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HEALTH AS A BRIDGE FOR PEACE
Briefing Manual

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Briefing Manual

About this manual

This manual provides background and support materials for understanding and developing a "health bridge for peace" (also called a "peace through health") strategic approach. It contains information about the theory and practice of using health care delivery as a bridge for peace. In addition it contains practical tools for building a health bridge project. These tools would best be used with a trained facilitator.

This manual is not meant to be a stand-alone training document, nor is it a manual to train individuals to facilitate a Health Bridges for Peace workshop.

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IRSS welcomes comments and suggestions from users of this manual. Appropriate suggestions will be incorporated in future editions of the manual.

HEALTH AS A BRIDGE FOR PEACE Briefing Manual

About the Institute for Resource and Security Studies, and the Health Bridges for Peace Project

The Institute for Resource and Security Studies (IRSS) is an independent, non-profit corporation, founded in 1984 to promote international security and sustainable use of natural resources. This objective is pursued through technical and policy analysis and public education. To complement its analytic and educational work, IRSS engages in public participation, dialogue facilitation and conflict management through its International Conflict Management Program. This program works with people of diverse perspectives and interests, to improve communication, build understanding, promote cooperation, and develop new models for sustainable community reconstruction and reconciliation. IRSS designs and convenes workshops and training sessions to facilitate dialogue, promote collaborative problem-solving, encourage cooperative actions, and develop inter-communal networks.

IRSS launched the Health Bridges for Peace project (HBP) in 1996 to help health care professionals realize their potential to heal violence-ravaged individuals and communities. The project utilizes a shared concern, namely the restoration of public health, as a vehicle to convene, engage, and train health care professionals in conflict management and community reconciliation techniques. In 1997, the first HBP field program was initiated in the former Yugoslavia. The second HBP field program was initiated in the North Caucasus in November 1998.

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

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IRSS is indebted to the many individuals and organizations who have supported its work on international conflict management, especially on the development of the Health Bridges for Peace project. These supporters include: the World Health Organization, through which support has come from the Japanese and Italian governments; the William and Flora Hewlett Foundation; the US Institute of Peace; the Rockefeller family; the Winston Foundation for World Peace; the Know How Transfer Center; Open Society foundations throughout former Yugoslavia; International Physicians for the Prevention of Nuclear War - Austria; and individual donors.

This manual was prepared by Dr. Paula Gutlove, who directs the IRSS International Conflict Management Program. The manual makes available the current development of theory and practice by the program. This evolution has been supported by a range of colleagues, both practitioners and scholars, in the conflict management field. Most invaluable has been the assistance and support of Dr. Gordon Thompson, executive director of IRSS. Moreover, we wish to acknowledge the hard work of numerous individuals and organizations that are collaborating with IRSS to apply integrated-action strategies and to promote dialogue, cooperation, personal contacts, practical solutions and the renewal of relationships in conflict-torn areas. These collaborators include: the WHO, OMEGA Health Care Center (Graz, Austria); the Slovene Philanthropy (Ljubljana, Slovenia); Netherlands Relief Committee for Chechnya; and the World Health Organization

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

Contents

I. Introduction

II. Health Bridges for Peace, Theory and Practice

- Early work in building Health Bridges for Peace
- Evolution of Health Bridges Concept: Employing Conflict Management Principles
- Reconstruction
- Community Reconciliation
- Integrated Action in Practice: The Health Bridges for Peace Project
- Health Care: a Special Opportunity for Integrated Action
- The Medical Network for Social Reconstruction in the former Yugoslavia
- The Medical Alliance for Peace through Health in the North Caucasus
- Lessons from HBP Field Programs
- Conclusions

III. Tools for Building Health Bridges

1. Dialogue
 - A. Dialogue for integrated action
 - B. Constructive communication and effective dialogue
2. Active Listening
 - A. The Active Listening Approach
 - B. An Experiential Workshop Utilizing Active Listening
3. Mapping the current state of public health using a "SWOT" analysis
4. Generating options
 - A. Encouraging a problem-solving approach
 - B. Positions, interests and needs
 - C. Strategic questioning
5. Moving from visions to goals to strategy to plans
 - A. Consensus building
 - B. Exercise In Project Development And Proposal Writing
6. A Health Bridge for Peace Action Plan Checklist
 - A. What , how and who
 - B. Planning for future meetings, checklist

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

I. INTRODUCTION

"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 ¹

At the turn of the millennium, the world is plagued by violence. Seemingly intractable conflicts devastate communities all over the globe. Physical and psychological health is the recognized province of health care providers, but social health is often considered outside of our territory. However, our traditional focus, healing physical and psychological ills, can provide an important basis for societal healing, particularly in communities traumatized by violence. By expanding the concept of healing to include the restoration of trust and confidence within a community, and by working cooperatively to help prevent future violence, the health profession can make a unique and essential contribution. This contribution involves a convergence between health care and the field of conflict management.

Peacekeeping, famine relief, public health and other humanitarian programs have always involved some degree of conflict management work. However, this work has often been done on an ad hoc basis, without specific planning or the training of personnel in conflict management. Deliberate integration of conflict management with other humanitarian efforts is a recent development. Through such integration, conflicting parties are brought together to work on a humanitarian or development program that involves super-ordinate goals, and are provided with significant, concrete incentives for cooperation. At the same time, the humanitarian program receives the benefit of conflict management expertise. Such programs can move divided communities towards coexistence and eventual reconciliation. However, before communities can be asked to engage in efforts towards reconciliation, it is essential that societal provisions exist for: basic human security; a functioning civil justice system; and enforcement of law and order.

Section II of this manual discusses the theory and practice of building health bridges for peace, a process which involves the systematic integration of public health with community reconstruction. There is a discussion of the special role of the health care community in peacemaking, and the early work that occurred in building health bridges for peace in conflict-torn areas. Then, Section II describes the evolution of the health bridge concept, which has led to the employment of conflict management principles. A basic framework for conflict management practice is then outlined, together with explanations of the concepts of reconstruction and community reconciliation. Experience building health bridges in the former Yugoslavia and the north Caucasus is summarized, and some lessons drawn.

¹ "Health in Social Development," WHO Position Paper, prepared for the World Summit for Social Development (Copenhagen, March 1995), page 19.

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

Section III of this manual consists of tools for developing a health bridge strategic approach or a health bridge project. These tools include techniques for the development of dialogue, active listening, mapping the status of public health, generating options, strategic planning and goal setting.

II. HEALTH BRIDGES FOR PEACE, IN THEORY AND PRACTICE

Health professionals have a special role to play in healing violence-ravaged communities.² They 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 professionals 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. Reconciliation after the trauma of war requires a healing process to restore relationships, for both the individual and the community.

Involvement of health 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 that is essential for sustainable peace. In a post-conflict community, the health sector is often one of the few sectors to be aided by international and NGO assistance. This can provide options for communication, transport, technology transfer and educational support that are otherwise unavailable.³ Furthermore, international medical organizations have experience in building bridges between medical communities in developing and developed countries, North and South, East and West.

