CONTENTS

1. Introduction ............................................. 1
   A. Background ........................................... 2
   B. The World Health Organization and peace ..................... 2
   C. A shifting operational landscape ............................. 3

2. WHO's responsibility to contribute to peace ............ 5
   A. Global processes ....................................... 6
   B. WHO's 13th Global Programme of Work ..................... 6
   C. WHO's added value: health diplomacy ......................... 6
   D. Guiding principles ....................................... 7
   E. Enablers .................................................. 7

3. Approach .................................................. 9
   A. Peace-responsive programming: from working in conflicts to working on conflicts .......... 10
   B. Working across the nexus ................................ 10
   C. Working across WHO ....................................... 11

4. Programmatic rationale .................................. 13
   A. Health and the prospects of local peace ...................... 14
   B. Working across tracks ..................................... 15
   C. Second-level theory of change ............................... 16
      • GPW Billion 1: Improving citizen-state cohesion through health equity .................. 16
      • GPW billion 2: Facilitating cross-line collaboration in health governance ............. 17
      • GPW billion 3: Promoting community healing through dialogue and inclusion ......... 17

5. Second-level theory of change and associated programmatic entry points .................. 19
   A. Improving citizen-state cohesion through health .......... 20
   B. Facilitating cross-line collaboration on health .............. 20
   C. Promoting health and well-being through dialogue and inclusion ........................ 27

6. Risk management strategy ................................ 23

7. Designing a peace-responsive intervention ............. 27

8. Conclusion ............................................... 31
   Political nature of peacebuilding: positioning a neutral WHO .................. 32

Annex: Working in and on conflict ........................ 34

References and notes ........................................ 37
<table>
<thead>
<tr>
<th>ABBREVIATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UN</strong></td>
</tr>
<tr>
<td><strong>WHO</strong></td>
</tr>
<tr>
<td><strong>HBP</strong></td>
</tr>
<tr>
<td><strong>FCV</strong></td>
</tr>
<tr>
<td><strong>SDGs</strong></td>
</tr>
<tr>
<td><strong>GPW 13</strong></td>
</tr>
<tr>
<td><strong>UHC</strong></td>
</tr>
<tr>
<td><strong>CCA</strong></td>
</tr>
<tr>
<td><strong>NGOs</strong></td>
</tr>
<tr>
<td><strong>MHPSS</strong></td>
</tr>
<tr>
<td><strong>FARC</strong></td>
</tr>
<tr>
<td><strong>MhGAP</strong></td>
</tr>
<tr>
<td><strong>UNITA</strong></td>
</tr>
</tbody>
</table>
1. INTRODUCTION

On 27 April 2016, the United Nations (UN) General Assembly and Security Council both unanimously adopted identical resolutions on a review of the UN’s “peacebuilding architecture” which introduced the concept of “sustaining peace” into the UN’s peacebuilding goals. The resolutions urged all UN bodies and the World Bank to mobilize capacities for mediation and conflict resolution in order to prevent “outbreak, escalation, continuation and recurrence of conflict”. The UN and its Member States were called on to “address root causes, assist parties to conflict to end hostilities, ensure national reconciliation, and move towards recovery, reconstruction and development”.

This White Paper outlines the contribution of the World Health Organization (WHO) to the Sustaining Peace Agenda. It explores how WHO’s comparative advantage as the leading global health agency can be brought to bear to mitigate the impact of armed conflict and violence and to improve the prospects of lasting, local peace within the scope of its mandate.

A. Background

The links between conflict, health and peace are multifaceted. Armed conflicts and violence have clear impacts on health. They kill civilians and combatants, cause physical and mental disabilities and often disrupt health systems. Conflicts and violence cause the collapse of essential medical supply chains and the breakdown of social and economic systems as health-care workers flee and starvation and epidemics spread. Rates of infant mortality, sexual violence and mental disorders such as depression, anxiety and post-traumatic stress increase significantly during and after conflicts.

To reinforce the role of health in the promotion of peace and to reinvigorate the efforts of WHO in this area, the Ministries of Health of the Sultanate of Oman and Switzerland, in collaboration with the WHO Regional Office for the Eastern Mediterranean, held a multilateral consultation in Geneva on 1 November 2019 on the concept of “Health for Peace”.

Following the conceptual approach of “health as a bridge for peace”, the Global Health for Peace Initiative was launched soon afterwards.

The lack of access to basic social services such as health care for specific populations (e.g. ethnic, regional, religious) can lead to feelings of exclusion and of unfair or unequal treatment. In many contexts, these inequities lead to grievances which in turn boil over into protests and, later, violence.

Some root causes and drivers of conflict relate to WHO’s mandate and competencies as the lead agency in health. Health is often viewed as a superordinate goal for all sides in a conflict, which allows health initiatives to serve as a neutral starting point for bringing rival parties together as they work towards mutually beneficial objectives [see Annex]. In the Ottawa Charter for Health Promotion, peace is the first of a list of prerequisites and fundamental conditions for health – along with shelter, education, food, income, a stable eco-system, sustainable resources, social justice and equity.

B. The World Health Organization and peace

WHO’s association with peace is not new.

WHO’s Constitution recognizes the connection between health and peace, stating that “the health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest co-operation of individuals and States”.

In a 1981 resolution (WHA 34.38), the World Health Assembly highlighted the role the health sector can play in preserving and promoting “peace as the most significant factor for the attainment of health for all” and required WHO to “facilitate the implementation of the UN resolutions on strengthening peace, détente and disarmament and preventing thermonuclear conflict”.

2 | HEALTH & PEACE INITIATIVE
The concept of health as a bridge for peace emerged in the 1980s as part of WHO’s approach to the provision of post-conflict health assistance. The 1990s and early 2000s saw WHO’s involvement in several initiatives that were intended to have an impact on both health and peace. The WHO Health as a Bridge for Peace (HBP) programme intervened in specific contexts under the premise that health has the potential to transcend disputes between parties in a conflict and may even foster social cohesion through cooperative action. The programme included the facilitation of vaccination campaigns through humanitarian ceasefires, with WHO playing a critical role in mediating between warring factions. Further activities included advocating for peace, values, medical ethics and human rights, as well as influencing health policies to address the root causes of conflict.

C. A shifting operational landscape

The scale, nature and complexity of conflicts have changed over recent decades. Violent conflicts have become more complex and protracted, involving more non-state groups and regional and international actors. This complexity has made conflicts resistant to political resolution – a situation that is often further complicated by some governments’ unwillingness or inability to protect their people – leading to failed infrastructure, disrupted public services, chronic hardship and poverty. This has made the resolution of conflicts more difficult and has led to a call for renewed efforts to prevent conflicts.

