

THE MEDICAL NETWORK FOR
SOCIAL RECONSTRUCTION IN THE FORMER
YUGOSLAVIA

**Reconciliation, Social Reconstruction
and Conflict Prevention:
The Role of Health Professionals**

**Report on an International Conference
23-26 April 1998, Sarajevo, Bosnia**

November 1998

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Without the support of our sponsors and the hard work of our members, the Network would be unable to continue its important mission, which is to promote dialogue, cooperation, personal contacts, practical solutions, and the renewal of relationships in the area.

REPORT INFORMATION

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(Appendices A, B and C are not available in electronic version of this report)

(Appendix G, titled "Abstracts of workshop presentations", is bound separately and is available on request.)

I. INTRODUCTION

This report describes an international conference that was held in Sarajevo in April 1998. The conference was organized by the Medical Network for Social Reconstruction in the Former Yugoslavia, whose history and purpose are described in Section II, below. Section III provides an overview of the conference, and Section IV gives a more detailed description of the various sessions at the conference. This report has seven appendices (A through G), beginning with a list of conference participants. Appendices A through F are bound with this report, and Appendix G is bound separately. (See the contents page for a list of appendices.)

II. HISTORY AND PURPOSE OF THE MEDICAL NETWORK

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 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 since 1991, and has grown from a core of about six to more than one hundred participants. Broad-based participation has been achieved in spite of severed communications channels and inadequate resources. The group's meetings have brought together polarized parties even during periods of extreme violence in the region.

The group met in Graz, Austria, in April 1997, and over sixty health care providers from all parts of the former Yugoslavia attended. That meeting was hosted by the OMEGA Health Care Center, which is based in Graz. At the Graz meeting 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. In pursuit of these goals the group has met twice since April 1997, in Bled, Slovenia, in November 1997 and in Sarajevo in April 1998.

III. AN OVERVIEW OF THE CONFERENCE

The Sarajevo conference brought together over 100 people from 12 countries. (Appendix A provides a list of conference participants.) Approximately 90 percent of those present were from the former Yugoslavia, and all parts of the region were represented. The conference was organized by the Medical

¹ A full report on the meeting in Bled is available upon request from the Institute for Resource and Security Studies, 27 Ellsworth Avenue, Cambridge, Massachusetts 02139, USA.

Network for Social Reconstruction in the Former Yugoslavia (hereafter described as the Network), but attendance was not limited to members of the Network. The objective of the conference was to examine and advance the role of health professionals in reconciliation, reconstruction and conflict prevention in the former Yugoslavia. In pursuit of that objective, the meeting provided opportunities for:

1. exchange of knowledge on substantive issues;
2. training in conflict prevention and reconciliation, both to repair relationships within the Network itself and to prepare Network members to lead community reconciliation programs;
3. organizational development of the Network; and
4. generation of spin-off benefits.

1. Exchange of knowledge on substantive issues

The conference addressed substantive issues facing health professionals in the post-war situation, in areas such as:

- health care and social reconstruction;
- refugees and resettlement;
- youth and the building of hope for the future;
- psycho-social support; and
- the development of civil society.

Participants agreed that documentation and analysis of their experience treating the physical, social and psychological ills of the post-war situation could be broadly applicable, both within former Yugoslavia and in other post-conflict situations.

2. Training in conflict prevention and reconciliation

While the conference itself was an important opportunity for relationship building, workshops were also integrated into the program to promote the healing of relationships among Network participants and to prepare Network members for a key role as health professionals engaged in conflict prevention and reconciliation. One workshop was an experiential/training workshop in conflict prevention and reconciliation; that workshop focused on the human need in post-traumatic situations to listen to the stories of others and to be listened to. Another, related workshop was a forum for the exchange of information about the role of health professionals in community reconciliation in parts of former Yugoslavia.

3. Organizational development of the Network

The last day of the conference was devoted to organizational development and action planning for the Network. The group elected a 12-member Contact Group to serve as a steering committee for the Network. It was suggested at one point that the selection of the group be based on ethnic representation, whereupon one of the participants stood up and made a moving speech, telling

the group that if they were to break down along ethnic lines at this point, then the work that has gone into the development of the Network, and the reconciliation processes they have participated in, were for nothing. The group applauded her sentiment and sincerity and agreed to elect Contact Group members based on practical geographic and programmatic considerations, not on ethnic divisions.

The Network made action plans for the next 13 months. They agreed to hold a Contact Group meeting in October or November 1998 in Igalo, Montenegro, and a large Network conference in Ohrid, Macedonia, in May 1999. Specific action plans to be implemented include:

- setting up a Web site for organizational and medical information exchange;
- publishing announcements of the Network's mission in medical professional journals throughout former Yugoslavia; and
- engaging in a coordinated public health survey to evaluate the impact of violence on public health in all parts of the former Yugoslavia.

The goal of the public health survey is two-fold: to evaluate public health parameters; and to promote specific public health functions on the community level. The survey will have a standardized methodology used throughout all parts of the former Yugoslavia, so that the results can be comparable. Ultimately, the survey will be used to assist the Network in developing a "call to action" for health professionals regarding the impact of violence on public health.

4. Generation of spin-off benefits

In addition to expanding and deepening contacts among participants from the former Yugoslavia, the Sarajevo conference provided the Network with an opportunity to develop collaborative ties with sympathetic international organizations. Among these are: the World Health Organization, which supported the conference and hopes to continue to support the Network's activities; the European Commission; the Program for Torture Victims (based in California); the Harvard Program in Refugee Trauma; and the Netherlands Relief Committee for Chechnya.

An exciting outcome of the conference is the spread of the Health Bridge concept to Chechnya. A physician from Chechnya attended the conference as a guest of the Network, and requested assistance in the organization of a similar Network which brings together Chechen, Ingush, Ossetian and Russian physicians for collaborative public health activities and training in community reconciliation.

IV. CONFERENCE SESSIONS

FORMAL OPENING AND WELCOME THURSDAY 23 APRIL (EVENING) AND FRIDAY 24 APRIL 1998 (MORNING)

The conference began informally in the evening of Thursday 23 April 1998 with a welcome party and an open display of materials from the many organizations represented at the conference. At the party, an official welcome and good wishes were expressed by Dr Valentin Inzko, Ambassador, Republic of Austria.

The meeting officially began on the morning of Friday 24 April 1998 when the conference was called to order by Dr Jadranka Ruvic, a member of the Network and a key conference organizer in Sarajevo. Dr. Ruvic moderated the first panel of welcoming speakers. The first speaker was Rasim Gacanovic, mayor of Sarajevo, who began by describing the crucial importance of reconciliation in Bosnia and throughout former Yugoslavia, stating that the greatest human evil is to not recognize the unity that resides within the apparent diversity of Catholics, Islam and others. He also said that the extreme human feelings that were expressed in Bosnia could arise anywhere in Europe and, similarly, the experiment in reconciliation that we are embarking upon in Bosnia could inform the rest of Europe and the world.

Prof. Dr Seid Hukovic made the next welcoming address, introducing himself as both a health professional and as the president of the human rights council of the Democratic Party of Sarajevo. Prof. Hukovic stated that the importance of communication and inter-group understanding was well known among many in Bosnia. He pointed out that the health professions have a unique opportunity in social reconstruction, as they have an obligation to treat everyone, regardless of gender, nationality, or ethnicity. He encouraged the conference participants to work together to promote reconciliation, understanding and a new spirit of hopefulness throughout Bosnia and the former Yugoslavia.

The president of the Canton of Sarajevo, Prof. Dr Midhat Haracic, next greeted the group and expressed his wishes for the success of the conference. He told the group that we are now entering the "Year of Return and of Tolerance", and that we all must act with commitment and courage in the great test that lies ahead. Health professionals are now asked to engage not only in physical reconstruction but also in internal reconstruction of the feelings and souls of their patients and themselves.

Next to welcome the group was Dr. Husan Kolanic, vice dean of the Medical School at the University of Sarajevo and also president of the parliament for the local government. Dr. Kolanic offered the group what he termed a "universal truth". He said that there are four things that cannot be recovered: words spoken; arrows shot; opportunities missed; and life passed. He also cautioned the group to understand the fluctuant nature of identity, while at the same time, not to take it too lightly. Identity, he stated, changes its features and its form throughout one's life. He noted that the recognition of identity is important,

because lack of recognition is oppression, but the importance of recognition can be overemphasized and distorted.

Prof. Dr. Slobodan Loga, president of the Psychological Association of Bosnia-Herzegovina, spoke next, keeping his remarks brief as he would be addressing the group again in the next panel discussion. He emphasized the importance of first establishing confidence within oneself, before attempting to establish confidence in others. He embraced the goals of the conference, stating that reconciliation was most honorable, and required a long-lasting commitment.

The last speaker was Bart Smet, a psychologist working with HealthNet International, an organization that played a key role on the conference organizing committee. Since 1992 HealthNet has been active in Bosnia, working to support health care, social reconstruction and reconciliation. Every day, health care professionals are faced with the consequences of wars and violence. The responsibility of the health care profession is not only to heal patients' wounds but also to increase public awareness and to prevent violence.

**PANEL DISCUSSIONS: NEW CHALLENGES FOR HEALTH
PROFESSIONALS
FRIDAY 24 APRIL 1998 (MORNING)**

Following the welcoming addresses, two panel discussions took place during the morning of Friday 24 April. The panels were moderated by two of the conference organizers: Dr Jadranka Ruvic of HealthNet International in Sarajevo; and Dr Sanja Jovanovic of the Slovene foundation in Ljubljana. Speakers examined "new challenges for health care professionals" in the post-war situation, in three categories: medical challenges; social challenges; and challenges with an international dimension.²

Speakers who addressed medical challenges were:

- Prof Dr Slobodan Loga, president of the Psychological Association of Bosnia-Herzegovina, who addressed "Reconstruction of mental health services after the war in Bosnia and Herzegovina";
- Prof Ugo Vlaisavljevic, Faculty of Psychology, Sarajevo, who addressed "Who is to be reconciled in Bosnia?"; and
- Gordana Miletic and Vera Litricin, medical students in Belgrade, who addressed "The Medical Students' Union".

