Report on the First World Health Organization Consultative Meeting on Health as a Bridge for Peace[1]

Les Pensières, Annecy, 30-31 October 1997

I. Introduction

The Consultative Meeting was convened by the World Health Organization Division of Emergency and Humanitarian Action (WHO/EHA), as part of the Health as a Bridge for Peace project, sponsored by the Department for International Development of the United Kingdom. The main purpose of the project is to develop practical guidance on peacebuilding skills for health professionals. The Consultative Meeting is part of the scope of work for the project. The meeting built upon earlier work undertaken by the World Health Organization's Task Force on Health in Development Policies, several international symposia, and regional initiatives most notably in Southern Africa, Central America, and Eastern Europe. (See Agenda in Appendix A.)

1.1. The stated objectives of the Consultative Meeting included:

- To build consensus on working definitions of terminology commonly referred to in conflict and health as a bridge for peace discussions and activities;
- To reach a common understanding of the dynamics of violent conflict and conflict cycles;
- To identify key issues to be address, and appropriate interventions, in the framework of health as a bridge for peace at different phases of conflict cycles;
- To identify stakeholders in other disciplines and sectors to be sensitized in the process of advocating health as a bridge for peace;
- To reflect on the possibilities and limits of peacebuilding through health, based on lessons learned in the case studies;
- To identify key skills necessary for health professionals to contribute to peacebuilding through health; and
- To propose a plan of action to advance health as a bridge for peace.

1.2. Expected outcomes of the meeting included a Plan of Action to include identification of:

- Documentation of experiences through case studies;
- Networking with other individuals and agencies involved in peace and health issues;
- Sensitization and advocacy involving other disciplines and sectors;
- Active skills training for health professionals; and
- Impact evaluation and analysis for further applied learning.

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[1] *Draft prepared by: The George Washington University Center for International Health, a WHO Collaborating Centre for Health and Development*

The two-day meeting brought together 25 representatives of the World Health Organization, international organizations, academic institutions, NGOs, and bilateral agencies (see Appendix B). Facilitators included Dr. Louisa Chan of WHO/EHA, Dr. Rosalia Rodriguez-Garcia of the George Washington University Center for International Health (GWCIH), Dr. Judith Large of the University of Kent, and Dr. Tom Weiss of Brown University. The Foundation Merieux graciously offered its facilities for the meeting and lodging of participants.

2. A preliminary classification of types of Health as a Bridge for Peace activities and illustrative case studies

In order to provide a context for discussions on particular instances of health serving as a bridge for peace, the GWCIH presented a framework applying an epidemiological approach to the analysis of conflict and health as a bridge for peace actions. For purposes of discussion, three stages of conflict were considered: latent phase, violent conflict, and post conflict. Consequently three major types of health as a bridge for peace actions were also identified: promotion of health and peace, prevention/mitigation of violence, addressing inequities during conflicts and post conflict rehabilitation and peace building.

Documented experiences suggest the following courses of action:

- At the latent phase, health for peace actions include the promotion of Health for All, working towards human development in order to address inequities that exacerbate conflict and violence, and advocating for the abolition or limited use of weapons with unacceptable health effects, such as nuclear weapons and land mines.
- During the stage of violent conflict, health professionals, and WHO in particular, may contribute to the promotion of health and peace by providing opportunities for dialogue between conflicting sides through joint cooperation in health, the coordination of health and humanitarian responses, and the preservation and protection of the health of civilian populations.
- During the stage of rehabilitation, there seems to be an opportunity to act as a neutral broker to bring conflicting sides together in joint health activities, to aid in activities such as the demobilization of troops, and to participate in guiding strategies for reconstruction and development that have health as a key component.

Strategic and creative ways of collecting, analyzing and using epidemiological data is seen as an important common thread throughout the different stages of conflict. This public health tool offers a powerful approach to influence policies which have an impact on violent conflicts.

2.1. The International Committee of the Red Cross and the campaign to ban landmines

One of the strategies of the ICRC campaign for banning landmines was to use health data to demonstrate that certain weapons have unacceptable and inhumane effects. The ICRC chose to focus not on the weapons technology itself (i.e. certain weapons are simply unethical) but rather to concentrate on the health effects of weapons technology (i.e. any weapon that purposefully leaves severe permanent disability by design is unacceptable). As the ICRC landmine campaign shows, in order to effect changes, it is necessary to activate **data-to-**

policy link. In addition to good epidemiological data, it is also essential to have images to convince, to be credible vis-a-vis policy-makers, and to create a public constituency.