Early work in building Health Bridges for Peace

Delivery of health care has been the basis for significant cooperation between parties that have been divided by violence. In the 1980s a program entitled "Health Bridges for Peace" was developed by the ministries of health in Central America, with the support of the Pan American Health Organization. This program was a significant force in reducing conflict in the area. The War and Health Program of McMaster University in Canada has documented additional programs.⁴ UNICEF has pioneered the promotion of humanitarian cease-fires for pediatric immunizations, beginning in El Salvador in 1985, and again in Lebanon in 1987. UNICEF also brokered a "corridor of peace" in 1985 between the government and

² Paula Gutlove, "Health Bridges for Peace: Integrating Health Care and Community Reconciliation," in *Medicine, Conflict and Survival*, Frank Cass & Co. Ltd., London, England, Volume 14, January 1998.

³ A Health to Peace Handbook, War and Health Program of McMaster University, Hamilton, Ontario, Canada, 1996, page 5.

⁴ Mary Anne Peters, "Shots of Vaccine Instead of Shots of Artillery", in A Health to Peace Handbook, War and Health Program of McMaster University, Hamilton, Ontario, Canada, 1996.

HEALTH AS A BRIDGE FOR PEACE Briefing Manual

the insurgent NRA in Uganda, to allow the transport of medical supplies and vaccines. In the Sudan in 1989, a corridor of peace was negotiated between the government and the SPLA to allow delivery of relief supplies to people in southern Sudan.

WHO has demonstrated the potential for health to be a unifying influence on a longer-term basis, through research/ action programs, sustained inoculation campaigns, and health education programs in conflict-torn areas. For example, WHO-Afghanistan and the Afghan Ministry of Public Health brokered a cease-fire in 1994 during which children throughout the country could be immunized. The two weeks of tranquillity became a two-month cease-fire during which an intensive "Mass Immunization Campaign" was carried out.⁵ An important aspect of the campaign's success was the broad consensus that the organizers achieved among leaders of the warring factions and representatives of government and non-government agencies, including Afghan health officials from all parts of the country. Also cooperating in the initiative were international NGOs and UN agencies. The neighboring governments of Iran and Pakistan assisted through the donation, transport and storage of medicines. In addition to immunizing children, the campaign educated people about pediatric health needs and worked to build the health care delivery infrastructure of the country. Campaign organizers provided training to over 14,000 health workers and regional directors, and provided needed health equipment to rural centers throughout the country. Many observers felt that, until the Taliban took over in 1996, this program raised the level of respect that the health sector commanded throughout Afghanistan, and enhanced this sector's status as an impartial and neutral actor. Unfortunately, it is doubtful that the initial achievements of this program were sustained after the Taliban took over.

WHO has also organized research/ action programs to integrate peacebuilding with health-related initiatives. The program, "Health and Development for Displaced Populations" (Hedip) ran from 1991 to 1995, conducting three pilot projects in Croatia, Mozambique and Sri Lanka.⁶ In the three projects, Hedip addressed health problems whose solutions required actions that integrated the health sector with other sectors, and sought to use health-related actions to promote community reconciliation. The projects aimed to provide emergency humanitarian aid in such a way that it could contribute to long-term sustainable development. Participation of many sectors, including government, social services, private entrepreneurs and citizen groups, was promoted through the development of local committees, which directed the project on the local level. The success of the projects depended upon the development of a participatory, problem-solving process within these local committees.

⁵ "Health in Social Development", WHO Position Paper, Copenhagen, 1995.

⁶ Sara Swartz (Division of Emergency and Humanitarian Action of the World Health Organization), "Local Support for Peace Through Health: The Hedip Program of the World Health Organization", in A Health to Peace Handbook, War and Health Program of McMaster University, Hamilton, Ontario, Canada, 1996.

HEALTH AS A BRIDGE FOR PEACE Briefing Manual

The WHO office in Bosnia and Herzegovina (WHO-BiH), through the Peace through Health (PTH) strategy, has worked to integrate health and conflict resolution across a wide range of programs.⁷ This integration has been based on two principles. The first principle is that common health issues can provide neutral fora for discussion and collaboration. The second principle is that health issues can provide a valuable medium for addressing fundamental obstacles to peace such as discrimination, polarization, and manipulation of information.

WHO-BiH has implemented the PTH strategy in programs such as health system reform and reconstruction, public health, primary health care, and mental health. Some specific areas that they have worked on include: joint immunization campaigns; efforts to harmonize health data collection across BiH; joint training workshops in all parts of the country; and the initiation of an inter-faculty medical students' journal. Implementing the PTH strategy has presented crucial challenges to the health profession. A particular challenge has been the need for reform and reconstruction of the health system in BiH, requiring a fundamental and widespread recognition that responsibility for health extends far beyond the health sector.

⁷ Gregory Hess, director of the Peace through Health Program, WHO, Sarajevo: "The WHO Peace through Health Program in Bosnia and Herzegovina", in Reconciliation, Social Reconstruction and Conflict Prevention: The Role of Health Professionals, Report on an International Conference by Paula Gutlove, 23-26 April 1998, Sarajevo, Bosnia, November 1998.

HEALTH AS A BRIDGE FOR PEACE Briefing Manual

Evolution of the Health Bridge Concept: Employing Conflict Management Principles

The potential for the medical community to promote communal reconciliation, to heal inter-communal⁸ relationships, and to transform violence-habituated systems can be significantly enhanced with training and assistance in concepts and skills of conflict management. The field of conflict management encompasses efforts to prevent violent conflict, to mediate existing conflict, and to reconcile communities in the aftermath of violent conflict. Conflict management has grown in importance since 1990 as part of an evolving model of peace and security (see Figure 1.)

