points from both entities participated together in a pan-European conference. Upon return, they have presented their experiences together and helped WHO to initiate a no-tobacco network of health professionals, building upon the energies of localized campaigns.

- **Common National Environmental Health Action Plan.** With the support of the Environment and Health Department in EURO, it is expected that the public health directors will complete a single, common environmental action plan.

- **Inter-entity tree planting and environmental awareness campaign.** Upon the initiative of a local environmentalist, WHO helped to recruit local NGOs and logistical support from SFOR to implement a very successful inter-entity grass roots campaign. The significance of the local initiative is a rare and positive break from the normal authoritarian approach. The event has led to discussions of forming an inter-entity environmental advocacy group.

- **Public health field workers’ manual.** Former co-workers from Doboj have come together to produce a joint field manual for public health workers. The manual is proceeding in spite of obstruction from RS authorities.

- **Domestic violence seminar.** In response to a large and very much hidden need, WHO organized an inter-entity and multisectoral seminar to address domestic violence. Participation of local authorities, local NGOs, and international agencies was very high and raised a great deal of public awareness to the issue of violence and the need for multisectoral responses.

- **Pharmaceuticals sector training.** Through WHO EURO, training programmes for pharmaceuticals professionals have brought the entities together to discuss new approaches and common issues. Several professionals have participated in external field studies with WHO Collaborating Centres in Europe.

- **Children’s dental health programme.** Implemented with SFOR (UK), a preventive programme to improve dental health among children has been launched in the highly sensitive inter-entity area commonly referred to as the “Anvil”.

- **National Family Medicine Conference.** Family medicine practitioners, including those being trained in Celinac (RS), discussed the transition to primary health care in this conference held in Sarajevo, November 1997. Previously, inter-entity family medicine discussions had been limited to MoH representatives.

**Social peace-building**

Social peace-building is relationship building to deal with feelings, attitudes, opinions, beliefs, values and skills as they are held and shared between peoples, individually and in groups. It is about building a human infrastructure of people who are committed to engendering a new culture, a “peace culture”, within the fabric of communal and intercommunal life.

- **International medical students conference.** More than 20 countries were represented in a conference entitled “Medicine, War & Peace” held in Sarajevo. With WHO’s support and encouragement, students from Banja Luka attended, the first post-war contact between the students. This conference and subsequent WHO-assisted negotiations have initiated working relations between Medical Student Associations.
**Inter-faculty medical student journal.** Each faculty (Banja Luka, Sarajevo, Tuzla) independently requested a medical students’ journal. Through mediated discussions, the format and process of journal production has been agreed. Numerous obstacles have delayed production but the first issue is expected in September 1998.

**STOP AIDS international summer school.** The PTH programme sponsored joint medical student participation (2 from each faculty) in this two-week programme.

**Inter-entity community house.** Through a local NGO, inter-entity discussion groups for health and social issues have been created for (primarily displaced) women from both sides of the IEBL. Located in a destroyed suburb of Sarajevo, the centre offers a unique programme of social, informational and recreational activities.

**Youth leadership training summer camp.** Implemented by the local NGO “Danas za bolje sutra” (Today for a better tomorrow), youth from across BIH participated in a peer educator training programme. These youth will be further supported to help use their skills in their local communities.

**Health promotion inter-entity workshops.** After months of obstruction and negotiations, health promotion workshops in Bosanska Krupa (FBiH) and Novi Grad (RS) were successfully held, uniting former colleagues in a very emotionally intense seminar.

**Doboj seminar series.** In partnership with the Atlas Project of Decentralised Cooperation, a seminar series for health professionals was implemented in the divided and volatile city of Doboj. Attendance swelled with each successive workshop and the series has spawned a number of independent initiatives.

**Doboj Physicians Association.** One initiative resulting from the above series is the locally-driven formation of a Physicians Association for all colleagues of the pre-war Doboj region. Physicians are coming from across the country and even from outside BIH to attend the meetings. WHO has been asked only to lend its moral support to the meetings to help ensure a level of comfort for all participants.

**Joint participation in European workshops.** External training is a key strategy of both peace-building and health sector capacity building. Entity counterparts have attended European workshops in numerous fields (occupational health, World AIDS Conference, nursing, family medicine, tuberculosis, no-tobacco and others).

**Facilitation of regular contact between health professionals.** One of the most important accomplishments of the PTH programme has been the renewal of contacts between professionals and former colleagues. Without the PTH approach, these would have taken years to develop or perhaps even never developed. The initial contacts facilitated in neutral environments by WHO staff are now leading to very encouraging self-initiated contacts.

**“Health Bridges for Peace” international conference.** WHO BIH sponsored and participated in this seminar to bring together a network of health professionals from the countries of the former Yugoslavia.

**“Kaspar Hauser” journal.** The absence of dialogue on social issues among health professionals is a principal obstacle to the introduction of new ideas and standards. “Kaspar Hauser” journal is a unique forum of social issues for health professionals, designed and produced by WHO in collaboration with local health professionals.
- **Mental health service field study.** Reforming the mental health system, in addition to meeting the overwhelming post-war needs of vulnerable groups, is an enormous task. However both entities are working together to implement similar reforms. The Mental Health programme brought the 15 leading mental health service directors to Trieste, Italy to study community-based approaches. Outcomes of the experience include critical exposure to practical examples of service provision and the strengthening of personal bonds between the professionals.

- **Mental health photography exhibit.** In an effort to raise awareness of vulnerable groups and to encourage social inclusion, a photo exhibit of international mental health community programmes was displayed and promoted in municipal centres throughout BIH.
Principles and strategies of Peace Through Health

At the inception of the PTH programme, the field staff outlined a range of principles and strategies that the WHO field team anticipated would be keys to success. Others came about as we got deeper into the integration of health and conflict resolution. This section attempts to highlight key principles and strategies of PTH using activities and events as illustrations. Lessons learned and suggestions for further programme development are also made explicit in this section.

Summary of Peace Through Health principles and strategies

♦ Our primary responsibility is health
♦ Work on all sides, openly and transparently
♦ Enlist the support of health authorities
♦ Multi-track diplomacy and initiatives
♦ Work according to geographic boundaries, not political ones
♦ Work with partners
♦ Provide comfortable, neutral environments
♦ Provide opportunities for internal links
♦ Create external links
♦ Foster and empower responsibility for health and environment
♦ Address human rights and ethics through health
♦ Public information and media
♦ Multi-sectoral approaches
♦ Patience and perseverance.

Our primary responsibility is health

Peace Through Health came upon the WHO field staff quite suddenly. Although we had been using health to bridge ethnic divides in certain instances, we were not quite sure what we were being asked to take on when we were asked if we could devise and implement a comprehensive health development programme which specifically attempted conflict resolution and peace-building. However, we were eager to try under one condition: that our primary responsibility is health.

Although health and peace are inextricably linked, WHO staff are technical health specialists, not conflict resolution experts. The staff felt strongly that we would be compromising our reputation and position should we deviate from our mandate. Furthermore, we could potentially do a lot of harm undertaking initiatives for which we were not qualified. Therefore, throughout the entire PTH process, we outlined health objectives and modified methodologies to achieve them. For example, capacity-building activities were selected on the basis of health sector priorities and implementation of these training programmes was modified to produce “secondary” peace-building outcomes.

Again it is important to highlight the flexibility with which DFID participated in the PTH initiative. While health remained our primary focus, DFID’s flexibility allowed WHO BIH to be creative and generated a great deal of enthusiasm among the field staff. Several “non-traditional” activities developed and implemented by WHO BIH have produced important lessons for creating healthy, peaceful environments in conflict situations.
Work on all sides, openly and transparently

When the WHO Special Representative for Bosnia and Herzegovina, Dr Jean LaLiberté, met with the new Republika Srpska Minister of Health in early 1998, the Minister began to express his appreciation to WHO for taking their side. Dr LaLiberté immediately interrupted, stating “Whoa, we’re not taking any sides. We are treating you as we treat the Federation: on the basis of needs, nothing more, nothing less.”

Throughout the war, the international community had relatively little interaction with the Bosnian Serbs for several reasons: the Sarajevo leadership was the internationally recognized government; the Bosnian Serbs were viewed widely as the aggressors of the conflict; and the Serbs held a huge military advantage, creating a vast disparity between relief needs of the Bosniak (and to a lesser degree Bosnian Croat) populations versus those of the Bosnian Serb population. Thus when the DPA created two internationally recognized Ministries of Health, the DPA created an awkward framework within which to work. While on paper the Ministries of the RS and FBIH were equally empowered institutions, the RS was almost completely isolated and impoverished, in part due to their leadership, in part due to natural continuation of the war-time status quo, and in part due to the post-DPA actions of the international community.

WHO adopted a position of “neutrality”, defined in this context as allegiance to the sanctity of health: under no circumstances should accepted basic standards of health be sacrificed to achieve political gains. WHO would work on all sides according to needs and advocate against sanctions (formal or informal) which create detrimental conditions compromising accepted basic health standards. As will be discussed later, this positioning did not preclude addressing and admonishing behaviour, positions and actions which undermined development and democratization and which destabilized peace processes.

Working on all sides was not an easy position for international agencies in 1996 and many health agencies did not do so. However, increased isolation of the RS could only serve to strengthen the position of nationalists. Political changes in the RS, including the emergence of an alternative to the SDS (nationalist governing party), have come about through the efforts of agencies and individuals that chose to interact with and engage the RS, not the isolationists. Furthermore, in practical terms, economic and social disparities are themselves great destabilizers and achievement of a lasting peace will only come about if the foundations are level.

The openness and transparency with which WHO worked are key elements of PTH. In 1996, it was too early to expect collaboration on most levels. However, sharing information through WHO and encouraging each side to be aware of what is happening on the other were fundamental steps towards collaboration and common participation. International agencies can (and did) remove a great deal of mistrust by facilitating direct communication. Adherence to these principles is the basis for the trust and respect that enabled WHO to push for increased collaboration later in the PTH process.

Enlist the support of health authorities

“Development, peace and social justice were ever present visions in the minds and hearts of the highest government officials of all the countries involved.”

– Dr Carlyle Guerra de Macedo, WHO Regional Director for the Americas, “Health as a Bridge to Peace: the Central American initiative”, Symposium on health, development, conflict resolution and peacemaking, 3 June 1994, Copenhagen, Denmark.
“When speaking privately, I must stress that I did not detect any reluctance or disagreement among the individuals I have spoken with: some of them were really delighted with the idea of PTH, some did not believe it could be possible, but all of them showed at least a certain degree of genuine interest and curiosity … Unfortunately, higher authorities (usually MoH) should be asked to approve every PTH initiative from the field. Large-scale (country-wide) initiatives have usually been hindered by MoH representatives … There is an obvious tendency to speak in favour of joint approaches but if the initiative is supported by one side, it will most likely be abandoned by the other.”

– Dr Boris Rebac, WHO Tuzla Head of Office in a briefing note to PTH Programme Manager, 3 September 1998.

By virtue of our mandate, WHO works through the Ministries of Health, assisting them to set standards, formulate health policy, strengthen local capacities and improve the health of the population. In complex political situations such as BIH, this formally recognized relationship is both a boon and a bane. More than any other programme, PTH raises numerous issues which highlight the dichotomous and often conflicting positions of WHO as advisor to the Ministry of Health and as the advocate of Health for All.