This presentation demonstrated means by which health professionals can influence and change policy through creative and strategic use of health data.

Finally, it was mentioned that health professionals must also be aware of the possibility of their work being manipulated. By simply reporting the health effects of certain weapons, we may inadvertently contribute to the research of new ways for weapons to injure or kill. Thus, just as in conflict situations, there is the potential for being manipulated. It is important to understand these risks in order to minimize and, if possible, to counteract them.

2.2 The World Health Organization in Eastern Slavonia

The goal of the WHO health-to-peace initiative in the Eastern Slavonia region of Croatia is to facilitate the reintegration of the health sector of Eastern Slavonia into Croatia, according to the principles of the Erdut Agreement. Beginning in January 1996, WHO played the role of the principal mediator in health by chairing the Joint Implementation Committee (JIC) in health. Activities undertaken included bringing together Croat and Serb health workers for confidence building, joint technical analysis of the health situation, joint planning and implementation of health activities, and the administrative reintegration of the health sector. Specific activities included developing commissions on administrative reintegration, technical activities in mental health, physical rehabilitation and epidemiology, health research, organizing a sub-national immunization day against Polio, and provision of essential drugs.

The strategy behind the initiative was to provide a safe space for dialogue on technical issues, creating the basis for mutual understanding and cooperation within the health sector. This included emphasizing the respect for both sides' roles as health professionals, and emphasizing their traditional neutrality and impartiality in situations of conflict. The case study presented preliminary evidence that the initiative has increased at least partially reciprocal acceptance of the two groups of health professionals, has partially increased the number of Serb and Croat health employees working together, and has begun to provide for more equal opportunities to the local Serb health workers.

Challenges include that fact that to date only a few Serb health professionals have received their contract to work under the Croatian administration, no Serb professionals have been selected from key positions in the health system, and only about 50 percent of the Serb population are covered by the Croatian National Insurance System.

The case study also highlighted operational issues for WHO, including:

- Can neutrality and impartiality avoid being linked with the very concept of human rights, according to international conventions?
- How can WHO take a stand in protecting human rights and also avoid political implications?

- What about conflicts that arise between conflicting humanitarian assistance and country programs due to one of the sides in the conflict's status as a Member State?

2.3. The World Health Organization in Angola

The WHO experience in Angola centered on assistance in the disarmament, quartering, and demobilization of soldiers from armies on both sides of the conflict. After the signing of the Lusaka protocol in 1994, WHO played an important role in the development and implementation of the health program during quartering and demobilization phases. Key activities included designing common protocols between groups, brokering arrangements for joint data collection activities, working with communities to develop public health programs, training military health personnel. Setting up health units in the quartering areas, development of an agreement for a joint medical team to classify disabilities, and supporting a legal basis for institutionalizing benefits to disabled war victims and demobilized soldiers.

Key lessons learned included:

- Multisectoral approaches to designing humanitarian activities involving all relevant actors can also be useful in building peace efforts.
- The role of WHO was not limited to a purely technical domain – WHO representatives were involved in negotiations with both parties, and in forging legal instruments for the inclusion of the disabled and demobilized ex-combatants.
- The health sector can be helpful in opening doors for the implementation of a peace agreement.

2.4 Both case studies illustrated lessons for health professionals in general:

- Health cannot be a substitute for political action, but it can monitor the political evolution of the peace process and take advantage of situations in which it can operate to reinforce the peace building efforts.
- The understanding of humanitarian and human rights law by health professionals is essential in conflict environments.
- Health professionals including WHO staff require certain skills in order to work in these health/peace initiatives. These skills might include:
  - Understanding of and sensitivity to the political, legal, socio-economic environment of the country, specifically in relation to the peace process;
  - Capacity to identify opportunities and crucial issues to bring technical people from conflicting parties to meet and work together;
  - Problem solving skills;
  - Leadership capacity to seek joint solutions to meet common needs and to bring the parties to the negotiating table;
  - Mediating skills,
  - Proposing clear technical principles as basis for negotiations to avoid political manipulation of aid.

3. Discussion on Concepts

This discussion focused on six thematic areas: the meaning of health as a bridge for peace, the use of data and information in influencing policy, the role of health professionals in situations of conflict, the role of WHO in promoting peace, the concept of health as neutral, and an analysis of stakeholders in Health as a Bridge for Peace. The main ideas of this discussion follows.

