THE MEDICAL NETWORK FOR
SOCIAL RECONSTRUCTION IN THE FORMER
YUGOSLAVIA

What can a Network of Health Care Providers do for Reconciliation, Social Reconstruction and Conflict Prevention ?

Report on a Meeting of the Network's Contact Group:
21-23 November 1997, Bled, Slovenia

March 1998

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REPORT INFORMATION

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REPORT CONTENTS

		page
I.	Introduction	1
II.	Opening session of the Bled meeting, Friday, 21 November 1997 Overview of the health and social situation in each region	2
III.	Second session of the Bled meeting, Saturday, 22 November 1997 Presentations and discussions	10
IV.	Third session of the Bled meeting, Sunday, 23 November 1997 Discussion about next steps for the Network	16

Appendices

Appendix A: Participants in the Bled Meeting

Appendix B: Program of the Meeting, 21-23 November 1997, Bled, Slovenia

Appendix C: Community Reconstruction and Reconciliation, Past, Present and Future

Appendix D: Looking at the past together, Workshop Exercise for the Medical Network for Social Reconstruction, November 1997

The Medical Network for Social Reconstruction in the Former Yugoslavia

Report on a Meeting of the Network's Contact Group:
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WHAT CAN A NETWORK OF HEALTH CARE
PROVIDERS DO FOR RECONCILIATION,
SOCIAL RECONSTRUCTION
AND CONFLICT PREVENTION ?

March 1998

I. INTRODUCTION

In what was once Yugoslavia, widespread intergroup violence has caused extensive physical, psychological, and societal trauma. The medical community has a unique and crucial role to play in healing this society, not only in mending the physical and psychological wounds of individuals but also in rebuilding structures for public health care and in creating bridges for community reconstruction.

A small but growing group of medical professionals from the former Yugoslavia has recognized this responsibility and struggled to respond. With the help of colleagues from neighboring European countries, this group has met sporadically since 1991, and has grown from a core of about six to more than sixty participants. Broad-based participation has been difficult to orchestrate, partly because of severed communications channels and inadequate resources. Nonetheless, the group's meetings have brought together polarized parties during periods of extreme violence in the region.

In April 1997, over 60 health care providers from all parts of the former Yugoslavia convened in Graz, Austria This meeting was hosted by the OMEGA Health Care Center in Graz. At this conference the **Medical Network for Social Reconstruction in the Former Yugoslavia** was established, as a "loose network of health care providers to reconcile existing conflicts and prevent root causes of new conflicts in the former Yugoslavia." The goals of the Network are to promote dialogue, cooperation, personal contacts, practical solutions and the renewal of relationships in the region.

To expedite its work, the Network has formed a "Contact Group" to implement the decisions of the Network and to plan future programs. The Contact Group is designed to have two people from each former Yugoslav Republic, but is flexible to

reflect the geo-political realities of the region[1]. The first meeting of the Contact Group was held in Bled, Slovenia, 21-23 November 1997. This meeting was hosted by the Slovene Foundation of Ljubljana. The meeting had three foci:

- review the status of health care delivery and social reconstruction in the former Yugoslavia;
- discuss the organizational development of the Medical Network, including its mission and program plans; and
- plan for the next meeting of the larger Network group.

This report describes the discussions, activities and decisions taken at the Bled meeting.

II. OPENING SESSION OF THE BLED MEETING
Friday, 21 November 1997
Overview of the health and social situation in each region

The meeting had 21 participants (see Appendix A for a list of participants). From the former Yugoslavia, participants came from Bosnia, Croatia, Macedonia, Montenegro, Serbia (Kosovo and Vojvodina) and Slovenia. Network supporters came from Austria, the United Kingdom, and the United States. Guest speakers attended from Norway and Canada. Members of the contact group who were scheduled to attend from the Republika Srpska were, just before the meeting, denied visas to enter Slovenia and therefore were unable to attend. A follow-up meeting with Republika Srpska representatives occurred in January 1998 in Austria. The representative from Belgrade had health problems just before the meeting and was therefore unable to attend.

The session began with informal reports from the regions that were represented. The reports were intended to answer the following six questions:

- what is going on in this region in the fields of physical, psychological and social health?;
- with whom do people cooperate (national or international organizations, governmental or non-governmental bodies...)?;
- what do members of the Contact Group and their organizations do?;
- how are communications within the medical community and between this community and the relief and humanitarian field?;
- what are the health (broadly defined) needs within a specific region?; and
- what are the wishes within the region regarding future communication and cooperation?

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[1] The Contact Group has representatives from Croatia, Slovenia, Serbia (plus representatives from Kosovo and Vojvodina), Macedonia, and Montenegro. Also, from Bosnia there are two representatives each from the Serbian Republic of Bosnia-Herzegovina (Republika Srpska) and from the Muslim-Croat Federation of Bosnia-Herzegovina.

Report from Slovenia

Within Slovenia there are now approximately 4,000 refugees, 99% of whom are from Bosnia and, of these, 60% are from the Republika Srpska. This number is down from 1996 when there were 8,000 refugees, and reflects the new refugee policies within Slovenia, which limit refugees' access to residency visas and decrease school access. Another result of this law is a significant increase in the number of illegal refugees, now estimated at 1,000 people.

The psychological state within the refugee community reflects a change in the traditional family structure, whereby parents are passive and depressed and children increasingly take charge. Many refugees are without private accommodation, and must live in collective centers with limited access to electricity, water or humanitarian assistance. Access to work is very limited, and the black market is growing.

There is a growing number of "deprived" children (not limited to refugee children) within Slovene society. These children have limited access to health, education and opportunities. A non-governmental organization called the "Friends of Youth" has been created to assist these children.

Report from Macedonia

Peak refugee influx in Macedonia was in 1993 when 50,000 refugees were living in Macedonia, coming primarily from Bosnia. This number has decreased since 1993, but the number of refugees is still significant. Two major organizations have been providing support to this community. One is UNICEF, which had been active in refugee camps but has decreased its presence as the number of refugees declined. The other is the Soros Foundation, which has supported a variety of camp services and health centers. Health services are offered also by the Medecins sans Frontier, and the International Red Cross/Red Crescent.

In recognition of the extreme state of psychological and social stress within the refugee communities, a network of psychologists and physicians has developed, whose members have been trained to recognize and treat traumatic stress in its early stages. Assistance in this effort has come from Dr. Kos, of the Slovene Foundation.