Some 1.8 billion people live in fragile, conflict-affected and vulnerable (FCV) settings. It is estimated that, by 2030, at least half of the world’s poor people will be living in FCV countries. In these contexts, weak health systems are unable to meet people’s health needs. The breakdown of essential public health functions makes populations more vulnerable to epidemics. In terms of the UN Sustainable Development Goals (SDGs), over 50% of the unmet needs for key target areas such as maternal and child mortality occur in 30 FCV countries. In addition, 80% of WHO’s humanitarian caseload as well as 70% of disease outbreaks that WHO responds to take place in such settings. Violent conflict is, therefore, a significant obstacle to achieving the SDGs by 2030, including SDG 3 which relates to good health and well-being.
WHO’S RESPONSIBILITY TO CONTRIBUTE TO PEACE
2. WHO’S RESPONSIBILITY TO CONTRIBUTE TO PEACE

A. Global processes

The 2030 Agenda for Sustainable Development recognizes that progress towards all the SDGs is interdependent. SDG 16, which sets out to “promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels” is particularly at risk of not being achieved. With regard to public health, SDG 13 implies that public institutions must be both effective and inclusive if they are to implement fair health policies and deliver quality health care in order to reach the various health-related targets of SDG 3.

Further, the Agenda for Humanity, endorsed at the World Humanitarian Summit in 2016, calls on global leaders and humanitarian actors to act on five core responsibilities. The first relates to peace and stresses that alleviation of human suffering requires political solutions, unity of purpose, sustained leadership, and investment in peaceful and inclusive societies.

The landmark resolutions on “sustaining peace” adopted in April 2016 by the UN General Assembly and Security Council put the prevention of violent conflicts and the need to address their root causes and drivers at the core of UN efforts. As a shared responsibility, “sustaining peace” must be integrated into the work of all UN entities, including WHO. To achieve this, UN agencies, funds and programmes are required to conduct joint analysis in order to reach a shared understanding of conflict drivers, define collective outcomes, and strategically plan together actions that directly aim at or contribute to sustaining peace.

B. WHO’s 13th Global Programme of Work

Health and peace programming is an integral part of efforts to achieve the “triple billion” targets set by WHO’s Thirteenth General Programme of Work 2019–2023 (GPW 13). Armed violence and conflicts have become normal features in an increasing number of contexts where WHO operates. The Organization needs to improve its work in such settings and tackle issues of peace and conflict before they become major obstacles to achieving universal health coverage (UHC), addressing health emergencies and promoting healthier populations.

The GPW 13 offers numerous opportunities to improve the prospects for peace. UHC, which includes the poorest and most marginalized, is a major contribution to more inclusive societies, which in turn is a key factor for sustainable peace. During health emergencies in fragile settings or conflict, WHO interventions that prevent health systems from collapse and rebuild them after crises help to prevent the lack of access to health from becoming a driver of grievances and further unrest. Healthier populations can participate more actively in their community and society and can be more constructively involved in post-conflict reconciliation. The following section elaborates on the links between health and peace, and the Approach chapter shows how health and peace programming can be tied to specific GPW 13 outputs.

C. WHO’s added value: health diplomacy

**LEGITIMACY**

WHO’s technical expertise and its role as a norm-setting organization give it legitimacy. In many contexts, including FCV settings, WHO commands respect among stakeholders both in the health sector and beyond. WHO may also be the only actor with the specialist knowledge to address specific health problems. These unique features can be leveraged to play a role as convenor, bringing opposing parties together to cooperate on health issues and facilitating collaboration where health governance has been fragmented or disrupted due to political differences.

**EVIDENCE-BASED APPROACH**

WHO’s public voice matters. Its global leadership role on health has great relevance to the agenda for sustaining peace. WHO’s scientific and evidence-based advocacy role can be mobilized when health issues are, or are at risk of becoming, drivers of conflict. In these settings, health promotion – including advocacy for health equity and the right to health, and monitoring and reporting on attacks on health care and health workers - becomes indistinguishable from peace promotion.

**INFLUENCE**

In most contexts, WHO traditionally provides technical guidance and support to national health authorities. Its close partnership with ministries of health gives WHO unique entry points that other UN agencies, funds, and programmes may not have. Especially in contexts where the national government is a party to the conflict, WHO can leverage its position to promote conflict resolution, as well as to influence national health policies, strategies and plans to ensure that they are designed and implemented in a peace-responsive and conflict-sensitive manner.
D. Guiding principles

PRIMACY OF HEALTH

Health outcomes must always have priority when planning interventions in FCV settings. When designed in a peace-responsive manner, health interventions address the drivers of conflict and violent action while peace-related outcomes supplement the core health effects. WHO’s contribution to sustaining peace will always be based on its technical competencies, added value and comparative advantage in health.

HUMANITARIAN PRINCIPLES

In emergency settings, WHO will deliver aid in accordance with humanitarian principles (of humanity, neutrality, impartiality and operational independence) and international humanitarian law. It is precisely because of the need to uphold humanitarian principles and to “do no harm” that health workers are required to have a robust understanding of the dynamics and drivers of conflict and the root causes of social unrest. This awareness allows humanitarian action to be designed in a conflict-sensitive manner.

E. Enablers

CONTEXT AND CONFLICT SENSITIVITY

WHO’s work in and on conflict should be both context- and conflict-sensitive. Interventions in FCV settings should be rooted in a thorough understanding of the context’s actors, dynamics and cultural specificities. Conflict sensitivity should be mainstreamed throughout the project management cycle and in the various aspects of organizational management, including human resources, financing and procurement. The targeting of beneficiaries, supplies procurement, delivery of services and re-settlements can have negative impacts on conflict dynamics if not carefully calibrated. Similarly, provision of humanitarian assistance can have a positive impact by reducing tensions and preventing competition for resources.

CONFLICT ANALYSIS

Conflict analysis is the instrument commonly used to ensure that WHO has appropriate information about a particular context. Conflict analysis can be conducted jointly with other actors, especially other UN entities, or in partnership with specialized organizations. Where WHO intends to develop peace-responsive interventions, conflict analysis should be used to inform the decision to engage. The analysis helps personnel to identify the root and proximate causes of conflict that the WHO programme has the potential to address.

MULTILATERALISM AND PARTNERSHIPS

As mandated in its Charter to “save succeeding generations from the scourge of war”, the UN plays a unique role in peacebuilding. As WHO engages in sustaining peace efforts, it must align with the positions and strategies of the UN system. In line with the resolutions on sustaining peace, WHO country and regional offices should team up with other UN entities and international organizations/NGOs to conduct joint analysis, strategic planning and, where appropriate, programming through the use of multi-cluster teams. Similarly, national authorities or government should be seen as partners. WHO must undertake this work through existing systems where the situation allows.