WHO BIH has worked hard to be completely transparent with the Ministries of Health on all issues, including the potentially sensitive objectives and methodologies of PTH. In many instances, the MoH have supported the stated objectives, at least publicly. However, much of the PTH programme (for example inter-entity training and geographical field office areas of responsibility) opposes official and/or unofficial MoH positions. This raises several sticky issues:

- What to do when our health objectives conflict with political objectives of the MoH?
- What is our position when the MoH is clearly on one side of the conflict (e.g. Kosovo FRY)?
- How do we reconcile our positions as advisors to the MoH and as the “health conscience” for the population?

For the WHO field staff in BIH, it is hard to imagine high-level governmental support for ideals such as was expressed in the Central American initiatives. Field officers are placed in a very difficult position and from the perspective of the field, these positions have not been well understood at higher WHO levels. As an illustration, public health authorities have insisted on purchasing rat poison for large-scale campaigns. Poor public health knowledge and alleged financial incentives are the suspected motives behind this priority. Is WHO consequently obliged to support public health priorities which the MoH has forsaken? How can a WHO field representative keep good standing with the health authorities and be expected to act as a policeman? What support will a WHO field representative get from higher WHO levels?

In general, WHO field staff, particularly the Heads of Office, have done a remarkable job balancing these positions. They have at every step consulted the health authorities while also being clear and explicit about WHO positions, including when the positions differ. This may not garner popularity but it has earned the respect of most health authorities and in the long run will do much more to serve the health of the population.

In the future, some steps may help to resolve some of the difficult positions raised by PTH. As always, we must be open and transparent with the health authorities, continually seeking their support. We must seek written commitments from them (such as the Joint Statement) and hold them to these commitments. Among other means, this can be done through public promotion of
these commitments among constituent populations and it can be done through the use of international solidarity – bringing the health sector to higher levels. Finally, serious internal WHO discussion is required to iron out policies which contain inherent inconsistencies and contradictions. These policies need to be translated to the field and supported from the highest levels of WHO.

**Multi-track diplomacy and initiatives**

*Health and wellbeing are not the outcomes of hierarchical decrees. The source and determinants of health are communities and their individuals. In July 1997, WHO’s Bihac Field Office brought together the health centre directors from Ribnik (RS) and Kljuc (FBIH), the first time they had met in five years. The meeting went well, ending in several significant agreements: freedom of movement for ambulances between the two communities, reciprocal treatment of emergency cases, and mutually expressed desire for cross-community workshops. Perhaps even more significant is the positive impression upon the local community. The meeting, the first of its kind for these proximate communities, was interrupted countless times by a wide variety of people wishing to say hello to their former neighbours.*

Due to the support of several donor agencies, WHO in BIH was fortunate to be able to maintain a network of field offices across the country. This network enabled WHO to work in-depth on several levels and the field offices were the primary facilitators of PTH. The day-to-day negotiations, nurturing of relationships, and joint activities in the community facilitated and strengthened links essential to stability and peace.

The PTH programme design encouraged initiatives at various levels which complemented and reinforced each other. For example, the Ministries of Health affirmed IHIC as the cornerstone of their future health systems. Field offices filtered information to the various communities and teamed with relevant partners (national and international) to implement training activities for family medicine teams. Fig. 2 illustrates the interaction fostered by PTH.

*Fig. 2. Interaction fostered by Peace Through Health*
It is important to note that activities in the PTH project are not necessarily cross-community. Several activities work to strengthen civil society and democratic processes within communities. These efforts are crucial to breaking the isolation of many communities, particularly in the Republika Srpska, and are necessary precursors to cross-community initiatives.

The importance of *intra*-community peace-building will become increasingly important as displaced persons and refugees return to their homes, either as part of the ethnic majority or the ethnic minority. Where people are returning to areas where they would be part of the ethnic majority, there can be a great deal of friction between those who stayed and those who left. In areas of ethnic minority returns, building a culture of acceptance and tolerance must happen within communities, not necessarily between communities.

**Work according to geographic boundaries, not political ones**

Perhaps the most important strategic adaptation of WHO programmes was the re-orientation of the field offices to cover geographic areas of responsibility, irrespective of political boundaries. (See Figure 3.) The original alignment was a natural occurrence, driven by practical issues of delivering humanitarian assistance. However, maintaining politically-defined areas of responsibility in the post-war period amounted to de facto support for strengthening ethnic divides and limited WHO’s ability to cover the entire country.

Realignment was not an easy task and would not have occurred without strong leadership of the WHO head of mission. Communication across the IEBL was difficult in most instances, and often impossible. At the end of 1996, freedom of movement was a reality only in the vocabulary of the international community. Most staff, local and international, did not believe the reorganization could be done without compromising our ability to do our jobs. National WHO field officers were intensely sceptical of how they would be accepted on “the other side”. Health authorities, including the Ministers of Health, were strongly opposed to it.

Realignment had several important effects. First, it delivered a strong message to health authorities and professionals that WHO was not going to support, tacitly or otherwise, activities which violate the sovereign integrity of Bosnia and Herzegovina. Second, realignment was a crucial step for bringing members of both entities together and erasing the “demonised” images each side had created of the other. Without confronting stereotypes through personal exposure, harmful convictions are allowed to fester and thrive. National WHO field officers were particularly crucial in this regard. Third, realignment built stronger relations between the field offices. No longer were vertical channels the sole communication routes. Field officers began to work much more directly together, creating a very healthy and effective synergy.
Work with partners

The incentives for working with partners are so overwhelming that this maxim should not have to be stated. However, as WHO was attempting to implement a new approach, highlighting a few key issues may help to improve the PTH strategy in future missions.

Secondly, partnerships could help to maximise efficiency and effectiveness among all agencies. WHO does not have the human resources to implement all the initiatives included in the PTH workplan. Most NGOs do not carry enough clout to gain political acceptance for peace-building activities. Complementing respective strengths can produce much stronger outcomes. For example, WHO and International Medical Corps (IMC) teamed together to implement a very successful countrywide emergency medicine training. For WHO, the use of an implementing partner was economically efficient while still ensuring that appropriate standards and objectives were met. For IMC, it provided work in their field of expertise but more importantly, it allowed...
them to implement a cross-community initiative, something IMC felt they, as an NGO, would have been incapable of doing without WHO’s support.

**Provide comfortable, neutral environments**

Health professionals are ordinary citizens with their own fears, stereotypes and experiences. Without a “safe” environment in which to meet, many health professionals would not have an opportunity to overcome these fears. Throughout the country, WHO field offices often fulfilled this vital criterion. The Health Education Centre, located in the WHO premises in Mostar, was (one of) the only place(s) where professionals from both sides of Mostar would meet. The WHO offices in Sarajevo provided a comfortable environment for Ministry representatives to meet.

A neutral physical meeting space is only half of the equation. The presence of WHO staff is equally paramount to establishing an adequate level of confidence. WHO staff made countless efforts to provide transportation, to mediate discussions, to promote a mutually agreeable agenda. This was perhaps the most time-consuming aspect of the PTH programmes but is invaluable to both the reconciliation processes and to health sector development on the field level.

**Provide opportunities for internal links**

“When I received your invitation to participate in the seminar, I couldn’t sleep for days. I couldn’t stop thinking about whether I should go, whether I could handle going. For four years I performed surgeries on café tables, being forced to move from village to village as they steadily destroyed our homes. All my emotions would rush over me as I lay in my bed thinking about the seminar. Then today when I entered and saw them all sitting together, talking loudly and laughing, all my hatred welled up inside me. Only my desire to learn and my wish not to cause any disruption kept me from leaving.

“Then the seminar began, and we started to work on the problems you gave us. We grew more comfortable speaking with each other. I was just finishing medical school when the war began so I am too young to know the Serb doctors but we all lived in this area before the war. By the end of lunch, I began to understand that many of them went through a terrible time too and that none of us wanted to go back. However hard the alternatives may seem, I think we all know they are much better than going back. It doesn’t matter whether or not we learned anything else today. What your seminar has done can’t be measured.”

– A young doctor from FBIH after participating in the Bosanska Krupa – Novi Grad health promotion seminar

The objective of Peace Through Health programming is not “to make people be friends”. After four years of war, pushing people together is unrealistic and can be extremely harmful and traumatic. *PTH must seek to provide opportunities for people to confront their own fears, stereotypes and experiences and to build upon positive developments.* It is not WHO’s responsibility to change personal opinions but to provide opportunities to allow people to do so on their own.

“Internal mapping” may have been a helpful exercise to undertake at an early stage. Thanks to the national staff, WHO was able to get a good sense of pre-war connections on both individual and community levels. However, explicitly mapping out pre-war connections could indicate areas which have more potential to achieve strong outcomes. Bosanski Krupa and Novi Grad, in spite of the immense effort required to hold a two-day seminar, were well suited to building relations due to the high number of displaced professionals between the two communities who
were interested to re-establish relations. In other cases, pre-war connections might not be as strong. For example, bringing together Trebinje and Mostar, although geographically proximate, might require different approaches since in pre-war Yugoslavia Trebinje traditionally collaborated with Dubrovnik (Croatia).

**Create external links**

One of the most important challenges of creating stable peace in BIH is to lift vision and awareness from an inward focus to broader perspectives. The constant internal focus and consequent lack of external points of reference is stressful, depressing, and completely counter-productive. It reinforces insecurity, fosters hatred, and limits learning. On individual and community levels, the absence of external benchmarks creates an atmosphere of competitive victimhood – a symptom of not being able or not willing to understand what has befallen the other side. Until the focus gets lifted to a higher plane, politics and polarisation will continue to dominate.

In terms of health professional skills, external links are essential to filling significant gaps. The impact and isolation of four years of war combined with the exodus of many professionals has created enormous training needs. Furthermore, the difficult transition from a socialist health system cannot be managed without external benchmarks and support. Three main methods were used by WHO to address the need for external links: external training, inclusion in European health networks, and decentralized cooperation.

**External training**

In several cases, health professionals were supported by WHO to participate in international seminars. In other cases, such as the mental health programme, a large group of professionals were taken out of BIH to undertake a study tour. One question that WHO should examine more closely is the possibility of supporting selected professionals to undertake longer studies abroad which are not available in-country, such as a Masters’ degree in health management.

One setback in developing external links has been the limited “absorption capacity”, the number of qualified professionals able to participate in external training and networks. It is an important issue to be considered when planning activities of this nature. In the RS, participation in international events is not limited by resources or opportunity: it is very difficult to find health professionals who speak English and who possess a passport, let alone who have appropriate professionals qualifications. In the Federation, access and authority is retained by a very limited number of professionals and therefore skills are not being acquired and transmitted to those who would apply them.

**Participation in European networks**

Facilitating inclusion in European networks is a natural role for WHO. Examples in the PTH programme include the European No-Tobacco Network, environmental health networks, and nursing associations. For the Bosnian professionals, participation was a very positive source of pride and provided incentives for continued commitment and hard work. Many have returned empowered with a sense of responsibility.

On the management side, since most of the WHO field staff are externally recruited, improving support to and communication with field staff about EURO networks and initiatives would strengthen this aspect of external linkages. Conversely, awareness within EURO technical units of programmes and initiatives in BIH would strengthen development of BIH professionals.
Decentralized cooperation

Decentralized cooperation is the creation and expansion of direct cultural, social and economic links between municipalities in order that exchanges through these links can play an active role in human development and the creation of healthy environments. Although not explicitly a part of the PTH programme, all WHO BIH programmes were horizontally integrated. “Twinned-municipality” initiatives in the health sector were coordinated by WHO, incorporating and complementing the PTH approach and programme.

