CAN BASIC HEALTH SERVICES SERVE AS A STABILISING FACTOR IN INSECURE AND FRAGILE SETTINGS?

Debarati Guha-Sapir
Director, Centre for Research on the Epidemiology of Disasters,
Professor, University of Louvain School of Public Health, Brussels

Health as a bridge to peace is an idea generated in the 1980s but that merits re-appraisal in these times of protracted crisis and persistent insecurity. Transition from emergency health responses by external humanitarian groups to ownership and strengthening of local health systems has not been adequately addressed in most post-conflict settings, setting the stage for renewed conflict fuelled by wide-spread discontent and hopelessness of the affected communities. Massive and sudden infusions of foreign aid and expertise compromise existing community public health operations by setting up parallel systems with different norms and resources (Leaning and Guha-Sapir, 2013).

Most active conflicts today have either been ongoing for years, perhaps decades, while some smoulder along with persistent insecurity, occasionally breaking out into active conflict. The history of conflict resolutions show a discouraging pattern of political accords and agreements that are often unable to bring about lasting peace, collapsing within a matter of years or even months. According to a report by the researchers from the Uppsala Conflict Data Programme, the numbers of civil conflicts have peaked in 2011, increasing by 20% from the previous year (Högbladh, 2012). Peace accords are difficult to bring about, taking years and most often do not last (Themné & Wallensteen, 2012; Högbladh, 2012). In general, in post-crisis situations lawlessness becomes a way of life in the absence of a return to systemic normalcy. Governments that are legitimately elected eventually lose authority and credibility, as they are unable to provide basic services to their people. In addition, inequities in provision of basic services can motivate conflict among different groups. In contrast, equity in services can generate confidence in the government and therefore stability.

Many of the insecure regions are characterized by their remoteness where health, food security systems, nutrition and basic education have broken down. In insecure settings, epidemics tend to be recognised well beyond their peak as surveillance systems do not function. For example, in Uige, Angola, international response came in nearly 3 months after the start of the epidemic of the highly virulent Marburg haemorrhagic fever outbreak, only when nearly 300 children died in the paediatric hospital. Identification of rare diseases still remains a major challenge in most conflict-affected regions where adequate laboratory services are unavailable.

These crises pose a moral imperative on the global community to provide help through humanitarian aid. But they also require effective action to stabilize the affected population, both in their own interests and that of global security.

The concept of Health as a Bridge for Peace, developed in the 1980s by the Pan American Health Organization (PAHO) integrated peace-building strategies into health relief and health development in post-conflict transitions. It is based on the idea that fundamental health needs is a universal concern transcending political, economic, social, and ethnic divisions among peoples and provides an entry point and nexus in the process of negotiation and dialogue (Guerra de Macedo, 1994). As a programme, it was adopted by the World Health Organization (WHO) in 1997 and used in many settings to bring warring parties around the table to begin discussions on local health problems. In 2009, the Human Rights Foundation of Turkey, the Norwegian and Turkish Medical and the World Medical Associations met to set up an operational approach to use Health as a Bridge to Peace in the Middle East. Cease fire days for vaccination campaigns have been highly successful in more than 20 conflict theatres, the descriptions of which can be found in the Health as a Bridge for Peace Humanitarian Cease-Fires Project (HCFP) website. This experience of the health humanitarian community and WHO provides compelling evidence in favour of including health services as an effective stabilising factor (Rushton & McInnes, 2006).

Today, more so than before, the importance of normalizing civil society through essential and universal services of health, education and other components of everyday life needs to be recognized as priority emergency services. Bøås, *et al* (2011) found that households ranked food, health and employment systematically higher than peace accords in opinion polls in nine conflict affected country. Providing health services consistently and in a visible way at the same time as peace negotiations can be a stabilizing approach at the grassroots level, providing civil society normalcy, care and reasons not to fight.

There are some studies that examine the importance of local ownership, local engagement, local financing and equity in access and distribution of health benefits in conflict settings (Aaby *et al.*, 1999; Mullany *et al.*, 2010). But we lack systematic evidence and research that illustrate the stabilizing potential of basic health services in a community and its contribution towards the pacification of a turbulent and chaotic situation. More importantly, lack of translational research that transforms normal health policies as guides to field humanitarian operations are stalling field operations at emergency services models.

Availability of health services in insecure areas play roles in other critical ways that are often not on the post-conflict policy radar screen. For example, non-state armed groups including extremist factions, often provide grassroots health services to the poor and disenfranchised in Afghanistan and some Middle Eastern countries. This reveals their understanding of the power of basic services, in this case, health as a pole of attraction and adherence. Services are also provided by other non-state groups, such as community traditional healers who replace the failed health structures, but who rarely form part of relief or

development aid policy. These issues are front line thinking, needing more attention and clear, evidence-based policy to apply to these situations. Health as a bridge to peace is unquestionably a promising approach. Peace accords come and go while communities remain victims of the war. Availability of basic and essential services is arguably a disincentive to fighting. Long-term political stability is dependent on civic services, especially health in tandem with high level political processes. Without civilian interest in peace, civil conflict will be difficult to end.

References

Aaby P.; Gomes J.; Fernandez M.; Djana Q.; Lisse I. and Jensen H. "Nutritional status and mortality of refugee and resident children in a non-camp setting during conflict: follow up study in Guinea-Bissau". *The British Medical Journal*, vol. 319, no. 7214 (1999), p. 878.

Bøås M.; Hatløy A.; Bjørkhaug I. and Tiltnes A.A. "Conflict, Security, Fragility: Violent life-worlds in Côte d'Ivoire, DR Congo, Mali, Sierra Leone, Colombia, the Gaza Strip and the West Bank", in : World Bank. World Development report 2011: Conflict, Security and Development. Washington: The World Bank, 2011. (on-line) http://siteresources.worldbank.org/INTWDRS/Resources/WDR2011_Full_Text.pdf

Guerra de Macedo C. "Society, violence and health". *Bol Oficina Sanit Panam*, vol. 117 no. 5 (1994), i.

Högbladh S. "Peace agreements 1975-2011 - Updating the UCDP Peace Agreement dataset", in : Pettersson, Therése & Themnér, Lotta (eds.) *States in Armed Conflict 2011*. Uppsala University, Department of Peace and Conflict Research (Report 99), 2012.

Leaning J. and Guha-Sapir D. "Disasters, armed conflict and public health". *New England Journal of Medicine*, vol. 369, no. 19 (2013), p. 1836-1842.

Mullany L.C.; Lee T.J.; Yone L.; Lee C.I.; Teela K.C.; Paw P.; Eh Kalu Shwe Oo; Maung C.; Kuiper H.; Masenior N.F. and Beyrer, C. "Impact of Community-Based Maternal Health Workers on Coverage of Essential Maternal Health Interventions among Internally Displaced Communities in Eastern Burma: The MOM Project". *PLoS Med*, vol. 7, no. 8 (2010), e1000317 (on-line) http://dx.doi.org/10.1371/journal.pmed.1000317

Rushton S. and McInnes C. "The UK, health and peace-building: the mysterious disappearance of Health as a Bridge for Peace". *Medicine, Conflict and Survival*, vol. 2, no. 2 (2006), p. 94-109.

Themnér, L. and Wallensteen, P. "Armed conflict, 1946-2011". *Journal of Peace Research*, vol. 49, no. 4 (2012), p. 565-575.

WHO – World Health Organization. "Health as a Bridge for Peace HUMANITARIAN CEASE-FIRES PROJECT (HCFP)". Geneva: World Health Organization, 2016. (on-line) http://www.who.int/hac/techguidance/hbp/cease_fires/en/index.html