Linking Peacebuilding and Health in post-conflict settings

The right to health, empowerment and civil society

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It is now a well-accepted presumption that war causes grave harm to the health of individuals caught in the maelstrom of violence. Death, mutilation, disease in addition to the destruction of governmental infra-structure complicate any post-conflict recovery plan that ultimately seeks to foster lasting peace, the rule of law and a culture of human rights. Indeed, since health is a state of being possessed by the people that 'operationalize' the collective norms of their commu-nity (both local and national) then it logically follows that their well-being is a prerequisite to a functioning and healthy society. Thus, public health policy should be a central concern of all post-conflict recovery activities.

Yet, it is only in the last decade that those working in this field have begun to not only priori-tize health of local populations as central components to post-conflict recovery. This shift in focus has brought into focus the critical question: What should health programming 'look like' in post conflict recovery? Certainly, peace time health approaches often fall woefully short of what is needed for war affected populations. This situation demands new ap-proaches to health care for the extraordinary demands of conflict recovery.

1. Introduction

The increased focus on health in post-conflict recovery reflects the sad truth that there seems to be no end to violent conflict. Moreover, contemporary war often directly targets civilian populations. More specifically, in the last 50 years, the nature of armed conflict has changed from inter-state officially sanctioned troops of foreign combatants in battle to-wards more intra-state conflict involving fighting parties composed of members of the same country such as state armed forces and rebel non state actors. Often this scenario results in state terror directed against particular political and ethnic groups, which may even rise to the level of genocide and politicide. The tactics used in these conflicts is often psychological, such as terror, torture, rape, arbitrary imprisonment, disappearances, extrajudicial killings, and other grave human rights violations. State terror intends to repress and break down the individual and community in order to undermine their power and capacity to resist and question the measures of authoritarian regimes. Women and children often suffer dispro-

portionately, struggling with the lingering effects of armed conflict. In the last decade, there have been approximately 200 such conflicts, 90 per cent of the casualties being innocent, usually poor, ethnic minorities, who represent the most marginalized members of society.

When societies seek to recover from these situations they are not dealing with just the physical health consequences of violence, but also the psychological and emotional harm arising out of the political context in which the abuse occurred. These 'person-made' catastrophes entail unique sequelae that differ from peace time disorders that might arise from chemical imbalances, inherited diseases and other forms of mental disabilities. Instead, the mental health harm caused by conflict should be viewed as a normal response to an abnormal situation. Perhaps equally important is that in these situations the government failed to protect its own population or even inflicted harm on the population, a condition that creates mental states of learned helplessness, disempowerment, intense distrust and fear. These emotional responses often pose the greatest challenges to transforming victims-survivors into productive citizens who will rebuild a cohesive polity.

2. Response frameworks

Transitional justice has become the predominant paradigm for understanding the various responses to armed conflict and the efforts to address the harm it causes. In 2004 the United Nations Secretary-General published the report *The rule of law and transitional justice in conflict and post-conflict societies* in which it defines transitional justice as:

"…the full range of processes and mechanisms associated with a society's attempt to come to terms with a legacy of large-scale past abuses, in order to ensure accountability, serve justice and achieve reconciliation. These may include both judicial and non-judicial mechanisms, with differing levels of international involvement (or none at all) and individual prosecutions, reparations, truth-seeking, institutional reform, vetting and dismissals, or a combination thereof."

The report recognizes the integrated and complementary approaches to post-conflict recovery to include traditional programming in the rule of law, governance, peacekeeping and peacebuilding. Yet, it is careful to signal that "pre-designed or imported projects" will not be effective. Instead, new projects must arise out of the specific needs and demands of local participants for the success of transitional justice programs. This approach includes the need for public awareness, education, consultation and local involvement:

Peace operations must better assist national stakeholders to develop their own reform vision, their own agenda, their own approaches to transitional justice and their own national plans and projects. The most important role we can play is to facilitate the processes through which various stakeholders debate and outline the elements of their country's plan to address the injustices of the past and to secure sustainable justice for the future, in accordance with international standards, domestic legal traditions and national aspirations. In doing so, we must learn better how to respect and support local ownership, local leadership and a local constituency for reform, while at the same time remaining faithful to United Nations norms and standards.

Although the Secretary General's report nowhere mentions the subject of appropriate health policies in transitional justice, it is nevertheless a subject of central importance as demonstrated by countries that have undertaken their own transitional justice experiences. Significantly, the emphasis on public participation is in fact an approach to mental health recovery in transitional justice experiences.