Decentralized cooperation has been an essential tool for ensuring that external links are being created on all levels, not just ministerial or professional. The multisectoral public meetings were among the first opportunities to discuss health and social issues at the local level. This approach has created a new means for the spread of information, away from the top-down approach characteristic of many government mechanisms.

Foster and empower responsibility for health and environment

A lack of accountability, a sense of powerlessness and little understanding of human rights are enduring legacies of the combination of war and an authoritarian system. These attributes permeate all levels of Bosnian society. Regulations and fear stifle initiative. Accountability and responsibility are minimally applied concepts. To a very large degree, professionals operate within a very narrow range of autonomy, rarely stepping out to identify and address problems or inefficiencies. The results include a system which operates inefficiently, a cadre of professionals who are prevented from achieving their potential, and a widespread unwillingness to act outside of authoritarian lines. These are the very characteristics which maintain Bosnia’s vulnerability to renewed conflict.

How does WHO address this issue through health? WHO’s advocacy role is an essential first step. It is within WHO’s responsibilities to highlight health priorities and to use supporting data to inform and drive policy decisions. Secondly, the capacity building ongoing across all WHO programmes directly contributes to professionals’ ability and confidence to identify and address problems. Finally, the field offices have worked hard to include all groups in their area of responsibility. Individuals or groups which have identified issues and demonstrated a desire to work on them have been supported by the field officers (technically, financially, and advocatively).

Supporting local NGOs is an extremely challenging initiative and, in certain regards, one which falls outside the traditional role of WHO. The decision to channel PTH resources and efforts towards fostering community participation (through volunteerism, NGOs, associations, etc.) stems from ideological and practical considerations. Practically, no health system is able to meet health or health care needs of an entire population without complementary activities of the “third sector” (volunteer/self-help). Ideologically, increased community participation leads to increased responsibility for health and decreased authoritarianism.

Formally, the “third sector” in BIH is in its infancy; it did not exist in the former socialist system. Informally, many people would not have survived the war were it not for supporting social networks. Many local NGOs spawned from the influx of resources during and after the war and have yet to develop sustainable approaches to their initiatives. These NGOs continue to chase activities for the funds they bring with them. By focusing on health priorities and supporting associations with well-structured ideas, PTH is contributing to the larger international community initiative of NGO development. Furthermore, coordination through the field offices helps to encourage an appropriate integration of third sector activities with the formal health care system.
Address human rights and ethics through health

Respect for human rights is an essential foundation of democracy. In BIH, human rights abuses such as polarization, manipulation of information and discrimination have become entrenched by war. Human rights are inextricably linked with the health sector and health professionals are in a unique position to influence the degree to which they are respected and observed in practice. As emphasized in WHO’s renewed Health for All policy, pursuit of the fundamental principle of equity in health cannot be done in abstentia of human rights. In BIH, ensuring equity, monitoring and advocacy are essential WHO roles in the promotion of human rights.

Overall, human rights issues have not been widely tested. Vulnerable and uninsured persons are provided for in health care law of both entities in principle but not in practice. In general, people do not even attempt to receive services from the “other” side. The only highly visible exception is in Sarajevo itself. The PTH project addresses a lot of these issues on a daily basis through our field contacts.

Human rights violations in the health sector are raised with the MoH by WHO. Furthermore, WHO is active in the development of civil society through the Decentralized Cooperation programme which is linking health professionals in BIH with European counterparts. These external links are crucial for the understanding and promotion of human rights.

In addition to obvious human rights violations such as denial of services, obstruction of access to education and information is a severe problem occurring in both entities. In essence, some persons in key positions are preventing health professionals from attending seminars or other opportunities for continuing education. The reasons for this are not entirely clear although at least two reasons seem to be the most plausible. The first reason is personal interest and financial incentive. Knowledge is power and some persons seem willing to sacrifice the wellbeing of their population to maintain their personal power. The second reason appears to be political orientation. Some relevant persons or institutes are not selected for participation by the health authorities because of their political affiliation (e.g. east/west RS or Croat/Bosniak).

Public information and media

In the middle of the war, an exchange of civilians was arranged and an old Muslim woman was brought from Serb-held territory to Sarajevo to be with her family. At her age she was relatively infirm, closely shadowed by the spectre of senility, and spent the most part of her day watching television. On one such occasion shortly after her relocation, she made a sudden exclamation, causing her children to come running.

“What’s the matter nana?” they asked.

She replied, “But Dr Karadzic is a hero. Why do they say such bad things about him?”

The influence of the media in the manipulation of the general population cannot be underestimated. Milosevic’s “media machine” is widely recognized as one of the most significant catalysts of the Serb nationalist resurgence in the late 1980’s. Equally in BIH, each side has successfully used the media to strengthen divisions. Breaking the manipulative stranglehold of the media will be one of the most important determinants of a lasting peace. It is also crucial to the attainment of real health gains.

WHO’s role in this process could provide a significant contribution. However, it is a relatively new foray for WHO and much needs to be developed in regard to its work with local media. In terms of PTH, there are two fundamental aspects which require further examination. The first is the question of when and how to promote successful PTH initiatives without compromising
individuals or the initiatives themselves. The second question relates to how can WHO use health in the media to combat fundamental obstacles to peace such as discrimination. (A third question, “when should WHO use the media to “blow the whistle” on unethical behaviour/activities?”, could be included here but is much more a question of organizational positioning and principles.)

The first question of when and how to promote successful PTH initiatives was one which the field staff have been pondering from the outset. Initially, there was a great deal of fear that we would be placing health professionals in danger (physical threats, threatened job security, etc.). Even use of the term “peace through health” was something we felt might jeopardize progress. As we gained confidence, we became much more prolific in communicating the aims and outcomes of PTH. Can a universal principle be derived from this? Probably not but in hindsight we could have been more aggressive at earlier stages in promoting positive outcomes. This is not to say that we would have thrown caution to the wind. Is WHO prepared to fight for a local professional who loses his/her job because of participation in a PTH activity? Fortunately this has never happened but its likelihood is not that far fetched and WHO should be prepared for it.

Can WHO use health in the media to combat fundamental obstacles to peace? The question is rhetorical but appropriate skills and tools need to be developed in order for WHO to be effective in this field. A good example of how this could be done is through discussion of diseases such as HIV/AIDS. Local journalists in BIH were far more likely to be able to discuss issues of discrimination in the media when talking about HIV than they would about ethnicity or politics. Discussions with Soros Media Centre to introduce health into their journalist training sessions have taken a long time to come to fruition but health topics are now being included in their training seminars. Furthermore, BIH will be an active participant in the upcoming European conference on Media and Health. A stronger package of training materials for journalists working in health would improve WHO’s ability to contribute in this area.

Beyond journalist training, regular exposure to the media through the head office (Sarajevo) and the field offices is an extremely important means to promote health and peace. To be effective, field staff must be made aware of organizational positions and must be encouraged to be clear and explicit. Working with the media can be intimidating and manipulation can be difficult to detect, especially through the use of a local language interpreter. Training sessions in how to handle the media would be very valuable for WHO field staff.

**Multisectoral approaches**

“All PTH ideas clearly address the weakest points of the health system. The activities which are traditionally insufficient and neglected, like health promotion, disease prevention, multisectoral approaches, and strengthening of local NGOs, were given a high priority. [PTH activities] were really the first moves ahead toward the proclaimed “intersectoral” or “holistic” approaches I have seen in this country. The greatest benefit of PTH may be to clearly identify misconceptions about approaches to health problems and to promote exchange of opinions among people with different professional backgrounds. But it is for sure the hardest task to change ways of thinking and it will take a lot of time.”

– Dr Boris Rebac, WHO Tuzla Head of Office in a briefing note to PTH Programme Manager, 3 September 1998.

Multisectoral approaches have two immediately apparent advantages. Firstly, the largest health gains in a post-conflict situation are going to be made through sectors other than health – job creation, housing, restoration of basic infrastructure, etc. Secondly, health issues can be used as a
means for bringing together representatives from highly polarized sectors such as education and media.

UNESCO (United Nations Educational, Scientific and Cultural Organization) was unfairly criticized when someone asked, “WHO can bring the two entities together, why can’t you?” Firstly, UNESCO has not had the level of support which WHO has been fortunate to receive. Secondly, the education and cultural sectors are so highly politicized that it is virtually impossible at this point in time to bring teachers and administrators together to discuss pedagogical issues. However, through inclusion of health promotion initiatives, teachers can become involved in inter-entity collaboration. The Bosanski Krupa – Novi Grad workshop included teachers. Through WHO EURO, the Health Promoting Schools programme is now underway and BIH will soon become a member of the European network. Other PTH initiatives are at the stage to become catalysts for promoting discussion between educational professionals and hopefully will do so in the near future.

Working through health issues can also have a significant influence on other sectors. When WHO supported an inter-entity initiative of a local RS NGO to raise environmental awareness, local NGOs promoted their work and collaboration through local media.

**Patience and perseverance**

Peace-building takes time and continual commitment. Unrealistic expectations will lead to frustration and a lost sense of purpose. This is true for both international organizations and national Ministries of Health. It has taken a long time for western countries to develop their health systems and will take a long time for Bosnia and Herzegovina to make the transition from a socialist system, especially without a solid economic base.

Furthermore, underestimating the amount of time required to build a solid foundation for peace is in itself destabilizing to the peace process. As an example, for very real and practical reasons IFOR had wanted to create a sense of urgency to resolve political differences at the negotiating table. Therefore the initial mandate was one-year in length. However, imagine if IFOR had stated at the outset that its mission would last for (a minimum of) five years. That announcement alone would have sent a much different message to BIH leaders. Indicted war criminals might not have taken the tack of “waiting out” the duration of the NATO-led mission. Optimism may have been buoyed and people might have felt much more secure to begin rebuilding their lives. Likewise in the health sector, short-term commitment diminishes WHO’s credibility and directly impacts the attitudes and actions of the health authorities and of partner agencies.

Time frames in the initial PTH workplan were over-optimistic and demands on the WHO field staff were underestimated. Although the situation is improving, the amount of time and energy it takes to complete otherwise routine activities is infinitely exaggerated in BIH. At several points, the frustrations and the disappointment with setbacks were almost paralysing. The importance of maintaining a long-term outlook cannot be overstated.
Analysis

Programmes do not operate in a vacuum and likewise cannot be analysed in such a manner. PTH, its achievements and shortfalls, must be placed in the context of the political, social and organizational environments in which it has been structured and implemented. When we initiated the PTH programme, we were operating in an unstable and unpredictable external environment and an uncertain internal environment. Not all of this has changed, but certain elements have changed, largely for the better. PTH has been both a catalyst and a beneficiary to these changes.

External developments

When the field team held a “taking stock” session in March 1998, we outlined what we felt had and had not changed in the past year, both in terms of the overall situation and also in terms of our expectations of peace building. Grouping these changes in terms of political, social and structural peace building, the field staff perceived the following differences to be the most significant for our work.

Political changes

Politically speaking, the team felt that the overall environment had become much more stable. Events which had precipitated violence in 1997, for example the Bajram parade in Mostar and the Brcko arbitration, had passed relatively smoothly the following year. The changes in the RS government were also viewed positively while in the Federation a marked increase in competition between the cantons (at least in the health sector) was perceived. Decreased isolation of the RS was enabling inter-entity initiatives to proceed with less obstruction and suspicion. The seemingly decreased dependence of the RS on Belgrade also helped in this regard.