3.1 Health as a Bridge for Peace. What does it really mean?

Health as a Bridge for Peace was coined in the early 1980's by the Pan American Health Organization/WHO Regional Bureau for the Americas. Health as a Bridge for Peace describes initiatives undertaken originally in Central America that were based on the idea that "shared health concerns can transcend political, economic, social, and ethnic divisions among peoples and between nations". Discussions during the Consultative Meeting reflected participants' concerns that this definition did not accurately reflect the reality of conflict in the post cold war era.

Further discussions also reflected concern over whether the proper role for health workers and organizations should be the promotion of peace or the promotion of health. In some circumstances it was perhaps not clear if certain types of actions would promote one at the expense of the other. Some even suggested that all health promotion could be interpreted as peace promotion and that all peace promotion could be interpreted as health promotion. Ultimately, participants suggested that as health professionals our priority should be health, but that we should be aware of the political realities we are working in, and should not only endeavor to "do no harm" but that we also have a responsibility to seek out creative opportunities to promote peace. In this sense, Health as a Bridge for Peace was said to reflect a "spirit" rather than a specific definition.

> **"*The Spirit of Health as a Bridge for Peace* affirms commitment to Health For All and its Renewal. In achieving the primary goal of health for societies prone to and affected by war, we as health professionals recognize responsibilities to create opportunities for peace. For this we need new strategies, awareness, stance, skills, and partners."**

3.2 The role of data and information in influencing policy and promoting peace

In all stages of conflict, reliable health data can be a powerful and convincing tool to move public opinion and can instigate policy change. Examples discussed included the lesson of the international campaign to ban land mines. Representatives from International Physicians to Prevent Nuclear War discussed how their organization used data and advocacy to facilitate the ratification of the atmospheric test ban treaty.

- Health professionals can influence policy by activating the data-to-policy link. This includes the strategic use of epidemiological data, making cases for policy change based on health data, and developing constituencies both from the grassroots up and from the level of decision-makers.

- Health data may also be collected and analyzed in a way to address the health effects of inequities resulting from conflicts and violence, **and to bring about policy changes.**

- In conflict and related situations (e.g. sanction regimes), data is often subject to manipulation. The highest standards must be upheld to assure the verification of data and sources to avoid manipulation.

3.3 The role of health professionals in situations of conflict

Although many of the case study experiences presented involved medical services and physicians, participants acknowledged the need to widen the discussion to consider all health professionals, especially given the potential role for health educators, policy makers and others to contribute to this process.

The role of the health professional as the "healer" offers unique opportunities as well as responsibilities. This intimate relation with individuals and communities may open doors for other sectors. Other strengths of health professionals in working for peace include the personal attributes of health providers, professional skills and know-how in rebuilding the health sector, and the potential ability to act in solidarity to address common collective concerns.

At the same time the idea of the sanctity of the medical profession and the overriding ethical imperative of "doing no harm" underline our responsibilities for upholding the values of equity, the right to health, the protection of public health assets, and the promotion of peace.

3.4 The role of WHO in promoting peace

The specific role WHO can play in promoting peace were identified:

- To act as a facilitator, or a catalyst to bring health professionals from all sides together on technical issues of common concerns;
- To set standards of "best practices" in public health aimed at reducing conflict and promoting reconciliation;
- To network with other professional institutions and individuals in supporting peace-building and violence reduction initiatives;
- To coordinate with other UN agencies, international organizations and NGOs in implementing peace processes in the health sector.

3.5 Networking

A brainstorming session on networking identified a wide group of possible advocates, stakeholders, and partners. These included:

- Policy-makers
- Business-Industry
- Academic centers
- Military leaders
- Legal community
- Collaborating centers
- Humanitarian assistance societies
- Students
- Media
- Women's groups
- Mothers
- Youth groups
- Religious groups
- Public opinion
- Civil society
- Victims of war

Participants organized stakeholders into three basic categories: Top-level leadership including political decision-makers, business leaders, diplomatic community, Member States and donors; middle range leaders such as ethnic or religious leaders, academics, highly visible health professionals, and international organizations; and grassroots organizations such as groups of war victims, mothers, youth, NGOs, and other avenues of influencing public opinion.

At each of these different levels, different types of actions are necessary. To influence top-level leaders, international agreements, accords, and credible leadership are necessary. It was also discussed that a grassroots movement may also trigger high-level leaders to recognize an issue (such as landmines). Two other elements were thought to be essential in mobilizing middle and grassroots level participation: information and the media. The data to policy link should be strengthened and targeted to influence public opinion through the use of the media.