3. Experience of the Peruvian Truth and Reconciliation Commission

Peru offers one case study that helps to show the central role of health programming in a transitional justice setting. The Truth and Reconciliation Commission (PTRC) was established in 2001 through an Executive Decree following the flight of authoritarian president Alberto Fujimori. The TRC worked for two years to investigate the causes and consequences of grave human rights violations that arose out of the twenty year internal armed conflict (1980 to 2000) between the State and non-state groups. In August 2003, the PTRC published its final report based on approximately 17,000 testimonies.

The PTRC concluded that there were approximately 70,000 fatalities in addition to thousands of people being disappeared, tortured, orphaned, and displaced. Significantly, 70 percent of the victims of the war spoke a native language other than Spanish, and three out of every four lived in a rural region, were farmers, poor and illiterate, thus belonging to the historically marginalized and forgotten population. Indifference towards this 'second-class' of citizens by the powerful elite contributed greatly to the prolongation of the conflict. The PTRC found that the process of violence not only highlighted but worsened these socioeconomic and ethno-cultural inequalities.

The mental health impact of the Peruvian war

The work of the PTRC helped offer a clearer picture of the serious impact that political violence and internal armed conflict had on mental health by dedicating an entire chapter to the psychosocial consequences of the internal armed conflict. At the personal level the PTRC found that many victims suffered heighted fear and distrust, generalized anxiety, depression, post-traumatic stress, psychosomatic problems, damage to the personal identity that give rise to secondary problems like alcoholism, intra-family violence, youth gangs and suicides. Of those who gave testimony 43.6 percent referred to feelings of permanent ineptness with regard to their participation in their personal and social lives. At the collective level, the PTRC found disintegration of the family and community bonds, and problems with coexistence and stigmatization. Often this situation resulted in great distrust among neighbors and family members that continues to challenge local reconstruction.

Significantly, despite the high report of mental health problems, only 3.2 percent of those victims-survivors who gave testimony to the PTRC made specific demands for public mental health services. This lack of demand, however, does not accurately reflect the lack of desire for health care.

Failure to claim the right to health

There are a host of socio-economic-political reasons for why victim-survivors do not attempt to access public health care nor make complaints when denied appropriate health care. For example, this population generally has low expectations of health care, viewing it more as a gift, favor or charity. Anything they receive is considered to be highly desired even if their actual experience is objectively of poor quality and might even amount to a violation of their rights (e.g. mistreatment, discrimination etc.) Deference to the opinion of doctors means that the traditionally disempowered are less likely to complain especially if they fear repercussions like the doctor refusing to give them medical treatment.

In terms of rights, this population often does not have sufficient knowledge of their rights or the appropriate channels to exercise these rights. They may rely heavily on specialists like lawyers, or non-governmental organizations that undermines their autonomy as rights-

holders. At the same time, the lack of time and resources can make it nearly impossible for these victims-survivors to fight for their rights. Competing priorities of survival like working, getting a roof over their head, food on the table and schools for their children make mental health care seem less urgent. Yet, what victims-survivors need to address the mental health needs may directly relate to meeting these everyday socio-economic needs along with their being empowered to achieve this human security. This unique approach to mental health presents new challenges to traditional approaches to public health care. Indeed, post-conflict recovery involves more than medicalized models of individual therapy, and instead must incorporate a rights-framework that may view economic, social and political aspects to health recovery. While there is overlap with development programs, the central difference is the placement of the survivor-victim as an agent within this process and the need for his and her empowerment to direct programming and reform.

4. The right to mental health and its application to post conflict recovery

International law recognizes a general right to 'the highest attainable standard' of physical and mental health. Treaties like the Covenant on Economic, Social and Cultural Rights (ICESCR) impose an obligation on State parties to respect, protect and fulfill these general rights. This duty means that governments must not only refrain from harming the health of a person within its jurisdiction, but must also prevent third parties from doing so. Moreover, governments have a 'positive' duty to affirmatively provide 'goods, services and programs' in health for the population. The standard for evaluating this health care is to ask if it is available, accessible, acceptable and of quality.

Despite this legal framework, war is rarely viewed as a direct violation of the right to health. Instead violent conflict is seen as violating other civil and political rights resulting in harm to physical and mental health. This harm must be redressed and the right to reparation is how the aspect of health comes into the transitional justice model of post-conflict recovery.

Indeed, the PTRC developed its Integral Plan of Reparations (PIR) to address the harm suffered by local population due to the war, including specific focus on health consequences. PIR, one of the most comprehensive and inclusive reparation plans developed by a truth commission, arose out of ongoing consultations with survivors and their advocates and thus reflects the demands of this population, and also the incorporation of stakeholder participation.

Each component of PIR (symbolic, education, restitution of rights, individual and collective economic reparation) is viewed as having transversal theme of addressing psychosocial consequences of the conflict. In particular the component on health includes both the individual and community perspective which leaves room for the alternative approach to mental health. The truth commission also made sure to justify PIR as based on a right to reparation, and thus left victims-survivors with a rights-based framework to lobby for its implementation.