Figure 1. Old and new models for peace and security

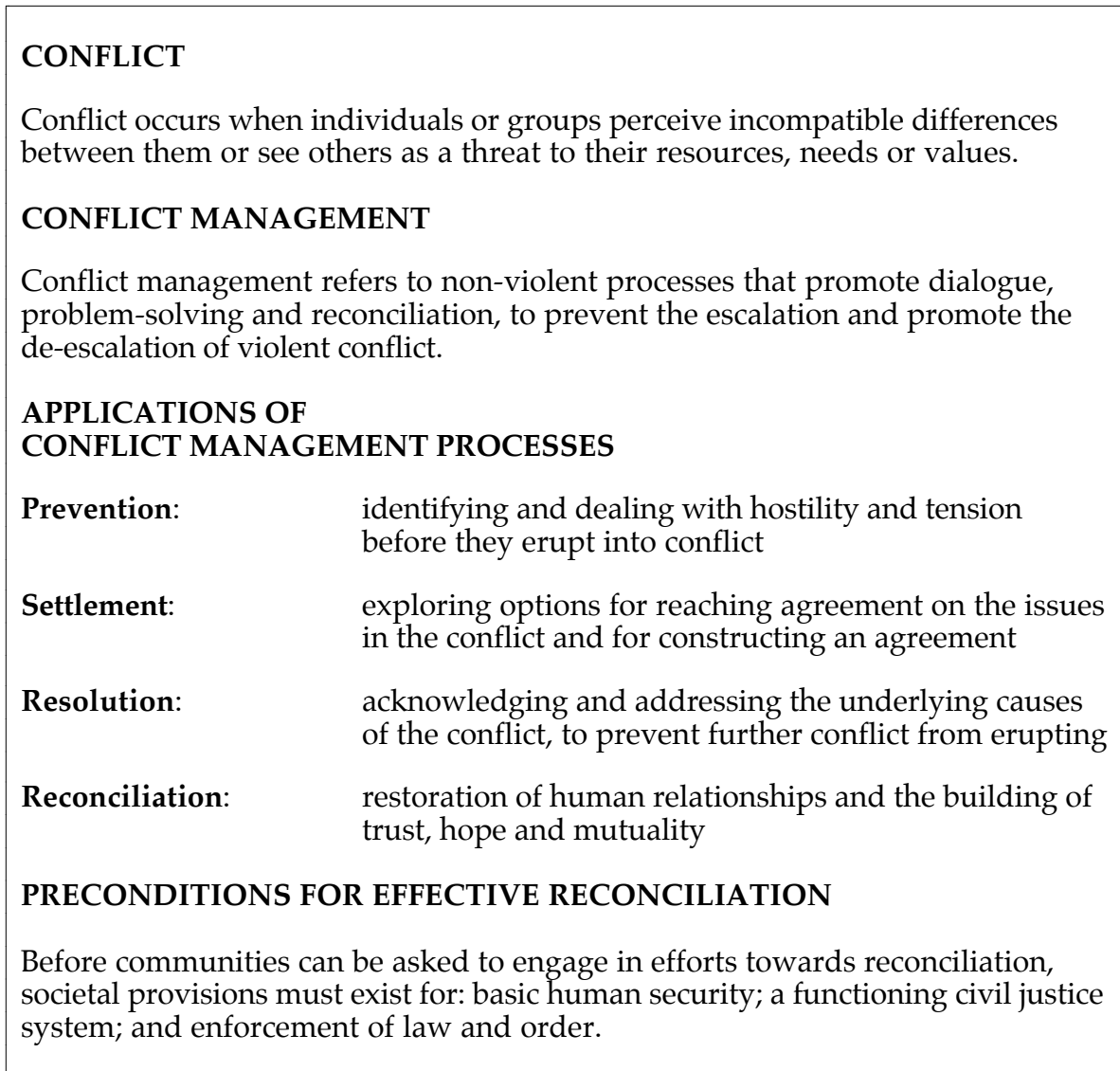
The Cold War model (1950-1990)	An evolving model (1990 +)
Power was highly centralized	Power is more dispersed
States were the dominant actors	NGOs have a growing role
International law had limited influence on governments and leaders	Governments and leaders are becoming more accountable to international law
States relied on military force to preserve equilibrium	Peace requires ongoing conflict management involving many actors
Many conflicts were "frozen" or suppressed	Previously suppressed conflicts have become violent
Many needs for identity, recognition and self-actualization were not met	There is social turbulence as needs for identity, recognition and self-actualization are expressed

⁸ The term "inter-communal" is used to encompass the class of racial, ethnic, religious, and ideological conflicts that involve differences between communities of people, rather than between individuals or governments, regardless of whether those communities exist within or across international borders.

HEALTH AS A BRIDGE FOR PEACE Briefing Manual

Conflict management processes that address the underlying causes of conflict and provide sustainable structures for adaptive social change can transform the ways in which groups and societies deal with differences. This transformation, away from dealing with differences through violence and destruction, and toward an approach based on constructive, cooperative interaction, is essential to long-term, sustainable peace. A basic framework for conflict management principles and practice is provided in Figure 2.

Figure 2. A basic framework for conflict management practice



In recent years, efforts to transform inter-communal conflict have benefited from the systematic integration of humanitarian activities with conflict management

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

expertise. This approach can be described as "integrated action".⁹ Peacekeeping, famine relief, public health and other humanitarian programs have always involved some degree of conflict management work. However, this work has often been done on an ad hoc basis, without specific planning or the training of personnel in conflict management. Deliberate integration of conflict management with other humanitarian efforts, through integrated action programs, is a recent development.

Through integrated action, conflicting parties are brought together to work on a humanitarian or development program that involves super-ordinate goals, and are provided with significant, concrete incentives for cooperation. At the same time, the humanitarian program receives the benefit of conflict management expertise. Such initiatives will be more effective and sustainable if they learn from previous successes and failures. Also, each initiative must respond to its unique cultural and historical context, and be developed by indigenous talent.

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, social reconstruction and community reconciliation.

Reconstruction

Reconstruction¹⁰ 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

⁹ Paula Gutlove and Gordon Thompson, A Strategy For Conflict Management: Integrated Action in Theory and Practice, Cambridge, Massachusetts, USA, Institute for Resource and Security Studies, March 1999.

¹⁰ 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.

HEALTH AS A BRIDGE FOR PEACE Briefing Manual

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-establishing of a civilian authority, preferably in a way that 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 psycho-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."¹¹ 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

¹¹ The New Lexicon Webster's Dictionary of the English Language, Encyclopedic edition, Lexicon Publications, Inc. New York, 1987.

HEALTH AS A BRIDGE FOR PEACE Briefing Manual

actions are only successful and sustainable when built on the foundation of a healthy, whole, 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 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."

In order for members of 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.

Integrated Action in Practice: The Health Bridges for Peace Project

On the eve of the nine-day war that began when Slovenia declared independence from the Yugoslav Federation in July 1991, a Slovene physician asked IRSS for help. She was aware of dialogue work that IRSS has facilitated with international groups of physicians, and she hoped IRSS could promote similar dialogue in Yugoslavia among people who were in a position to make a difference in the region. Within

HEALTH AS A BRIDGE FOR PEACE Briefing Manual

weeks, similar requests came from physicians and other prominent individuals and groups in Serbia and Croatia who were concerned about the violent course they saw their countries taking. Thus began a long-term commitment by IRSS to the former Yugoslavia.

Working with people from Serbia, Croatia, Slovenia, Macedonia, Montenegro and Bosnia-Herzegovina, IRSS convened numerous dialogue and training workshops for a range of professional groups, including politicians, educators, religious leaders, refugee workers and health care providers. Gradually our work came to focus on the unique and crucial role that health care professionals, primarily physicians, can play, not only in mending the physical and psychological wounds of individuals but also in rebuilding structures for public health care and in creating bridges for community reconciliation.