Speakers who examined social challenges and possible responses were:

- Dr. Anica Kos, director of the Center for Psychosocial Help to Refugees, of the Slovene Foundation in Ljubljana, Slovenia, who addressed, "The social responsibility of the medical profession in crisis situations, and possibilities for action";

² The conference program (see Appendix B) did not explicitly divide presentations into the three categories described here.

- Dr Paula Gutlove, director of the Program on Cooperation and Understanding at the Institute for Resource and Security Studies, who addressed “Expanding the concept of healing: integrating community trust-building and violence prevention into health care delivery”; and
- Dr.med. Anne-Marie Miörner Wagner, director of the OMEGA Health Care Center in Graz, who addressed “History of IPPNW and the Medical Network for Social Reconstruction in the former Yugoslavia”.

Speakers who addressed challenges with an international dimension were:

- Gregory Hess, director of the Peace through Health Program of the World Health Organization, Sarajevo, who addressed “The WHO Peace through Health program in Bosnia and Herzegovina”;
- Dr Ake Bjorn, Medical Centre for Refugees, University Hospital, Linköping, SWEDEN, who addressed “MEDEVAC in the post-war period”;
- Dr Ljuba Archakova, program director of the Netherlands Relief Committee (RCC) for Chechnya, who addressed, “Report on post-war conditions in Chechnya and the efforts of the RCC”; and
- Dr. Jose Quiroga, Physicians for Social Responsibility, California, USA, who addressed “The importance of international cooperation in the field of human rights”

The panelists’ remarks are summarized below. The full text submitted by each speaker appears in Appendix E. 3

Prof Dr Slobodan Loga, president of the Psychological Association of Bosnia-Herzegovina: “Reconstruction of mental health services after the war in Bosnia and Herzegovina”

Reconstruction of psychiatric institutions in the post-war period in Bosnia has focussed on meeting the needs of a large number of psycho-traumatized persons to the greatest extent possible. A new organization of psychiatric services has become our primary concern due to the devastation of all the capacities that existed before the war, and the vast increase in the need for psychiatric care. These services must include: the range of acute and chronic care for debilitated populations; new legislation for the treatment and prevention of mental illness; and research to support these programs.

Through the evaluation of epidemiological data on the current situation of medical and mental health services and personnel, it is possible to make an accurate estimate of the needs of psychiatric patients, particularly psycho-traumatized people. Leading this effort in Bosnia is the Department of Psychiatry, where a project titled “Psychosocial aspects of the war in BiH” has recently been finalized.

Mental health has been affected by the stresses of the war, including the experiences of loss and violence, changes in social structure of the population,

3 A summary of remarks and a text for Dr Quiroga are currently unavailable.

and diminished economic potential for most people within the society. The infrastructure of Sarajevo, for example, has been completely destroyed as a result of repeated attacks, with resultant severe deterioration of public health. Also, the majority of the population was psychologically unprepared for the war. Psychiatric facilities in BiH, which were over-burdened during the war, were even more stretched after the war, particularly in view of the fact that studies indicate that approximately 60 percent of the population currently suffers some sort of psychiatric disorder.

The reconstruction of psychiatric services in BiH has been based on principles of community-based rehabilitation. Future strategies focus on increasing the coordination among different social service providers, to allow:

- efficient and accurate psychological assessments;
 - efficient and effective patient treatment;
 - timely intervention, particularly in crisis situations;
 - the provision of adequate, supported housing;
 - prompt discharge of patients when they are ready;
 - continuity of care to patients with longer-term psychological problems;
- and
- improved institutional education for professionals and nonprofessionals in mental health services, including social workers, psychologists, mental health nurses, occupational therapists and psychiatrists.

Prof Ugo Vlasisavljevic, Faculty of Psychology, Sarajevo: “ Who is to be reconciled in Bosnia?”

Reconciliation between the ethnic communities of Bosnia-Herzegovina is high on the political agenda at the moment. It is evident, especially if our situation is viewed from the outside, that reconciliation is needed -- at least in order to avoid a new war. However, in the aftermath of the war, any kind of more organic unity between the communities seems to be excluded. Even the need for and possibility of living together have become increasingly uncertain, perhaps as never before in the history of this country. Now, not only nationalists but more moderate people remind us that one should not forget that it is living together in its organic form that has created the gravest danger. After our brother, or our neighbor, has shown himself to be a stranger and an enemy, one should, they warn us, watch over the process of reconciliation and prevent it from going too far. We are warned, “the other (ethnic community) should not be allowed another opportunity to get too close to us”.

This distrust is not only a lesson of bitter war experience but an indication of its major outcome: the appearance of new subjects of history, of politics, even of reality. For so-called “epic cultures” such an experience has always been particularly productive. The question: “Who is to be reconciled?” seems less pertinent than the question: “What sort of reconciliation is to be effected at present? (or in what way?)” It is important to notice a certain instability of the dominant subject in the recent history of the region, and especially its metamorphosis during the last war. Then it will be clear that the conditions that

would make reconciliation possible must be examined. In this case, anthropological research may blaze a path for a realistic politics.

What particularly interests me here is a process which takes place within post-colonial liberation and emancipation. This process hasn't yet come to an end, nor is it predetermined, although it follows a certain logic which makes it understandable. War can be considered as the most effective instrument of the subject constitution. I am going to compare the two last "national liberation wars", the world one and the local one, in order to reveal mechanisms of the constitution of two dominant types of subject: collective as an interethnic brotherhood; and collective as an ethnic brotherhood. Thus I hope to explain why reconciliation should not give rise to a fraternization but to a recognition (which requires a stable state form in which the newborn subject seeks to establish itself). Regarding reconciliation, one should bear in mind that a certain distance (from the "other") -- much longer than it might seem to "the untrained eye" -- is constitutive for ethnic communities generated by the war as ultimate subjects of the postwar reality.

Gordana Miletic and Vera Litricin, medical students, Belgrade: "Medical Students' Union"

The Medical Students' Union (SUMC) in Belgrade was founded in 1996 with the primary purpose of providing first aid to public demonstrators. (At the time there were student protests in Belgrade.) Now, SUMC has over 150 members, including medical students from all academic years. It is registered with the Federal Ministry of Justice as a biomedical students' humanitarian, volunteer organization. It is a specialized, non-profit organization of medical students gathered to develop humanitarian ideas and programs. In its activities, SUMC makes contact with other students, physicians, other professionals, and national and foreign organizations (including Red Cross Yugoslavia, Urgent Center of Yugoslavia, Fund for Open Society, International red cross, IPPNW, etc). SUMC's goals are:

- promote respect, protection and improvement of human rights;
- improve the rights and standards of students;
- monitor and improve student's and citizens' health;
- promote harmonization of national, constitutional legal and sub-legal regulations with international and European standards in the field of medical knowledge and skills;
- promote autonomy of the University;
- educate and train students and citizens in basic public health and medical skills;
- improve the professional knowledge and skills of medical students;
- collect and distribute humanitarian assistance; and
- maintain and foster cooperation with national and foreign societies, organizations and associations with similar aims.

Dr. Anica Kos, director of the Center for Psychosocial Help to Refugees, of the Slovene Foundation, Ljubljana, Slovenia: "The social responsibility of the medical profession in crisis situations, and possibilities for action"

The post-war situation in Bosnia and Herzegovina raises questions about the role of the medical profession in the process of reconciliation and conflict prevention. I consider that the topic should be extended to the social responsibility and role of the medical profession in reducing the tremendous social problems, characteristic of post-war countries and BiH especially. The medical profession has social responsibilities in all circumstances. But in circumstances of sudden social change producing poverty, unemployment, and important social divisions into "haves" and "have-nots", characteristic of Eastern post-socialist countries, the obligation of the medical profession is even more important.

The situation in BiH is particularly complex concerning social tensions. In addition to inter-ethnic tensions there are tensions among other groups, including those who left and those who remained during the war, and the widening gulf between rich and poor. Medical workers can be a living example of positive social conduct: by involvement in the processes of their communities; by advocating for equality (or to put it in a more realistic way -- for less inequality); and by advocating for peaceful coexistence. Medical workers serve as important role models in the community. When people in a village or in a rural local community say about a physician or about a nurse: "She does not mind whether you are rich or poor, of which nationality or religion you are....", they are noting an important model of mutual respect and reconciliation.

Activities for reduction of various tensions and social inequality could be run at the level of individual patients or clients, at the level of deprived groups and groups at risk, or at the level of the global community or the state. Advocacy, lobbying and other public activities are a part of social reconstruction of the country. For the participants in this Sarajevo conference, perhaps all this sounds self-evident. Alas, there are many members of our profession who show indifference to social issues. This does not mean that they do not perform their professional work responsibly, perhaps as surgeons or cardiologists. Nevertheless, in the present global social situation (not only in BiH, but worldwide) the concept of social responsibility of the medical profession is spreading in our collective professional consciousness. We hope that this conference will serve to mobilize more medical workers to join the movement and to contribute in an active way to the values and realization of the conference's title.

Some medical workers are excellent social activists. The ethic, the philosophy and the know-how of social involvement should be an essential part of basic education of medical workers and the theme of post-graduate studies. Social obligation to the community and not only toward the individual patient should be stressed again and again, and practical guidelines for such activities must be provided. To fulfill a socially active function in communities with manifold tensions requires energy and courage. Therefore, a supportive network is very important. Such a network can articulate problems in which to become involved, motivate medical workers, and provide some kind of moral reward.