Elections, held at the time of writing this report, have increased volatility and hindered (temporarily) implementation of PTH activities. Election results seem to indicate a shift back towards nationalist policies in Bosnian Serb and Bosnian Croat areas but the short- and long-term implications of the results are not yet clear. Such a shift illustrates the health sector’s vulnerability to political developments but does not diminish the achievements or importance of PTH objectives, strategies and activities.

Social changes

The biggest perceived social changes are perhaps direct results of the fatigue of the general population. The continuum of emotions has moved from the initial post-war euphoria, through disappointment, through fatigue to a stage where people are more realistic about their situation. Less thought is given to ethnicity and politics and much more to essentials for living.

The awareness that “somehow we must get along as one country” is also spreading throughout the population. When the Zenica Head of Office, Ferid Huseinbegovic (himself a Bosniak), informed the RS Doboj hospital director that he was moving to Mostar and would be responsible for Trebinje (an isolated and hard-line pocket of the RS), the director expressed regret that he was leaving and offered any support he could give to help Ferid do his work in Trebinje. A year ago, diverging publicly from nationalist positions would have been unthinkable.

Structural changes

Several structural changes implemented recently will have a significant impact upon the development of a peaceful society. Most notably, the imposition by OHR of standardized licence plates will greatly increase the ability of people to move freely and safely throughout the
country. This follows a series of developments which have increased opportunities for people to move and communicate more freely. Public bus lines now operate between Banja Luka and Sarajevo. Direct telephone links are now available whereas when we started the PTH programme we had to use Copenhagen to communicate between field offices.

There does appear to be increased repatriation although much to the disappointment of the international community it is primarily to majority areas. Municipal governments of pre-war populations have been elected in many towns although most are having a difficult time to return. Minority returns to one town are often linked to the current residents' opportunities to return to their town thus creating a re-settlement logjam.

**Impact evaluation**

Has WHO contributed to sustainable peace processes in BIH? Methodologically, the PTH programme has consistently applied conflict resolution strategies throughout its health development work. As presented by Professor Assen Jablensky (1994):

> “… Considering the intensity of emotion which is invested in ethnic conflicts, the very fact of bringing adversaries to the negotiating table should be considered a very significant step. The general principles which are then to be applied are these: (Ross and Stillinger 1991).

First, it is important to create or enhance motivation for conflict resolution … The second principle is to identify and wherever possible dismantle barriers to conflict resolution … The third principle is the need for careful management of the negotiation process.”

PTH activities at all levels – medical students, health professionals, directors and ministers – have integrated and applied these principles. At the outset of the PTH programme, the possibility of integrating conflict resolution strategies into a wide range of health development activities was not a certainty. If nothing else, the PTH experience demonstrates that it is possible.

How do we measure success and shortcomings of the PTH approach? In terms of measurable causal impacts, it would be impossible to put a precise indicator on WHO’s contribution, as it would on any other agency’s contribution. However, we may be able to gauge peace-building outputs in the health sector through four parameters: field observations, the level of independent cross-community activity, the number of health agencies operating with a PTH approach, and the results of a survey of health professionals conducted by WHO in April 1998.

**Field observations**

Referring to the six determinants of a democratic civil society set out by the field team at the first PTH project planning session in March 1997, we can anecdotally assess WHO’s contribution to the reduction of barriers to peace.

**Polarization.** Political desires to divide BIH have not abated although they have been suppressed by the international community. Concessions by nationalist groups have come about not so much from an ideological shift but rather from the increasing political and financial pressures to comply with the DPA. Likewise, “independent” media in many cases is little more than an adopted label to gain access to financial support.

In the health sector, polarization has been reduced through opened lines of communication. Numerous seminars, although seemingly small in scope, have dented the physical, psychological and political barriers which are keeping people apart. Demand for these seminars has increased
dramatically as information about them has spread. Countrywide networks, such as the no-tobacco association, have demonstrated the potential of health issues to over-arch political bounds.

**Discrimination.** Until we achieve a modicum of respect for basic human rights, peace will remain illusive. The continued high level of discrimination is perhaps indicative of how far we have to go in this regard especially when we see how far beyond ethnic divides discrimination extends. For example, persons with disabilities are classified according to the cause of their disability, not the severity of it. Persons disabled during the war (civilian or military) are entitled to more benefits than those who were living with disabilities prior to the war. In an extreme example, an amputee from the Second World War is not entitled to services and resources offered to an amputee of this conflict.

In such an environment, it is important to ensure that the legislative foundations for equality are properly installed. Through the health system reform process, WHO has ensured that the legal framework appropriately addresses discrimination. Addressing the needs of all vulnerable groups has been a central pillar of the health service re-orientation. And the advocacy work of the field offices has brought human rights onto wider platforms of discussion.

**Manipulation of information.** Data collected during the war was highly sensitive and tightly controlled by the authorities. Introducing transparency to the data collection and publication processes signals a significant reduction of the manipulation of information. Ownership of health data is a much more important issue than presentation of health data. For example, public health monitoring has resumed through the institutes of public health and both entities are willing to share this data in common WHO EURO country reports. However, the RS is particularly sensitive to (incorrect) perceptions that the Federation Public Health Institute (PHI) is the overarching public health authority. As such, they have insisted on independent channels through which to provide WHO with the data. In the end, the data is compiled by WHO into single reports for Bosnia and Herzegovina but the PHI of each entity remain on equal footing.

**Centralization of power and authority.** Resources and opportunities still remain in the control of a few individuals. In general, local health professionals are very receptive to proposals for common workshops. Most are willing to travel and to participate in common skills-based training. However, there is such a strong legacy of authoritarianism which prevents professionals from acting upon their own. Letters of permission are consistently requested, regardless of the level at which the activity is to take place or even acknowledged verbal permission from superiors. In several instances, professionals have not attended courses because ministerial support was not provided in writing.

WHO’s approach has been consistent and improvements have been gradual. We have steadfastly maintained the position that professionals have the right to attend courses to which they are invited; obstruction of access to education is a violation of fundamental human rights. In practice, enforcing these principles has been a difficult but achievable task. At the first major inter-entity seminar, an advanced epidemiology course, the majority of FBIH representatives did not attend even the first week which was held in Sarajevo. Behind the scenes, the lead epidemiologist had threatened positions of health professionals should they choose to attend. However, a few chose to attend on their own initiative and the Ministry of Health representative for foreign agencies attended the first part of the course. When he realized what the FBIH professionals were missing, he pressed the Minister of Health for a written acknowledgement of the rights of health professionals to attend inter-entity seminars. The letter from the Minister was too late to salvage the epidemiology course but did create an important precedent for future inter-entity seminars. Although resistance remains, inter-entity workshops are becoming easier to organize and implement. Furthermore, local professionals have begun to organize inter-entity gatherings on their own initiative.
Isolation. The isolation of BIH has been dramatically reduced. Very visible signs, such as the ease of external travel and the improvements in communication systems, are testaments to how far things have come in a couple of years. In the health sector, BIH is now an active participant in international health networks as the emergency phase is all but over and the health situation resembles that of other central and eastern European countries. Given the depth and breadth of WHO BIH programmes, in addition to the multitude of activities of other international health agencies, one would be hard pressed to find a community in BIH which has not been involved with international activities. By comparison, no other country of central and eastern Europe could make the same claim.

Pockets which do remain relatively isolated must bear at least partial responsibility. Bosnian Croat and Bosniak representatives of Middle Bosnia canton (Travnik) refused for a long time to cooperate with each other and unrealistically expected the international community to create separate programmes for each community. These cantonal Ministers of Health were behaving as cantonal Ministers of Culture, making development assistance next to impossible. As funding diminished throughout 1997, Middle Bosnia canton received less and less attention from international agencies. Finally, seeing inter-ethnic collaboration in other areas and not wishing to be isolated further, the cantonal MoH has begun to put forward unified requests for technical assistance.

Violence. WHO is limited in its ability to address violence directly. On a large scale in BIH, violence prevention is a matter over which military and police have jurisdiction. On a smaller scale, WHO has begun to directly address violence through the specific issue of domestic violence. A multisectoral inter-entity seminar with a high level of participation from the international community (most notably Ms Elisabeth Rehn, Special Representative of the UN Secretary General), local authorities and community groups brought a lot of attention to the issue.

More important have been the indirect approaches of the PTH programme to violence reduction: the promotion of dialogue and confidence building. Averting a recurrence of widespread violence requires collective action opposing violence. However, given that the siege of Sarajevo began with sniper fire into a mass demonstration for peace, can we really expect that promotion of dialogue will make a difference?

Dialogue is not the only answer but it is a critical part of the solution. People on all sides have lost a lot during this conflict and, knowing that it is a lose-lose situation, are much more reluctant to enter into conflict again. Dialogue gives them the opportunity to break down the demonised image each side has developed of the other. Catalysing this process through cross-community health workshops has been one of the most valuable contributions of the PTH programme.

Health professionals have also demonstrated both the willingness and ability to take a stand against violence. One of the most dramatic and stirring examples of this occurred during the first of a series of Mostar cross-community workshops led by the Andalusian School of Public Health. Held on the west (Croat) side of Mostar, the seminar was interrupted by armed undercover policemen. The police entered the room, weapons drawn and said the Muslims have to leave. After a moment of shock, one of the Croat doctors stood up defiantly and said “This seminar is for all of us. If they leave, we leave.” Dumbfounded, the police withdrew, threatening (hollow) reprisals. The seminars continued on alternating sides of the city for the duration of the series.

Level of independent cross-community activity

Perhaps the most telling indicator of the achievements of Peace Through Health is the number of independent cross-community activities which are now occurring. In the beginning of the PTH programme, there was no inter-entity collaboration and very little desire. Peace Through Health was, in the words of one Cantonal Minister of Health, “science fiction”. Joint participation in
certain activities was a pre-condition for WHO technical and financial support. (In this sense, PTH was forced onto the health sector.)

As inter-entity and cross-community events became more common, joint participation started becoming a voluntary condition. The Doboj Physicians’ Association started a series of independent meetings, requesting only political support from WHO to bolster the confidence of RS colleagues. Organized without international assistance, the World AIDS Day conference included representatives from all sides. The Breastfeeding Association, very active in parts of the Federation, requested WHO’s assistance to get RS counterparts involved. In 1997, WHO served as an intermediary between public health directors, delivering messages by hand. Now details of our meetings in Banja Luka reach Sarajevo long before we do!

**Number of agencies implementing cross-community initiatives**

In 1996, many agencies were not working on both sides of the IEBL, let alone implementing cross-IEBL initiatives. The pariah status of the RS government was upheld by many of the incoming development-oriented agencies as sufficient reason not to work in the RS. Humanitarian agencies, including WHO, operated on both sides of the IEBL but to the effect that it might have been a border between two countries.

The PTH programme was, with one exception, the only health sector programme which sought to directly influence conditions for peace through health sector activities. The one exception was the Andalusian School of Public Health which successfully started a series of cross-community public health training programmes in Mostar.

It was not until we had gained some experience and confidence in cross-community initiatives that we began to promote the PTH approach among other agencies. Soon we developed effective partnerships with agencies such as International Medical Corps (IMC), Pharmaciens sans Frontières (PSF), and Queen’s University (Canada). The PTH approach has begun to influence the planning and implementation of international health agencies. Likewise, local NGOs have begun to reach out with cross-community initiatives. To do over again, promoting PTH among other agencies should be done earlier and more consistently.