Drawing from our experience in the former Yugoslavia, IRSS launched the Health Bridges for Peace (HBP) project in 1996. The purpose of the project is to utilize a shared concern, namely the restoration of public health, as a vehicle to convene, engage, and train health care professionals in conflict management and community reconciliation techniques. Also, once these professionals are trained, they are assisted in designing and implementing inter-communal activities that integrate community reconciliation and conflict prevention strategies into health care delivery.

The first field program in the Health Bridges for Peace project, initiated in response to requests from medical professionals in the region, has operated in the former Yugoslavia since 1996. In April 1997, local physicians formed the Medical Network for Social Reconstruction in the former Yugoslavia. (Hereafter, this body is referred to as the Medical Network.) In addition to working within the former Yugoslavia, the Medical Network has engaged in active outreach to other war-torn areas to spread the Health Bridges concept. IRSS initiated its second Health Bridges for Peace field program in the North Caucasus in November 1998, when we brought together Chechen, Ingush, Ossetian and Russian health professionals in South Russia.¹² At this meeting the Medical Alliance for Peace through Health in the North Caucasus was born.

Health Care: a Special Opportunity for Integrated Action

The Health Bridges for Peace project works with the medical profession to promote a systematic integration of public health with social reconstruction and community reconciliation. The project convenes meetings with health professionals who share a common concern for public health issues. Participants are introduced to a variety of conflict management and community reconciliation processes. They engage in facilitated dialogue about their past, their present and their potential shared future, seeking to identify common health care needs that can be addressed effectively through a cooperative approach. The HBP project then assists them in designing and

¹² Paula Gutlove, Health as a Bridge for Peace in the North Caucasus: a Workshop for Health Professionals in Pyatigorsk, Russia, 29 October - 2 November, 1998, World Health Organization, Copenhagen and Institute for Resource and Security Studies, Cambridge, Massachusetts, December 1998.

HEALTH AS A BRIDGE FOR PEACE Briefing Manual

implementing inter-communal programs that integrate community reconciliation and conflict management techniques into health care delivery. Some areas of common ground include re-integration of war-affected people, resettlement of refugees and displaced peoples, reconstruction of health care delivery systems, civic education for human rights protection, and the development of sustainable processes for managing community conflict.

Facilitating community reconciliation can be difficult, demanding great sensitivity, patience and courage. Many of the health practitioners involved in local Health Bridges programs have special knowledge and unique skills that have contributed to the development of a culture-specific process of acknowledgment, mourning and grieving about the past. Engaging in this process has made it possible for the HBP project to help people who are locked in polarized, painful, antagonistic relationships to engage in a collaborative problem-solving approach. Documenting this process and training others in its application has been a key factor in promoting the transformation of a community characterized by violence, mistrust, injustice and anger to one characterized by hope, trust and wholeness.

An internationally known specialist in trauma recovery, Dr. Judith Herman, describes three stages -- safety, acknowledgement, and reconnection -- through which patients must move as they recover from a traumatic experience.¹³ While it is not necessary or even expected that patients will move from one stage to another in a linear fashion, recovery from trauma is predicated upon the patient's moving from a feeling of unpredictable danger to one of reliable safety and security, from a sense of dissociated trauma to acknowledged memory, and from feeling isolated and stigmatized to restoring meaningful social connections. These stages have proven to be very relevant to the recovery of communities from the trauma of war. Through a process of dialogue and shared actions, the HBP project has helped to train medical professionals to address these stages as individuals, as healers and as leaders of conflict-divided groups.

Reconnection is crucial to reconciliation within a violence-ravaged community. Here, the ultimate goal is the restoration of healthy human relationships and the building of trust, hope and interdependence. The concept of trust can encompass trust in other individuals to behave with compassion, and trust that the political system will be fair and equitable. The building of hope means that people can begin to believe that the future life of their community can be better than its recent, violent past. Interdependence comes from the knowledge that values and experiences, and the desire for trust and hope, are shared throughout a community.

By identifying issues of mutual interest, in which they can work together cooperatively, the HBP project allows participants an opportunity to rebuild their relationships in a sustainable, meaningful way.

¹³ Judith Herman, MD, Trauma and Recovery, New York, BasicBooks, 1992.

HEALTH AS A BRIDGE FOR PEACE Briefing Manual

The Medical Network for Social Reconstruction in the former Yugoslavia

The Medical Network was initiated in 1997 to promote the resolution of existing conflicts and the prevention of future conflicts in the former Yugoslavia. It is founded upon two major beliefs. First, violent conflict and war are the ultimate threat to public health. Second, the medical community has a unique and crucial role to play in promoting a healthy society, not only by mending the physical and psychological wounds of individuals but also by rebuilding structures for public health care and creating bridges for community reconstruction and social reconciliation. To these ends, the Medical Network aims to promote dialogue, cooperation, personal contacts, practical solutions and the renewal of relationships in its region. Acting on these beliefs, the Medical Network runs periodic training workshops, conducts a range of inter-communal health care projects, and convenes annual conferences.

Medical Network conferences serve to promote professional and organizational development while promoting the social reconstruction of the region. Each conference generally consists of plenary sessions and workshops, through which participants work together to examine and advance the role of health professionals in reconciliation, reconstruction and conflict prevention in former Yugoslavia. There are opportunities for exchange of knowledge on substantive issues, development of training programs for use by medical professionals to prevent conflict and encourage reconciliation, and organizational development of the Medical Network. The exchange of knowledge on substantive issues covers practical issues facing health professionals in a post-war situation, in categories such as: health care, social reconstruction and community reconciliation; refugees and resettlement; youth and the building of hope for the future; psycho-social support; and the development of civil society.

Annual conferences provide important opportunities for relationship building, across conflict divides, among the participants. These opportunities are built upon through training workshops designed specifically to promote the role of health professionals in conflict prevention and community reconciliation. In April 1998, with assistance from the WHO office in Bosnia, the Medical Network held its annual conference in Sarajevo. More than 100 health professionals, from the former Yugoslavia and internationally, convened to explore the role of health professionals in reconciliation, social reconstruction and conflict prevention.¹⁴ In April 1999 the annual conference was held in Ohrid, Macedonia. In view of the violence in the region at that time, the conference focussed on training Kosovar and Macedonian health care providers in three areas: treatment of traumatic stress; the use of volunteers in social reconstruction; and the integration of conflict management and community reconciliation with trauma recovery.

In May 2000 the Network plans its most ambitious conference to date, in Gracanica, Bosnia. Gracanica, in northeast Bosnia, falls within both the Federation of Bosnia - Herzegovina and the Serbian Republic. It is also part of a wider

¹⁴ Paula Gutlove, Reconciliation, Social Reconstruction and Conflict Prevention: The Role of Health Professionals, report on an International Conference, 23-26 April, 1998, Sarajevo, Bosnia, Medical Network for Social Reconstruction, Sarajevo, November 1998.