In conclusion, health workers and workers in allied professions are not sufficiently aware of their capacities and capabilities to shape social processes in

the community. They often lack practical skills and have not the needed support for social actions. The Medical Network for Social Reconstruction in the Former Yugoslavia could be an important basis for enhancing motivation, support and know-how for social involvement of health workers.

Dr Paula Gutlove, director of the Program on Cooperation and Understanding at the Institute for Resource and Security Studies: "Expanding the concept of healing: integrating community trust-building and violence prevention into health care delivery"

Good health includes the physical, psychological and social well-being of individuals and their community. While physical and psychological health is the recognized province of health care providers, social health is often considered outside their province. Yet, healing physical and psychological ills can provide an important basis for social healing, particularly in communities traumatized by violence. By expanding the concept of healing to include restoring trust and confidence within a community, and by working cooperatively to help prevent future violence, healers can make a unique and essential contribution to their community.

Health care providers are well placed to forge cooperation and build trust in communities that have experienced violent conflict. Of particular significance are their skills and social stature, their intimate association with mental and physical suffering, and their access to a wide range of community groups. Furthermore, the health infrastructure of a post-conflict community is often bolstered by international and NGO assistance, which may provide options for communication, transport, technology transfer, and educational support.

Many health care providers are aware of this potential, and health initiatives have been used successfully in different contexts to forge cooperation and prevent violence between divided communities. Examples include humanitarian cease-fires, cooperative health initiatives and health-related research programs in a variety of international contexts, such as El Salvador, Uganda, Lebanon, the Sudan, the Philippines, Afghanistan, Mozambique and Sri Lanka. 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.

The Institute for Resource and Security Studies (IRSS) is engaged in several initiatives to promote the integration of community trust-building and violence prevention into health care delivery in pre- and post-conflict areas. IRSS has termed these initiatives "Health Bridges for Peace". The Medical Network for Social Reconstruction in the Former Yugoslavia is an important Health Bridge for Peace initiative, providing an excellent model for integrating community trust-building and violence prevention into health care delivery.

Dr.med. Anne-Marie Mjörner Wagner, director of the OMEGA health Care Center in Graz: "History of IPPNW and the Medical Network for Social Reconstruction in the Former Yugoslavia"

The International Physicians for the Prevention of Nuclear War (IPPNW) was founded in 1980 with the goal of preventing the use of nuclear weapons and to build communication and programmatic bridges between the East and the West. After the Cold War, we expanded our goals to support cooperation, peace, and trust-building activities in a wider context. Eventually, I founded the OMEGA Health Care Center, which has become the organizing force of the Austrian affiliate to IPPNW.

Beginning in 1991, IPPNW physicians and other health care workers organized a series of international meetings with the goal of promoting dialogue between colleagues from the former Yugoslavia. The first meetings, in 1991, took place in Zagreb and Belgrade. Subsequently, international meetings were convened in Vienna, March 1993; in Göd, Hungary, March 1994; in Graz, October 1994 and January 1995; and in Ljubljana, September 1995. The meeting in Ljubljana was organized by the Slovene Foundation.

After 1995 OMEGA organized two conferences in Graz in co-operation with the Slovene Foundation. The first took place in April 1996, titled "Repatriation - Psychosocial Support to Children and their families". The second occurred in April 1997, titled: "Psychosocial Support in Post-War Communities". The April 1997 meeting was attended by over 60 health care providers from all parts of the former Yugoslavia, who decided at the meeting to form the Medical Network for Social Reconstruction in the Former Yugoslavia. The Network 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". Specifically, the Network intends to promote dialogue, cooperation, personal contacts, practical solutions and the renewal of relationships in the region. In line with this goal was the desire to hold future meetings, to the extent possible, in countries of the conflict area. Thus, a contact group meeting was held in Bled, Slovenia, in November 1997, hosted by the Slovene Foundation. The present conference is the next meeting in this series.

All of these meetings and the founding of the Network were meant to serve two important purposes: (i) to create opportunities for colleagues, who face difficult circumstances, to meet and exchange their experiences; and (ii) to promote trust- and peace-building programs among professionals working in the same field.

Gregory Hess, director of the Peace through Health Program, World Health Organization, Sarajevo: "The WHO Peace through Health Program in Bosnia and Herzegovina"

The World Health Organization in Bosnia and Herzegovina, through our Peace through Health (PTH) strategy, has been attempting to integrate health and conflict resolution across a wide range of programs. In practice, this integration works on two principles. The first is that common health issues can serve as neutral fora for discussion and collaboration. The second is that health issues provide a valuable medium for addressing fundamental obstacles to peace such as discrimination, polarization, and manipulation of information.

In BiH, the health sector has been one of the leading sectors in terms of reconciliation and inter-entity collaboration. This is a tribute to those Bosnian health professionals who have shown the vision and courage to take steps towards reconciliation. It is also a tribute to those agencies and organizations which have not recognized the Inter-Entity Boundary Line as a border and which have not allowed it to become one.

WHO-BiH has implemented the PTH strategy in all of its traditional programs such as health system reform and reconstruction, public health, primary health care, and mental health. Our field offices are arranged according to geographical, not political, boundaries. PTH activities are multi-sectoral and multi-level. Implementing the PTH strategy has presented some very difficult challenges to the health professional community. A particular challenge is the need for reform and reconstruction of the health system in BiH. This requires a fundamental and widespread recognition that responsibility for health extends far beyond the health sector.

Health professionals, particularly physicians, can serve as advocates for constructive change. They can do so in at least two ways. First, they can act as agents of change in their positions of influence and respect. Second, they can lead by example in their work and daily lives.

Accomplishing social change requires solidarity among many groupings of health professionals. If the international community lacks coherent and clear principles, many initiatives can build walls between communities. If actors in the health sector, including both local and international actors, are unable to agree upon priorities, the effective outcomes of investment will be less than optimal.

Dr Ake Bjorn, Medical Centre for Refugees, University Hospital, Linköping, SWEDEN: "MEDEVAC in the post-war period"

Since the summer of 1995 the Swedish government has redirected part of the refugee annual budget to the Medical Evacuation Program (MEDEVAC) in Bosnia and Herzegovina. The general purpose of MEDEVAC in the present post-war period is to help strengthen National Health Service capacity in BiH for managing complicated but potentially curable conditions of identified individuals during the transitional period of reconstruction.

Thirty-five patients and around forty accompanying relatives have been evacuated to Sweden in this project so far. Of these, 30% have been patients with severe war injuries and 50% have been patients in need of heart surgery. As this is a small program in relation to actual needs, there are ethical dilemmas associated with the selection process.

In order to support mutual exchange of knowledge and experience between our countries, Bosnian specialized doctors have accompanied some patients to Linköping, Sweden, participating in preoperative discussions and surgery of evacuated patients, as well as ordinary routine work. Both the Bosnian and the Swedish counterparts have found this to be very valuable, sometimes resulting in continued contact and decreased need for future evacuations. Alternative actions in BiH can achieve the same beneficial result for an individual for less

monetary and psychosocial cost than evacuation to another country. Co-operation between Swedish and Bosnian health professionals during investigation, treatment and surgery of pre-selected patients allows evacuation to be used only for those cases where alternative possibilities do not exist, and develops possibilities for future professional contacts.

During the transitional period of reconstruction and rebuilding in BiH, there is a need for MEDEVAC as a support to the health service, in combination with targeted donations and support to the educational system by training of health professionals. Co-operation and co-ordination with health authorities in BiH and with other international organizations is essential. Re-establishment of a referral system in regard to secondary health care, covering all parts of the country, is desirable. The population density is not large enough for the establishing of parallel health systems on specialized levels. Hence, as long as the present situation prevails, it is desirable to support programs like this to all parts of BiH. Further bilateral exchange and education-oriented projects, in combination with administrative and personal support to highly qualified professionals in BiH, will gradually diminish the need for MEDEVAC.

Dr. Ljuba Archakova, program director of the Netherlands Relief Committee (RCC) for Chechnya: "Report on post-war conditions in Chechnya and the efforts of the RCC"

The greatest post-war problems in the Chechnya region are the destruction of the social and civil society. Children, in particular, have suffered severe psychological and physical trauma. Many are still wounded daily by mines and weapons, many are living in incomplete families or orphaned. Hospitals and schools function on a marginal level where they function at all. Young people take to drugs and criminal activities on a very large scale.

The Netherlands Relief Committee for Chechnya (RCC) has been founded to deal with the medical and psycho-social needs of war-traumatized children in Chechnya. RCC, established in 1995, is supported by Dutch Interchurch Aid (DIA) and Caritas Netherlands (MIN). RCC is unique in the context of Chechnya, as no other organization is involved in community-based care for these children. RCC has been engaged in setting up community centers (for recreational groups, trauma work, and work with women and teenagers) and in providing initial training for field workers. Also, RCC aims to educate and influence governments and international organizations as to the needs of this community. Last year they co-hosted a training seminar with UNICEF that addressed psycho-social issues of refugee children. This seminar provided an important venue for bringing together medical and psycho-social professionals from the region.

WORKSHOPS: EXPLORING THE ISSUES
FRIDAY 24 APRIL (AFTERNOON) AND SATURDAY 25 APRIL (MORNING)

Five workshops were held to explore social and medical challenges in the post-war situation. These workshops addressed:

- refugees and resettlement;
- health care and social reconstruction;
- youth issues and building hope for the future;
- psychosocial support; and
- civil society and human rights.

An additional, sixth, workshop was an experiential workshop which addressed communication skills for difficult dialogues; a full report on this workshop is provided in Appendix F. The workshops, the topics presented and the speakers are listed below. Abstracts of presentations at the first five workshops appear in Appendix G (which is bound separately).