Women's health issues, domestic violence and health education have been foci of attention from the "Humanitarian Association for Women". It was recognized that the refugee community was receiving outside assistance, but that the general population was not, although the latter group is also suffering from low employment and poverty related to political transitions in the region. The incidence of domestic and societal violence has been rising steadily, parallel to a rise in unemployment for Macedonian, Albanian and Romany groups within Macedonia. The Humanitarian Association for Women has instituted self-help groups for all ethnic sectors, and these groups seem to be most helpful to the Romany women.

Reports from Bosnia

Sarajevo

Medecins sans Frontier has been a consistent source of health care delivery in Sarajevo since 1991. They began with the delivery of medicines, expanded to more general medical care, and in 1994 expanded their programs to include psychosocial care. They are also expanding their programs to other parts of Bosnia. During the war there was an urgent need for mental health counseling. In the current post-war situation, the need is less acute but no less urgent. There is an alarming increase in marital problems and familial problems, with a rising incidence of domestic violence. Children in particular are in a crisis phase as they try to adapt to the post-war situation. Many returning refugee children have no families and little or no memory of home, and have often lost their indigenous language skills. Handicapped children need both mental and physical treatment.

The long-range plan is to build rehabilitation centers which integrate mental and physical treatment. For the special case of children there are efforts to create liaisons between health, education and psychosocial services, particularly for middle school and handicapped children.

West Mostar

The population of West Mostar is roughly 50% refugees. There are 16,000 refugees in West Mostar, with another 20,000 in the surrounding area. Most are refugees from Central and North Bosnia.

In 1994 UNICEF funded a research and training project in Mostar. The project utilized international NGOs to train teachers to recognize and refer or treat (as appropriate) psychosocial trauma. It also is researching the psychosocial effects of the war by tracing 700 children, 78% of whom had direct experience of the war, and 40% of whom are separated from their family.

Right after the war there was an influx of external assistance and people felt motivated to rebuild. However, as time has gone by, people, especially children, have become less motivated and more depressed. During the war and immediately after the war, health care services were free. Now, in the post-war situation, health care services are provided through state-run companies, and many health centers have shut down.

Many training and assistance projects promoted by international organizations were very useful in the immediate post war period. Now, however, there are in Mostar a large number of international NGOs trying to promote different types of psychosocial and educational training. These NGOs do not coordinate their programs so that, unfortunately, often the same group is targeted for training over and over. This has happened so much for teachers of young children that there is a growing resistance to international assistance. The Medical Network could play an important role in coordinating the contributions of these NGOs so that their efforts will be directed where they are most needed.

East Mostar

There are about 103,000 people in East Mostar, of which 37,000 are the home population and 47,000 are refugees[2]. In theory the Croats and the Muslims share power in Mostar, but the reality is that it is a divided canton (east and west). There is no infrastructure to secure the sharing of power, although there is a great deal that the two sides could do together. The greatest problem we have in Bosnia is a lack of coordination. At the moment health care is inaccessible (geographically or financially) to a large percentage of the population. International aid has helped build a health center in West Mostar. In East Mostar there are plans to rebuild an old baths building to have a health center.

Report from Igalo, Montenegro

There are several active projects in Montenegro that are focused on social reconstruction among young people. The Soros Foundation has funded a

[2] It is unclear who the remaining 19,000 people are.

system of "Open Clubs" to bring young people together around music, art, computer games, and a variety of workshops. In 1996-1997 a project funded by an NGO called "Save the Children" helped families of children with special needs by providing training and setting up library centers with relevant specialized information. A number of other projects have been instituted, through local government efforts, to help adolescents and adults gain a broader understanding of the diagnosis and treatment of trauma. Telephone hotlines have been set up to for domestic violence assistance.

A goal now is to ensure a transition from the war-related programs to programs that serve a developing, recovering civil society. To do this, local people feel the need to increase the number of local NGOs and to decrease the number of international NGOs.

Report from Vojvodina

There are 50,000-100,000 refugees in Vojvodina. Many of the refugees are living in private accommodations, and perhaps 50% of them are not officially documented. Refugees who live in collective centers have very difficult conditions, with no heat, electricity or money for food.

There is a two-tiered economy in which one part of the society is prospering through a thriving black market, while the other part of society is barely surviving. Health care in Vojvodina is the worst it has ever been in Yugoslavia. State-supported health care is either unavailable or completely inadequate. If you have money you can pay for health care privately. There is a dramatic increase in violence within families and within society. The homicide and suicide rates have dramatically increased.

Vojvodina is one of the most heterogeneous areas in Yugoslavia. Political parties are forming along nationalist lines, taking advantage of the high level of frustration and despair within society. There is an urgent need to encourage multiethnic mixing.

There is little or no international help in Vojvodina, and the only consistent source of assistance comes from the Soros Foundation. The needs within Vojvodina are great. The Network could assist with networking, training and exchange programs to:

- raise the general level of health care;
- increase psychosocial training to make counseling available; and
- encourage and support multi-ethnicity.

Report from Kosovo

The health situation in Kosovo is desperate, with problems in the following areas:

- minimal health education within the general population;

- few medical professionals for the size of population;
- lack of institutions providing primary health or psychosocial care;
- low immunization rates and high rates of epidemics (including TB, polio, meningitis, lice, and scabies); and
- high natality but very high infant mortality, with most deliveries occurring without professional support;

The social-economic situation is also desperate, notably:

- general unawareness of basic human rights;
- hostility and confrontation between nationalist groups;
- unequal distribution of humanitarian aid; and
- rampant unemployment and poverty.

The Network could be very helpful in a number of ways, for example by establishing Psychosocial Support Centers which would link up with other similar programs in other regions. Also, the Network could establish a Center for NGO Development which would encourage the development of civil society and have the following three foci:

- function as an information center which: (i) collects and distributes information through publication of brochures (for public health education) and collection of books and directories; (ii) mediates contacts and communications; and (iii) provides counseling;
- provide training and educational programs (e.g., convene professional educational conferences and seminars); and
- conduct research programs (in cooperation with scientific groups and NGOs).

Reports from Croatia

General report

The number of refugees in Croatia has dropped from roughly 400,000 during the war period to about 100,000 now. There are three regions that have continuous, war-related problems: Krajina; East and West Slavonia; and Baranja. The atmosphere is very tense, with lack of trust and fear between returnees and those who stayed, and between Serbs and Croats. The process of return is as difficult and traumatic as the process of being a refugee. There is a great deal of apathy and depression. Children and parents are at odds with each other. Often, the children did not want to return but the parents did, and this divides families. Children and parents often switch roles, with children taking the role of caregiver and liaison with external authorities. There is a high degree of psychological stress and traumatization in society, demonstrated by unreasonable risk taking , drug use and criminality. People would rather go to jail than pay a traffic fine, because in jail they are taken care of.