**Survey of health professionals**

A survey of health professionals was undertaken in April 1998, administered in each area of the country by the WHO field offices. No individual names or identifiers were used and instructions clearly stated the purpose, anonymity, and confidentiality of the survey. The purpose of the survey was to gain a measure of health professionals’ attitudes, opinions, and behaviour towards inter-ethnic and inter-entity collaboration. Analysis of the survey, through the use of Epi Info Version 6, sought to identify relationships between defining variables (ethnicity, profession), exposure variables (e.g. participation in seminars), and attitude/opinion variables.

In spite of some obstruction to carrying out the survey in the RS, a good sample was obtained with the following characteristics. A total of 201\(^1\) health professionals participated: 81 Bosniaks

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\(^1\) Sample size was not predetermined. Each field office tried to collect a representative sample from their area of responsibility. In cross-tabular analyses, the p-value represents the statistical significance of the association under investigation. For example, for a p-value of 0.05, there is a 5% chance that the association observed occurred by chance. For larger p-values, either the association is weak/non-existent or the sample size was insufficient to confirm the association.
(40.3%), 56 Bosnian Croats (27.9%) and 64 Bosnian Serbs (31.8%). On an ethnic basis, these numbers are quite proportional to those of the general population. Professionally, 91 (45.3%) identified themselves as physicians, 71 (35.3%) as nurses, and the remainder were distributed across a variety of other health professions. Only 2 persons (1.0%) worked in a Ministry of Health while 33.3%, 44.8% and 8.0% worked in a hospital, dom zdravlja or ambulanta, respectively.

Table 1 gives an overview of the main exposure and attitude variables gathered in the survey. Percentages of each ethnicity responding affirmatively are given as well as the percentage of the total sample. P-values for each association are also indicated.

Table 1. Overview of main exposure and attitude variables

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>Bosniak (%)</th>
<th>Bosnian Croat (%)</th>
<th>Bosnian Serb (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exposure</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has participated in a cross-community health activity in past 2 years</td>
<td>32.5</td>
<td>32.1</td>
<td>17.7</td>
<td>27.7</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(p=0.11)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>(n=195)</td>
</tr>
<tr>
<td>Is aware of Joint Statement signed by both MoH</td>
<td>24.7</td>
<td>16.4</td>
<td>48.3</td>
<td>29.7</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(p&lt;0.0005)</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(n=192)</td>
</tr>
<tr>
<td>Has minority patients in own health facility</td>
<td>98.7</td>
<td>94.6</td>
<td>90.5</td>
<td>94.9</td>
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<td></td>
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<td></td>
<td></td>
<td>(p=0.08)</td>
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<td></td>
<td>(n=198)</td>
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<tr>
<td><strong>Attitude/opinion</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feels comfortable working with health professionals from other entity</td>
<td>74.0</td>
<td>86.0</td>
<td>50.8</td>
<td>69.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(p&lt;0.005)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>(n=182)</td>
</tr>
<tr>
<td>Wants more inter-entity health activities</td>
<td>80.3</td>
<td>82.2</td>
<td>50.9</td>
<td>71.6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(p&lt;0.001)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>(n=169)</td>
</tr>
<tr>
<td>Believes health workers can help to improve relations between communities</td>
<td>87.5</td>
<td>90.6</td>
<td>66.1</td>
<td>81.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(p&lt;0.001)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>(n=195)</td>
</tr>
<tr>
<td>Believes health workers from different communities should work together</td>
<td>82.5</td>
<td>87.3</td>
<td>62.7</td>
<td>77.8</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(p&lt;0.003)</td>
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<td></td>
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<td></td>
<td>(n=194)</td>
</tr>
<tr>
<td>Personally wishes to work with health professionals from other community</td>
<td>55.8</td>
<td>60.8</td>
<td>39.3</td>
<td>51.9(p=0.051)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(n=189)</td>
</tr>
<tr>
<td>Is worried about repercussions from health authorities</td>
<td>6.4</td>
<td>16.0</td>
<td>14.8</td>
<td>11.5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(p=0.17)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(n=182)</td>
</tr>
<tr>
<td>Would like to be able to refer patients to other entity</td>
<td>58.6</td>
<td>51.1</td>
<td>31.0</td>
<td>47.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(p&lt;0.007)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(n=173)</td>
</tr>
<tr>
<td>Believes one BIH health system is possible</td>
<td>84.6</td>
<td>74.1</td>
<td>42.1</td>
<td>68.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(p=0.0000)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(n=189)</td>
</tr>
<tr>
<td>Would personally like to see one health system in BIH</td>
<td>86.3</td>
<td>78.8</td>
<td>36.2</td>
<td>68.9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(p=0.0000)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(n=190)</td>
</tr>
</tbody>
</table>

2 Participants were not asked to identify their ethnicity. The surveys were coded to identify political control of their area and used as a proxy for ethnicity. For example, respondents from west Mostar have been identified as Bosnian Croat and those from east Mostar as Bosniaks.
The survey data can demonstrate associations between variables; for example that those who have participated in seminars are more likely to be comfortable working with health professionals from other communities. In this manner, the data does illustrate some of the obstacles to the formation of a democratic civil society which the PTH programme has attempted to address. However, the survey data cannot confirm causal relationships, for example that participation in seminars leads to a decrease in discrimination.

The issues of isolation and polarization perhaps come out most clearly in the survey data. Generally, Bosniaks and Bosnian Croats have had more interaction, feel more comfortable with inter-entity activities, and express more desire for increased collaboration. These data conform to general impressions in the field. However one potential confounder may be how each group defines “inter-entity”, for although they are legally clear and distinct, in practice many people consider FBIH to be two entities. So when Bosniaks or Bosnian Croats say they would like to see increased collaboration they potentially could be referring to each other, to the RS, or to both.

Again without establishing causality, those who have participated in an inter-entity health activity are more likely to have a changed level of comfort and vice-versa (n=183, p<0.00003). The least comfortable with inter-entity activities have not changed their minds in the past year (n=178, p<0.02). In terms of ethnicity, Bosnian Serbs represent 65% of all respondents who cited being “very uncomfortable” with inter-entity activities and 53% of those who were either “very uncomfortable” or “somewhat uncomfortable”. However, the Bosnian Serbs also have the strongest association between participation and increasing comfort level. Only 4.2% of Bosnian Serbs who did not participate in an inter-entity activity changed their level of comfort over the past year while 45.5% of Bosnian Serbs who did participate did report a changed level of comfort (n=59, p<0.002).

Overall, exposure is closely associated with more willingness or desire to collaborate. Of the respondents who have participated in inter-entity activities, 83.0% want more, while only 66.4% of non-participants want more activities (n=169, p=0.013). Those who have participated in an inter-entity activity are more likely (63.3% versus 42.0%) to wish to be able to refer patients to the other entity (n=168, p=0.012). Likewise, those who have participated are more likely to personally wish to see one health system for BIH (n=185, p=0.008). This is consistent across all ethnic groups.

The survey data also illustrate issues related to authoritarianism and individual responsibility. When compared to what we expected, relatively few respondents said they were afraid of repercussions from health authorities should they participate in inter-entity activities (although one in six Bosnian Serbs and 10% of Bosnian Croats did not answer the question). It is not clear whether this is a true reflection, whether people did not want to admit fear, or people were not confident in the anonymity of the survey. Those who did fear repercussions were more likely to want to work with health professionals from the other entity. This holds true when stratified by ethnicity. Perhaps the hand of authority is perceived as a greater threat to those who try to cross it.

The data also highlight inconsistencies between generic beliefs and personal commitment or desire to uphold those beliefs. The vast majority (81.5%) of health workers believe that “health workers can contribute to improved relations between communities” (n=195). A slightly smaller majority (77.8%) “believe health professionals should work together” (n=194). And while there are differences across ethnicities, each group clearly supports these positions. However, when asked, “do you personally wish to work with health workers from the other entity/community?”,

38
only 51.9% responded positively (n=189). The Bosniaks and Bosnian Croats maintained slightly positive majorities (55.8% and 60.8% respectively) while the majority of Bosnian Serbs (60.8%) responded negatively.

Why the discrepancies between ideals and personal commitment? In part, this is a reflection of human nature. While on an academic level people feel that “yes we must get along”, on a personal/emotional level, the wounds of war are still fresh. There may also be an issue of perceptions of personal responsibility. Many of the challenges encountered in the PTH programme are not war-related. The legacy of the socialist system is one in which personal responsibility and accountability are minimized. These issues are discussed in other sections of the case study.

In sum, it can be stated with a fair degree of confidence that the data have confirmed many of the assumptions and observations of the WHO field team and supported the validity of the objectives and strategies of the PTH programme. Surveys give a voice to those who often go unheard and what these voices have to say is very encouraging in many respects. Empowering these voices is the challenge of Peace Through Health.
Discussion

Is promoting “peace through health” a role for WHO?

Following the end of the cold war, “the internationalisation of civil wars is now considered primarily as an impartial pursuit through the United Nations rather than an aggressive and side-taking military strategy carried out on a bilateral basis. The main posture of international action in contemporary civil wars is thus one of third-partyism which seeks to engage between warring parties rather than bilateralism which seeks to support one side or the other.” (Slim 1998) It is this shift which is in part responsible for the seemingly inordinate length of time it took the international community to “get its act together” in Bosnia and Herzegovina and to achieve a consensus for unified action. Member states of the United Nations, in addition to the various United Nations agencies, IGOs and the rapidly expanding multitude of NGOs, have been working through this shift, trying to clarify new roles while still attempting valiantly to meet the needs of populations suffering the horrific consequences of war. These positions and challenges are no less for WHO.

If health is accepted to be a basic and inviolable human right, then the attainment of health will require far more than a fixed sum of curative medical interventions. Thus, the role of the health sector in conflict situations cannot be limited to the provision of health care and, by extension, WHO in its leadership capacity cannot be limited to its traditional normative role. By virtue of the inextricable associations between politics and wellbeing, WHO has both a role and a responsibility to extend itself beyond the technical dimensions of public health and health care service provision. The Peace Through Health programme in Bosnia and Herzegovina is probably the most extensive practical WHO intervention to acknowledge and address these responsibilities.

This is not to say that Peace Through Health is a substitute for political action at higher levels. Quite the contrary, it is dependent upon higher political processes and seeks to complement these processes. Peace agreements, security, justice, amnesty create the framework within which WHO must work.

In Bosnia and Herzegovina, if the Dayton Peace Agreement creates the framework within which WHO must work and the DPA also specifies autonomous health systems for each entity, is PTH an over-extension of WHO’s mandate? Are we imposing unwanted ideals? Are we politicizing health? To a certain extent, the answer to each of these questions is “yes”. Unlike the Health as a Bridge to Peace work in Central America, the Ministers of Health did not hold reconciliation to be among their priorities, responsibilities or interests. Within the DPA, there is no legal binding for inter-entity cooperation in the health sector. Health care systems can be built without inter-ethnic collaboration. However, (at least) three imperatives supercede these objections.

Firstly, in the sphere of public health, Ministries of Health cannot perform their duties without collaboration. In the European Community, an over-arching public health commission has been created to harmonize policies and strategies in order to mitigate public health threats brought about by the economic union. Much as WHO in BIH, this body is not a threat to the autonomy of Ministries of Health and does not constitute an over-extension of the coordination function.