HEALTH AS A BRIDGE FOR PEACE **Briefing Manual**

Bosnia-Croatia-Serbia triangle. Since 1998, Network members from Slovenia, Bosnia, Serbia and Croatia have cooperated on a training program in Gracanica, integrating trauma recovery with community reconciliation and developing a network of volunteers to assist in social reconstruction. The conference will provide training in: medical assistance to handicapped children; psychosocial treatment for war-affected people, including refugees and veterans; and the integration of trauma recovery with community reconciliation.

The Network has a 12-member Contact Group that serves as its steering committee. The Contact Group meets every six months, has email and fax communication on a regular basis, and leads the Network as it engages in cooperative medical projects that cross conflict lines. Examples of Network inter-communal health care programs include:

- Psychiatrists and psychologists from Slovenia, Bosnia and Croatia have helped to set up inter-ethnic counseling and reconciliation programs in their own republics and have worked together with colleagues in Bosnia, Kosovo, Montenegro and Macedonia to set up similar programs there.
- Training, in psychosocial support for traumatic stress and the use of volunteers in psychosocial programs, is being carried out throughout the region by a core of Network members from Slovenia and Croatia.
- The Network has established an electronic communications linkage that functions for long-range planning and as an emergency alert system.
 - Network members from Slovenia and Croatia collected hospital equipment from West European sources and, with IFOR military escort, brought it to two hospitals, one in the Bosniac Federation and the other in the Republika Srpska.
- The Network plans to publish a bi-monthly Network Newsletter and establish a Mobile Medical Library.

The Medical Alliance for Peace through Health in the North Caucasus

In April 1998, physicians from Chechnya were guests at a Medical Network conference in Sarajevo. This stirred an interest in the North Caucasus for a Health Bridges for Peace field program, and a request to IRSS for assistance. In October 1998, IRSS convened and facilitated a workshop at which the Medical Alliance for Peace through Health in the North Caucasus (Medical Alliance) was born. The five-day workshop took place in Pyatigorsk, Russia, from 29 October to 2 November 1998. The workshop brought together 21 health professionals from Chechnya, North Ossetia and the Stavropol and Krasnodar regions of Southern Russia. Health professionals from Ingushetia were scheduled to attend but were unable to travel into Southern Russia for political reasons at the last minute. Workshop participants included ministers of health, heads of hospitals, directors of community health facilities, and a range of clinicians and administrators with significant public health responsibilities.

The workshop was organized through local and international networking and cooperation. The primary organizers on the local level were the Netherlands Relief Committee for Chechnya (RCC) and the Association for the Protection of the Rights

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

of Refugees and Forced Migrants (ADEPT). The OSCE Assistance Group in Chechnya provided logistical support. WHO provided information about potential participants, as well as invaluable program assistance, before and during the workshop. The workshop was a carefully facilitated mixture of lectures and small-group experiential work, which sought to:

- sensitize participants to the potential, inherent in their role as healers, for promotion of public health, social reconstruction and peace;
- provide training in communication and problem-solving skills;
- address specific war-related public health issues;
- identify opportunities for cooperative actions within the health sector to promote public health and peace building; and
- explore the potential for the development of an ongoing network of health professionals who can use health as a bridge to peace in the North Caucasus.

Workshop participants unanimously agreed to continue their work together and to expand their network to include all 10 republics of the North Caucasus. To do this they decided to form the Medical Alliance for Peace through Health in the North Caucasus. The mission of the Medical Alliance is to work collaboratively in the North Caucasus to promote peace through health, engaging in collaborative initiatives that improve physical, mental and social health in the region.

In order to enhance communications within the region, the Medical Alliance made plans to publish a monthly newsletter through the WHO/EURO office in Copenhagen. The Medical Alliance also started planning on a range of cooperative public health programs, including: a regional network on tuberculosis control; cooperative centers for psycho-social rehabilitation; a North Caucasus inter-regional training center for the prevention of drug addiction; and a cooperative program for prosthetic assistance to amputees in the North Caucasus.

The Medical Alliance had plans to hold its second regional meeting in November 1999, and received support to do this through a generous gift by the Japanese government to the WHO/EURO office. Unfortunately, the escalating violence and instability in the region have caused a temporary suspension of regional program plans. Until the region is safe for a region-wide meeting, IRSS will work with WHO/EURO to define and implement cooperative programs in response to the current crisis situation.

Lessons from HBP Field Programs

Experiences in the former Yugoslavia and the North Caucasus have confirmed the enormous potential for HBP programs in post-conflict areas. They have also demonstrated important principles for integrating health initiatives with community reconciliation in a systematic and sustainable manner, as follows:

- A Health Bridges program should be guided by a broadly representative group of indigenous personnel. Only the local people can identify the crucial health needs of their communities. Moreover, important resources for understanding and transforming conflict can be found within a culture from

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

- which the conflict has emerged. Wherever possible, participants should be involved in developing their own training programs.
- The greater the ownership local groups have of a training program, the greater is the likelihood that they will find ways to use it and sustain it.
 - In order for training to have a long-term impact, it must be embedded in a structure that has the potential for long-term sustainability. Thus, the organizational development of the Medical Network and the Medical Alliance is in each case crucial to the success of the program.
 - Setting up channels for ongoing communication and information exchange among a range of parties is essential for preserving the gains made at meetings and training sessions. For example, at times when direct communications were impossible, members of the Medical Network have creatively sent messages and medical aid through “third” parties. These symbolic and substantive acts were crucial to maintaining the gains in trust and human connection that each meeting of the Network has achieved, and were ultimately essential to the survival of the Network.
 - A Health Bridge program is not sustainable or maximally effective unless it relates to other organizations and actors. Thus, the local medical networks are able to grow and gain stability by maintaining communication links with a range of relevant humanitarian and development agencies and NGOs, and with government and intergovernmental agencies. The most important link can be the WHO.
 - Ongoing program evaluation and the ability to change in response to critical evaluation are essential to the efficiency and sustainability of any training program. Also, the program must be able to adapt to a changing political landscape.

Conclusions

Medical professionals have a special role to play in healing violence-ravaged communities. They can do much to heal a community's damaged sense of wholeness by creating peacetime bridges between groups 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. 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

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

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.