Refugees and resettlement (Moderator: Ramic Lejla)

- "Psychological assessment and individual work with children in the community of resettlement," Ljiljana Vrdoljak, Society for Psychological Assistance, Zagreb, Croatia
- "Psychological problems of refugees in Vogosca area," Mevlida Ovuka, Sarajevo
- "Home-coming trauma," Tanja Franciskovic, Rijeka, Croatia
- "Working with Bosnian migrants in Switzerland," Philippe Conne & Catharine Corbaz, Lausanne

Health care and social reconstruction (Moderator: Dr Paula Gutlove)

- "Community-based facilitation of social reconstruction in Bosnia and Herzegovina," Dr Sejla Kulenovic-Latal, Catholic Relief Service B&H, Sarajevo
- "Integrating community trust building and violence prevention into health care delivery," Paula Gutlove, IRSS
- "Different models of treatment of war-traumatized persons in order to manage anger constructively," Jasmina Tanovic, Zineta Dvizac, Amira Gradincic, HealthNet Int.
- "Breaking barriers and prejudice through training work with teachers and the development of voluntary work," Anica Kos and Sanja Jovanovic, Slovene Foundation
- "Logical model of reconciliation and peacebuilding through mental health delivery," Ljiljana Vrdoljak, SPA, Zagreb, Croatia
- "Social reconstruction of targeted population: from the passive role of the victim to the active role of the survivor," Mirha Pojskic, Zenica
- "Medevac in the post-war period," Ake Bjorn, Linkoping, Sweden
- "Neighborhood facilitators program in Banja Luka," Jelena Rodic, Banja Luka

- "Peace through Health," Gregory Hess, WHO, Sarajevo
- "More constructive guidance of anger," Izudin Unkic, Sakib Alibegovic, Travnik

Youth issues and building hope for the future (Moderator: Dr Anne-Marie Miorner Wagner)

- "Work with children: hope for the future," Sonja Kosac, Igalo, Montenegro
- "The youth of Sarajevo: perception of its perspective for 21st century," Mirjana Music, Jadranka Kolenovic and Enedina Hasanbegovic, Sarajevo
- "Integrative approach to building hope in multi-traumatized children," Eva Andela Delale, SPA, Zagreb, Croatia
- "Some experiences in work with adolescents," Milos Pokrajac, Mirjana Novkovic, HealthNet Int., Sarajevo
- "Improvement of the position of disabled people," Halit Ferizi, Pristina, Association of Paraplegics and Paralyzed Children of Kosovo
- "Working with children to build hope for the future," Marijana Mitrovic, Osijek, Croatia

Psychosocial support (Moderator: Zineta Dvizac)

- "Principles of efficient psychosocial support: the community under stress," Mirjana Kletecki, Zagreb, Croatia
- "Mourning and loss: how to cope with it," Vesna Jevremovic, Sasa Zivic, Cila Tiri, Novi Sad
- "Mental health care for helpers," Olja Druzic, SPA, Zagreb
- "Mental health: vulnerable groups," Renzo Bonn, WHO, Sarajevo
- "The role of volunteers in the field of mental health care in Bosnia," Jadranka Mikic, Fatima Basic
- "Volunteers in mental health protection through the experience of corridor organization," Habiba Rahic, Sarajevo

Civil society and human rights (Moderator : Dr Emir Kuljuh)

- "Concept of civil society in Kosovo," Argentina Grazhdani, Kosovo
- "SUMC (Union of Medical Students, Belgrade)," Dragan Veljkovic, Maja Bijelic, Beograd
- "Decentralized cooperation project: public dialogue on civil society"; Ambro Manteti, WHO, Sarajevo
- "From ocean to Medicins ... (and others) without Borders," Dr Narcisa Sarajlic, Zagreb, Dr Emina Kapetanovic, HealthNet Int., Sarajevo

Communication skills for difficult dialogues: an experiential workshop
(Leader: Dr Paula Gutlove)

This was an experiential/training workshop in conflict prevention and reconciliation. It focused on the human need in post-traumatic situations to listen to the stories of others and to be listened to. A full report is provided in Appendix F.

**A PLANNING DISCUSSION: MEETING THE CHALLENGES
(ORGANIZATIONAL DEVELOPMENT OF THE MEDICAL
NETWORK AND PLANS FOR THE FUTURE)
SATURDAY 25 APRIL (AFTERNOON) AND SUNDAY 26 APRIL**

Discussion of the goals and plans of the Network was held as a plenary session.

Goals of the Network

The first order of business was to confirm the desire of those present to continue to work on the development of the Network, and to clarify its purpose. The group unanimously confirmed their desire to continue to work together, and reiterated the goals of the Network as decided at the Graz meeting in April 1997, stating: "The Network is a network of health care professionals from all parts of the former Yugoslavia. It is dedicated to the reconciliation of existing conflicts and the prevention of future conflicts in its region."

Organization of the Network

It was decided that the Network will operate through a Contact Group of 12 members, one person from each of the 12 geographic areas listed below. In addition there will be a student representative from each of these 12 areas, composing a Student Contact Group which will operate synergistically with the Contact Group. Eligible students will be students of medicine and other professional health disciplines. The 12 geographic areas agreed upon are:

- 3 areas in Bosnia-Herzegovina: Sarajevo, Mostar, and Banja Luka
- 3 areas in Croatia: Rijeka, Osijek, and Zagreb
- 1 area in Macedonia
- 1 area in Montenegro
- 3 areas in Serbia: Belgrade, Kosovo, and Vojvodina
- 1 area in Slovenia

Contact Group members are listed in Appendix C, with their contact information. The responsibilities of these members include:

- "vertical" communication to the Contact Group members in other geographic regions and to Network sponsors and organizers;
- "horizontal" communication among Network members and potential members within their own geographic area;
- participation in planning and coordination for Network meetings;
- gathering information about activities within their own region, to be presented at meetings;
- applying for funds (primarily to the local Soros Foundation) for travel expenses for Network members from their region to attend small and large Network meetings; and
- attending the Contact Group meeting in Igalo, Montenegro in Fall 1998, and reporting back the decisions of this meeting to Network members in their own region.

Network meetings

It was agreed that the Network will hold at least two meetings per year, a large meeting in the spring and a smaller meeting in the fall. The purpose of the small meeting is to discuss ideas and plans for specific projects and to plan the organizational development of the Network. The purposes of the large meetings are to provide a venue for wider networking and an opportunity for education on issues of mutual interest, and to promote the programmatic and organizational development of the Network. The small meeting will bring together members of the Contact Group and the Student Contact Group as the primary participants. The large meeting will draw a larger audience, to increase the visibility of the Network, its activities and its goals.

Participants agreed to hold the fall (October or November) 1998 meeting of the Network in Igalo, Montenegro, hosted by Sonja Kosac of the Igalo Institute. In spring 1999 the large meeting of the Network will be held in Macedonia, at Lake Ohrid. A date in May 1999 will be chosen.

Network activities

Of immediate importance to the Network is to increase its visibility both within the former Yugoslavia and outside the region. The Network agreed to do this by developing local outreach programs to medical professionals, with a particular emphasis on general practitioners, medical school professors, and pediatricians. In addition, outreach programs will try to attract other related professionals, nurses, social workers, and psycho-social professionals.

A part of the Network's outreach will be the distribution of information about the Network, for publication in professional journals. A draft "mission statement" for the Network, that could be used for this purpose, is attached here as Appendix D. Contact Group members are asked to submit this mission statement to their local professional publications.

Other avenues for outreach include the development of a Web site for the Network. Once approved, the mission statement will be posted on the Network Web site. In addition, the Network would like to produce reports and other publications (possibly a training manual) that address the role of medical professionals in community reconstruction and reconciliation.

The Network is committed to developing collaborative projects that bring together medical professionals throughout the former Yugoslavia. One project now being pursued by the Network is the development of a "call to action" against violence as a threat to public health. Related to this call, the Network plans to engage in a region-wide survey of the impact of violent conflict and war on public health.

Appendix D

Mission statement for the Medical Network (Draft version, May 1998)

The Medical Network for Social Reconstruction in the Former Yugoslavia is a network of health care professionals from all parts of the former Yugoslavia. It is dedicated to the reconciliation of existing conflicts and the prevention of future conflicts in its region. 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 Network aims to promote dialogue, cooperation, personal contacts, practical solutions and the renewal of relationships in its region.

The Network has evolved from its origins in 1991, as a small group which met sporadically, to a present network of over one hundred health professionals, including physicians, psychologists, university professors, and local and national government health-related ministers, who convene on an annual basis. Even during periods of extreme violence in the region, the Network has orchestrated broad-based participation and has brought together polarized parties. The network was officially established in its present form in April 1997, at a conference in Graz, Austria. Most recently, in April 1998, health professionals from more than 10 countries convened in Sarajevo to exchange knowledge and to plan collaborative programs.

The Network functions through a "Contact Group" composed of representatives from 12 different geopolitical points throughout the former Yugoslavia. The Network's collaborative programs cover a range of content areas, including:

- a. refugees and resettlement;
- b. health care and social reconstruction;
- c. youth issues and building hope for the future;
- d. psychosocial support;
- e. development of civil society; and
- f. training for trust building between groups.

Reconciliation, Social Reconstruction and Conflict Prevention
Appendix D2

In addition to these subject-specific programs, there are generic Network-wide programs including: a Web site for organizational and medical information exchange; and a region-wide, coordinated public health survey to evaluate the impact of violence on public health in all parts of former Yugoslavia.

Network members believe fervently that it is necessary and possible to rebuild social health in violence-ravaged communities. They welcome other health professionals to join them in this crucial task.

In regard to the present situation in Kosovo/a: The Network urgently calls upon the parties to the conflict and the international community to recognize that the situation must not proceed to war, which would devastate the public health interests of all parties and be a crime against humanity.

Appendix E

Texts of plenary presentations (Texts are presented as received, without further editing.)