RISK MANAGEMENT

While health interventions in crises entail risks – such as attacks on health-care workers and facilities – contributing to peace, particularly outside formal peace processes, is not without danger. Peace processes are inherently political and can be perceived by some groups or conflicting parties as being against their interests – especially when those parties have no part in negotiations, feel their views are not adequately taken into account, or benefit more from war and instability. In peace-responsive actions, WHO must pay due attention to security and risks to staff, health-care providers, patients and other beneficiaries in order to maintain health gains and uphold the right to health. To achieve this, security, reputation and risk analysis supplement the need for conflict analysis.
APPROACH
3. APPROACH

A. Peace-responsive programming: from working in conflicts to working on conflicts.

The Health and Peace approach is rooted in Article 1 of WHO's Constitution, namely: the "attainment by all peoples of the highest possible level of health". It is articulated by WHO's Director-General as "a world in which everyone can live healthy, productive lives, regardless of who they are or where they live" and where the "right of every individual to basic health services" is realized. Peaceful, resilient and inclusive societies are indispensable to the attainment of health in FCV settings.

Vision: To this end, WHO will build on its technical competencies, legitimacy, relationships and convening power in health to develop innovative ways to address conflict, strengthen resilience to violence and empower people to (re)build peaceful relations with each other. Harnessing its comparative advantages, WHO will contribute to generating peace dividends in settings where health, and/or the provision of health care, is hampered by violence and civil unrest.

Interventions by WHO and other health organizations in conflict situations can be understood as either

- working in conflict – for instance: 1) by implementing interventions that mitigate the impact of conflict on people's well-being, prevent further health consequences and support health systems and service delivery in conflict-prone regions; and 2) by life-saving humanitarian actions as well as interventions targeting development goals which need to be sustained despite ongoing conflict; or
- working on conflict – for instance: by designing health projects in such way that they address the drivers of conflict and/or foster the cooperation of opposing groups on health issues in a peace-responsive manner.

What is peace-responsive programming? So far in FCV settings, WHO has been addressing the symptoms of armed violence, saving lives through provision of emergency health care, and supporting health systems to prepare for, detect and respond to health emergencies in conflict situations. In doing so, WHO has generated some contributions to social cohesion but peace itself has been a by-product. In conflict-affected areas with internally displaced persons (IDPs), basic health-care services – e.g. emergency primary health care, trauma care, epidemic prevention and control – contribute to ensuring access to health as a basic right. Providing health care in conflicts certainly contributes to improving and/or restoring a sense of normalcy to those who may feel marginalized. The new Health and Peace approach seeks to build on these peace-relevant "by-products" by deliberately working towards improving the prospects for peace.

Peace-responsive health interventions represent how WHO can move from working "in" to working "on" conflicts. Health interventions can be explicitly designed to achieve both health and peace outcomes. WHO can play a critical role in promoting the two-way relationship between health and peace. WHO can achieve health outcomes through peace promotion while at the same time achieving peace dividends through health interventions.

B. Working across the nexus

As an organization with multiple mandates, WHO is well positioned to build bridges between sectors. The Health and Peace initiative provides yet another opportunity to give substance to the links between humanitarian, development and peace actions – the "triple nexus" – from a health perspective. WHO has already worked extensively to tear down barriers between its life-saving, sustainable development and norm-setting activities through its 13th Global Programme of Work (GPW 13) 2019-2023. However, the peacebuilding dimension is the missing link that remains to be fully explored. To do so, WHO can leverage current activities and plans towards implementing the GPW 13 triple billion strategies through an implicit peace-responsive approach or develop explicit peacebuilding strategies based on underlying health benefits.

Strategic positioning in the nexus: What does the humanitarian-development-peace nexus mean for health and for health actors? For WHO the nexus means expanding UHC (development) in fragile and conflict-affected settings (humanitarian) in a way that promotes and advocates for equitable access to essential health services (social cohesion, resilient and robust response to recurrent crises), and contributes to addressing the root causes of tension and marginalization (peacebuilding).

WHO needs to adapt its analysis, planning, programming and coordination tools to deliver on this vision of an integrated response. The current lack of coherence and long-term planning between the humanitarian and development responses may result in gaps and inconsistencies in service delivery and a lack of service provision to the most vulnerable populations. This can undermine the response to a health crisis, create difficulties for overstretched national governments and in some cases may cause lasting harm to the health system.

Humanitarian and development needs may be in part due to governments' and authorities' inability or
unwillingness to provide basic services to their people, leading to grievances, mistrust and social unrest. Consequently, in addition to ensuring a coherent response between short-term humanitarian needs and long-term health system support, assistance must be provided in a manner that does not contribute to the root causes of the conflict or exacerbate adverse sentiments. Working across the nexus is essential in conflict settings if WHO is to secure sustainable health outcomes.

As the lead agency for health in the UN system, WHO, through its country representatives, has a role in shaping system-wide responses. Health is a primary concern of populations in many vulnerable contexts and thus offers multiple opportunities to prioritize concrete, achievable and measurable results. When humanitarian and development country teams develop outcomes based on the triple nexus, WHO and the health cluster must prioritize health in the formulation of these outcomes.

C. Working across WHO

Delivering peace-responsive health programming across the three tracks of society – government, civil society and community – and across the humanitarian-development-peace nexus requires WHO to refine its operating model. In this regard, the GPW 13 provides a platform where all WHO programmes can contribute to achieving common outputs.

At country level, appropriate internal coordination between programmes needs to be determined as part of the context analysis. For instance, if WHO’s main peace-responsive intervention relates to supporting the reintegration of demobilized health personnel into local health systems, the appropriate internal coordination platform should be under Output 1.1.5 of GPW 13 which includes efforts to strengthen the health workforce.

Regardless of the context and choice of intervention, key priorities to improve coordination within WHO to deliver peace-responsive interventions should include:

1. Leadership: enhancing leadership at country level to ensure that WHO country representatives and other senior leaders are familiar with health diplomacy.

2. Analysis: in line with the UN Common Country Analysis (CCA), undertaking analysis jointly, bringing together public health analysis, macro-economic analysis, conflict analysis, and service availability and readiness assessment.

3. Planning and programming: jointly developing humanitarian response plans, common country strategies, contributions to the UN sustainable development plans and, by doing so, bringing together WHO country, regional and global expertise in emergency response, the right to health, health systems strengthening and social determinants of health.
PROGRAMMATIC RATIONALE
4. PROGRAMMATIC RATIONALE

A. Health and the prospects of local peace

Peace results from the equitable distribution of resources, well-functioning institutions and acceptance of others’ rights. This approach aligns with WHO’s commitment to human rights, universality and equity. Important aspects of WHO’s work already contribute to sustaining peace in different ways. Health interventions have the highest potential to improve the prospects for peace when they are explicitly designed to address well-identified causes, drivers and triggers of conflict. Moreover, well-designed peace-responsive programming can make health outcomes more sustainable.

Peace is often overlooked when we discuss the social determinants of health, perhaps because the focus tends to be on changing domestic policy. Yet the absence of peace, whether because of armed conflict or structural violence, is a danger to the health of all in society.