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

III. TOOLS FOR BUILDING HEALTH BRIDGES

1. Dialogue

A. Dialogue for integrated action¹⁵

1. What is a dialogue for integrated action?

- A dialogue to develop programs for collaborative activities among parties where tense inter-group relations may exist
- An interactive process
- More structured than a conversation, less structured than a negotiation
- A process that integrates training and action with a specific set of goals
- A program-generating process that can design and spin off into a community ideas and practical steps for concrete activities and for reducing tension and improving relationships
- A process designed to change concrete situations and relationships over time

2. Five stages of dialogue for integrated action:

Stage i. Pre-dialogue, deciding to engage in dialogue

- Decide **who** should meet, **where** to meet
- Agree on the **nature and purpose** for the dialogue:
 - *Do you want to try to improve the level of physical, psychological and social health in your community?*
 - *With whom is it most important to rebuild relationships in order to achieve community "health"?*
- Agree on the mode of **facilitation**. It is recommended that the dialogue be facilitated by an experienced third party.
- Develop **Ground rules** for the dialogue
- Ground rules define how the group will conduct itself during meeting sessions. It will reassure participants to know that the process will be well-structured and facilitated with care and sensitivity. Ground rules can be generated before the parties meet. These can be reviewed and added to when the parties meet, and agreed to by all participants. Some potential ground rules:
 - *Allow each participant to participate fully.*
 - *Define roles of facilitator, assistants, and observers, if any.*
 - *Listen respectfully to each other.*

¹⁵ Adapted from H. Saunders and R. Slim, "Dialogue to Change Tense Community Relationships", Draft, December 5, 1994

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

- *Don't interrupt when someone is speaking.*
- *Everyone is free to suggest ideas or express feelings without ridicule.*
- *Confidentiality and non-attribution during the workshop and after it (confidentiality in the small groups, only tell the wider community what a group agrees to make public).*
- *You may disagree with the substance of what someone is saying, but no personal verbal attacks are permitted.*
- *Punctuality: We will begin and end each session on time.*
- *Smoking rules (where, when, etc.) are to be negotiated by the group.*
- *Translation:*
(Translation can be simply a logistical issue, making it possible for people who don't speak each other's languages to understand each other. The choice of language used may, however, be of political significance to some of the participants. Explain how translation will be conducted, and why one language rather than others had been chosen.)

Stage ii. Map out the public health situation

- Map out the current state of public health, in the different regions. Allow each side to tell their story.
- Get out on the table the main problems that affect the situation, (including the relationships between the parties).
- Identify the significant causes for the problems, and what needs to be solved to change them.
- Talk constructively about the situation, the relationships.
- Prioritize selected problems that should be worked on in-depth together:
 - *What would you like to achieve together?*
 - *What are the main problems that you deal with?*
 - *Why do you care?*

Stage iii. Problem solving

- In-depth probing of specific problems, one at a time, to understand the dynamics of the problem and the potential for change
- Define main elements of each problem:
 - *Who are the main groups involved in the problem?*
 - *How does the problem affect your group's **interests** (what you really care about)?*
 - *What does each group **need** from the other group to full fill its interests?*
 - *What changes are needed?*

Stage iv. Building cooperative Health Bridge for Peace scenarios

- Define the obstacles that stand in the way of change

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

- Discuss how to overcome these obstacles
- Reframe problems as shared concerns. View the problem as “our problem”, not that we are each other’s problem
- List steps to overcome the obstacles
- Create a realistic sequence for these steps
 - *What changes are needed to deal with the problems discussed?*
 - *What are the main obstacles to these changes?*
 - *Name as many steps as you can to overcome each of the obstacles listed.*
 - *Who can take the steps listed?*
 - *What is a realistic sequence for these steps?*

Stage v. Implementing Health Bridge for Peace projects

2. Develop practical cooperative projects, to put the scenarios into action.
3. Define, the “what, how, who and when” for each project:
 - *What can you do? What can your organization do?*
 - *How can you do it? How can it be done cooperatively?*
 - *Who else needs to be involved (people, organizations, governments)?*
 - *What do you need and where can you get it?*
 - *When will you do it?*

HEALTH AS A BRIDGE FOR PEACE Briefing Manual

B. Constructive communication and effective dialogue

*Aspects of constructive communication:*¹⁶

Constructive (rather than destructive) communication is essential to promote understanding, develop cooperation and reach agreements. It conveys an expression of respect, while at the same time it can create respect between parties. Constructive communication is marked by:

- curiosity and interest among the parties
- listening with an open mind
- empathy
- compassion
- honesty and
- humility.

Constructive communication requires that the parties feel safe, psychologically and physically, to engage in honest communication. If groups are in a conflictual relationship or have a history of mistrust, the presence of a third party facilitator can be of important assistance. The facilitator can help the group develop ground rules, enforce these ground rules, and train the parties in listening and speaking in a non-combative mode. This includes:

- listening actively
- talk with each other, not at each other
- listen openly to each other
- respond directly to each other
- ask clarifying questions
- speak clearly
- confront creatively
- reframe the problem
- encourage a problem-solving approach

*Changing debate to effective dialogue*¹⁷

For many people, talking to someone who holds different opinions means to debate, to convince, to argue, or to threaten. When using dialogue to resolve or address conflicts, the intention is not to advocate, argue, or convince, but to listen, to learn, and to create new options.

Dysfunctional behavior patterns may be exhibited in 'conversations' between parties involved in a chronic conflict. These patterns include:

¹⁶ Adapted from the International Alert Resource Pack for Conflict Transformation, 1996.

¹⁷ Adapted from the Public Conversations Project, "Creating Systemic Interventions for the Sociopolitical Arena", by Richard Chasin, MD, and Margaret Herzig, in The Global Family Therapist, Benina Berger-Gould and Donna Hilleboe DeMuth, Eds., Allyn and Bacon, Needham, MA, 1993.

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

- i. Limited, ritualized interactions, in which adversaries don't listen to each other, and engage in rhetorical questioning.
- ii. An assumption that the members of an adversarial group are all alike--in particular, the most extreme members are assumed to represent the whole group. Within each alliance, differences are minimized, especially in the presence of the adversary, while those who choose not to take a polarized position are suspect by both sides.
- iii. Blaming the other party, holding assumptions about what the other thinks and believes, and being tied to fixed opinions about the other. Rarely do parties take responsibility, or exhibit genuine curiosity or open-mindedness.
- iv. Open display of fixed and simple convictions and concealment of complexity, ambivalence, or confusion. If an adversary displays openness to conciliation it is met with mistrust.
- v. Overvaluing of the struggle itself. In a stalemate, adversaries perceive the struggle itself as valuable, even though outside parties may tell them the struggle is more destructive than any alternative outcome.

Differences between polarized debate and effective dialogue are highlighted in Figure 3.

HEALTH AS A BRIDGE FOR PEACE
Briefing Manual

Figure 3. Distinguishing Polarized Debate from Dialogue¹⁸

<u>Polarized Debate</u>	<u>Dialogue</u>
Atmosphere is threatening	Atmosphere is safe
Participants speaks as representatives of groups	Participants speak as individuals
Participants speak to their constituents	Participants speak to each other
Differences within sides are minimized	Differences within sides are revealed
Views are expressed with absolute certainty	Uncertainties are expressed
Issues are simplified	Complexities are explored
Participants listen in order to refute	Participants listen in order to understand
Statements are predictable and offer little new information	Issues are looked at from new perspectives, and new information surfaces

¹⁸ Adapted from “Distinguishing Debate from Dialogue” by the Public Conversations Project of the Family Institute of Cambridge, 51 Kondazian Street, Watertown, MA 02172

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

2. Active Listening

A. The Active Listening Approach

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 listening¹⁹ 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 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.