The international community doesn't understand the complicated dynamics, and there is a severe lack of coordination among the foreign agencies in Croatia and their projects. Indigenous NGOs cannot meet the needs of these communities. The Network could play an important role in addressing the following issues:

- refugee/returnee relations;
- transition of society to a post-war, post-communist civil society;
- psychosocial assistance; and
- coordination of fundraising so that resources are used efficiently.

Osijek (East Slavonia)

There are many displaced people in Osijek, from Bosnia and from other parts of Croatia. The problems of returnees are very complicated because there aren't enough resources for returnees and people have no homes to which they can return There has been a politicization and ethnicization of every-day life. One hundred percent of the children here are traumatized. A government organization, the Center for the Victims of War, offers counseling, but lacks adequately trained personnel. The NGO, "Sunshine", maintains a telephone crisis hotline and has a variety of programs for children, including workshops, play groups and exchange programs. All of these programs are barely "keeping the fire from spreading". They are not able to put the fire out.

The Center for Peace, Nonviolence and Human Rights was founded in 1992. It has three main areas of work:

- conflict resolution programs;
- organizing cross-cultural workshops to increase understanding; and
- counseling programs.

Rijeka

All segments of society suffer from a high degree of psychological stress, predominantly post-traumatic stress disorder. There are many refugee and displaced people in Rijeka, who are stressed by their displacement, the uncertainty, the lack of resources and the dilemma of whether to return or stay. The army veterans have a high degree of anxiety, alcoholism, guilt, bereavement, and great difficulty reintegrating.

The Center for Psychosocial Treatment is run through a psychiatry clinic supported by the ministry of health. It is understaffed and underfunded and cannot cope with the large number of problems. It is trying to develop innovative methods to treat large numbers of people (e.g., group work, seminars).

The Network would be most useful if it could serve as an umbrella of organizations engaged in similar work, so that we can all learn from each other. We need to know what others in similar situations are doing.

An overview of all regions by Dr. Anica Mikuö Kos

There are two major problems that we face in former Yugoslavia. One is that the humanitarian assistance received from the international community during the war has not continued during the transition to peacetime society. The physical and psychosocial impact of the war has not been recognized or treated as a long-term chronic problem but as an acute one. Now, the vast majority of people do not have access to health services. Health care systems need to be built from the base level upwards, so as to cover the maximum number of people. The opposite happens in wartime relief, which leaves a population without access to care when the relief is terminated.

The other major problem is that the positive impact of health care and other humanitarian work is too often weakened by political barriers. The professional and moral question for health care deliverers and humanitarian workers is: what is our professional and moral obligation in the face of political barriers? We cannot tackle health care in isolation from other issues.

III. SECOND SESSION OF THE BLED MEETING
Saturday, 22 November 1997
Presentations and discussions

Presentation by Dr. Inger Agger[3]: what is needed to develop a sustainable organization?

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[3] From 1993-1996, Dr. Agger coordinated psychosocial projects in former Yugoslavia for ECHO, the European Union's humanitarian aid organization. From 1996-1997 Dr. Agger worked in the OSCE office in Sarajevo as psychosocial projects adviser, to promote the psychological aspects of peace building and reconciliation projects. She is currently back in her native Denmark, teaching psychology at the University in Copenhagen.

The sustainablity of an NGO is directly related to the tasks it undertakes, and to the longevity of its deeds and actions. This talk will focus on local NGOs whose programs deal primarily with psychosocial issues. Such an NGO generally aims to:

- improve the emotional and social status of its target population;
- help its target population (re-)integrate into society; and
- develop a social infrastructure within the target population to promote:
    a. self organization;
    b. democratic participation;
    c. tolerance between ethnic groups;
    d. peace and justice; and
    e. human rights.

One of the biggest problems that face these NGOs is that their staff usually suffer from many of the same traumas as do their target populations, including traumatic stress, refugee status, ethnic discrimination, and a lack of social networks. This leads to a situation called the "wounded healer", in which the healer and the patient have the same problems. This can be a source of solidarity and commitment between healer and patient, but it can also lead to over-identification of the healer with the patient, resulting in secondary stress (a transference of the patient's trauma to the healer), burnout and frustration.

Coping with the wounded healer problem is one of the biggest issues that psychosocial NGOs need to deal with in order to be sustainable. One of the most important lessons learned from evaluation of NGO programs during and immediately after the war is that the most important thing they could provide was a safe space for people to rebuild their social contacts and make new contacts. The safe space was more important than any particular type of psychological intervention or therapy. Thus, a practical focus for these NGOs is to provide a safe space for their staff (the healers) and support and training for these healers, to help them cope with their own primary and secondary stresses.

More and more donors and other observers are realizing that local NGOs are the most potent agents of social change. They are flexible, fast, innovative, and can model democratic participation. They can inspire governments to promote institutional change. Some NGOs are actually doing the government's jobs.

During the war there was great interest in psychosocial work on the part of donors. Now that the war is over, there has been a shift of donor interest to peace building, human rights, conflict resolution, and education for a democratic society. But psychosocial work is as important now as it was during the war. During the war the focus of intervention was on survival, not on development. The post-war focus on development needs to build upon the experience and lessons learned by the local NGOs that were initiated during the war. But in order to do this, the NGOs need to reframe their mission so that funders will

understand that they are interested in, and capable of, fulfilling the community's post-war psychosocial needs, such as development of new social structures and democratization. These tasks include many of the same tasks that these NGOs engaged in during the war, namely:

- promotion of mental health;
- promotion of human rights;
- facilitating dialogue, confidence building, and reconciliation; and
- decreasing social and ethnic tensions.

One of the biggest problems faced by these NGOs is a lack of coordination and an outright competition with each other over funds. Unfortunately, donors do not understand the need to invest in local infrastructure and do not fund local coordination. This can only be rectified through intensive donor re-education.

Presentation by Dr. Paula Gutlove[4]: theory of community reconciliation, past, present and future

The text for this presentation appears in this report as Appendix C. A brief overview follows here.

Community reconstruction after violent conflict refers to the rebuilding of the physical, political and social aspects of a community that have been damaged or destroyed.[5] Physical, political and social reconstruction are interdependent, and they must be addressed simultaneously.

In the context of rebuilding a community after violent conflict, reconciliation refers to the restoration of human relationships and the building of trust, hope and mutuality within a violence-ravaged community. The restoration of trust can encompass both trusting other individuals to behave compassionately, and trusting that the political system will be fair and equitable. The restoration of hope means that people can begin to believe that the future life of their community can be better than its recent violent past. The healing of mutuality comes from the knowledge that values and experiences, and the desire for trust and hope, are shared throughout the community.