1. MEDICAL CHALLENGES

- Prof Dr Slobodan Loga, president of the Psychological Association of Bosnia-Herzegovina: "Reconstruction of mental health services after the war in Bosnia and Herzegovina"

" The reconstruction of psychiatric institutions in the post-war period in Bosnia has focussed on meeting the needs of a large number of psycho-traumatized persons to the greatest extent possible. A new organization of psychiatric services has become our primary concern due to the devastation of all the capacities that existed before the war.

Organization of services for prevention and treatment of mental illness must include:

- introduction into primary health care services of activities leading to the prevention and treatment of mental illness;
- development of high quality care for patients with psychological disorders;
- review and analysis of legislation governing the treatment and rehabilitation of the mentally ill;
- development of programs to help the chronically ill, the disabled and the elderly;
- operational research supporting the above project.

Through the evaluation of epidemiological data on the current situation of medical and mental health services and personnel, it is possible to make an accurate estimate of the needs of psychiatric patients, particularly psycho-traumatized people.

Leading this effort in Bosnia is the Department of Psychiatry where a project titled "Psychosocial aspects of the war in BH" has recently been finalized.

Mental health has been affected by the stresses of the war, including the experiences of loss and violence, changes in social structure of population and diminished economic potential for most people within the society. The infrastructure of Sarajevo has been completely destroyed as result of repeated attacks. Many areas were without electricity for prolonged periods, and the water supply was either nonexistent or inadequate and unreliable. The lack of water resulted in a severe decline of hygiene made possible a variety of epidemics including intestinal disorders and widespread lice infestations.

The majority of the population was psychologically unprepared for the war.

At the start of the war most psychiatrists were organized through the Department of Psychiatry to work in local communities, shelters, refugee camps etc. Some doctors were working in the Department of Surgery of the Clinical Center, working through a program called "Liaison Psychiatry" to provide psychiatric treatment for the great number of wounded and injured people. The greatest responsibility for treatment of psychiatric patients fell to the staff of the Department of Psychiatry. As soon as the war began this service demonstrated a crucial shortage of both nurses, and hospital beds.

Problems with today's services in BH include:

- loss of many social service organizations in BH;
- remaining social service organizations are increasingly dispersed, with a lack of communication and coordination between them;
- all social service organizations are under-staffed; and
- lack of good social service has led to an increase in homelessness among some groups of people with mental health.

Our investigations of hospital treatment records showed that incidence and prevalence of stress reactions and reactive psychoses greatly increased during the war. On the other hand, there was a decreased incidence and prevalence of alcohol psychoses. Our field investigation on the free territories of Sarajevo's Communities shows enormous increase of mental disorders among the citizens:

- over 40 % of the population had identifiable neuroses;
- 20 % of the population had identifiable psychoses; and
- over 60 % of the general population of the town Sarajevo had some degree of mental disorder.

The reconstruction of psychiatric services in BH has been based on principles of community-based rehabilitation. Future strategies focus on increasing the coordination among different social service providers, to allow:

- efficient and accurate psychological assessments;
- efficient and effective patient treatment;
- timely intervention, particularly in crisis situations;
- the provision of adequate, supported housing;
- prompt discharge of patients when they are ready;
- continuity of care to those with more long-term psychological problems; and
- improved, institutional education for both professionals and nonprofessionals in mental health services, including social workers, psychologists, mental health nurses, occupational therapist and psychiatrists.

- Prof Ugo Vlasisavljevic, Faculty of Psychology, Sarajevo:
"Who is to be reconciled in Bosnia-Herzegovina?"

Reconciliation between the ethnic communities of Bosnia-Herzegovina is high on the political agenda at the moment. It is evident, especially if our situation is viewed from the outside, that reconciliation is needed - at least in order to avoid a new war. However, in the aftermath of the war, any kind of more organic unity between the communities seems to be excluded. And even the need for and the possibility of living together has become increasingly uncertain, perhaps

as never before in the history of this country. Now, not only nationalists but more moderate people remind us that one should not forget that it is the living together in its organic form that has created the gravest danger. After our brother, or our neighbor, has shown himself to be a stranger and an enemy, one should, they warn us, watch over the process of reconciliation and prevent it from going to far. We are warned, "the other (ethnic community) should not be allowed another opportunity to get too close to us."

This distrust is not only a lesson of the bitter war experience but an indication of its major outcome: the appearance of new subjects of history, of politics, even of reality. For so-called "epic cultures" such an experience has always been particularly productive. The question: "Who is to be reconciled?" seems less pertinent than the question: "What sort of reconciliation (or in which way it) is to be effected at present?" It is important to notice a certain instability of the dominant subject in the recent history of the region, and especially its metamorphosis during the last war. Then it will be clear that the conditions that would make reconciliation possible must to be examined. In this case, the anthropological research may blaze a path for a realistic politics.

What particularly interests me here is a process of subject of constitution, which takes place within the modern process of post-colonial liberation and emancipation. This process hasn't yet come to an end, nor is it predetermined, although it follows certain telos and logic, which make it subsequently understandable and indispensable. The war will be considered as the most effective instrument of the subject constitution. I am going to compare the two last "national liberation wars", world one and local one, in order to reveal mechanisms of the constitution of two dominant types of subject: collective as an interethnic brotherhood and collective as an ethnic brotherhood. Thus I hope to explain why the reconciliation should not give rise to a fraternization but to a recognition (which requires a stable state form in which the newborn subject seeks to establish itself). Regarding reconciliation, one should bear in mind that a certain distance (from the Other) - much longer than it might seem to "the untrained eye" - is constitutive for ethnic communities generated by the war as ultimate subjects of the postwar reality.

- Gordana Miletic and Vera Litricin, medical students in Belgrade: "The Medical Students' Union"

The Medical Student's Union in Belgrade was founded at the time of the student protests in Belgrade in 1996, with the primary purpose of providing first aid to public demonstrators, both students and citizens. Now SUMC has over 150 members, including medical students from all academic years. It is registered with the Federal Ministry of Justice as a biomedical students' humanitarian, volunteer organization. It is a specialized, non-profit organization of medical students gathered to develop humanitarian ideas and programs.

In its activities, SUMC makes contact with other student's physicians, other professionals, national and foreign organizations (including Red Cross

Yugoslavia, Urgent Center of Yugoslavia, Fund for Open Society, International red cross, IPPNW, etc).

SUMC's goals are:

1. Respect, protection and improvement of human rights;
2. Improve the rights and standards of students;
3. Monitor and improve student's and citizens' health;
4. Harmonization of national constitutional. Legal and sub-legal regulations and international and European standards in the field of medical knowledge and skills;
5. Autonomy of the University;
6. Education and training for students and citizens in basic public health and medical skills;
7. Improving the professional knowledge and skills of medical students;
8. Collecting and distributing humanitarian assistance;
9. Maintaining and fostering cooperation with national and foreign societies, organizations and associations with similar aims;

SUMC realizes its goals by:

1. organizing free health care services for students and citizens;
2. organizing regular and periodic counseling services, lectures seminars and other activities for students and citizens;
3. disseminating information about public health and human rights issues;
4. Engaging in related research;

Current SUMC projects include:

1. care for elderly people;
2. care and counseling for asthmatic children;
3. project for health protection during public gatherings and demonstrations (including sports matches, concerts, demonstrations, etc.);
4. collection and distribution of humanitarian aid, including medical related aid;
5. open competition for student scholarships;
6. education and training for medical students in traditional medical skills, including shiatsu massage, acupuncture, etc.);and
7. cooperation with the Urgency center in Belgrade and other professional organizations that share similar aims.

Planned future projects include:

1. scientific research to support our public health and social action assumptions;
2. publication of a student journal;
3. opening free health care facilities for students and others;
4. public lectures on related topics;
5. polls to assess student satisfaction with aspects of medical education;
6. programs to introduce high school students to the medical profession; and
7. computer center for Yugoslavia with collected international medical information.

2. SOCIAL CHALLENGES

- Dr. Anica Kos, director of the Center for Psychosocial Help to Refugees, of the Slovene Foundation in Ljubljana, Slovenia:
“The social responsibility of the medical profession in crisis situations, and possibilities for action”

The post-war situation in Bosnia and Herzegovina (BiH) raised questions about the role of the medical profession in the process of reconciliation and conflict prevention. In time of war and armed conflicts, there are many ethical and social issues concerning the behavior of the medical institutions and individual professionals to be solved on the practical and fundamental level. This paper deals only with the post-war situation.

The title of the meeting in Sarajevo was "Reconciliation, Social Reconstruction and Conflict Prevention - The Role of Health Professionals". I consider that the topic should be extended to the social responsibility and the role of the medical profession in reducing the tremendous social problems, characteristic for post-war countries and for BiH especially. These problems require social commitment of the professional establishment, which has a huge impact on the quality of life of the population and on its feeling of security. The medical profession has social responsibilities in all circumstances. But in circumstances of sudden social changes producing poverty, unemployment, important social divisions in "haves" and "have-nots", characteristic of Eastern post-socialist countries, the obligation of the medical profession is even more important.

The situation in BiH is particularly complex concerning social tensions. In addition to inter-ethnic tensions there are tensions among other groups. These include: the native population who remained in BiH during the war and those who repatriated after living some years in exile (refugees); and the native population and internally displaced persons. There are rising tensions among people whose economic level fell drastically in the post-war period and those who became very wealthy. This differentiation is particularly difficult to deal with for people in post-socialist countries who spent their life in a socio-political system that did not permit huge differences in wealth and in access to the goods of health and social welfare. Medical workers are living in this situation along with the rest of the population. They are a part of all these social processes. However, it is important for them to be aware of the active, positive, social role they can play by virtue of their profession. They can do this by being a living example of positive social conduct; by involvement in the processes of their communities; by advocating for equality (or to put it in a more realistic way - for less inequality); and by advocating for peaceful coexistence.