¹⁹Carl R. Rogers and R.E. Farson, "Active Listening" from Seminar Program for Instructors in Professional Schools, University of Chicago, Industrial Relations Center, (no date).

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

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

- Active listening is an acquired skill, which improves with practice.
- 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.
- 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?"
- 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.
- 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.

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

- 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:
 - Speaker: "Don't you think they could have given me better supplies to work with?"
 - Listener: "Do you feel they could have given you better supplies?"
(Instead of "Well they were probably doing the best that they could," or, "of course they should have given you X and Y.")
- 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.

B. An Experiential Workshop Utilizing Active Listening

Workshop Ground Rules

Ground rules should be reviewed and new ones suggested as needed, to serve the purpose of defining how the group will conduct itself during the listening session. Attention to ground rules at this stage may help to 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:

- Listen respectfully to each other.
- Don't interrupt when someone is speaking.
- You may disagree with the substance of what someone is saying, but no personal verbal attacks are permitted.
- 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 substituted to meet the needs of the particular group and the conditions under which they are working.

HEALTH AS A BRIDGE FOR PEACE Briefing Manual

Setting the mood

It is useful at this time to have the group read together poetry or prose that illustrates the power of listening to another person's story. A very useful selection is the excerpt from Yevgeny Yveteshenko's **A Precocious Autobiography**, "When one person reaches out with Love". This is available upon request.

Workshop process

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 discussion:

- What are some of the greatest obstacles you faced as a health care provider during the last 7 years?
- Describe something you did in the past that you wish you would have done differently. What was it, what were your alternatives, and what do you wish you had done instead?
- Describe something you did in the past that you are proud of. What was it?

Alternative questions for discussion:

- How did you maintain your commitment to the health care profession in the face of the conditions under which you were forced to work?
- How did you maintain your respect for yourself as a professional in spite of the obstacles you had to overcome?

HEALTH AS A BRIDGE FOR PEACE Briefing Manual

*Questions for contemplation:*²⁰

- Contemplate 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?
- Contemplate 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?

²⁰Peter Lang, "Counseling and support skills for community workers in the Former Yugoslavia, Resources and Pathways", Kensington Consultation Centre (no date).

HEALTH AS A BRIDGE FOR PEACE
Briefing Manual

3. Mapping the current state of public health using a “SWOT” analysis

Figure 4. Template for a “SWOT” analysis of the current (and anticipated) state of public health care delivery in a selected region.

<u>Strengths</u>	<u>Weaknesses</u>
<u>Opportunities</u>	<u>Threats</u>

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

B. Positions, interests and needs²¹

Definition of terms

- **Positions:** stands taken emphatically, as unchangeable statements of reality, as demands, or as preconditions for settlement of a conflict.
- **Interests:** structures, boundaries, activities and circumstances that serve to satisfy basic needs.
- **Needs:** the basic conditions required by groups for their well-being; needs themselves are not negotiable, although ways to satisfy those needs are.

Basic human needs²²

- **Physical** needs: food, shelter, and clothing.
- **Security** needs: safety from physical and psychological danger; the ability to provide for basic economic and social necessities.
- **Community** needs: belonging to a social context, relationships with others.
- **Identity** needs: the racial, ethnical, tribal, national, cultural or religious distinctiveness of a group; the knowledge that your group will not become extinct.
- **Recognition** needs: the need for dignity, self-respect, esteem, prestige, status, knowledge and power.
- **Self actualization:** achievement, competence and mastery, the desire to learn, and to understand, to satisfy one's curiosity, to fulfill one's unique potential.

²¹ Institute for Multi-Track Diplomacy, Washington DC, 1993

²² A. H Maslow, 1943

HEALTH AS A BRIDGE FOR PEACE Briefing Manual

C. Strategic questioning²³

Strategic questioning is the skill of asking questions that can promote social and personal change. It involves a special type of questioning and active listening. It is a process that can change the listener and the person being questioned.

Strategic questions:

- create motion, they help people explore how they can move on an issue;
 - * *What would you like to do to help?*
- create options, open up new possibilities;
 - * *What else could you do to make things better?*
- avoid “why don’t you....” and questions that demand a “yes” or “no” answer;
- are empowering, creating confidence that change is actually possible;
 - * *What would it take for us to function as a team?*
 - * *How do we want to work together?*
- dig deeper;
 - * *What haven’t you considered yet?*
 - * *How can we approach this problem from a different perspective?*
- ask the unanswerable, as they can challenge the values and assumptions that are usually taken for granted.
 - * *What makes our differences worth dying for?*
 - * *How can we live together without violence?*

²³ Fran Peavey, *By Life’s Grace*, New Society Publishers, 1991

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

5. Moving from visions to goals to strategy to plans

A. Consensus building²⁴

Consensus building is an alternative to voting as a method for decision-making by a group. While voting may be the fastest and most familiar method by which a group reaches a decision on a course of action, it may not be the best method. Those who lost the vote may feel unhappy and dissatisfied. They may choose not to cooperate in implementing the decision, or they may actually leave the group. Consensus building is a group decision-making process that attempts to gather and synthesize the ideas of the whole group into a decision that is acceptable to everyone. The idea is that not only will this be the most satisfactory decision, but also the process of achieving it will foster group cohesion and commitment to the outcome.

Consensus does not mean that everyone will feel that the decision reached is the best one possible. What it does mean is that in coming to an agreement, no one felt that his or her views were misunderstood or went unheard, and that the decision made is one he/she can live with and therefore take responsibility for implementing. Sometimes this form of collective decision making can produce more creative agreements than any of the options proposed by individuals at the outset of the discussion.

How to use the consensus-building process

Here is an example of how a consensus building process might be used:

- A situation arises which requires a group decision.
- The group meets to discuss the situation.
- Proposals are made: "I suggest that we all do x"
- Rather than voting, everyone's point of view on the proposal is heard. Dissenters are encouraged to speak out, and express their differences clearly. They are responsible for suggesting modifications or alternatives to the proposal.
- Once a proposal is well understood by everyone, and no new changes are being suggested, someone in the group should ask if there are objections or reservations. One way to do this is to ask: Is there anyone who can't live with this? If there is no dissent, this is a consensus.

²⁴ Eileen Babbitt, Paula Gutlove and Lynne Jones, Handbook of Basic Conflict Resolution Skills: Facilitation, Mediation, and Consensus building, *Balkans Peace Project*, December 1994

HEALTH AS A BRIDGE FOR PEACE

Briefing Manual

- If a group member feels unhappy with the decision but has no alternative proposals that are agreeable to the others, there are several formal ways to express objections:
 - Non-support: "I do not agree with this but I will go along with it."
 - Reservations: "I think this may be a mistake, but I can live with it."
 - Standing aside: "I personally cannot be involved in this course of action, but I will not stop others from doing it."
 - Blocking: "This decision violates fundamental principles, and I cannot support it or allow the group to do it."