This paper articulates a Theory of Change that links WHO’s health programmes to the attainment of peace outcomes. In this sense, the Global (1st) Level is as follows:

**IF**

*individuals and groups* enjoy equitable access to health services fulfilling their rights to physical and mental health and *health actors* design neutral health interventions that promote trust and dialogue and communities are empowered to cope with violent conflict,

**THEN**

*health coverage* is more universal, grievances can be heard and addressed to generate *trust around health emergency* concerns, affected communities are more likely to make meaningful contributions to *peace and reconciliation* and to resist incitements to violence.

Cascading from the global theory of change above, peace-relevant health interventions can help improve the prospects for local peace in three ways:

**BETWEEN STATE AND CITIZENS**

1. By improving the vertical two-way relationship of trust between state and citizens through the expansion of social protection and justice in underserved areas.

**BETWEEN BELLIGERENTS**

2. By providing the opportunity for confidence-building measures between all sides in a conflict by serving as a platform that restores contact, collaboration and cooperation.

**BETWEEN AND WITHIN COMMUNITIES**

3. By helping mend horizontal relations between individuals and communities, through trust-building and inclusive processes that promote dialogue.
IF

Individuals and groups enjoy equitable access to health services that fulfil their rights to physical and mental health, and health actors design health interventions that promote trust and dialogue, and communities are empowered to cope with violent conflict

IMPROVING CITIZEN–STATE COHESION THROUGH HEALTH EQUITY:

IF dialogue is facilitated between state authorities, local medical practitioners and communities in conflict zones; and authorities and humanitarian actors adapt health reforms and service delivery to address needs and grievances expressed by the population

FACILITATING CROSS-LINE COOPERATION IN HEALTH GOVERNANCE:

IF health-care professionals from across the conflict divide are provided with a neutral platform facilitated by a credible technical third party that allows them to work together to address mutual health concerns amid ongoing conflict

PROMOTING HEALTH AND WELL-BEING THROUGH DIALOGUE AND INCLUSION:

IF community members engage in processes of healing and inclusive dialogue to overcome social divisions, as well as the physical and mental scars of war, and are provided with the opportunities to voice their grievances in a safe and constructive manner

THEN

Health coverage is more universal, grievances can be heard and addressed to generate trust regarding emergency health concerns, affected communities are more likely to make meaningful contributions to peace and reconciliation, and resist incitements to violence.

B. Working across tracks

Delivering across these three pillars requires efforts involving a variety of actors. In peacebuilding practice, interventions and processes occur on different “tracks” depending on the type of actors involved.

Track 1 initiatives involve top government officials and high-level leaders of conflicting parties, either in a formal setting such as an official mediation process or informally (so-called “track one and a half”).

Track 2 initiatives engage “influencers” such as civil society representatives, business leaders, religious figures and academics, who have the potential to influence decisions taken at Track 1 level and enjoy legitimacy among Track 3 groups.

Track 3 initiatives engage at grassroots level to generate community mobilization for peace.

The health sector in a given country typically involves actors across these three tracks. Health interventions can be designed to effect change at any track, depending on where the conflict and context analysis has identified opportunities for genuine change.

Track 1: health dialogue and diplomacy

As the lead agency for health, WHO is uniquely positioned to address health issues at Track 1. WHO can promote peace-responsive health policies at global level through the engagement of its top leadership with world leaders, including with bodies such as the UN Security Council which it has briefed on the health consequences of specific conflicts. A similar role can be played at regional and national levels – e.g. by advocating for change with government officials, including with the health ministry but also other state agencies, when a health-related policy is fueling
conflict. WHO can also use its convening power to foster cooperation on health issues in specific contexts, taking the role of a third party that facilitates technical health dialogue between opposing factions.

**Track 2: engaging actors within and beyond the health sector**

Track 2 health actors are usually integral parts of the health sector – e.g. health NGOs, charities, professional medical and paramedical associations, health businesses, activists representing the rights of specific groups (war victims, people affected by disease), and research/academic institutes in the health field. In health and peace interventions, WHO may need to engage with some or all of these players who have the potential to address a conflict driver constructively or, conversely, because their activities fuel violence directly or indirectly. WHO can also play a facilitating role between actors to encourage the resolution of health problems amid conflict or to involve them in a dialogue with Track 1 actors. Engaging other Track 2 actors who would traditionally not relate to the health sector can also be relevant. For instance, religious leaders and organizations may exert a strong influence on people's perceptions of, and behaviour towards, a given health issue, sometimes in ways that may generate exclusion, violence and conflict.

Conversely, seeking the support of influential religious figures may be of help when WHO implements the Health and Peace approach. Likewise, the media can play either disruptive or constructive roles in situations of armed conflict and violence. Well-crafted interventions can help promote more accurate and more critical reporting on health issues by local journalists, thereby contributing to both health benefits (e.g. awareness of specific health risks) and peacebuilding efforts (e.g. addressing conflict-generating rumours; preventing narratives that breed hate, stigma, xenophobia and violence; reinforcing positive perceptions of health-service delivery).

**Track 3: community resilience and health**

An important number of WHO interventions during emergencies take place at community level. Listening to, understanding, working with and empowering communities in outbreak preparedness and response are core requirements because otherwise the interventions may create new tensions, be refused and even resisted, with potentially serious consequences for responders (as learned from the Ebola responses in the Democratic Republic of the Congo and West Africa).

Community engagement is equally important to Health and Peace. Efforts to rebuild the social fabric after conflict take place to a large extent at community level, within and between groups, and between community groups and the authorities. For instance, improving health-care delivery during and after conflicts, in particular for frontline communities most affected by the health consequences of the conflict, has important potential to foster social cohesion. This is particularly true when service delivery is coupled with consultations and other local participatory mechanisms to better understand people’s needs and perceptions of the health system.

**C. Second-level theory of change**

**GPW Billion 1: Improving citizen state cohesion through health equity**

For citizens, the delivery of health care and other basic services is often the most tangible manifestation of national authority and an important factor in state legitimacy. When health care and other services are delivered unequally, state legitimacy can be undermined and the risk of violence increases – especially when inequities in coverage are perceived by a particular group as intentional exclusion, marginalization and neglect by the government. In some settings, it has been found that lack of access to basic services, including health, has contributed to recruitment into violent extremist groups.

Health systems that eliminate economic, geographical, epidemiological and cultural barriers to access, and that work towards UHC, are powerful foundations for building or rebuilding positive links between citizens and the state. In FCVs, this can make an important contribution to local peace, instilling trust in institutions.