Facilitating community reconciliation can be difficult, demanding great sensitivity, patience and courage. Medical professionals are ideally placed to take a leading role in the healing processes of community reconciliation, because of

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[4] Dr. Gutlove is the director of the Program on Promoting Understanding and Cooperation at the Institute for Resource and Security Studies in Cambridge, Massachusetts. She is the founder of the international Health Bridges for Peace project, which integrates health care delivery with conflict management.

[5] Dr. Gutlove wants to acknowledge the Resource Packet for Conflict Transformation, International Alert, November 1996, Book 3, Capacity Building, pp. 77-79, for basic information and inspiration about reconstruction and reconciliation.

their shared interest -- across ethnic boundaries -- in public and community health, and because of their access to a wide range of community groups. There is no precise prescription for community reconciliation as it is best developed within each community, so as to be sensitive to the cultural and experiential nuances of that community. However, reconciliation usually includes processes that allow people to explore together their past, their present and their future.

Medical professionals have a special role to play in healing violence-ravaged communities. They can do much to heal the community's damaged sense of wholeness by creating peacetime bridges between communities that have been in conflict. Health care providers have an intimate association with the people who have suffered mentally and physically from armed conflicts. They are often well-educated, and have stature and access to a wide range of community groups. Health care providers can create a bridge of peace between conflicting communities, whereby delivery of health care can become a common objective and a binding commitment for continued cooperation. The involvement of medical professionals from different sides of a conflict in the delivery of health care can be a model for collaborative action, and can create the long-term community involvement, reconciliation and healing that are essential for sustainable peace.

Many practitioners, in particular psychosocial specialists, have specialized knowledge and unique skills which can contribute to the development of a culture-specific process of acknowledgment, mourning and grieving about the past. Documenting this process and training others in its application will promote the transformation of a community characterized by violence, mistrust, injustice and anger to one of hope, trust and wholeness.

By working together and modeling inter-ethnic cooperation, health professionals will give other members of their communities a symbol for hope and a reason to believe that the promise of their shared future can shine brightly enough to begin to heal the pain of the memories of their shared past.

Envisioning the future (discussion of the whole group): building the Medical Network for Social Reconstruction

The group discussion was meant to address the following questions:
Who are we now and what do we want to become? What is our mission?
What is the content of our work together? What do we plan to do?
How shall we do it? What is our organizational structure ? Has the contact representatives concept worked since the last meeting in Graz?
What kinds of communications do we have between the regions?
What do we need? Where shall we get funds ?
Which local organizations do we want to incorporate ?

In a general way the group touched upon each of these issues, and reached some conclusions. First, the group agreed that the Medical Network needs a firm focus and joint projects to carry out together. Potential projects discussed included:

- human rights projects (because there are funds available from the EU for such projects);
- trans-regional projects to build an overall, larger network (e.g., research projects such as a suicide project that can be carried out with other regions--an inter-regional project); and
- organizing a Network meeting in Sarajevo in April 1998.

It was further agreed that, in addition to conducting projects, the Network should:

- be a forum for the exchange of experiences and expertise;
- develop within the Network a circle of responsibility so that the Network can function with less dependence upon outside actors;
- publicize our own work through the media;
- organize a Network meeting in Sarajevo in April 1998;
- hold seminars and educational events;
- meet with other networks;
- coordinate with existing projects; and
- include more younger people to build a vision of the future.

Presentation by Dr. Anne Marie Miorner Wagner:[6] when is the war over?

The text of this paper will be made available by Dr. Wagner. Its main points are: war is a series of multiple traumas; war never ends; it takes active work to keep peace; and the first victim of war is truth.

Workshop facilitated by Dr. Paula Gutlove: looking at the past together

Background text for this workshop appears as Appendix D of this report. This section provides a brief summary of the workshop and the group discussion that followed it.

The remainder of the afternoon was spent in a workshop session designed specifically for this meeting. The workshop was based on the assumption that the rebuilding of relationships within a conflict-ravaged community requires that all parties acknowledge the traumas of the past. Implicit in this is that within individuals and groups there is a tremendous need to grieve and to mourn the losses that they have suffered themselves and that they have inflicted upon others. For people who suffer loss or trauma, telling stories of their experiences helps them make sense of the past, restores a sense of identity, and makes it possible to create a future. Furthermore, being listened to reduces each individual's sense of being alone with her thoughts and feelings. Thus, people gain a sense that others are with them.

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[6] Dr. Miorner Wagner is a psychotherapist, the director of the OMEGA Health Center in Graz, Austria, and a member of the regional council of the International Physicians for the Prevention of Nuclear War.

The workshop began with some discussion of the need to listen and to be listened to and the tools to use for this sharing process. This kind of exchange must be facilitated in a safe and carefully structured environment so that it does not rekindle conflict but unifies divided communities through a collective acknowledgment of the past. Instruction was given in active listening[7] -- a particular type of listening skill in which the listener has a responsibility to actively grasp the facts and the feelings that she is hearing, and to try, by listening, to help the speaker understand herself better.

For the workshops, the entire group split into small groups of three to four people. In the small groups each person took turns to be the listener, the speaker and the observer (or facilitator). A series of three questions was posed. For each question everyone had the opportunity to play each role (speaker, listener, facilitator) for five minutes within their small group. After the three questions were processed in this way, the group returned to a plenary for discussion and reflection.

The questions posed in the small groups were:

1. What are some of the greatest obstacles you faced as a health care provider during the last 7 years?

2. Describe something you did in the past that you wish you would have done differently. What was it, what were your alternatives, what do you wish you had done instead?

3. Describe something you did in the past that you are proud of. What was it?

A group discussion followed the small group workshops. In this group discussion it was generally agreed that the process was surprisingly useful in bringing out new information and in building trust, understanding, cohesion and strength within the group in a relatively short time. Some people were surprised that the trust-building process began so quickly and that this trust building could be applied in the context of other healing work that individual practitioners are engaged in. Many aspects were thought to be particularly useful for medial practitioners, as follows:

- the emphasis on empathic listening was an important aspect of trust building and healing;
- the strict time limitation (five minutes) required that important things push to the surface very quickly and that there was no feeling of boredom or that the subject had been exhausted -- rather, there was clearly more to discuss the next time around;

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[7]Carl R. Rogers and R.E. Farson, "Active Listening", in Seminar Program for Instructors in Professional Schools, University of Chicago Industrial Relations Center (no date).

- the diversity within the group made the process more valuable because there are very few other opportunities to have this type of intimate and honest exchange (for many, the process was an opportunity to acknowledge that, while there are things to learn about each other, the differences between the regions are not so large as they might appear);
- the small group context made it easier to be intimate and to learn; and
- the process was a model that has wide application in community health care delivery practice.