Secondly, if we feel that peaceful co-existence is essential to health, and we believe that the vast majority of Bosnian citizens do not wish for continued conflict, then we would be highly remiss in our mandate to improve health for all should we not provide opportunities for peace.
Thirdly, while health care system administration is an entity responsibility, we cannot morally accept the restriction of access to health services in either entity on ethnic grounds. If we are to achieve the return to homes and meet the consequent need for public services, as envisaged in the DPA, substantial conflict resolution and peace-building measures are required. Thus, PTH does not impose systems, nor does it usurp decision-making powers from the health authorities. PTH catalyses processes which address fundamental barriers to peace and are ultimately necessary to the creation of conditions conducive to health and wellbeing. It seeks equality and empowerment within the framework of the DPA.

If PTH is about processes, what is the end-state of PTH? At the outset, specific targets were not set. At the programme’s inception, we were uncertain how to elaborate an ideal end-state other than “sustainable peace”, and it was not known how much, if any, success we would have with any one of the strategies. Verifiable indicators (see Appendix III) were proposed to measure progress and to varying degrees each one has been met or surpassed. In this measure, our strategies were realistic. But were they effective?

A central issue in our initial programme risk assessment was concern whether the PTH strategy would contribute to peace-building whilst at the same time improving health status and services in BIH. There are two questions in this issue. Firstly, have we distracted ourselves from performing our technical role? Secondly, would separated health system development ultimately contribute more to stability and peace?

As to the former question, for reasons outlined above, to view contributions to peace-building as extraneous to our technical role is at best myopic, at worst negligent. In a situation with such high levels of misinformation and polarization, health and wellbeing will forever be held prisoners to fear and insecurity until these obstacles are addressed. Each side has demonised the other to the point where it is not possible to feel secure. More than two million people are displaced from their homes and deserve the opportunity to return. The personal contact facilitated by PTH is crucial to dismantling negative and prejudiced stereotypes and therefore crucial to the creation of healthy environments.

Would separated health system development ultimately contribute more to stability and peace? Put in another way, are the selected PTH strategies – facilitating inter-ethnic and inter-entity high level policy discussions, bringing health professionals together for technical discussions, joint activity development, etc. – the most effective means to make real contributions to the peace process in the long run? It is too early to make a definitive judgement on measurable contributions to the peace processes. It can be said, however, that the health care systems would be no more stable or more advanced than if WHO had dealt with each ethnic group separately.

It is hard to tell at this point in time whether improving stability, including that of the health sector, is solely a result of international pressures or if there is indeed a culture of peace emerging. In spite of some positive political developments, the political compromises achieved within the DPA do not form a stable foundation for long-term peace. The onus of making progress towards reintegration and peace is placed upon leaders who see different objectives in the same peace accord. The democratization processes of three parallel systems have been severely underestimated as they depend upon ideals which are sacrificed in the face of threats (perceived or real) to personal security. This is compounded by the DPA’s institutionalization of political representation on the basis of ethnicity. Take for example lack of plurality in election results at any level. Election results reflect an entrenchment of polarization. If you were Bosnian Serb, Bosnian Croat, or Bosniak: for whom would you vote? Is there any space for idealism when the security of your family is at stake?
Is PTH just international pressure or does it help to create a culture of peace? Certainly in some senses, as mentioned earlier, PTH is an imposition of ideals. However, no programme can impose peace, and in no sense does PTH try to do that. What PTH tries to do, and has successfully done, is to create opportunities for peace. It is empowering people who wish to live in and contribute to peaceful environments. It is giving people choices for peace which they otherwise would not have. And it promotes the principles which are fundamental to a peace culture.

Returning then to the peace-building processes initiated by a programme such as PTH, how far can we go? Looking at the issue of discrimination, it could be argued that discrimination is merely a manifestation of a deeper issue of identity. Should we address the issues of identity? The construction of polarized identities is a very difficult evolution to reverse and a very dangerous one with which to live. It is not unique to the conflicts in the former Yugoslavia. The platform of India’s current nationalist governing party can be traced to Indira Gandhi’s equating of “Hindu” and “Indian” as synonymous in the mid-1970’s. China and Taiwan have developed nationalist identities around ideology. So if we hope to create a stable and lasting peace, should we be trying to deconstruct identities?

In effect, PTH has tried to address the question of identity, although not in a deconstructionist approach. Each individual has several levels of identity: personal, familial, professional, religious, national, global, etc. PTH has worked to emphasise certain levels (individual, professional, global) while downplaying others (religious, ethnic, national). The contrasts between identities are striking and the emergence of a peace culture is very much dependent upon how much people are allowed to interact on levels which promote peaceful co-existence. The Ministers of Health for Neretva canton (Mostar) provide a good illustration. On a personal level, they are friends and advocate for collaboration. As Ministers, they are not willing to initiate cross-community activities. The authoritarian structure does not permit personal identities to influence professional roles. As a counter to this, WHO has created venues where they can interact safely on personal levels, together with other health professionals. Whether these opportunities translate into (lasting) changes in their professional identities has yet to be determined.

This is an extremely crucial question of PTH: how do we transform passive participation of health workers into catalytic members of peace processes? Again this is a question which requires time before an evaluation of PTH strategies can provide definitive answers. However, viewed in stages, health workers are undergoing a transformation in which they are becoming advocates for peace. The first stage is one of acceptance: acceptance of their professional and ethical responsibilities, of the need for peace, of the legitimacy of grievances on the other side. From acceptance, the step to participation is not difficult and generally speaking, health professionals have been very willing to participate in cross-community activities. Finally, through participation, health professionals can become advocates for peace, promoting harmony from within, as a necessity for peace and not as an externally imposed condition. In BIH, we are beginning to see examples of this third stage, a very encouraging sign. Continued commitment and empowerment, in skills and attitudes, will sustain this process.
Appendix I. Management notes

In addition to some of the key issues highlighted in the preceding sections, the following are key recommendations from the WHO BIH field staff for future humanitarian assistance operations in complex political emergencies.

WHO Staff

PTH has placed new demands on the field staff and in doing so has created a need to adapt our staffing. The first question it raises is the type of staff needed. The combination of one medical professional and one non-medical professional as co-coordinators of the PTH programme proved to be very effective. The field team felt that more diversity in the field staffing could only strengthen our performance. Some specific suggestions include a media professional, a nursing specialist, a legal/human rights specialist, and various technical health specialists (often filled by EURO professionals or consultants, e.g. pharmaceuticals). Not all of these would need to be full time. Regular contributions of the DFID conflict resolution specialist (who had in-depth knowledge of the conflict in Former Yugoslavia) were highly valued by the field staff.

Training needs of the field staff must also be carefully considered. Some of the areas where it was felt the staff could use some external training include conflict resolution strategies, negotiation techniques, management skills, working with the media, principles and applications of human rights, and report writing. Appropriate preparation of field staff before being sent to the mission area is also needed.

WHO was very fortunate to have a good mix of national and international staff. It is more than obvious that we would not be able to operate in BIH without the “local” professional and support staff. Investments in these team members are particularly valuable and should be made early and regularly. The rationale for such investment is deep: to maintain staff morale, to improve the quality of WHO interventions, and to provide a direct contribution to the development of BIH as the local staff will be there long after the mission has withdrawn.

In terms of PTH, national staff understands the situation on the ground and can interpret nuances otherwise invisible to the foreign eye. There is always a danger in polarized political situations that personal biases will interfere with professional duties but it is felt that the WHO local staff have displayed a remarkable level of professionalism and in performing their duties have done so unequivocally as WHO representatives.

A constant over-shadowing concern of the field staff has been the length of contract and the duration of the mission. At points, it became very difficult to motivate or to plan because of these uncertainties. There was also a feeling that the mission could easily become donor driven, not objective oriented. Although the funding situation is somewhat unpredictable, the field staff would rather have clear mission objectives and a longer-term perspective, even if resources are not in hand.

WHO Structure

WHO BIH has been extremely fortunate to have a network of field offices throughout the country. The field offices were invaluable in their ability to monitor the health situation, to involve people and groups on all levels, and to ensure that health needs were being met to the extent possible in all areas of the country.
Maximizing the effectiveness of our field offices in the PTH programme took some learning and adjustment. Prior to the inception of PTH, programmes were administered vertically, leaving little room for independent field office actions. At the outset of PTH, we maintained the same rigidity: what one field office does, so do the others. It soon became apparent that such programming limited the creativity inspired by PTH and its potential to address the fundamental obstacles to peace as they variously presented themselves in different communities. Strategic adaptation required a reassessment of expectations and responsibilities of field offices. Are they the implementing arms of the central office or do they have semi-autonomous responsibility for their areas? An appropriate balance was achieved whereby the field offices implemented central initiatives such as family medicine training programmes while also having an amount of PTH funding available for discretionary use.

A second structural issue which had created a great deal of frustration but is now being resolved is that of the use of liaison officers. It became very difficult in the countries of former Yugoslavia to implement “humanitarian assistance” programmes through field offices while “development” programmes were being implemented independently by EURO through a national liaison officer. Dual lines of responsibility and accountability leads to confusion, wasted resources and diminished results.

**WHO policies and positioning**

Perhaps more than any other programme, PTH has pushed the field staff to take a stand in the (often untenable) meeting ground between policies and practices. What does it mean to be “neutral” when every action has perceived political significance? Does impartiality impute moral equivalence on all parties? If so, can we live with that given the nature of the conflicts in the former Yugoslavia? How can we be “advisers to the Ministry of Health” and at the same time the “health conscience”? If the Ministries are not prepared or able to honour their commitments, at what point do we re-assess our obligations to the Ministries? To what extent can we apply or withdraw resources to enforce our positions? Whom will EURO support in case of divergent opinions: field staff or Ministries?

Field officers must deal with these questions on the front line. The lack of clarity on organizational positions and the lack of visible support for the field officers create a great deal of frustration and tension. Dialogue is required on these issues, both in-house and with the host country.

WHO must also ask itself if it is committed to the ideals of PTH. From the perspective of the field, there is little understanding or commitment to PTH at higher levels outside of the humanitarian assistance units of EURO and headquarters. Peace Through Health is not a uniquely humanitarian assistance challenge. It can and should be applied in other phases of country health development, not just post-conflict. Much needs to be done to promote PTH at the highest levels of WHO and to elicit true commitment from these levels. DFID and other donor agencies may have an instrumental role in this process.

**Evaluation**

Evaluating the impact of the PTH programme is an extremely difficult task. One very effective means of evaluation was the active participation of DFID representatives. Field visits exposed DFID to a wide range of persons and organizations directly involved in post-war reconstruction of health and other sectors. For the WHO field staff, the external vantage of the DFID representatives provided very refreshing perspectives of a situation from which it is very difficult to step away. The regularity of these visits also helped to provide benchmarks for progress.
Other means of evaluation could be further developed. Were we to begin again, conducting a survey at the outset of the PTH project could provide a more tangible baseline from which to measure progress. Quantifying cross-community initiatives of all health agencies, through our coordination mechanisms, may also provide an indicator of the peace-building processes.

**Partnerships**

Partnerships have been crucial for the PTH programme. By partnerships we mean the combination of respective strengths in a transparent and honest relationship in order to improve the outcomes of interventions. In terms of implementation, there is no way that WHO staff alone could implement all of the resources. Using consultants is one method of implementation and the use of implementing partners is another. The use of partnerships was somewhat ad hoc, largely dependent upon personal contacts in the field. Developing more formal relations at higher levels may be an effective way to address the health sector needs while ensuring appropriate standards.