**Sri Lanka 2016: Psychosocial services in support of the reparation and reconciliation process**

As part of the national Peacebuilding Priority Plan, WHO supports the government in leading a victim-centric process of accountability, truth-seeking, reparations for past violations and guarantees of nonrecurrence in line with international standards and obligations. As part of this plan, WHO provides psychosocial support to address the psychological impacts of the conflict on women, children and persons with conflict-related disabilities.
Strengthening health systems by consulting and involving citizens, with feedback and complaints mechanisms, helps to craft well-informed health policies, empower people and increase transparency and accountability. Providing a safe space for inclusion, participation and decision-making has the potential to improve citizens’ perceptions of, and rebuild positive ties with, the authorities.

**GPW billion 2: Facilitating cross-line collaboration in health governance**

WHO and its partners can act as technical and neutral third parties by fostering cooperation on health issues between conflicting parties. WHO has already contributed to peace processes where its technical expertise on health proved relevant. For instance, it supported the reintegration of the health personnel of demobilized armed groups into the national health system as part of the peace accord provisions on disarmament, demobilization and reintegration. WHO facilitated working groups that brought together health personnel belonging to former adversaries or opposing groups to address specific health issues or to rebuild the post-conflict health system.

While third-party roles are typically found in frameworks for implementing peace agreements after a conflict is over, WHO can also take on a third-party role during open hostilities. For instance, collaboration with opposing parties (e.g. to allow strengthening of IHR core capacities, outbreak responses or a temporary truce for vaccination campaigns) can be leveraged to advocate for community engagement and cessations of violence. By making clear that addressing a health emergency can be of mutual benefit to all parties, cooperation between them on health issues can form a positive precedent on which a mediating entity can build to facilitate peace talks.

**GPW billion 3: Promoting community healing through dialogue and inclusion**

Conflict impairs the ties that bind people together. To address this, peacebuilding interventions try to rebuild the social fabric in a variety of ways, including dialogue. However, people’s participation in rebuilding a post-conflict society depends on their well-being. Consequently, opportunities for communities torn by conflict and mistrust to jointly plan the reconstruction, staffing and rehabilitation of local health systems can become entry points for strengthening social cohesion.

WHO has developed operational guidance on various forms of social dialogues for health, such as large-scale public debates, consultative meetings and focus groups, with specific considerations for fragile environments.

WHO’s Community Engagement Framework outlines the need to “develop relationships within communities that enable stakeholders to work together to address health-related issues and promote well-being to achieve positive health impact and outcomes”. The desired relationships are characterized by respect, trust and a common sense of purpose between health workers and affected communities. Particular attention must be given to involving groups within communities that are often not visible, are marginalized and are not represented by institutions such as youth groups. It is important to employ participatory approaches and to give communities the power to decide how best to be involved. One example is to implement focus group discussions to empower groups and communities to influence decision processes.

Mental health and psychosocial support (MHPSS), as well as physical rehabilitation, can make a critical contribution to societies affected by the physical and mental scars that result from violence and armed conflict. Providing safe spaces – in individual or collective formats – for people to process, work through and share their traumatic experiences helps build an environment that is conducive to healing and which can be designed in a peace-responsive manner. At the same time, supporting and enhancing access to assistive technologies that address the needs of people living with disabilities can also be a tangible in-conflict and post-conflict peace intervention that strengthens social cohesion.

**El Salvador, 1985: Health as a confidence-building measure:**

A negotiating framework between the government, army and rebel forces, mediated by the church, was created at national and local levels and was supported by UNICEF and WHO. Fighting stopped for three days each year from 1985 until the peace accord in 1992 to permit the immunization of children. Major gains in the health goals of the campaign were achieved, with some 300,000 children immunized each year. This framework, which was seen as a confidence-building measure, contributed to the establishment of the peace accord.
SECOND-LEVEL THEORY OF CHANGE AND ASSOCIATED PROGRAMMATIC ENTRY POINTS
5. Second-Level Theory of Change and Associated Programmatic Entry Points

Legend: XXX = GPW13 output reference number

A. Improving citizen–state cohesion through health:

Conflict factors / dynamics
Low level of trust in authorities and central institutions due to a sense of neglect and isolation and poor performance in delivery of social services. Strong mistrust of health reforms/system and the institutions that represent them.

Theory of change
If dialogue is facilitated between state authorities, local medical practitioners and communities in conflict zones, and authorities and humanitarian actors adapt health reforms and service delivery to address needs and grievances expressed by the population, then progress towards UHC can be achieved and trust in state institutions will be reinforced.

Policy dialogue and recommendations
1.1.3
by WHO to the Ministry of Health to address requirements of most dissatisfied populations, and support to implement recommendations.

Health care delivery
1.1.1
by government, WHO and humanitarian partners to affected communities, based on participatory needs assessment and essential health package of services.

Health workforce promotion strategies
1.5.5
addressing issues of ethic, political and language stigmatization.

Participatory dialogue
1.1.4
facilitated by WHO and involving communities, health practitioners and state institutions in conflict-affected areas to understand patients’ needs, grievances and perception of health reforms.

B. Facilitating cross-line collaboration on health

Conflict factors / dynamics
Mistrust between conflict parties stemming from issues related to religion, ethnicity and/or other differences are politicized, Disputes over limited resources.

Theory of change
If health-care professionals from across the conflict divide are provided with a neutral platform facilitated by a credible technical third party that allows them to work together to address mutual health concerns amid ongoing conflict, then mutual understanding and cooperation can be fostered to prepare for and respond to health emergencies, and cooperation/dialogue on broader health system and more sensitive political issues can be encouraged.

WHO-facilitated dialogues
2.2.2
bringing together health professionals belonging to all conflicting parties on issues of communicable diseases and IHR.

Training on technical health issues
2.1.2
performed by WHO, jointly targeting health professionals coming from all conflict parties.

Health mediation
2.2.2
participatory peacebuilding approaches to improve trust in communities and negotiate access to hard-to-reach areas.

Cross-lines health service delivery
2.3.2
facilitated by WHO (e.g. patient referrals, delivery of medication), benefitting local communities affected by the conflict and/or stopping transmission of diseases.
C. Promoting health and well-being through dialogue and inclusion

Conflict factors / dynamics
Lingering collective trauma linked to war-related atrocities, leading to marginalization, grievances and violent behaviours, and impairing efforts for reconciliation and rebuilding the social fabric after violent conflict, plus meeting the needs of victims as an important contribution to the successful implementation of post-conflict reconciliation.

Theory of change
If community members engage in processes of healing and inclusive dialogue to overcome social divisions, as well as the physical and mental scars of war, and are provided with the opportunities to voice their grievances in a safe and constructive manner, then they will deepen their resilience to violent conflict and be able to participate constructively in the reconciliation process.