IV. THIRD SESSION OF THE BLED MEETING
Sunday, 23 November 1997
Discussion about next steps for the Network

This discussion focused entirely on the next meeting of the Network, and sought to address the key issues necessary to organize a conference in Spring 1998, as follows:

Where should the meeting be held, when, and for how long?

It was immediately decided by consensus that the next meeting of the Network should take place in Sarajevo, as was discussed in Graz in April 1997. People who volunteered for specific tasks included:

- Meliha Sakic, who will get hotel prices;
- Inger Agger, who will ask OSCE for assistance;
- Jadranka Ruvic, who will work through a local NGO in a coordinating role; and
- Alija Suko, who will assist with coordination in Sarajevo

It was further decided that the meeting would take place 23-26 April 1998. The first announcement would be sent out by the end of December 1997. The second announcement would be sent out by the end of February 1998.

Topic of the meeting, and organizational roles

It was agreed that the topic will be the role of health care providers in reconciliation, social reconstruction and conflict prevention. The invitations will be sent out by the Medical network for Social Reconstruction. The local address for conference correspondence will be the Medecins sans Frontier office in Sarajevo. OMEGA volunteered to send out the announcements.

Financial aspects

Participants from the region will be asked to contact their local Soros Foundation to seek coverage of their travel expenses. A conference fee will be charged to underscore that this is a professional meeting which will be of high caliber and will supply valuable professional knowledge and contacts. The following fee structure was agreed:

- participants from former Yugoslavia: 10 DM (5 DM for students)
- international participants: 100 DM (50 DM for students)

Information about funds raised towards the conference will be collected and disseminated through Jadranka Ruvic at the Sarajevo office of Medecins sans Frontier.

Associated events

In addition to the professional program, there will be social events, media coverage, and tours of local medical facilities. People who register for the conference will be asked what they most want to see.

Participants from Republika Srpska

In view of the fact that the Contact Group members from Srpska were not in Bled, extra effort will be made to include them in the Sarajevo conference, beginning with the sending of a card signed by Bled conference participants expressing their regret that these members were unable to came to Bled. Also, it was agreed to use excess funds from the Bled meting to host a "mini meeting" of people from Srpska and members of the Network in Graz, Austria. This meeting took place in Graz in January, 1998.

Role of the Contact Group

The Contact group will help by spreading the word about the meeting within their regions. Contact Group members, and their contact coordinates, are:

- Bosnia: Jadranka Ruvic, tel#: 387-71-663-350, fax#: 387-71-444-158; Marko Romic, tel#: 387-88-317-271; Meliha Sakic, tel and fax#: 387-71-664-457; and Alija Suko, tel#: 387-71-551-824, fax#: 387-71-551-825
- Croatia: Liljana Vrdoljak (SPA), tel#: 385-(1) 46 15 076, fax#: 385(1)46 15 078; email: spa@dpp.hr
- Kosovo: Shpend Rizvanolli, tel: 381-38 48205 or 381-38 47526, fax#:381-38 40129
- Macedonia: Biljana Gerasimovska, tel & fax #: 389-91-22-48-23, email: esem@lotus.mpt.com.mk
- Montenegro: Sonja Kosac, tel#: 381-82-59-084 or 59-236, fax#: 381-82-58-963
- Serbia: Ksenija Kondic, tel#: 381-11-659-823, fax#: 381-791-659-823
- Slovenia: Slovene Foundation, Anica Kos and Sonja Jovanovic, tel# 386 61 125 13 52, fax#: 386 61 125 13 77, email: anica.kos@guest.arnes.si
- Vojvodina: Slobodanka Stankovic, tel and fax#: 381-21 32 35 49, email: cica@uns.ns.ac.yu

<u>NB</u>: Contact Group members from Republika Srpska remain to be added to this list.

Sub-topics for the conference

There was general agreement that the Sarajevo conference should have comparatively few speeches and more workshops. All the speakers (and workshop presenters) should be given questions to help them focus on the main topics of the conference. The Network wants speakers to discuss what went wrong in the past and what they would want to do differently, in addition to discussing positive things.

Suggested sub-topics were:

- coordination, cooperation and collaboration among NGOs, between local and international NGOs, and between NGOs and state authorities;
- social reconstruction in targeted populations such as:
  a. children (working to build hope for the future);
  b. the elderly;
  c. the handicapped and disabled; and
  d. single mothers;
- how NGOs and volunteers can contribute to the protection of mental health through solidarity and modeling cooperation;
- refugees and repatriation;
- expanding the concept of healing to encompass the health profession's role in reconciliation and trust-building;
- the philosophy and practice of "reconciliation" (or trust-building and confidence-building);
- the moral and ethical dimensions of a new society, including global and social problems;
- dialogue and confidence building, and the roles of psychosocial NGOs and mental health professionals;
- managing anger constructively; and
- building hope, and moving from despair to hope.

Conference schedule

The following schedule was proposed:

<u>23 April 1998</u>

- Participants arrive
- Set up poster exhibition and information tables about the different groups represented at the meeting. This exhibition should remain set up and be available throughout the conference.

<u>24 April 1998</u>

- Morning: introductions
  Suggested opening speaker: Anica Kos (for the introductory speech). Also suggested were: Adam Curle and Katarina Kruhonja, to talk about the work they are doing in Osijek
- Lunch
- Afternoon: workshop sessions

<u>25 April 1998</u>

- Morning:
    1. one speech
    2. workshop sessions
- Lunch
- Afternoon:
    1. one speech
    2. workshop sessions

<u>26 April 1998</u>

- Morning session, split between 2 panel discussions:
    1. reports from the workshop sessions
    2. a panel (4 or 5 people) to address:
        a. conclusions from the overall meeting
        b. visions for the future