4. Framework for Action

Action plans were developed through small group discussions and feedback from facilitators. Each of the three groups was composed of WHO, NGO, and other personnel, representing a variety of geographic and technical affiliations and expertise. Each workgroup developed the action plan according to guidelines developed by the workshop facilitators and based on discussions during the first day of the Consultative Meeting. Action plans were presented to the plenary for discussion and endorsement. The full action plan outlines are presented in Appendix C. Summaries of the action plans appear below.

4.1 Enlarging the Knowledge Base

The action plan for enlarging the knowledge base was charged with identifying current gaps in knowledge, developing criteria for further research on health as a bridge for peace,

discussing appropriate methodologies and mechanisms for the collection and analysis of information, and presenting a plan for sharing and disseminating lessons learned.

The main types of study proposed were:

- Case studies were suggested as a means to look at country-level work reflecting both positive and negative experiences, in addition to the roles, attributes, skills required to carry out the health as a bridge for peace tasks.
- A briefing kit could be developed to provide knowledge and guidance in humanitarian and human rights laws, and their applications in practice.
- Further research should be directed towards the strategic collection and analysis of data for the promotion of peace.
- The development and establishment of an institutional framework for humanitarian and human rights action.

Criteria for selecting which experiences to investigate include:

- Assuring a mix of experiences from different stages of conflict
- Experiences of agencies other than WHO should be compiled
- There should be a geographic distribution of studies
- The span of types of conflict should be covered (wars of succession, ideology, etc.)
- Gender perspectives in promoting health and peace
- The relationship between human development and conflicts

Finally, sharing and dissemination of experiences should take place within WHO through its consultative process, and through a policy framework looking at managerial, technical, and normative aspects of the lessons learned. The results of research should feed into advocacy, networking, institutional learning and skills development for health professionals, inside and outside of WHO.

4.2 Institutional Learning and Individual Skill Development

The action plan for institutional learning and individual skills development identified means by which lessons learned from health as a bridge for peace activities could be systematically identified, documented, analyzed and disseminated. It also suggested specific skills, knowledge, and mechanisms necessary to assimilate lessons learned from the field into the daily work of health professionals working in situations of conflict.

The group identified several mechanisms to institutionalize lessons learned. First, placing health as a bridge for peace within the policy framework for WHO, through the Renewal of Health for All process, and through WHO's constitutional review process. In addition, HBP could be incorporated within specific programming areas, as it is within EHA's scope of work. This policy-level institutionalization should be accompanied by documentation explaining the policy and illustrating its applications in the field. Target groups for dissemination of this information include sensitizing and advocating for HBP within WHO headquarters, providing briefing

materials, advocacy and other information to WHO country representatives, national health workers, and providing specific training materials to WHO staff, consultants, and health NGOs.

Through an analysis of case studies and discussion with those involved in such initiatives, the group identified specific skills that health professionals may need in order to take advantage of opportunities to promote peace. These include negotiation, problem-solving, situation analysis, fact-finding, coalition building, and conflict handling training. These skills should be presented within the context of lessons learned from the field, both positive and negative. The content of specific training would differ according to the target audience. For example, materials might include a core set of briefing materials for advocacy and sensitization. Other more specific materials for health personnel working in situations of conflict could include in-service training materials on negotiation, conflict resolution and other skills, checklists, and summary information on international human rights and humanitarian law.

Finally, as one mechanism to institutionalize the study and documentation of experiences, field experiences can be collected through the use of a "black box" similar to an airplane flight recorder. This involves the systematic reporting of events related to health as a bridge for peace, allowing for evaluation and appraisal of initiatives, and facilitate dissemination of new tools, techniques, and lessons learned. It was suggested that the black box reside within WHO headquarters in Geneva.

4.3 Advocacy and Networking

The action plan includes a preliminary mission statement on health as a bridge for peace (See Appendix C.3). The advocacy message should be shaped according to each of the major target audiences: members of WHO's governing bodies, governments at large, the media, ad the public at large. Specific messages should reflect the differing interests of the target audiences. For example, governments will be more interested in their image and the impact of certain actions on their own citizens, while the public at large will be more sensitive to individual suffering and risks. Other target audiences might include military health personnel, and ex-military leaders. The latter will be particularly important in counteracting the messages of the military and weapons manufacturers. Messages should be formulated looking at the data to policy link, focusing on the health impact of violence, weapons and war, and should be both realistic and credible. The plan also indicated that it is unrealistic to expect to compete with other types of lobbying without the use of professional communications specialists to present these messages.