Note: This Theory of Change is provided as a starting point. It is global and therefore at a very high-level and only inspirational in nature. In countries, the specific context will determine which activities can be carried out and how.
RISK MANAGEMENT STRATEGY
6. RISK MANAGEMENT STRATEGY

Sound conflict and context analysis is critical to managing the risks associated with undertaking peace-responsive programmes. In conflict settings, it is necessary to adapt the focus or approach of activities or, in extreme circumstances, to stop an activity altogether. The main risks include:

- (Perception of) inequitable delivery of the benefits of activities exacerbates real or perceived inequalities between different community groups and worsens intercommunal relations.
- Engagement with competing authorities reinforces political polarization and perceptions that WHO may not be impartial.
- Engagement with armed groups or communities involved in conflict increases mistrust in WHO and raise the likelihood of reprisals, attacks on health care and health facilities, and/or jeopardizes staff safety.

However, risk management is not about risk avoidance. In fact, harm may be caused by not delivering peace-responsive and conflict-sensitive interventions if those activities respond to urgent humanitarian needs or are effectively addressing long-term structural drivers of conflict.

The responsibility of the WHO country representative and field staff is to weigh carefully the potential benefits (better health outcomes) and potential harms (contributing to the drivers of conflict) of those activities and then to minimize/mitigate the risks above.

Specific risk considerations for cross-line cooperation.

While health is a universal right and is apolitical in nature, playing a third-party role between conflicting parties will be the most politically sensitive aspects of WHO’s Health and Peace approach. Sound and robust risk management is essential for this type of engagement, in order to maintain WHO’s reputation and access and, above all, to ensure the safety and security of WHO staff and other medical personnel.

In some instances, the risks to WHO’s presence may be such that WHO may not be the best actor to facilitate and encourage this cooperation, or at least not explicitly. Staff must choose whether to accept, mitigate, transfer or avoid the inherent risks to this activity. The use of a risk management strategy is an appropriate way to guide the decision.

### NEGATIVE IMPACT ON STAFF, MEDICAL PERSONNEL, GENERAL ACCESS TO HEALTH

<table>
<thead>
<tr>
<th>Probability that WHO’s institutional profile will limit engagement possibilities</th>
<th>Insignificant</th>
<th>Minor</th>
<th>Moderate</th>
<th>Major</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very unlikely</td>
<td>LOW</td>
<td>LOW</td>
<td>MEDIUM</td>
<td>MEDIUM</td>
<td>HIGH</td>
</tr>
<tr>
<td>Unlikely</td>
<td>LOW</td>
<td>LOW</td>
<td>MEDIUM</td>
<td>MEDIUM</td>
<td>EXTREME</td>
</tr>
<tr>
<td>Possible</td>
<td>LOW</td>
<td>MEDIUM</td>
<td>MEDIUM</td>
<td>HIGH</td>
<td>EXTREME</td>
</tr>
<tr>
<td>Likely</td>
<td>MEDIUM</td>
<td>MEDIUM</td>
<td>HIGH</td>
<td>HIGH</td>
<td>EXTREME</td>
</tr>
<tr>
<td>Almost certain</td>
<td>MEDIUM</td>
<td>HIGH</td>
<td>HIGH</td>
<td>EXTREME</td>
<td>EXTREME</td>
</tr>
</tbody>
</table>

This matrix is indicative, and therefore requires a clear understanding of the conflict and conflict drivers as well as a clear theory in order to be useful.

### RANKING SCALE:
PROBABILITY THAT WHO’S ENGAGEMENT WILL BE PERCEIVED NEGATIVELY BY STAKEHOLDERS

**Very unlikely:** The Ministry of Health, other ministries and Member States openly welcome peace efforts. WHO’s engagement in mediation and dialogue with armed groups and nongovernmental forces is not questioned. Armed groups see WHO’s mediation positively. WHO seen as credible, neutral AND impartial.

### RANKING SCALE:
NEGATIVE IMPACT ON STAFF, MEDICAL PERSONNEL AND ACCESS TO HEALTH

**Insignificant:** no increased insecurity of staff and medical personnel or access to health for populations.
**Unlikely:** The Ministry of Health, other ministries and Member States openly welcome peace efforts. Armed groups see WHO’s mediation role positively. However, there is a possibility of politicization by outside actors/spoilers. WHO seen as credible AND neutral, BUT impartiality is uncertain.

**Minor:** No increased insecurity for staff and medical personnel, but limitations on access to health data may be put in place as a reprimand for WHO’s engagement.

**Possible:** Delicate political environment where health may be politicized. Uncertain reaction by armed groups to WHO’s engagement in mediation which is potentially seen as partial. WHO seen by Ministry of Health and authorities as credible, BUT neutrality and impartiality are uncertain.

**Moderate:** Increased risk for SOME WHO staff directly engaged in negotiations and based in dangerous areas. NO increase in risk of insecurity for medical personnel. Access limitations to health data may occur and intermittent bureaucratic limitations to access may be expected.

**Strong possibility:** Precarious/fragile political environment with a clear history of polarization and politicization on major issues, potentially including health care and health service delivery. Armed groups and local authorities distrust some international organizations. Credibility, neutrality AND impartiality is sometimes questioned.

**Major:** Increased risk for ALL WHO staff directly managing the negotiations and based in dangerous areas. SOME increase in risk of insecurity for national medical personnel AND intermittent reduced access to health linked to WHO’s mediation role.

**Almost certain:** Highly volatile political environment, with clear statements by government and national stakeholders warning against the interference of international actors, including WHO, in peace-related efforts. Negative attitudes by armed groups towards WHO. Credibility, neutrality AND impartiality openly contested and admonished.

**Catastrophic:** Increased risk for ALL WHO staff AND increased security risk for health personnel, AND severe health access restrictions due to WHO’s mediation role. Public threats made; clear injunctions to cease and desist issued directly to WHO which is facing retaliation.

### RECOMMENDED RISK RESPONSE ACTIONS

<table>
<thead>
<tr>
<th>Level</th>
<th>Action Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LOW</strong></td>
<td><strong>Accept the risks:</strong> The benefit of WHO playing an effective neutral third-party mediation role is high and the risk is low: the activity should be pursued. If possible the intervention can be publicized and highlighted as a significant contribution to improving the prospects of peace.</td>
<td></td>
</tr>
<tr>
<td><strong>MEDIUM</strong></td>
<td><strong>Mitigate the risks:</strong> There are some risks to WHO playing a neutral third-party mediation role. These risks should be codified and mitigated (e.g. trust-building measures, support by regional or headquarters executive management, organization of consultation with Member States prior to acting, etc) and addressed where possible with clear communication, evidence and data showing health needs.</td>
<td></td>
</tr>
<tr>
<td><strong>HIGH</strong></td>
<td><strong>Transfer the risks:</strong> The risks of WHO playing a direct third-party mediation role are too high but the activity nonetheless has high peacebuilding and public health benefit, in addition there is also an identified harm in not undertaking the intervention. WHO should identify other partners specialized in peacebuilding/mediation and/or identified as neutral to do the work.</td>
<td></td>
</tr>
<tr>
<td><strong>EXTREME</strong></td>
<td><strong>Avoid the risks:</strong> The risk is too high and can cause institutional harm to WHO, endanger the physical integrity of staff and medical personnel, and/or have negative public health consequences. There is no space yet for effective third-party mediation around health issues in this context and this should not be done.</td>
<td></td>
</tr>
</tbody>
</table>

**Deciding how to proceed**

It is important to reiterate the overriding humanitarian principles and the primacy of health. At all times, WHO’s communication on and around its interventions should be based on its apolitical mandate as the guardian of the right to health and the custodian of the International Health Regulations. The key message and operational objective at all times is to achieve significant progress towards UHC and equitable access to quality health services in spite of conflict dynamics, ethnic, religious and other political considerations.
DESIGNING A PEACE-RESPONSIVE INTERVENTION
7. DESIGNING A PEACE-RESPONSIVE INTERVENTION

Detailed operational guidance on designing and implementing health and peace interventions remains to be developed. However, this section sketches out some important steps for staff to bear in mind when building peace-responsive interventions. These steps are illustrated in the chart on page 29.