Appendix A

Participants in the Bled Meeting

Dr. Marijana Mitrovic, Osijek, Croatia;
Dr. Slobodanka Stankovic, professor neurophsiology, SRCE, University Novi Sad Medical School, Yugoslavia;
Dr. Shpend Rizvanolli, Physician, Mother Teresa Charity and Humanitarian Organization, Pristina, Kosovo;
Dr. Anica Micus Kos, Child Psychiatrist, President, Slovene Foundation, Ljubljana, Slovenia;
Professor Marko Romic, Mostar, FBiH;
Dr. Sonja Kosac, IGALO Institute, Montenegro
Dr. Meliha Sakic, Pediatrician, Ministry of Health, H-N Canton, MOstar, BiH;
Dr. Anne-Marie Moirner Wagner, Psychiatrist, OMEGA, Graz, Austria;
Dr. Ika Roncevic-Grzeta, Center for Psychotrauma, Rijeka, Croatia;
Dr. Maria Wheeler, child psychiatrist, MedAct, UK;
Dr. Alija Suko, Vice Minister of Health, Canton Neretva-Hercegovina, FBiH;
Dr. Sanja Derviskadic Jovanovic, General Practitioner, Center for Psychological Help to Refugees, Ljubljana, Slovenia;
Dr. Jadranka Ruvic, Medecins sans Frontier, Clinicki Centar, Sarajevo, FBiH;
Dr. Paula Gutlove, IRSS, Cambridge, Massachusetts, USA;
Dr. Dragan Jusupovic, Society for Psychological Assistance, Zagreb, Croatia;
Dr. Sonja Kosac, Physical Medicine and Rehabilitation, Igalo, Montenegro;
Dr. Emir Kuljuh, psychiatrist, OMEGA, Graz, Austria;
Dr. Biljana Gerasimovska, Humanitarian Association for Women, Skopje, Macedonia;
Dr. Marija Kisman, Slopje, Macedonia;
Professor Lucille Guilbert, Cite Universitaire, Quebec, Canada;
Dr. Inger Agger, Denmark; and
Marko Kerac, MedAct, London, England.

Appendix B

The Medical Network for Social Reconstruction in the Former Yugoslavia

WHAT CAN A NETWORK OF HEALTH CARE PROVIDERS DO FOR
RECONCILIATION, SOCIAL RECONSTRUCTION
AND CONFLICT PREVENTION?

Program of the Meeting
21-23 November 1997, Bled, Slovenia

Friday, 21 November 1997

Arrival to hotel Jelovica during the day

16.00 - 19.00	Opening meeting: overview of the situation in each region*
19.30	Dinner and social evening

Saturday, 22 November 1997

9.30 - 9.45	Welcome - Dr. Anica Mikuö Kos
9.45 - 10.15	What is needed to develop sustainable organizations - Prof. Inger Agger
10.15 - 10.30	Theory of community reconciliation, past, present and future - Dr. Paula Gutlove
10.30 - 11.00	Coffee break
11.00 - 13.00	Visions of the future (discussion of the whole group): the Medical Network for Social Reconstruction** the next meeting of the Network***
13.30 - 14.30	Lunch
15.00 - 15.30	When is the war over?- Dr. Anne Maria Miorner Wagner
15.30 - 16.30	Looking at the past together (a workshop) - facilitator: Dr. Paula Gutlove
16.30 - 17.00	Coffee break
17.00 - 18.00	Continuation of the workshop
18.00 - 19.00	Group reflection and closure

Dinner and social evening from 19.30 on

Sunday, 23 November 1997

9.00 - 11.00	Group discussion: our next steps****
11.00 - 11.30	Coffee break
11.30 - 12.30	Continuation of the above discussion as needed; any other issues that the Network needs to address
12.30 -13:30	Closure

Meeting Notes

* Please limit your presentations to 10 minutes maximum
* We kindly request a brief presentation in writing:

What is going on in the region in the field of health and mental health in a very broad sense?
With whom do the people cooperate (national, international organizations, governmental nongovernmental...)?
What do they do ? How are communications ?What are the needs ?
What are the wishes regarding communications and cooperation ?

** The Medical Network for Social Reconstruction

Who are we now and what do we want to become? What is our mission?
What is the content of our work together? What do we plan to do?
How shall we do it? What is our organizational structure ? Has the contact representatives concept worked since the last meeting in Graz?
What kinds of communications do we have between the regions?
What do we need? Where shall we get funds ?
Which local organizations do we want to incorporate ?

*** The next meeting of the Network

What are our goals for the next meeting of the larger network?
Who should be included?
How large a meeting should we aim to have?
What are the main topics and the side topics?

**** Our Next Steps

The next meeting of the Medical Network
Goals of the Meeting

Where should the meeting be held? When? How long?
Issues and topics to cover
Types of Interactions (large groups, small groups...)
Speakers to invite
Preliminary agenda
Fundraising - amount needed, who is responsible for what?
Time line
Reporting process

Appendix C

INSTITUTE FOR RESOURCE AND SECURITY STUDIES
27 Ellsworth Avenue, Cambridge, Massachusetts 02139, USA
Phone: (617) 491-5177 Fax: (617) 491-6904 Electronic mail: irss@igc.apc.org

COMMUNITY RECONSTRUCTION AND RECONCILIATION, PAST, PRESENT AND FUTURE

by
Paula Gutlove

Reconciliation is to understand both sides, to go to one side and describe the suffering being endured by the other side, and then to the other side, and describe the suffering being endured by the first side.

Thich Nhat Hanh, Vietnamese Zen master[8]

Community Reconstruction

Community reconstruction[9] after violent conflict refers to the rebuilding of the physical, political and social aspects of a community that have been damaged or destroyed. Physical, political and social reconstruction are interdependent, and they must be addressed simultaneously. With this in mind, the three types of reconstruction will be discussed in turn as distinct operations.

Physical reconstruction is the rebuilding of the infrastructure needed for a society to function during peacetime. This includes the repair of housing, hospitals, schools, factories, transportation, water and sewage lines, and communication systems. It includes the re-establishment of economic endeavors such as growing food, making goods, and providing services. Many aspects of physical reconstruction are directly pertinent to the rebuilding of a community's public health, from the rebuilding of hospitals to the regaining of clean water and the provision of adequate trash removal.

During periods of violent conflict a civilian government is often overpowered or destroyed by a military group or groups. Political reconstruction is the re-

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[8] Cited in J. Montville, "The Healing Function in Political Conflict Resolution", in Conflict Resolution Theory and Practice: Integration and Application, Dennis J.D. Sandole, Hugo van der Merwe, eds. (Manchester University press, 1993), page 115.

[9] The author wants to acknowledge the Resource Packet for Conflict Transformation, International Alert, November 1996, Book 3, Capacity Building, pp. 77-79, for basic information and inspiration about reconstruction and reconciliation.

establishing of a civilian authority, preferably in a way which fairly represents the populace. It may also include establishing the rule of law, and including in this law provisions for humanitarian needs and human rights. Further, it can mean setting up an independent judiciary and rebuilding a police force to enforce the agreed-upon laws. Elements of political reconstruction can also include the development of electoral and legislative reforms to encourage popular participation, fair representation and political stability.

Social reconstruction is the rebuilding of the social infrastructure and the fulfilling of the pycho-social needs of a violence-ravaged society. It includes the reintegration into communities of war-affected people, the resettlement of refugees and displaced peoples, demobilization of soldiers, and the retraining of people for gainful employment. It also encompasses the physical and psychological care and treatment of war victims, from orphaned children to abandoned elderly. It can include civic education to encourage respect for human rights. Clearly, much of this rebuilding can be assisted or initiated by the professional medical community.