Developing partnerships, however, is more than just a means to implement programmes. PTH is a strategy whose impact can be significantly strengthened as more agencies incorporate conflict resolution into (health) development. International solidarity in BIH has taken a long time to reach its current, albeit far from optimal, state. The PTH approach is something which should be discussed among agencies at a headquarter level to ensure consistency at the field level. WHO has a leading role in this process.
Appendix II. Peace Through Health activity analysis

Sample activities are selected here to illustrate some of the issues involved in activity implementation. The lessons may be useful for planning PTH activities in other areas. They also illustrate the necessity for undertaking “stakeholders analyses” in conflict situations, e.g. understanding who’s involved, what are their motivations and limitations, etc.

<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>MEDICAL STUDENTS JOURNAL</th>
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<tbody>
<tr>
<td><strong>OBJECTIVES</strong></td>
<td>To provide Bosnian medical students with current medical literature and an opportunity to publish original works.</td>
</tr>
<tr>
<td></td>
<td>To promote inter-faculty cooperation.</td>
</tr>
<tr>
<td><strong>PRINCIPAL OUTCOMES</strong></td>
<td>Renewal of dialogue between the medical faculties.</td>
</tr>
<tr>
<td></td>
<td>Explicit working agreement between student leaders.</td>
</tr>
<tr>
<td></td>
<td>A format and publishing schedule for the journal.</td>
</tr>
<tr>
<td><strong>KEY FACTORS TO SUCCESS</strong></td>
<td>All three faculties independently expressed desire for a journal.</td>
</tr>
<tr>
<td></td>
<td>Individual leadership from the head of the Sarajevo students.</td>
</tr>
<tr>
<td><strong>CONSTRAINTS</strong></td>
<td>Deans of Tuzla and Banja Luka medical faculties.</td>
</tr>
<tr>
<td></td>
<td>Lack of organization among Banja Luka and Tuzla associations.</td>
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<tr>
<td></td>
<td>Opposition among wider student body in Banja Luka (initial proposals to invite Sarajevo students to Banja Luka for a seminar were rejected by the Banja Luka Medical Students Council).</td>
</tr>
<tr>
<td></td>
<td>Competition between FBIH and RS in the International Federation of Medical Students Association.</td>
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<tr>
<td></td>
<td>Time required to build relationships with all faculties.</td>
</tr>
<tr>
<td><strong>WHAT WOULD WE DO DIFFERENTLY?</strong></td>
<td>Not delay initiative when one side does not meet obligations. (In effect we punished those who did want to proceed.)</td>
</tr>
<tr>
<td></td>
<td>Pressure Faculty Deans for open, written support.</td>
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<thead>
<tr>
<th>ACTIVITY</th>
<th>ADVANCED EPIDEMIOLOGY COURSE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>OBJECTIVES</strong></td>
<td>To improve epidemiology skills.</td>
</tr>
<tr>
<td></td>
<td>To promote inter-entity cooperation.</td>
</tr>
<tr>
<td><strong>PRINCIPAL OUTCOMES</strong></td>
<td>Successful completion of training for 12 professionals, the first major inter-entity workshop.</td>
</tr>
<tr>
<td></td>
<td>Establishment of a precedent for inter-entity workshops.</td>
</tr>
<tr>
<td><strong>KEY FACTORS TO SUCCESS</strong></td>
<td>Calibre of the course was indisputable.</td>
</tr>
<tr>
<td></td>
<td>Commitment of WHO/CDC to implement course.</td>
</tr>
<tr>
<td><strong>CONSTRAINTS</strong></td>
<td>Lack of support from FBIH MoH.</td>
</tr>
<tr>
<td></td>
<td>Unwillingness of FBIH lead epidemiologist to be a part of the course and its organization, and subsequent obstruction.</td>
</tr>
<tr>
<td></td>
<td>Lack of freedom of movement.</td>
</tr>
<tr>
<td><strong>WHAT WOULD WE DO DIFFERENTLY?</strong></td>
<td>Obtain and distribute written commitment from MoH. If not possible, proceed as we did.</td>
</tr>
<tr>
<td></td>
<td>Outsource more aspects of course preparation, e.g. translation. Course preparation demanded a lot of staff time.</td>
</tr>
<tr>
<td>ACTIVITY</td>
<td>PARTICIPATION IN EUROPEAN WORKSHOPS</td>
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</tbody>
</table>
| OBJECTIVES | To improve skills of BIH health workers.  
To develop external links for BIH. |
| PRINCIPAL OUTCOMES | Exposure of professionals to new ideas, attitudes and methodologies.  
Inclusion of BIH professionals in European networks.  
Increased sense of pride and responsibility among professionals. |
| KEY FACTORS TO SUCCESS | Individual desire to participate.  
Network and seminar opportunities available to WHO.  
Resources of PTH programme. |
| CONSTRAINTS | Selection of participants usually done by health authorities.  
Limited possibilities to apply skills upon return. |
| WHAT WOULD WE DO DIFFERENTLY? | More consistent reporting from participants.  
Develop better mechanisms for dissemination of skills and knowledge upon return. |
Appendix III. Original project proposal

DRAFT PROJECT MEMORANDUM

WHO PEACE THROUGH HEALTH PROGRAMME BOSNIA-HERZEGOVINA 1997

Implemented by ODA and WHO

Draft 9.3.1997
Dubrovnik

Second draft 12.3.1997

Emergency Aid Department
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C. Background ............................................................................................................................... 54
D. Programme approach .............................................................................................................. 54
E. Implementation .......................................................................................................................... 56
F. Risk analysis ............................................................................................................................. 56
A. BASIC DATA SHEET

Name of programme: WHO PEACE THROUGH HEALTH PROGRAMME
BOSNIA-HERZEGOVINA 1997

Location: Bosnia-Herzegovina

Implementing agencies: ODA AND WHO

Project cost: £650 000

Programme Summary:

The goal of this programme is to contribute to peace-building within BIH through appropriate strategic health sector development.

The purpose is the integration of peace-building awareness and capacity-building for reconciliation into health care systems. It will deliver the following outputs (all with a multisectoral approach).

(a) Continued health care coordination work with INGO, LNGO, Ministry, local authority and professional levels.

(b) The development of new forms of training.

(c) Health promotion.

(d) Public health activities.

(e) Active learning for WHO facilitators in conflict resolution, health advocacy, situation analysis and accountability. Particular emphasis will be placed on relationship building and facilitating local involvement.
### B. LOGICAL FRAMEWORK

**WHO Peace Through Health Programme 1997**
First draft: Dubrovnik 9.3.1997

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Verifiable indicators</th>
<th>Means of verification</th>
<th>Key assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOAL:</strong>  To contribute to peace building within BIH through appropriate health sector development</td>
<td></td>
<td>Final Project Report by March 1998</td>
<td>1. General</td>
</tr>
</tbody>
</table>
| PURPOSE:   To integrate peace building awareness and capacity building for reconciliation into health care systems | • increased cooperation between local authorities  
• enhanced access to cross-community care for all, through:  
• removal of barriers to freedom of movement  
• increased community participation in health initiatives | 1. Monitoring by WHO field officers  
2. Reporting from WHO Sarajevo | • that the political framework for peace, that is, the Dayton Peace Accords, will be maintained and supported by the international community, and the current peace process continues |
| OUTPUTS:   1. Cooperation and confidence building through **health coordination** at government, local and NGO levels | • sectoral task force on health policy and system addresses strategic issues regarding inter-entity and interethnic participation  
• policy and implementing partners across the sectors reach consensus and are mobilized to carry out activities which decrease polarization, discrimination, and manipulation of information.  
• quantifiable increase in cooperation and intersectoral projects | • minutes of sectoral task force meetings, coordination meetings at local and cantonal levels, ministerial expert groups facilitated by WHO, including list of participants  
• spot interviews with authorities, NGOs and WHO field offices  
• NGO project sample project reviews | • that there will continue to be a critical mass of health professionals and the population who desire reconciliation, cross entity and cross ethnic contacts |

• that economic reconstruction will gather momentum  

• that health is a neutral platform on which the peace process can be facilitated |
<table>
<thead>
<tr>
<th>Objectives</th>
<th>Verifiable indicators</th>
<th>Means of verification</th>
<th>Key assumptions</th>
</tr>
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</table>
| 2. Pilot courses in **health training** on HIV prevention and primary health management, including communication and negotiation skills, problem solving and conflict resolution, active learning and group dynamics and community involvement. | • concerted effort in producing and exchanging reliable and accurate public health data.  
• joint action plans, policy statements and implementation of plans.  
• usage of data for political purposes diminished  
• planning of courses, with interethnic culturally acceptable approach to formulation of course material  
• interethnic and inter-entity participation in courses by health workers, and other sectors (education, arts, private, conflict resolution inputs)  
• multiplier effect from learning interpersonal relationship building, practical problem solving and negotiations skills, in addition to new health skills demonstrated  
• increased awareness of gender issues particularly in HIV pilot training courses  
• consultations undertaken with communities (through local health workers and NGOs) on their primary health concerns, and participatory decision-making on priority areas for health promotion and strategies  
• multisectoral groups enabled to organize campaigns using acceptable means of communication  
• community ownership in local efforts  
• improvement in lifestyles and living conditions  
• improvement in awareness of and responsiveness to vulnerable needs groups  
• number of courses (planned one training of trainers for each topic, and one pilot training course in each canton where WHO field offices are located)  
• reports on courses undertaken including participants  
• questionnaires filled in by trainees  
• course evaluation by participants and partners  
• follow up contacts between and amongst health workers, and other sectors  
• availability of printed materials in local language  
• number of campaigns, subject matter, no and type of participation, type of communication used  
• private resources for campaigns  
• sample household surveys of effectiveness of message by joint teams with NGO/local groups participation  
• formation of professional and patients association  | • that the population perceives the improvement in their health status as a “peace dividend”  
• that resources are available to maintain the required field structure in Bosnia and Herzegovina to implement the project  | 2. For WHO  
• that there is adequate external inputs and internal capacity to implement the project  
• that available resources will not be diverted to meet sudden more priority needs |
<p>| 3. Cross-sectoral partnerships in <strong>health promotion</strong> which cultivates self-help, shared responsibility, and community involvement |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 4. Promotion of <strong>public health activities</strong> as above |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 5. Increased peace building strategic awareness for WHO staff |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |</p>
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<tr>
<th>Objectives</th>
<th>Verifiable indicators</th>
<th>Means of verification</th>
<th>Key assumptions</th>
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<tr>
<td>ACTIVITY FRAMEWORK:</td>
<td>INPUTS:</td>
<td></td>
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<tr>
<td>1. Support initiatives and activities that empower local institutions and</td>
<td>1997/1998 £650 000 from ODA</td>
<td>workshops with field officers participation with external expert inputs</td>
<td>• that the strategies chosen do contribute to peace building, as well as to the</td>
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<td>communities to decide on resource allocations, manage key programmes, and</td>
<td></td>
<td>quarterly meetings to take stock of progress of project, need for redirection of</td>
<td>improvement of health status of the population, in tangible and in intangible</td>
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<td>feedback to the national network with increased cooperation</td>
<td></td>
<td>strategies, with active learning and small group brainstorming sessions</td>
<td>terms</td>
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<td>2. Continue coordination meetings building on 1996 experience</td>
<td></td>
<td>major midterm review of project, with built in report writing learning sessions</td>
<td>• that the field officers are actively engaged in the process, are capable of</td>
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<tr>
<td>3. Design and promote active learning in conflict resolution, health</td>
<td></td>
<td>midterm report and final report with financial data</td>
<td>objectively documenting and taking stock of the ongoing the process, and seizing</td>
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<td>advocacy, situation analysis and accountability</td>
<td>WHO field staff participation in active learning workshops on conflict issues</td>
<td></td>
<td>opportunities as they arise</td>
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<td></td>
<td>appropriate channels for advocacy selected from different options</td>
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<td></td>
<td>coordinated effort in taking stock of strategies chosen for the project, analysis of</td>
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<td></td>
<td>situation and impact of activities</td>
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<td>training for improved reporting</td>
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<td></td>
<td>• that the channels chosen for advocacy for peace by the field will be supported</td>
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<td>within the hierarchy of the Organization</td>
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C. BACKGROUND

1. In 1993 WHO began discussions with Bosnian, Croat and Serb health authorities in Bosnia-Herzegovina on the possibility of a tripartite meeting to address common problems, an initiative finally realized in Copenhagen, April 1994. A previous UNICEF-sponsored meeting on vaccination had also brought representatives together from the three sides to discuss professional and humanitarian issues across political lines of confrontation. This “health diplomacy” on an official level set precedents for regional and local health care teams to consider, particularly after the formalizing of the Dayton agreement.