A. The 5-step strategy

STEP 1
Understand the context. Regardless of whether programmes are consciously or explicitly pursuing peace objectives, their presence affects the conflict environment. It is therefore important to understand the context: learn from existing conflict analysis or conduct one, where possible jointly with partners of the UN system or beyond. Include stakeholder analysis and mapping, root and proximate causes, triggers, conflict dynamics and peace capacities. Other questions may include:
1. What is the background history of conflict in the area?
2. What are the factors that influence peace and conflict? Who are the stakeholders and what are the relationships between them?
3. What are the conflict dynamics or interactions between stakeholders that could worsen or improve the conflict in the short and medium terms?

STEP 2
Identify relevant drivers of the conflict: Focus on those that can be adequately addressed through a health intervention and which have a link to health concerns. Use two methods, namely:
1. Identify those that may be negatively impacting the drivers of the conflict. How and to what degree is WHO delivering services in an equitable manner? How and to what degree are geographical targets chosen?
2. Scan the environment to pinpoint if and how other actors already address this conflict driver, and consider ways of acting in a coordinated, coherent or complementary manner.

STEP 3
Risk analysis: Map risks in order for WHO to implement a health and peace intervention. Develop mitigating measures accordingly.

STEP 4
Map WHO’s in-country planning frameworks: Determine whether an existing WHO intervention can be adapted to be more peace-responsive and address conflict drivers identified, or whether a new health and peace action should be built from scratch.

STEP 5
Design the peace-responsive health intervention: Develop the theory of change. A theory of change articulates the logic of an intervention, linking planned actions to a measurable “peacebuilding change”, including a monitoring and evaluation framework. Identify contributions to GPW 13.

It is important to note that, sometimes, the way in which WHO interventions are delivered can improve relationships between stakeholders and thus contribute to peace and social cohesion. Some ways this could be achieved include:
• participatory design, planning, implementation, and monitoring and evaluation processes of WHO interventions;
• incorporation of processes that foster trust across conflict divisions, such as collaborative needs assessments or participatory decision-making processes;
• dialogue and grievance mechanisms;
• delivery of assistance in a way that fosters interdependency across conflict divisions;
• enhanced trust among groups and between the population and the government; and
• application of approaches that ensure that communities or social groups which may not otherwise have a voice, including women and young people, can be heard by other stakeholders and their views incorporated into needs assessments and decision-making.
B. Visual guide to Health and Peace programming

**STEP 1: DATA**
Understand your context, linking your understanding of health needs with the root causes of the conflict.

**STEP 2: ANALYSIS**
Identify relevant conflict drivers: focus on those which have a link to health issues or that can be adequately addressed through health interventions.

**STEP 3: RISK MANAGEMENT**
Where context and conflict analysis does not allow for peacebuilding programming because of increased risk, develop a programme that at the very least does not worsen conflict dynamics. Conflict sensitivity should be the minimum threshold.

**STEP 4: PLANNING**
Map in-country planning frameworks of WHO and partners. Determine if existing interventions across humanitarian and development action need to be adapted to do no harm or can be augmented to contribute to peace.

**STEP 5: PLANNING**
Where context allows, design peace-responsive health interventions: develop the theory of change, plus outcomes, outputs and a framework for monitoring and evaluation. Identify contributions to GPW 13.

**Note:**
There are different “tracks” where these opportunities exist. Initiatives that involve political processes managed by government officials and other high-level decision-makers are referred to as Track 1. Initiatives that work with influential actors from civil society are referred to as Track 2. Those that engage the local population at the community and grassroots level are called Track 3.

**Technical interventions in conflict situations, in the health sector or other sectors can be described as peace-responsive when their sector-specific outcomes and interventions are designed to address the deep-rooted causes of fragility and conflict and/or reinforce factors of resilience, while also achieving their technical mandate.**

---

**Conflict analysis**

**Health & health system analysis**

**Do No Harm**
Minimize negative impacts of conflicts by ensuring that health interventions do not worsen or exacerbate the drivers of the conflict.

**Working IN conflict**

**Working ON conflict**
Maximize positive impacts on conflicts by ensuring that health interventions explicitly contribute to social cohesion and community dialogue.

**STEP 3**
**RISK MANAGEMENT**

**Conflict-sensitive programming**

**Peace-responsive programming**

**Track 1**
Working with governments/local authorities
- E.g. Inclusion of commitments related to access to health systems in peace treaty.
- Promoting citizen-state cohesion
- E.g. Negotiating ceasefire to conduct vaccination campaign.
- Facilitating health cooperation
- Improving social cohesion

**Track 2**
Working with elites/group leaders influential stakeholders
- E.g. Develop national health development plans that include marginalized and excluded groups.
- E.g. High-level intervention by WHO DG with influential politicians.
- E.g. Mediated exchange of experience and training between health practitioners.

**Track 3**
Working with communities/community members
- E.g. Participatory dialogues with communities to garner trust in health systems reforms.
- E.g. Negotiating ceasefire to conduct vaccination campaign.
- E.g. Reintegrating health personnel of demobilized militia into health system.
- E.g. Mental health support as part of post-war reconciliation.

**Note:**
The Health and Peace initiative provides yet another opportunity to give substance to the linkages between humanitarian, development and peace actions - the “triplex nexus” - from a health perspective.

**Note:**
Cascading from the global theory of change, peace-relevant health interventions can help improve the prospects for local peace in three ways.
CONCLUSION

HEALTH & PEACE INITIATIVE | 31
Political nature of peacebuilding: positioning a neutral WHO

It is important to emphasize that peacebuilding is a complex and political process that requires careful consideration, evidence and caution.

There is a need to be

• more explicit about WHO’s work in and on conflicts, but also
• more systematic in how WHO links conflict analysis to its interventions and to an overall theory of change, and
• more attentive of the political implications of WHO’s health programming in the context of conflicts.