Community Reconciliation

The word reconciliation means: "to reach a compromise agreement about differences, or to bring together again in friendship"[10]. In the context of rebuilding a community after violent conflict, reconciliation refers to the restoration of human relationships and the building of trust, hope and mutuality within a violence-ravaged community. The restoration of trust can encompass both trusting other individuals to behave compassionately, and trusting that the political system will be fair and equitable. The restoration of hope means that people can begin to believe that the future life of their community can be better than its recent violent past. The healing of mutuality comes from the knowledge that values and experiences, and the desire for trust and hope, are shared throughout the community.

Violent conflict damages the relationships between people and groups. In so doing, it damages the sense of wholeness which is essential to a healthy community. Protracted violent conflict can destroy the common values and experiences upon which communal life is based. Reconciliation aims to heal the damaged sense of wholeness. It includes a process of transforming social relationships, from relationships that have become characterized by conflict, injustice and violence, to mutual relationships that are trusting and hopeful. This transformation is essential to physical, political and social reconstruction as these actions are only successful and sustainable when built on the foundation of a heathy, whole, community.

Facilitating community reconciliation can be difficult, demanding great sensitivity, patience and courage. Medical professionals are ideally placed to take

[10] The New Lexicon Webster's Dictionary of the English Language, Encyclopedic edition, Lexicon Publications, Inc. New York, 1987.

a leading role in the healing processes of community reconciliation, because of their shared interest -- across ethnic boundaries -- in public and community health, and because of their access to a wide range of community groups. There is no precise prescription for community reconciliation as it is best developed within each community, so as to be sensitive to the cultural and experiential nuances of that community. However, reconciliation usually includes processes that allow people to explore together their past, their present and their future.

The traumas of the past need to be acknowledged across communities if there is to be successful reconciliation. There is within individuals and groups a tremendous need to grieve and to mourn the losses both that they have suffered themselves and that they have inflicted upon others. Acknowledgement of the past could include acknowledging the role of bystanders, active and passive, individuals and nations, in addition to the role of victims and perpetrators. The grieving must be facilitated in a safe and carefully structured environment so that it does not rekindle conflict but unifies divided communities with a collective acknowledgement of the past. This is sometimes done through a process of constructive communication facilitated by a third party. The facilitated communication may begin by teaching parties how to actively listen to each other, a process which allows both the listener to understand and empathize with the speaker, and the speaker to achieve a clearer idea of what he or she is thinking and feeling.

Community reconstruction and reconciliation depend upon the ability of parties to work together in the present, cooperatively, on issues of mutual interest. When people work together, trade with each other, or seek medical care from the same sources, these acts will contribute to the development of trust between groups. Designing common tasks that will bring people to work cooperatively, and integrating into these tasks some training and facilitation in conflict management is a form of "Integrated Action." Integrated action weaves together conflict management with other humanitarian activities for several purposes. The humanitarian action is an incentive for parties to come together and provides a basis for continued engagement of indigenous parties. As parties work together they create a context for training in conflict management skills, which can be applied on many levels, promoting community reconciliation among ever larger circles. The first circle encompasses the providers of a humanitarian action, the second circle encompasses people directly reached by the humanitarian action, and the third circle encompasses the surrounding community. Other, wider circles will be reached by replication of this process in other locations. Finally, the conscious integration of conflict management with humanitarian actions can provide a sustainable structure for long-term cooperation and community reconciliation.

In order for a community to nourish hope that they might be able to have a future together that will be better than their recent past, they need to be able to envision their common future. Sharing positive visions of the future can mark an important turning point, away from the trauma of the past towards a shared optimism for the future.

The Medical Professionals' Role in Community Reconciliation

Medical professionals have a special role to play in healing violence ravaged communities. They can do much to heal the community's damaged sense of wholeness by creating peacetime bridges between communities who have been in conflict. Health care providers have an intimate association with the people who have suffered mentally and physically from armed conflicts. They are often well-educated, and have stature and access to a wide range of community groups. Health care providers can create a bridge of peace between conflicting communities, whereby delivery of health care can become a common objective and a binding commitment for continued cooperation. Public health, valued by all parties, can provide an opportunity to bring people together for collaborative action, education, and dialogue. As noted by the WHO:

> *"Health is valued by everyone. It provides a basis for bringing people together to analyse, to discuss and to arrive at a consensus acceptable to all. The potential for using health as a mechanism for dialogue, and even peace, has been demonstrated in situations of conflict."*
>
> World Health Organization, 1995 [11]

The involvement of medical professionals from different sides of a conflict in the delivery of health care can be a model for collaborative action, and can create the long-term community involvement, reconciliation and healing that are essential for sustainable peace.

Many practitioners, in particular psycho-social specialists, have specialized knowledge and unique skills which can contribute to the development of a culture-specific process of acknowledgment, mourning and grieving about the past. Documenting this process and training others in its application will promote the transformation of a community characterized by violence, mistrust, injustice and anger to one of hope, trust and wholeness.

By working together and modeling inter-ethnic cooperation, health professionals will give other members of their communities a symbol for hope and a reason to believe that the promise of their shared future can shine bright enough to begin to heal the pain of the memories of their shared past.

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[11] "Health in Social Development," WHO Position Paper, prepared for the World Summit for Social Development (Copenhagen, March 1995), page 19.

Appendix D

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LOOKING AT THE PAST TOGETHER
Workshop Exercise for the Medical Network for Social Reconstruction
November 1997

Paula Gutlove

The need to listen and to be listened to

If relationships within a conflict-ravaged community are to be rebuilt, the traumas of the past must be acknowledged. There is within individuals and groups a tremendous need to grieve and to mourn the losses that they have suffered themselves and that they have inflicted upon others. For people who suffer loss or trauma, telling stories of their experiences helps them make sense of the past, restores a sense of identity, and makes it possible to create a future. Furthermore, being listened to reduces each individual's sense of being alone with her thoughts and feelings. Thus, people gain a sense that others are with them.

Telling stories of the past should be facilitated in a safe and carefully structured environment so that it does not rekindle conflict but unifies divided communities through a collective acknowledgement of the past. This is sometimes done through a process of constructive communication facilitated by a third party. The facilitated communication may begin by teaching parties how to actively listen to each other, a process which allows both the listener to understand and empathize with the speaker, and the speaker to achieve a clearer idea of what he or she is thinking and feeling.