The World Health Organization (WHO) advises medical professionals to go beyond traditional medical, providing conceptual and practical guidelines for activities and interventions aimed toward the welfare of the population in social crisis. These paradigms and strategies of health promotion are an excellent guide for social involvement. They are based on linking social action and advocacy. The slogan "Health for All" expresses the concept of social equality. "All" in this context means not only for those who have money, for those who have information, or even for those who have the status of patients. It includes the

protection of health and mental health by preventing the damaging consequences of inter-group conflicts and tension.

From her/his professional position the health worker, physician, nurse or member of allied professions, have numerous opportunities to spread ideas of human rights and to decrease tensions among groups. Social activism can be performed through usual everyday professional work and through broader social activities. As a member of the national elite (the word is used in the sociological meaning) the medical worker can become a spokesperson for deprived groups, advocating friendly coexistence and solidarity.

Medical workers can contribute to feelings of security and of psychosocial welfare of the served people and of the general population in the community. Or on the contrary, they can contribute to feelings of helplessness, feelings of deception and humiliation. We are all aware that the social system and economic circumstances decisively defines the health care system, the quality of provided services and users' rights. But medical workers as actors of the system and members of the establishment modulate its functioning and its impact on actual and potential users. Furthermore, people seeking medical health are a more vulnerable segment of the population, and they consequently very sensitive to the quality of interactions and the messages they receive.

Medical workers serve as important role models in the community. When people in a village or in a rural local community say about a physician or about a nurse: "She does not mind whether you are rich or poor, of which nationality or religion you are....", they are noting an important model of mutual respect and reconciliation.

The activities for reduction of various tensions and social inequality could be run on the level of individual patients or clients, on the level of deprived groups and groups at risk and on the level of global community or on state level. Advocacy, lobbying and other public activities are a part of social reconstruction of the country.

For the participants of the Sarajevo Conference and probably for many readers all this sounds self-evident, and the reaction of many of them will be: "But we already do it." We should be aware that we are facing a common situation: participants of the conferences and the readers of papers are in majority themselves partisans of exposed and promoted ideas. Alas, there are many members of our profession who show indifference to social issues. This does not mean that they do not perform their professional work as surgeons or cardiologists responsibly. In the present global social situation (not only in BiH, but worldwide) the concept of social responsibility of the medical profession is spreading in the collective professional consciousness. We hope that the Sarajevo Conference will serve to mobilize more medical workers to join the movement and to contribute in an active way to the values and realization of the Conference title.

Some medical workers are excellent genuine social activists. But the social function should not remain a matter of individual gift and preference. The ethic,

the philosophy and the know-how of social involvement should be an essential part of curricula of basic education of medical workers and the theme of post-graduated studies and other modules of complementary education. The social obligation to the community and not only toward the individual patient should be stressed again and again, and practical guidelines for such activities must be provided.

To fulfill a socially active function in communities with manifold tensions requires energy and courage. Therefore, a supportive network is very important. The network articulates problems in which to become involved, motivates medical workers, and provides some kind of moral reward. The Sarajevo Conference with its intention to build a network of socially active medical workers could be considered as a small but important piece of a puzzle in enhancing social responsibility and social action in the medical field. Being a social activist for equality, peaceful living together and solidarity is often difficult in the situation faced by many communities in BiH. Therefore, it is of crucial importance for our colleagues to have the opportunity to link, to exchange ideas, to develop critical thinking. Sharing models of good practice of socially active behavior and group actions has an informative and motivating value. Realized models of good practice prove that actions oriented toward social reconstruction are possible and feasible in the frame of medical settings.

I would like to present some reflections, based on my personal experience, on the social function of medical workers and their role in post-war situations and also in countries that are in transition from socialism to a free market economy.

In such circumstances there is a great danger for health and mental health workers to be trapped by their personal or institutional interests. This can happen in different ways. Let me mention an example from the field of mental health. In war-affected areas, foreign mental health professionals and institutions are selling their "goods". These goods are sometimes neither appropriate to the situation nor are they culturally adapted. Domestic professionals may accept foreign concepts and practices regardless of their utility as a part of whole program. The program may be donated or sold (it is always paid for by somebody!) and usually includes additional financial incentive to run the program activities. The basic premise is that any mental health program is better than no program. Sometimes foreign funding is the basis for local NGO survival. Moreover, foreign funders may offer selected some local mental health professionals the opportunity to study abroad. So there are different reasons for accepting and becoming involved in offered programs regardless to their appropriateness.

During wars on the territory of former Yugoslavia it took some time before mental health workers learned to stand up and dared to articulate aloud the local needs or even to refuse funding for inappropriate programs. The most important responsibility of medical and allied professions in war and post-war situations is to develop health care delivery systems and that serve the needs of the population, and not to serve personal and institutional ambitions.

In the post-war situation, and in circumstances of "wild capitalism" (as we often call economic processes in post-socialist countries) there is a considerable danger of personal or institutional profit-making which transgress the ethic code of conduct of medical workers.

The social responsibility of health professionals requires new modes of behavior, openness toward the community, capacity to establish partnership in collaboration with various institutions, services, political fora and groups of citizens.

The active engagement of health professionals in NGOs can provide an important contribution to a community. Organizations of the civic society, NGOs or less formal groups, can make a difference in many fields of health and social welfare. NGOs are often sensitive to the needs of deprived segments of society. They can be flexible and inventive in producing proposals for solutions. Furthermore, they can serve a significant function in the care of sick and handicapped individuals. The efficiency of NGOs and volunteers can be strengthened through good collaboration with health care professionals.

In all post-war situations there is also a tremendous lack of human resources. Volunteers invited by and collaborating with the medical workers can significantly improve the quality of life of persons with medical and psychosocial problems. Through voluntary work the values and the practice of solidarity and of mutual help regardless to religious, national or other attributes are reinforced and promoted.

The post-war situation brings with it widespread poverty and lack of state supported health services. Thus, the health worker will be often obliged to look for resources, taking on the role of fund-raiser as well as healer.

I would also like to express a warning concerning the social impact of our published or lectured professional statements. Again an example from the field of mental health: At the beginning of war in Croatia and in BiH, the prevailing opinion among mental health professionals* was that all or most children who experienced war or asylum would suffer long-lasting psychological damage. Such statements could be heard as a condemnation of whole generations. Some authors critically noted that such statements could become a self-fulfilling prophecy for children who experienced war and armed conflicts. Such expert* opinions may contribute to feelings of helplessness and victimization, life-long psychological.

Common sense statements and research show that the experience of war causes suffering and certainly affects the emotions and the cognition. In spite of this, the vast majority of children manage to cope with traumatic events and lead a normal adult life, establishing good relationships and enjoy productive, fruitful existence. If this were not so, the European adult population whose childhood experience was the second world war would be much more psychologically disturbed than the post-war generations. The generalization of long lasting psychologically devastating effects of the war on the whole generation might be founded on incorrect professional conclusions, but it can also be strengthened by

some emotional processes. We should be very careful stating "truths", which have insufficient scientific basis, especially if those can have far reaching harmful.

In conclusion: Health workers and workers in allied professions are not sufficiently aware of their capacities and capabilities to shape social processes in the community. They often lack practical skills and have not the needed support for social actions. The Medical Network for Social Reconstruction in the Former Yugoslavia could be an important basis for enhancing motivation, support and know-how for social involvement of health workers.

- Dr Paula Gutlove, director of the Program on Cooperation and Understanding at the Institute for Resource and Security Studies: "Expanding the concept of healing: integrating community trust-building and violence prevention into health care delivery"

"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 ⁴

Good health includes the physical, psychological and social well-being of individuals and their community. While physical and psychological health is the recognized province of health care providers, social health is often considered outside their province. Yet, healing physical and psychological ills can provide an important basis for social healing, particularly in communities traumatized by violence. By expanding the concept of healing to include restoring trust and confidence within a community, and by working cooperatively to help prevent future violence, healers can make a unique and essential contribution to their community.

The medical community is particularly well placed to forge cooperation between communities in conflict. Health care professionals have skills and social stature that can be a particular asset in building bridges between conflict-divided communities. 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. The health infrastructure of a post-conflict community is often bolstered by international and NGO assistance, which may provide options for communication, transport, technology transfer and educational support that are otherwise unavailable due to destroyed infrastructure.⁵ Furthermore, international medical organizations have experience in building bridges between medical communities in developing and developed countries, North and South, East and West.

⁴ "Health in Social Development," WHO Position Paper, prepared for the World Summit for Social Development (Copenhagen, March 1995), page 19.

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

Delivery of health care can be the basis for cooperation between parties that have been divided by violence, particularly when common medical goals are clearly articulated. This has been demonstrated repeatedly, when parties engaged in violent conflict have been persuaded to engage in a humanitarian cease-fire while health care workers provide a short-term, basic health care need, often aimed at children from all sides of the conflict.⁶ UNICEF and the World Health Organization (WHO) have demonstrated the potential for health to be a unifying cause, through research/action programs, inoculation campaigns and health education programs in conflict-torn areas such as : El Salvador, Uganda, Lebanon, the Sudan, the Philippines, Afghanistan, Mozambique and Sri Lanka. In addition, local NGOs have worked with international organizations to use health initiatives to promote local processes of mutual cooperation and community reconciliation. By working together on the programs of mutual interest and need, and through the development of broadly participatory processes, people were able to engage in a collaborative problem-solving process.

The potential for the medical community to promote communal reconciliation, to heal inter-communal⁷ relationships, and to transform violence-habituated systems can be significantly enhanced with training and assistance in concepts and skills of conflict management. The practice of conflict management includes efforts to prevent violent conflict, to mediate existing conflict, and to reconcile communities in the aftermath of violent conflict. 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.