Partners with which to network may range from all those interested to a selective group of targeted partners, which include collaborating centers, NGOs, and other types of groups. Mechanisms for networking and advocacy could include a Health as a Bridge for Peace advocacy task force composed of high-level political and health leaders from around the world. A technical working group might also be established to develop messages and implement recommendations of the task force. Monitoring impact could include surveying the media for mentions of the key messages, conducting polls, looking at international conventions which include health as a bridge for peace, and others.

5. Recommendations for next steps

Participants suggested the following strategy to prioritize actions and ensure follow-up to the Consultative Meeting.

5.1. Leadership and Coordination

➥ *The Health as a Bridge for Peace effort should be housed within WHO*

It was agreed that WHO is the appropriate organization to ground and consolidate this effort. Within WHO, EHA should serve as a focal point for the process of investigation and institutionalization of health as a bridge for peace. It was also acknowledged that in order to do this, WHO would need to undertake a process of learning and growing. This might entail confronting risks, and institutional barriers. Therefore the endeavor should be approached with both healthy skepticism and humility.

➥ *The Health as a Bridge for Peace initiative should bring together WHO with other partners*

It was agreed that the initiative should not operate in a vacuum. WHO cannot implement this initiative alone, and should draw on its partners and collaborators. Participation and shared responsibilities will also be important to the fulfillment of the Plan of Action.

➥ *Leadership and coordination mechanisms may include a task force and/or working group*

Suggestions for future leadership mechanisms include establishment of a working group that might include participants of this consultation meeting. In addition the idea of a Task Force created of higher-level policy, technical and political figures would be discussed in order to move forward the agenda of Health as a Bridge for Peace at the highest political levels.

5.2 Prioritization of activities to be undertaken

➥ *Identification of knowledge gaps - documenting field experiences*

- Compilation of documented experiences in health as a bridge for peace
- Field evaluation of current awareness, knowledge skills for health as a bridge for peace activities
- Assimiliation of lessons learned

➥ *Networking*

- Enlarge the current contacts to other stakeholders identified during the Consultative Meeting
- Mainstreaming and institutionalization of Health as a Bridge for Peace into WHO programmes, in particular, Renewal of Health for All.

➥ *Active learning*

- Guidelines and training materials to be developed following field needs evaluation. The emphasis should be to provide practical skills and application of human rights and humanitarian principles.

6. Conclusions

Group consensus was reached on the importance of the meeting and its excellent organization which allowed participants to share ideas and debate issues in a spirit of collegiality. Follow-up actions include a conference report to be completed within one month of the Consultative Meeting and distributed to all participants. A second consultative meeting was agreed to be scheduled after six months in order to review the implementation of the action plans.

7. Appendices

A) Agenda

B) Participants

C) Health as a Bridge for Peace Mission Statement

A. Agenda

First Consultative Meeting on Health as a Bridge for Peace Les Pensières, Annecy, 30-31 October 1997

Chair	Dr. F Bassani
Facilitators	Dr. J. Large, Dr. R. Rodriguez-Garcia, Dr. T. Weiss, Dr. L. Chan
Rapporteurs	Dr. J. Large and Dr. L. Chan

Thursday, 30 October

0900	Introduction Objectives of HBP Consultative Meeting *Dr. F. Bassani*
0930	Presentation and Discussion: HBP Working Definitions *Facilitators: Dr. J. Large; Dr. R. Rodriguez-Garcia*
1030	Coffee Break
1045	Presentation and Discussion: Dynamics and Cycle of Conflict *Facilitators: Dr. J. Large; Dr. L. Chan*
1230	Lunch
1400	Discussion on Health Interventions at Different Phases of the Conflict Cycle *Presenter: Mr. J. Macinko*
1530	Coffee Break
1545	Case Presentations: Lessons Learned: Limitations and Possibilities of Peacebuilding through Health *Presenters: Dr. R. Coupland; Dr. P. Balladelli; Dr. N. Zagaria*
1930	Drinks/Dinner

Friday, 31 October

0900	Discussion: Stakeholders, Sensitization and Advocacy *Facilitator: Dr. J. Large*
1030	Coffee Break
1045	Plan of Action: Group sessions A. Further Research and Case Studies Facilitator: *Dr. R. Rodriguez-Garcia* B. Active Skills Training Facilitator: *Dr. J. Large* C. Networking and Advocacy *Facilitator: Dr. H. Siem*
1300	Lunch
1400	Presentation and Discussion of Action Plans
1600	Closure *Dr. F. Bassani*