Obviously, if many people express reservations or stand aside, the group may not have a viable decision, even if no one blocks it. This is what is known as a "lukewarm consensus," and it is not a desirable outcome. It may indicate that the issue needs more thought. If a single individual actively blocks consensus, the choices are for the group to continue discussion until a new consensus is reached, for the group to stay with the previous decision on the issue, or for the individual concerned to leave the group.

The consensus-building process is likely to be much easier if the group appoints a facilitator at the outset. The facilitator should remain neutral in behavior, whatever are her/his views. S/he is likely to find this easier if s/he does not have strong views on the subject under discussion. The facilitator's role is to help the group define the decisions to be made, help it through the stages of making the decision, focus discussion on the point in hand, make sure everyone has a chance to participate, and test whether consensus has been reached. The facilitator helps to direct the process of the meeting, not its content. However, when members of a group are highly involved in a discussion, participants may not be aware that they are actually voicing the same proposals in different ways. It is the facilitator's task to listen carefully to the content, see where consensus appears to exist, and clarify those areas already in agreement and those which are still disputed.

For example: "We seem to be agreed that we should invite the camp administrator to meet with us, but we still have to decide who else should be at that meeting. Is that right?" If everyone agrees: "I have noted the decision on the administrator. Let's concentrate on who else should come to the meeting."

One technique for getting a sense of the meeting is for the facilitator to take a "straw poll," that is, a show of hands to see how near to consensus is the group. This is not a vote, but it allows the facilitator to see who is still unhappy and to encourage them to air their views and suggest modifications.

When the facilitator thinks there is consensus, s/he should state the decision clearly, check that there is no dissent, and then put the decision in writing.

Everyone in the group has the responsibility to help the meeting go well. The facilitator may want to spell out some ground rules, such as:

HEALTH AS A BRIDGE FOR PEACE Briefing Manual

- Participants must be respectful of other speakers and not interrupt when someone else is speaking.
- Participants are responsible for voicing their opinions, participating in the discussion, and actively implementing the agreement.
- Blocking consensus should be done only on matters of principle. The participant who blocks consensus should try to suggest alternatives.
- Everyone should search for areas of agreement and common ground. The aim is not to win the argument but to find a joint solution.

It should be understood that consensus is not always the most suitable method of decision making. There may well be matters that are most effectively dealt with by brief discussion and a vote. Large membership organizations often find voting more efficient, but it should be noted that the Religious Society of Friends uses consensus for everything, including business at yearly and monthly meetings. When people are familiar with the technique and each other, and self-disciplined enough not to feel a need to repeat at length views that have already been expressed, consensus can be efficient. In matters of substance where there are a variety of opinions and feelings are involved, the consensus method allows these views and feelings to be heard.

Shortage of time may necessitate combining the two methods. That is, a group might agree that if consensus cannot be reached after a fixed amount of time, a vote will be taken. The important thing is for a group to choose a decision-making method appropriate to the subject under discussion, the nature of the group, and the situation.

The key differences between consensus building and voting are summarized in Figure 5.

HEALTH AS A BRIDGE FOR PEACE
Briefing Manual

**Figure 5. Summary of the main characteristics of
Consensus Building and Voting**

<u>Consensus building</u>	<u>Voting</u>
Decision making occurs through synthesis of different positions.	Decision making occurs through obtaining majority support for a single position.
Rules can alter, depending on style of facilitator and group.	Rules are well-established, and procedure is clear.
Process can take a long time.	Process can move quickly.
Positions may be clearly stated at outset, but those holding them may shift or alter to incorporate variations suggested by others. Views may converge in course of discussion.	Positions need to be clearly stated, so that individuals can vote for or against. It is difficult to include subtle modifications or variations. Discussion can become polarized between fixed opinions.
Process allows for discussion around a variety of different options and creating a "package" of issues.	Process allows for voting for or against only one option at a time.
All views are heard. Unusual ideas may allow for creative reframing of the problem.	Those with views that do not fit the terms of debate may not wish to confuse the issue and therefore stay silent, or leave.
Object of discussion is to find a solution with which the whole group is comfortable.	Object of discussion can become winning support for one's own position and defeating one's opponent's, rather than searching for the best solution.
Decision cannot be forced. (For what happens when group fails to reach a consensus see below.)	Decision is sometimes the result of coercion and trade-offs rather than full discussion.
Reaching a consensus requires inclusion of whole group.	Voting can produce disaffected minority, which may leave group or sabotage decision.

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Briefing Manual

B. Exercise In Project Development And Proposal Writing
(Sample Proposal for a Cooperative Health Bridge Project)

1. Information about the Applicant:

Organization name _____
Mailing address _____
Phone and Fax numbers _____
Email address _____
Project supervisor _____

2. Project Title: _____

3. Grant Period: from _____ to _____

4. Amount Requested: _____

5. Proposal Narrative:

5.a. Abstract: a brief overview of the project, describing the project's goals, what the project will do and how it will do it.

5.b. Objectives and strategy: how will the project prevent or manage violent conflict?

5.c. Background: the project's context and its history to date.

HEALTH AS A BRIDGE FOR PEACE
Briefing Manual

5.d. Implementation: whom will do what, and when will they do it? Discuss tasks and responsibilities, and create a project timeline.

5.e. Products: what products will result from this project? Who will use the products? How will they get them?

5.f. Evaluation: how will the success of the project be evaluated?

6. Project Budget

Category	Funds from Delta Fund	Other funds available	Total
Wages			
Benefits			
Consultants			
Travel			
Meetings			
Printing			
Supplies			
Communications			
Equipment purchase			
Office costs			
Other			
Total			

HEALTH AS A BRIDGE FOR PEACE Briefing Manual

6. A Health Bridge for Peace Action Plan Checklist

A. What, how and who
(What shall we do, how shall we do it, who is involved?)

1. Who are we now and what do we want to become?
2. What is our mission?
3. What is the content of our work together?
4. What do we plan to do?
5. How shall we do it?
6. What avenues of communications do we have between us?
7. What is our organizational structure ?
8. What do we need? Where shall we get funds ?
9. To whom (local, international organizations) do we want to relate?

B. Planning for future meetings, checklist

When and **where** shall we meet, **what** are our goals, **how** will we achieve them, **who** is responsible for what?

1. When are the next meetings of the Medical Network
2. Goals of the Meeting
3. Where should the meeting be held? When? How long?
4. Issues and topics to cover
5. Types of Interactions (large groups, small groups.)
6. Speakers to invite
7. Preliminary agenda
8. Fundraising - amount needed, who is responsible for what?
9. Time line
10. Reporting process