In recent years, efforts to transform inter-communal conflict have benefited from the systematic integration of humanitarian activities with conflict management expertise. This approach can be described as "integrated action". 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

⁶ 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.

⁷ 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.

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.

The Institute for Resource and Security Studies is engaged in several initiatives to promote the integration of community trust-building and violence prevention into health care delivery in pre and post conflict areas. The IRSS has termed these initiatives "Health Bridges for Peace". It seeks to integrate health initiatives with community reconciliation in a systematic and sustainable way, building on lessons from the experiences of the WHO, UNICEF and others, and on the evolution of the conflict management field. The project works with local health care providers (doctors, nurses, and mental health workers) in conflict-torn areas to develop tailored programs that integrate the delivery of health care with conflict management and sustainable community reconciliation. It documents these programs as models for conflict management, community reconciliation and peace building in other conflict-torn areas. Finally, the project promotes the Health Bridges concept before governments and international organizations.

The Medical Network for Social Reconstruction in the former Yugoslavia is an important Health Bridge for Peace initiative, providing an excellent model for integrating community trust-building and violence prevention into health care delivery.

- Dr.med. Anne-Marie Miörner Wagner, director of the OMEGA Health Care Center in Graz: "History of IPPNW and the Medical Network for Social Reconstruction in the former Yugoslavia"

The International Physicians for the Prevention of Nuclear War (IPPNW) was founded in 1980 by the US cardiologist Prof. Bernard Lown and the Soviet cardiologist Prof. E.Tschasov. IPPNW was founded with the goal of preventing the use of nuclear weapons and to build communication and programmatic bridges between the East and the West. After the cold war we expanded our goals to support cooperation, peace, and trust-building activities in a wider context. Other Western European physicians and I worked with IPPNW to organize cooperation among health care institutions from former Yugoslavia and other countries. Eventually I founded the OMEGA Health Care Center, which has become the affiliate for IPPNW from Austria.

Beginning in 1991, IPPNW physicians and other health care workers organized a series of international meetings with the goal of promoting dialogue between colleagues from the former Yugoslavia. The first meetings, in 1991, took place in Zagreb and Belgrade. Subsequently, international meetings were convened in Vienna, March 1993; in Göd, Hungary, March 1994; in Graz, October 1994 and January 1995; and in Ljubljana, September 1995. The meeting in Ljubljana was organized by the "Slovene Foundation". In addition to these meetings IPPNW organized "Working Together Programs" in the summers of 1992, 1993 and 1994 at which medical students and young physicians from each of the constitutive

parts of former Yugoslavia were invited to work together at the Medical University Clinics in Graz.

After 1995 OMEGA organized two conferences in Graz in co-operation with the "Slovene Foundation". The first of these took place in April 1996, and was titled "Repatriation - Psychosocial Support to Children and their families". The second occurred in April 1997, and was titled: "Psychosocial Support in Post-War Communities". This meeting was attended by over 60 health care providers from all parts of the former Yugoslavia, who decided at the meeting to form the **Medical Network for Social Reconstruction in the Former Yugoslavia** (Network). The Network 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 group articulated the goals of the Network to be: the promotion of dialogue, cooperation, personal contacts, practical solutions and the renewal of relationships in the region. In line with these goals was the desire to hold future meetings, as possible, in countries of the conflict area. The next large group meeting was scheduled for Sarajevo, for the Spring of 1997.

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 was designed to have two people from each former Yugoslav Republic, but is flexible to reflect the geo-political realities of the region⁸. 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.

All of these meetings and the founding of the Network were meant to serve two important purposes: to create opportunities for colleagues, who were under difficult circumstances, to meet and exchange their experiences; and to promote trust- and peace-building programs among professionals working in the same field.

⁸ 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.

3. CHALLENGES WITH AN INTERNATIONAL DIMENSION

- Gregory Hess, director of the Peace through Health Program of the World Health Organization, Sarajevo: "The WHO Peace through Health program in Bosnia and Herzegovina"

The World Health Organization in Bosnia and Herzegovina, through our Peace Through Health strategy, has been attempting to integrate health and conflict resolution across a wide range of programs. In practice, this integration works on two principles. The first is that common health issues can serve as neutral fora for discussion and collaboration. The second is that health issues provide a valuable medium for addressing fundamental obstacles to peace such as discrimination, polarization, and manipulation of information.

In BiH, the health sector has been one of the leading sectors in terms of reconciliation and inter-entity collaboration. This is a tribute to those Bosnian health professionals who have shown the vision and courage to take steps towards reconciliation. It is also a tribute to those agencies and organizations which have not recognized the Inter-Entity Boundary Line as a border and which have not allowed it to become one.

WHO BiH has implemented the PTH strategy in all of its traditional programs such as health system reform and reconstruction, public health, primary health care, and mental health. Our field offices are arranged according to geographical, not political, boundaries. And PTH activities are multi-sectoral and multi-level.

Some examples of PTH outcomes include:

- _ a Joint Statement to the International Community issued by the entity ministers of health in September 1996;
- _ development of compatible and transparent health systems;
- _ regular communication between public health directors leading to joint action;
- _ joint immunization campaigns;
- _ efforts to harmonize health data collection across BiH;
- _ joint training workshops in all parts of the country;
- _ the initiation of an inter-faculty medical students journal.

Implementing the Peace Through Health strategy has presented some very difficult challenges to the health professional community. The following examples highlight just a few of the "new challenges for health professionals" which have arisen in the WHO's work in BiH.

Health system reform and reconstruction

Bosnia and Herzegovina is undergoing an intensive health system reform process. The need for reform is driven much more by the previous social and economic system than by the war. Nonetheless, it presents fundamental challenges to the health professions and to health professionals. It necessitates the acquisition of new skills such as management techniques. It requires increased responsibility for the non-physicians, for example nurses and

pharmacists. And the reform process also requires a fundamental and widespread recognition that responsibility for health extends far beyond the health sector. Often it is the medical professionals who are most resistant to this shift in perspective.

Advocacy

Health professionals, and particularly physicians, have a significant stature in the community and often wield a good deal of political power. Health professionals can serve as advocates in (at least) two manners: first, to act as agents of change in their positions of influence and respect; and second, to lead by example in their work and daily lives.

Specific examples abound in BiH, where health professionals could, and in many cases are, taking on an advocacy role. Advocacy for vulnerable and marginalised groups is not only a role which health professionals should play, but one that they must play. Reducing authoritarianism, one of the fundamental factors of the war, is an advocacy role that is essential both inside the health sector and across BiH in general. And a third example, health professionals are in a position to promote cross-community collaboration. They could be using their opportunities as examples to encourage others.

Solidarity

Accomplishing social change requires solidarity among many groupings of health professionals. If the international community lacks coherent and clear principles, many initiatives can build walls between communities. If the actors in health, local and international, are unable to agree upon priorities, the effective outcomes of investment will be less than optimal.

- Dr Ake Bjorn, Medical Centre for Refugees, University Hospital, Linköping, Sweden: "MEDEVAC in the post-war period"

Introduction

Since the summer of 1995 the Swedish government has redirected part of the quota refugee annual budget to the Medical Evacuation Program (MEDEVAC) in Bosnia and Herzegovina, which is implemented by the International Organization for Migration (IOM). The Swedish Immigration Board (SIB), in co-operation with Medical Centre for Refugees (FMC) at the University Hospital, Linköping, was made responsible for the program. The general purpose of MEDEVAC in the present post-war period is to help strengthen National Health Service capacity in BiH for managing complicated but potentially curable conditions of identified individuals during the transitional period of reconstruction.

In supporting reconstruction of national health care one may always consider the question whether to support specialized medical care for a minority or primary and preventive health care for the majority. The situation in BiH is complex in regard to specialized medical care and fundamentally different from the situation in many developing countries. Before the war the standard of health care in former Yugoslavia was at a level equal to most European countries. In the post-

conflict society in BiH there has been a substantial loss of health professionals. Other aspects are destruction of infrastructure and health facilities and destruction of established referral systems through new geographical, ethnical, political, and economical borders. Many citizens in BiH have thoroughly been deprived accessibility to potentially curative civilian medical care for many years to come. For how long will depend on the speed of reconstruction. The aim of this report is to present the MEDEVAC program in terms of the care process and program experiences from the Swedish point of view. Specifically, the role of health professionals and medical teams in the reconciliation process will be discussed.

Care process

Thirty-five patients and around forty accompanying relatives have been evacuated to Sweden in this project so far. Of these, 30% have been patients with severe war injuries and 50% have been patient in need of heart surgery. All patients except two have returned to BiH after completed treatment. The basic criterion for selection is that the individual suffers from a potentially curable disease where treatment not yet is available in BiH. As this is a small program in relation to actual needs there are highly qualified ethical dilemmas associated with the selection process. Some of these dilemmas will be discussed during the workshop.

Experiences

Multi-disciplinary co-operation in the receiving hospital is necessary for these patients in order to avoid misunderstandings and unnecessary delay of treatment. Routines adjusted to present knowledge in the area of post-traumatic stress and cross-cultural issues are not always available within specialized somatic departments. Hospital staff might be subjected to transference in a psychological sense without psychotherapeutic understanding. The psychological impact of four years of traumatic war experiences might easily be misunderstood regarding a patient, or accompanying family-member, who need to mobilize all available psychological strength during the treatment and rehabilitation period. This is especially necessary when unforeseen complications occur in a foreign culture, especially when the medical condition appears to be far more complicated than expected. Linguistic misunderstandings could further complicate the situation. Nurses, family therapists, or psychiatrists with experience in migration medicine and severe post-traumatic care can therefore be consulted at the Medical Centre for Refugees regarding these patients when necessary, and regardless of which specialized clinic the patient is referred to.