There is a need to do the above in a non-political manner that does not breach our commitments to uphold the humanitarian principles. Fortunately, WHO has a clear and neutral entry point: health is the uniting factor and shared aspiration of all people, regardless of political affiliation, gender, ethnicity or religion. The simple but powerful, rights-based approach that underpins UHC can allow WHO to naturally enter the peacebuilding space without negative political associations.

In his remarks to the 71st World Health Assembly, WHO’s Director-General emphasized the inextricable link between health and peace. The aim of this White Paper and subsequent Health and Peace interventions is to buttress this interlinkage by bringing WHO’s technical, norm-setting, and operational capacities to bear on the promotion of sustainable peace. It is also the first step towards outlining a clear vision, built on a rich history, a powerful and far-reaching mandate and global commitments to achieving UHC for all.

Against the background of unprecedented humanitarian needs, intractable protracted conflicts and massive displacement, it is incumbent on WHO – now more than ever – to learn the lessons from the Health as a Bridge for Peace programme and to forge new and improved interventions that contribute to sustainable peace and that support Member States that are at risk of continued violence. It is precisely in these fragile, conflict-affected and vulnerable settings that WHO needs to build on its long history and, where necessary, to adopt a new menu of interventions whose aim is to contribute to building conflict-resilient health systems and communities.
“Everywhere I go, I have the same message: health as a bridge to peace. Health has the power to transform an individual’s life, but it also has the power to transform families, communities and nations.”

Director-General, WHO, 2018
**ANNEX: WORKING IN AND ON CONFLICT**

**Working in conflict**

*Polio outbreak response in northeastern Syrian Arab Republic (2017-2018)*

In 2017, several dozen polio cases were reported in Deir ez-Zor, Raqqa, and parts of Homs governorates in north-eastern Syrian Arab Republic amid an ongoing serious humanitarian crisis. The transmission rate was high, and the risk that the outbreak could spread to neighbouring countries was taken seriously, in view of previous instances in the region. Because of the complex geopolitical realities in the area WHO’s outbreak response was coordinated from Jordan and implemented from various field presences in Syrian Arab Republic and across the border in Turkey. Between July 2017 and January 2018, three rounds of vaccinations were conducted using oral polio vaccines and leading to eventual coverage rates of 80–90% in areas where cases had been detected. Surveillance activities were also implemented and in December 2018 the polio outbreak was declared ended.

The response managed to put an end to the outbreak in less than 110 days, a remarkable achievement given the ongoing hostilities, large scale population movements, inadequate health infrastructures and accessibility issues. Key to this success were the strong coordination at national and supranational levels, the rapid availability of resources, the branding of the intervention as neutral and impartial, and most importantly a sophisticated approach to community engagement. Based on a careful stakeholder analysis that was regularly updated, the programme identified and collaborated with community representatives that enjoyed access to and acceptance from conflict parties.

**Working on conflict**

*Participatory mechanisms to develop a national health policy in Tunisia and build trust (2012-2014)*

In post-revolution Tunisia, policy reforms were required in several key public sectors, including health. To break with the past denial of citizen participation in public policy processes during the authoritarian regime, a “Societal Dialogue for Health System Reform” was launched to capture the needs, perceptions and ideas of Tunisians for a new national health system. The mechanism aimed genuinely to involve all segments of society in order to address the lack of confidence and misunderstandings between institutions and citizens which were legacies of decades of autocratic rule.

Three popular consultation methods were used. First, the “citizens’ meetings on health” gathered several thousands of people at governorate level and identified key challenges of the health sector and attitudes towards reforms. Second, focus groups with vulnerable and marginalized populations (e.g. patients living in poor urban areas, single mothers, families living in polluted industrial areas) helped capture group-specific challenges in access to health care which otherwise would not be heard in large gatherings. Third, a “citizens’ jury” composed of approximately 100 randomly selected persons from across the country was tasked with making decisions on specific issues related to the major topics emerging from the wider meetings and focus groups.
Tunisia, 2013: Etats-Généraux de la Santé: Community consultations and health systems promotion as a peace-supportive mechanism.

In post-revolution Tunisia, WHO supported the government to organize “Etats Généraux de la santé” whereby semi-randomized consultations were organized across the whole spectrum of the Tunisian population. The consultations allowed various population groups to express their grievances, provide constructive requests and engage in a dialogue with each other, with the overall objective of improving public health in a nationwide effort. This work reinforced state legitimacy through the openness of the dialogue and was also a significant and decisive stage in the overall state-building for the country.

Colombia, 2016: Integration of health personnel into the health system

As part of the demobilization and reintegration programme linked to the peace agreements of 2016, some 200 young Colombians with health expertise – mostly former FARC members – were sent to medical school in Cuba. The student doctors were trained in accordance with the Cuban family medicine model and returned to Colombia to improve and strengthen primary health care for the underserved.

Nepal, 2013: Mental health support as a violence reduction intervention.

After a number of years in the cantonment under military command, former combatants of the Maoist Army experienced a sense of unaddressed expectations in returning to civilian life, making them more likely to opt out of the demobilization process. Targeted MHPSS interventions were undertaken specifically to support their adjustment to the change from military to civilian life, thus reducing rates of recidivism.

Angola, 1997: Reintegration of demobilized health personnel into the national health system

A technical committee comprising representatives of the Ministry of Health, the Angolan armed forces and the UNITA military forces was set up to shape legislation related to the national health workforce. The aim was to legally recognize demobilized ex-militia health personnel, to define pathways for training and accreditation of the UNITA health personnel, and to map under-resourced municipalities to which these health personnel could be deployed.

Coordination meetings to organize polio vaccination campaigns (in some countries including the use of “days of tranquility”, cross-border activities and safe military corridors to enable access) involved opposition groups, representatives from minority communities, government officials and local NGOs. Their aim was to implement polio eradication strategy/policy such as surveillance, immunization coverage, capacity-building, etc.

North Macedonia, 2002: Inclusive health services

As national health authorities were not ready to make their services more friendly to the displaced, WHO provided additional medical personnel and supplies to the town of Kumanovo where over 10,000 ethnic Albanians were displaced. The medical centre was reinforced temporarily to provide free-of-charge essential care services to the displaced persons. The WHO-supported, ethnically mixed health-care teams enjoyed full acceptance by the displaced, as indicated by the number of daily consultations. The team was backed up by other services of the medical centre.
REFERENCES AND NOTES
9. REFERENCES AND NOTES


14. The assumptions that link a programme’s inputs and activities to the attainment of desired ends. A set of beliefs about how and why an initiative will work to change the conflict. Theories of change enable an evaluation of peacebuilding interventions: hypothetical causal pathways to effect change can be either validated and possibly replicated or may show no/little results and be adapted accordingly.


18. MHPSS interventions can help overcome fear, hate and victimization and can empower divided groups to mutually accept each other, coexist and build some degree of cooperation, thereby paving the way for the reconciliation process.