2. ODA supported WHO in its first post-Dayton transition year as it moved from a war-time relief delivery role to an effective presence in the gradual normalizing of health policy and service development. WHO has a resident presence in both entities and a network of professional relationships with organizations and officials. Its respected local and international staff and active demonstration of the practicalities of medical ethics, combined with WHO as a “historical” actor (as opposed to many new ones flying in and out) give it credibility for confidence building, as envisaged in Dayton. Examples of this include cross-entity task forces, professional interest meetings across the ethnic divide, public information campaigns, and support for cross border transport and communications.

3. ODA has worked in Bosnia since the beginning of the war and has in-depth knowledge and documentation of the complexity involved in post-war reconstruction. Physical reconstruction of infrastructure, housing, schools, hospitals is the visible face of post-war recovery. The ODA mandate for conflict reduction through aid takes into account not only the “relief to development” continuum, but also the cycles of recurrent violence possible in the absence of conflict preparedness, prevention measures and mitigation. The reconciliation of groups within divided societies is an essential element in any sustainable peace.

D. PROGRAMME APPROACH

1. Just over one year after Dayton physical reconstruction is underway, but the structural underpinnings of a divided society remain. Telecommunications remain unresolved, with western Bosnia still using a telephone exchange through Zagreb and eastern entities through Belgrade. The repatriation issue is enormous and is used by some entrenched authorities to fan old fears and animosity. In autumn 1996, 213 homes outside and inside the ZOS were destroyed. Freedom of movement is still non-existent for citizens in Mostar and elsewhere, compounded by politics and by the presence of land mines.

2. WHO has moved from an emergency to a development footing in post-Dayton Bosnia, offering technical support to ministers in the framing of new health legislation, holding a coordination role for health and reconstruction agencies and initiatives as well as health professionals themselves, and enabling appropriate national and local bodies to resume responsibility for production and distribution of supplies, physical and mental rehabilitation, data collection and the reconstruction of health facilities. Recent WHO decentralization policy (re: financial management from Copenhagen) through the Bosnia office has increased the delegation of authority to the field level for technical and programme decisions. This should maximize efficacy and strengthen local consultation processes in context.

3. Central to the visible post-war projects concerning health has been the respected professionalism and trust of staff, which has leant itself to non-official mediation, the gradual discreet rebuilding of fractured relationships and a discernible confidence building between individuals, communities and entities. Were WHO to cease its operations in BIH a political mediation void vis-à-vis policy could hamper or set back current processes. It is probable that INGOs would attempt current coordination functions, but with a break in continuity and an unpredictable approach. In short, a lot of work would need to be started all over again. A 1996 SIDA evaluation of NGO interventions (with
reference to conflict resolution) documents the value of continuity and proven in-country performance.

4. Divisions in BIH are multiple in nature, complex and intertwined in society. There is the obvious division of RS and the Federation, and the visible politicized ethnicities in both. There is enormous division within the Federation with regional and economic disparities often underlying Croat and Bosniac divisions. Moreover, there are severe social divisions along urban/rural lines which is hardly disguised, and expressed in phrases (even from health professionals) such as “those dirty peasants” with reference to people living within a twenty mile radius. There are signs of new “haves and have-nots” as articulate local advocacy NGOs consolidate their own funding, equipment, and styles in what may be called the professionalizing – of NGOs – in contrast to acute residual economic underdevelopment, unemployment, and uncertainty. The most basic of salaries are not guaranteed – as evidenced in a strike by health professionals themselves in March 1997 due to non-payment. Post war and war-induced economic paralysis and structural reform for financial responsibilities from federal to canton level mean it will be some time before stabilization.

5. Stakeholders in the WHO Peace through Health programme are seen as the general population of BIH. The vision of a new health system based on family doctors and decentralized medical centres can be realized only with comparable community development and access to services. Health activity can be a force for positive mobilization, involvement and even a forum for emergent (but non-expert) leadership. The concern and interest in health is probably one of the few common denominators in the current confused and economically depressed situation.

6. Particularly vulnerable and marginalized groups have previously been identified and worked with; the elderly, children with handicaps and their parents, disabled veterans and mental health constituencies. Target groups for PTH would include self-help group development on single issues (alcoholism, infant care, diabetics, ) as well as youth-physical fitness themes and HIV training. A pilot training course will target hospital and primary health care workers, many of whom experience new marginalization given the multiple ministerial reproductions of hierarchical decision making which neither consults nor informs them re: policy formation or mass reorganization.

7. Participation of beneficiaries is essential for social reconstruction, building a climate of trust and “ownership” in a difficult transition period. Conditions of fear, polarization, and “disinformation” will be addressed through social development strategies, which in this case also intend the benefit of better public health. In the long term what stands to lose in this strategy may be the “cult of the expert” and those with a long-term interest in hierarchical rigidity.

8. Both men and women will benefit from this project. Attitudinal aspects of gender inequality should be designed into both HIV and staff development training.

9. Specific issues relevant to conflict exist on four distinct levels. HIV and staff training would address personal communication and conflict handling styles, self-development and team building (which In the long term could contribute to organizational change given degrees of external stabilization) Public Health activities and health promotion campaigns would seek to reduce polarization through shared community participation and focus, coordination activities will serve to assist canton level and inter-entity government communication.

10. The enabling emphasis of PTH is intended to strengthen indigenous capacity and development.

11. Previous experience indicates that localized projects centring on specific interest issues can lead to the gradual renewal of trust and sense of mutuality necessary for viable peace building. The Italian Atlas Project refers to this as “horizontal and decentralized co-operation”. In Gorni Vakuf a mobile gynaecology and infant care ambulance/clinic situated on the town’s dividing line has drawn women from both Croat and Bosnian sectors to a shared focus and meeting ground. Both the Vive
Jena women’s refuge and Oxfam “LOTOS” centre for persons with disability or handicaps in Tuzla have had this function with positive community response. Inter-personal skills development and group development has been the basis of local reconciliation initiatives in East Slavonia (Osijek peace centre, Baranja civic initiative, Vukovar women’s group, Group 484 from Belgrade which includes refugees from West Slavonia. It is significant that the OSCE “Democratization Programme” works on themes of 1) confidence building, 2) dialogue, and 3) reconciliation, which are compatible with PTH objectives. Informal links have been made in Banja Luka with the OSCE representative for human rights.

E. IMPLEMENTATION

1. The programme will be managed and monitored under the overall leadership, guidance and responsibility of the WHO Special Representative in Bosnia-Herzegovina.

2. The programme will be implemented through the public health experts in the WHO field offices Bihac, Banja Luka, Mostar, Zenica, Pale/Sarajevo and Tuzla.

3. Technical guidance will be provided by the health promotion unit and public health unit in the WHO BIH office in Sarajevo. Other expertise not available in the field will be provided by EURO or outside consultancy.

4. Currently WHO plans to be actively present in BIH until end of 1997. The need for a continued WHO presence after 1997 will be re-evaluated late summer 1997. Should WHO close at the end of 1997 sustainability will be guaranteed through active involvement of EURO technical units, and counterparts in the field. Attainment of outputs will be enhanced by ongoing collaboration with national and international counterparts such as NGOs and other UN agencies who will execute the programme in line with the DHA interagency appeal for BIH in 1997.

5. Support is still needed from other donors to maintain WHO presence in BIH in 1997 and that are indications that this support will be forthcoming.

6. Three months after receiving funds WHO will organize a participatory workshop for field officers with the objective of reflection and the monitoring of progress to date. This will be combined with training in more analytical report writing skills. After six months a similar process will be used for evaluation and the production of a report to ODA. ODA will be requested for inputs on report writing to sustain both these activities.

F. RISK ANALYSIS

In assessing the risk involved in undertaking this project, the participants in the preparatory workshop (Dubrovnik, 6–9 March 1997) analysed the current political, economic situation in Bosnia and Herzegovina, as well as WHO’s internal capacity. In summary, the group agreed that the main risks are:

1. Disruption of project activities due to resumption of armed conflict. Although opinions were divided as to the risk of this, the consensus was that large-scale conflict would be unlikely during the current mandate of SFOR. UNHCR and the High Representative Office’s analysis were also taken into account.

2. The WHO internal factors that may potentially lead to failure to complete the project are mainly linked to resources. The implementation of the activities relies on the integrity of the current field structure of WHO in BIH. Provided that contributions are pledged from other sources in response to the 1997 Appeal, the network of field offices will be sustainable throughout the lifetime of the project. Currently, it looks optimistic that Sweden, and the US will provide support to the WHO coordination and field structure.
It is recognized that the peace process in Bosnia and Herzegovina is hanging on a delicate thread. After four years of war, fear and mistrust is still pervasive amongst the population, as well as amongst the professional elite.

Over the years of presence in the field, WHO has been perceived as a neutral party by the authorities and health professionals, largely due to its role as a technical agency. The field officers have, in a sense, “depoliticized” health, despite the tendency in this context to do the contrary, by sticking to technical issues.

In making “peace building” the one of the key objectives of its activities, there is a risk that WHO’s technical role would be compromised, particularly if it is perceived to be involved in a political process. This may result in WHO being drawn into a political quagmire. WHO’s technical authority and its efforts to contribute to sustainable reconciliation will have to be skilfully balanced to maintain its acceptability as a neutral and unbiased agency.

Regarding advocacy, whether this concerns human rights violations, or violations of the Peace Accords (notably Freedom of Movement), there is a risk that by using the inappropriate channels or means, reconciliation “successes”, however small in scale, may be placed in jeopardy. Too much publicity of successes may also tip the balance in this transition phase. Sound judgement by WHO staff as to when and how advocacy or quiet diplomacy should be used will be crucial to the peace building process.

Finally, the unknown factor is whether the strategies chosen (facilitating inter-entity and interethnic high level policy discussions, bringing health professionals together for technical discussions, joint implementation of activities with highly desirable positive outcomes etc) will make real contributions to the peace process in the long run, whilst at the same time, improving the health status and services in BIH. This may not be measurable in the short term.
Appendix IV. References and background literature


UNITED NATIONS. Universal Declaration of Human Rights.