In order to support mutual exchange of knowledge and experience between our countries Bosnian specialized doctors have accompanied some patients to Linköping, Sweden, participating in preoperative discussions and surgery of evacuated patients, as well as ordinary routine work. Both the Bosnian and the Swedish counterparts have found this to be very valuable, sometimes resulting in continued contact and decreased need for future evacuations. Alternative actions in BiH can achieve the same beneficial result for an individual for less monetary and psychosocial cost than evacuation to another country. Therefore a

Swedish Medical Team will arrive in Sarajevo April 25, 1998, for a third mission in Gorazde, Lukavica and Sarajevo.

The purpose of such medical teams is to facilitate international professional contacts and to decrease the need for evacuation. Co-operation between Swedish and Bosnian health professionals during investigation, treatment and surgery of pre-selected patients save evacuation for those where alternative possibilities do not exist and develop possibilities for future professional contacts.

Conclusion

During the transitional period of reconstruction and rebuilding in BiH, there is a need for MEDEVAC as a support to the health service in combination with targeted donations and support to the educational system by training of health professionals. A child born in the post-war period with for example a completely curable heart malformation is a war victim in spite of a purely civilian pathological condition. Within the present border of BiH there was no heart surgery performed even before the war. Adequate treatment and surgery was, however, available in other centers through the established referral system within former Yugoslavia. Until possibilities for heart surgery exist in Sarajevo the only possibility for such a child to survive now is by evacuation. Co-operation and co-ordination with health authorities in BiH and with other international organizations is essential. Re-establishment of a referral system in regard to secondary health care covering all parts of the country is desirable. The population density is not large enough for the establishing of parallel health systems on specialized levels. Hence, as long as the present situation prevails, it is desirable to support programs like this to all parts of BiH.

Further bilateral exchange of education oriented projects, in combination with administrative and personal support to highly qualified professionals in BiH will gradually diminish the need for MEDEVAC.

Acknowledgements

The author wants to express his sincere respect and deep admiration for all hard working health professionals involved in the reconstruction and maintenance of adequate health service to the population of their country, and for the staff at the IOM office in Sarajevo, who continuously deals with these extremely difficult questions.

- Dr Ljuba Archakova, program director of the Netherlands Relief Committee (RCC) for Chechnya: "Report on post-war conditions in Chechnya and the efforts of the RCC"

(A concise background to the situation in Chechnya is provided below through excerpts from *Chechnya*, by the Minority Rights Group International written by Helen Krag and Lars Funch, following this excerpt is information from Dr. Archacova's presentation. No paper was submitted.).

*Background*⁹

“The North Caucasus region stretches along the high peaks from the Black Sea in the north west to the Caspian Sea in the south east. Through the centuries great empires have endeavored to cross this barrier between the Orient and the Occident and conquer the lands beyond. This region has been acclaimed by anthropologists for its extraordinary ethnic and linguistic diversity. More than 40 distinct ethnic or national groups are resident in the region. However what unites many of the peoples of the North Caucasus is a distinctive Caucasian identity.

Despite fierce resistance, the region was gradually incorporated into Russia in the eighteenth and nineteenth centuries. In the twentieth century the region became the scene of Russian influx on a massive scale, being integrated in the Sovietization process of industrialization, urbanization and education. The region was subject to barely concealed atrocities against the peoples, with their forced incorporation into the Russian Empire and decades of arbitrary, bureaucratic acts passed by the Soviet administration which affected individuals as well as entire peoples, culminating in forced population transfers within the region, and deportations of entire peoples out of the region, fostering feelings of victimization and marginalization.

During the late 1980s, however, the political changes which were taking place in the Soviet Union, gave rise to new hopes for equal participation in decisions concerning the Region and for self-determination. With the break-up of the Soviet Union in 1991, the region was divided between three new countries: the largest part belongs to the Russian Federation, while the smaller parts reach into Georgia and Azerbaijan. As a result, the North Caucasus has now become a border region of renewed geopolitical interest. Today, most of the administrative and national units and ethnic groups want to redefine their identities, their territories and their lines of cooperation. All peoples and republics are now engaged in an ongoing discussion regarding their futures and are forming shifting political alliances, a process which is made more complex by economic difficulties and growing political pressures, including armed conflicts and voluntary as well as forced migratory flows.

Many of the aspirations of the peoples in the region are contradictory and several forces play off one group against the other. The region is witnessing a number of internal conflicts over territories and borders with the struggle for sovereignty, and difficult relationships with the new central governments at the forefront. Complex internal claims and disagreements, coupled with a growing antagonism between the region and its political centers dominate the political agenda. The absence of constructive policies and political will to implement them have led in some areas to cruel open conflicts. Any new attempt to enforce solutions and ignore claims will add to the feeling of estrangement and feed nationalist tendencies both among North Caucasian peoples and among Russians. This contributes to a general feeling of uncertainty and insecurity in a

⁹ This concise background to the situation in Chechnya was excerpted from *Chechnya*, by Helen Krag and Lars Funch, published by Minority Rights Group International.

region that could become subject to major turmoil and violence. The North Caucasus is therefore a region not only at the crossroads of Europe and Asia, and of different cultural and political norms, but also at a distinct crossroads concerning its future development. “

From 1991 Chechnya has agitated for independence. Until then the Ingush and Chechens had lived in one administrative region. Ingush and Chechens are ethnically related, their languages are very similar. Ingushetia did not want to break with Russia so they separated from Chechnya leaving a very flexible border between the two regions. Some Ingush who had lived in Chechnya returned to Ingushetia and when Yeltsin issued the decree to return land that was seized in 1944, from the people who were deported, the Ingush hoped to receive the Prigorodnie District back. The Prigorodnie District is a relatively small bit of land to the east of the Terek river (but includes part of Vladikavkaz) which was annexed to North Ossetia when the Ingush were deported. In 1957 Khrushchev allowed people to return and Ingush returned to the Prigorodnie District which was administered from Vladikavkaz by the North Ossetians.

Yeltsin's decree was never enforced leaving the Ingush angry. Into the Prigorodnie D. had also come South Ossetians who fled the war with Georgia in 1990/91. So there was a double pressure on the land which led in the autumn of 1992 to a 10 day war between North Ossetia and Ingushetia. Russians who came in to keep the peace sided with the Ossetians and cruelly pushed all the Ingush out. Almost all the Ingush (about 60 000) were forcefully displaced, their homes looted and burned, and most of them live even today in makeshift displaced peoples camps. In the camps there is no work and even schooling is difficult. Five and a half years of that kind of existence leaves tragic scars.

Officially the Ingush have made adjustments to the claim they now hold for the Prigorodnie District, for example they now no longer claim parts of Vladikavkaz. Gradually Ingush are being returned to the PD but the process is very slow because the Ossetians are very hostile. There are killings and newly built homes are burned down.

The war in Chechnya started in December 1994 and went on until the autumn of 1995 with tremendous violence and destruction. The most terrible damage was done by contract soldiers who were often high on drugs.

The problems for all these three regions are the destruction of the social and civil society. Children, in particular, have suffered severe psychological and physical trauma, many still wounded daily by mines and weapons, many living in incomplete families or orphaned. Hospitals and schools function on a marginal level where they function at all. Young people take to drugs and criminal activities on a very large scale. Ingushetia is perhaps the least affected by the moral collapse. On the other hand the rule of the elders in the Ingush society, who are slow to change and adjust to modern life causes internal tension.

The Netherlands Relief Committee for Chechnya (RCC) has been founded to deal with the medical and psycho-social needs of war-traumatized children in Chechnya. RCC, established in 1995, is supported by Dutch Interchurch Aid

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(DIA) and Caritas Netherlands (MIN). RCC is unique in the context of Chechnya, as no other organization is involved in community-based care for these children. RCC has been engaged in setting up community centers (for recreational groups, trauma work and work with women and teenagers), and in providing initial training for field workers. Also, RCC aims to educate and influence governments and international organizations as to the needs of this community. Last year they co-hosted a training seminar with UNICEF that addressed psycho-social issues of refugee children. This provided an important venue for bringing together medical and psycho-social professionals from the region.

APPENDIX F

TEXT OF A WORKSHOP PRESENTATION BY PAULA GUTLOVE

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**COMMUNITY RECONSTRUCTION AND RECONCILIATION,
PAST, PRESENT AND FUTURE¹⁰**
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 master¹¹

1. Community Reconstruction

Community reconstruction¹² 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

¹⁰ This paper was used in a workshop at a conference organized by the Medical Network for Social Reconstruction, Sarajevo, April 1998.

¹¹ Cited in J. Monville, "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.

¹² 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.

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-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.

2. Community Reconciliation

The word reconciliation means: "to reach a compromise agreement about differences, or to bring together again in friendship"¹³. 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

¹³ The New Lexicon Webster's Dictionary of the English Language, Encyclopedic edition, Lexicon Publications, Inc. New York, 1987.

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." 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.

3. 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, 1995¹⁴

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.

4. Looking at the past together, workshop process

4.a. The need to listen and to be listened to

¹⁴ "Health in Social Development," WHO Position Paper, prepared for the World Summit for Social Development (Copenhagen, March 1995), page 19.

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 listening¹⁵ 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.

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

¹⁵Carl R. Rogers and R.E. Farson, "Active Listening" from "Seminar Program for Instructors in Professional Schools", University of Chicago, Industrial Relations Center, (no date).

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.

4.b. 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:
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 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.

4.c. Workshop process

4.c.i. Ground rules

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:

- 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.

4.c.ii. Reading:

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 an excerpt from Yevgeny Yveteshenko's **A Precocious Autobiography**, "When one person reaches out with Love". This is included, in English and in Serbo-Croatian, at the end of this paper.

4.c.iii. 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 reflection¹⁶:

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?

¹⁶Peter Lang, "Counseling and support skills for community workers in the Former Yugoslavia, Resources and Pathways", Kensington Consultation Centre (no date).