B. List of Participants

Dr. Charles Mérieux, Fondation Marcel Mérieux

Dr. R. Coupland, International Committee of the Red Cross (ICRC), Geneva
Dr. M. Christ, International Physicians for the Prevention of Nuclear War (IPPNW), Cambridge, MA, USA
Dr. M. Kapila. Department for International Development (DFID), UK
Dr. J. Large, University of Kent, UK
Mr. J. Macinko, George Washington Center for International Health (GWCIH), The George Washington University, Washington, USA
Dr. Gururaj (Raj) Mutalik, International Physicians for the prevention of Nuclear War (IPPNW), Cambridge, MA, USA
Dr. R. Rodriguez-Garcia, George Washington Center for International Health (GWCIH), The George Washington University, Washington, USA
Dr. R. Russbach, Geneva Foundation, Geneva
Mr. G. Templer, Department for International Development (DFID), UK
Dr. M. Toole, Macfarlane Burnet Centre for Medical Research, Australia
Dr. T. Weiss, Watson Institute for International Studies, Brown University, USA
Dr. N. Zagaria, Instituto Superiroe Sanita (ISS), Rome, Italy

WHO
Regional Offices:
Dr. R. Alderslade, Regional Advisor/Coordination and Resource Mobilization, WHO Regional office for Europe (EURO)
Dr. P. Balladelli, WHO Special Representative to Croatia
Dr. J. Larusdottir, Emergency Humanitarian Coordinator, WHO Regional office for South-East Asia (SEARO)
Dr. J. Nsue-Milang, WHO Representative, Sierra Leone

Headquarters:
Dr. F. Bassani, EHA
Dr. L. Chan, EHA
Mr. S. Fluss, HPD
Dr. E. Kita, EHA
Dr. J. Martin, ICO
Mrs. C. Mulholland, HPD
Dr. H. Siem, EHA
Dr. D. Yach, PPE

C. Health as a Bridge for Peace Mission Statement

The Constitution of WHO states "The Health of all peoples is fundamental to the attainment of peace and security and is dependent upon the fullest cooperation of individuals and states." Thus underlining the inextricable link between health and peace, clearly such a link is mutually interdependent—health being essential for peace and peace being essential for attainment of health for all.

The 20th century has been the most violent in human history. In addition to two major world wars, 250 armed conflicts have taken place in all parts of the world with over 109 million causalities, more than half being civilians. The trends in more recent conflicts are a higher toll of civilian deaths.

A culture of violence driven by insecurity, intolerance, inequity and poverty, coupled with easy access to lethal arms seems to be spreading and has profound adverse effects on health in the affected countries. In addition to huge loss of human life and suffering, there is a major drain on the already scarce resources of the health sector, leading to serious deterioration in the quality of outreach of health services.

The ravages of mass violence have claimed children and women among their victims, leaving long-lasting scars on the society, retarding their recovery. There have been other adverse social implications on this culture too. In many countries, violence and insecurity have spurred an arms race and inordinate increase in military expenditures at the cost of the social sector investment, affecting health, education of human resources, poverty and economic decline have often led to high indebtedness which further enhances poverty and dependency, setting up a vicious cycle leading to social unrest and political instability, further conducing to conflict and ultimate health consequences.

To countries, these trends of violence, conflict and insecurity and to facilitate a shift to a culture of peace and health, WHO has the responsibility and opportunity to make its unique contribution. This is the essential spirit of the Health as a Bridge for Peace initiative.

Such a culture of violence, driven among other factors such as poverty, intolerance, inequity and ignorance, has profound adverse effects on health. Ware injuries and disability to the civilian sectors is a major drain in the already scarce resources of the health sector and would lead to major deterioration of the quality and outreach of health care services. The ravages of war on children and women leave long-lasting scars on society. The culture of violence and insecurity spurs and arms race which severely depletes social sector resources, health being the first casualty. Poverty and economic set backs lead in indebtedness which further enhance poverty and sets up a vicious cycle leading to social unrest and political instability.

To countries, these trends of violence, conflict and insecurity and to facilitate a shift to a culture of peace and health is the essential spirit of the "Health as a Bridge for Peace" initiative. This initiative calls upon WHO and its partners to recognize responsibility to create opportunities for peace. For this end, we need:

- Strategies
- Analyses
- Skills
- Collaboration with like-minded organizations and individuals. Effective and meaningful key players at specific target groups, who can help fulfill the objective to health and peace.