Active listening[12] is a particular type of listening skill. The listener has a responsibility to actively grasp the facts and the feelings that she is hearing, and to try, by listening, to help the speaker understand herself better.

Active listening can bring about changes in people's attitudes towards themselves and others. It can bring about changes in basic values and personal philosophy in both the speaker and the listener. People who have been listened

[12] Carl R. Rogers and R.E. Farson, "Active Listening", in Seminar Program for Instructors in Professional Schools, University of Chicago Industrial Relations Center (no date).

to with sensitivity tend to listen to themselves with more care, and work hard to make clear exactly what they are thinking and feeling. Through active listening, the speaker will learn that the listener is interested in him as a person, and in what he thinks and feels is important. Through active listening, the listener conveys the message: " I respect your thoughts even if I may not agree with them. I know they are valid for you. I am not trying to evaluate or change you. I want to understand you."

For the listener, active listening requires an honest interest in the thoughts and feelings of the speaker. This sincere interest can only be developed by being willing to risk seeing the world from the speaker's point of view. This act has the potential to change the listener, because in order to sense deeply the feelings of another person, to understand the meaning his experiences have for him, to see the world as he sees it, the listener's own basic attitudes may have to change.

When active listening is used within a group, the group's members tend to become less argumentative, more ready to work collaboratively, and more understanding of the diversity of opinions and views amongst them. Because listening reduces the threat of having one's ideas criticized, the group members are better able to present their ideas and more likely to feel their contribution will be both respected and worthwhile. When group members see that individuals are being listened to with concern and sensitivity, they feel more secure in the group. They feel that they can contribute more freely and spontaneously to the group. Within a group, over time and with practice, listening will become reciprocated. Just as anger is met with anger, and argument with argument, so listening will be met with listening.

How to engage in an active listening process

1. Active listening is an acquired skill which improves with practice.

2. The setting must be safe enough to allow both speaker and listener to incorporate new experiences and new values to his/her self concept. There must be a climate that is neither critical nor evaluative nor moralizing, but instead is characterized by equality and freedom, permissiveness and understanding, acceptance and warmth. The foundation for such a setting can be laid down by getting agreement among the parties on a set of ground rules, and by appointing an outside facilitator to ensure that the ground rules are respected and to assist the speaker and the listener in their tasks.

3. Speakers need to be informed by the listener that they are being heard. The listener can do this through eye contact and facial expressions. The listener can also encourage the speaker by asking simple questions that prompt the speaker to continue with their story. Typical questions might be: "What happened next? What did you do? Would you like to tell me more?"

4. A listener should try to capture the total meaning of the speaker's message. Messages usually have two components, the content of the message and the feeling or attitude underlying this content. To be sensitive to the underlying

feelings, the listener must try to note all cues. This includes verbal cues, such as what words are stressed or mumbled, and nonverbal cues, such as facial expression, body posture, eye movements, and breathing.

5. When the listener wants to verify that he has understood what the speaker has told him, he can do so by reflecting back what the speaker has said. This reflection can be the listener simply repeating what was said in the speaker's words. However, in situations that are emotionally charged and/or where the potential for misunderstanding is great, it is more effective if the speaker can reflect in his own words the total message (words and actions) that the speaker is conveying. In complex situations it is safest for the listener to assume he hasn't understood the speaker until he can communicate this understanding back by reflecting it to the speaker's satisfaction.

6. A listener should avoid responding to questions that are really demands for decision, evaluation or judgement. Instead, the listener should try to reframe the question so that the speaker must thoughtfully answer it himself. In illustration:
<u>Speaker:</u> "Don't you think they could have given me better supplies to work with?
<u>Listener:</u> "Do you feel they could have given you better supplies?"
(Instead of "Well they were probably doing the best they could," or,"of course they should have given you X and Y.")

7. The listener's own emotions can be a barrier to active listening. The more involved the listener is in a situation, the harder it is for that person to put aside their own feelings and listen to the feelings of the speaker. The more the listener's own needs come up, the less able the listener is to respond to the needs of the speaker. The listener should try to sense when he is feeling defensive, resentful, threatened or hostile. The more the listener can differentiate his own needs from the needs of the speaker, and can focus on the speaker's needs, the better able he will be to hear and understand the feelings of the speaker. In a group where listening is an accepted mode of interaction, where listening promotes listening, it will be possible for the listener and speaker to change roles, so each person has the opportunity to express their needs, thoughts and feelings, with the knowledge that their message will be heard with respect, sensitivity and understanding.

Workshop process

<u>A. Ground rules</u>

Ground rules serve the purpose of defining how the group will conduct itself during the listening session, and may alleviate some anxieties among participants, especially if the participants come from groups that are engaged in conflict outside of the workshop. Some possible ground rules are the following:

1. Listen respectfully to each other.
2. Don't interrupt when someone is speaking.

3. You may disagree with the substance of what someone is saying, but no personal verbal attacks are permitted.
4. We will begin and end each section on time, and ask all participants to observe the time constraints that we are working within.

Additional ground rules can be added or substitued to meet the needs of the particular group and the conditions under which they are working.

B. Format

The entire group will be split into small groups of three people each. In the small groups each person will have a turn to be the listener, the speaker and the observer (or facilitator). A question will be posed, and the first speaker will have 5 minutes to speak. Then the roles will rotate and the next speaker will answer that question for 5 minutes. The roles will rotate one last time and the third speaker will address the question. After each person has had an opportunity to be a speaker, a listener and an observer, the group will have 15 minutes to discuss the stories they have heard and reflect on the experience. The group will disband and a new group of three people will form for the second question. The process is repeated for the second question. The group again disbands and a new group of three people will form for the third question. The process is repeated for the third question.

After the third question the group will return to a plenary for discussion and reflection.

Questions for reflection[13]:

1. Reflect on the process, the way the conversation went, how the listener responded, and the role of the facilitator. What worked, what did not work, what should be done differently and why?

2. Reflect on the substance of the stories that were told. What have you learned from each other about events? What have you learned about how people were affected by events? Have you learned anything that you were not expecting to learn?

Questions for discussion:

1. What are some of the greatest obstacles you faced as a health care provider during the last 7 years?

2. Describe something you did in the past that you wish you would have done differently. What was it, what were your alternatives, what do you wish you had done instead?

3. Describe something you did in the past that you are proud of. What was it?

Alternate questions:

1. How did you maintain your commitment to the health care profession in the face of the conditions under which you were forced to work?

2. How did you maintain your respect for yourself as a professional in spite of the obstacles you had to overcome?

[13]Peter Lang, "Counseling and support skills for community workers in the Former Yugoslavia, Resources and Pathways", Kensington Consultation Centre (no date).