Indeed, after the PTRC closed its doors, survivors-victims were left with the task of lobbying for reparations, a situation that required them suddenly to become citizen-activists, empowered to demand their right to health. Due in part to the rights-based approach of PIR and lobbying, in the early days of its implementation, the Peruvian Minister of Health (MINSA) began to take positive steps towards addressing psychosocial effects of internal armed conflict working progressively by implementing a reparation program. However, MINSA ran into the challenge of not knowing how to provide appropriate mental health programs with a communitarian focus that adequately met the demands of victims-

survivors. Thus it began to work with civil society to adapt its programming, even hiring a former psychologist from the truth commission as a consultant.

MINSA also ran into budget challenges and appealed to its beneficiaries (the victims-survivors) to exert pressure on the executive to designate funds, viewing them as allies in the struggle for rights. In Peru it is generally agreed that the implementation of PIR depends on the survivors mounting pressure on the government, but despite their key critical role they are not yet political actors with a voice. The paradox is that victims-survivors need mental health to become these political actors, which requires capacity building and empowerment.

5. Empowerment and capacity building in post conflict reconstruction

A transitional justice process, with a focus on rights, has the potential to transform passive victims into citizen activists with rights. This process is imperative since rights must be activated by rights holders to be meaningful. The formula of this hypothesis is:

- Knowledge of a wrong done +

- Knowledge of rights +

- Knowledge of how to exercise those rights

When examining this formula in the context of a transitional justice setting, one can see how a truth commission can set off a potential process of empowerment. For example, the PTRC served as an "awakening" for many victims-survivors who not only learned that they were not isolated in their experience but also they became aware that these events amounted to a violation of their human rights which gave a right to reparation including entitlement to health care. Suddenly armed with the language of rights survivors began to reframe their demands from pleas to claims of entitlements.

In fact, of the 120 or so victim-survivors organizations in Peru, as many as 40% formed during the work of the PTRC. Survivors most closely involved with the work of the Truth Commission tend to display more sophistication regarding their knowledge of rights. The inclusive process of the development of PIR has led these survivors to fully endorse the PTRC's recommendations despite evident compromises in its content. Their organizations have adopted the TRC Final Report and recommendations as a common platform to unite their claims for truth, justice and reparations.

However, awareness and knowledge of rights is not enough. Despite the noticeable positive impacts made by the truth commission, it was not sufficient to overcome the historical organizational weakness of victim-survivors associations. For example, soon after the PTRC concluded its work, 70% of most survivor organizations lacked an operative or strategic plan. Weak leadership, lack of coordination and poor lobbying skills, among other problems, have diluted their efforts. Survivors of Peru have encountered great challenges, specifically related to how to strengthen their organizations and to gain access political channels for lobbying for their rights in health after many years of marginalization. Above all else, the psychosocial consequences of the war, such as fear and distrust, also undermines their ability to engage in political participation and thus highlights how mental health forms a prerequisite to exercising ones rights.

Moreover, victims-survivors have often depended on human rights organizations to defend their rights, undermining the autonomy and self-sufficiency of their organizations. With funding being scarce, this situation puts survivor organizations at a disadvantage when it comes

to competing for financial backing, leaving them to choose between daily survival and dedication to the political cause. Unfortunately, some human rights organizations maintain this paternalistic role out of self-interest, excluding survivors from decision-making power. If the human rights community struggles to include survivors in the political process, one can only imagine the great difficulty of getting the rest of society to do so.

Mental health through empowerment

The challenges that victims-survivors face to become active participants in civil society and citizen organizations points to one of the greatest paradoxes of talking about mental health in transitional justice. Indeed, addressing these abovementioned obstacles goes towards addressing mental health of war affected populations. In this way, "acceptable" health care includes notions of cultural appropriateness as well as responding to the particular demands and needs of the beneficiaries of health services which may not fit into traditional notions of mental health care.

Over the last decade, the debate in the public health field has revolved around the most appropriate approach to attending to the mental health of survivors of internal armed conflict and political violence. Civil society advocates who have worked closely with local populations often critiquing more conventional approaches to mental health that offered a narrow pathological, clinical view of mental health in post-conflict settings.

Yet, the alternative approach challenges health providers since it seeks to include a psycho-social model of empowering survivors to be not only protagonists in the decisions on their own health care, but also active participants in their country's reform. It also puts more focus on the individual within the community, thus contextualizing his recovery as wholly dependent on the environment and context. This communitarian focus addresses the causes of continued mental health suffering such as: insecurity, distrust, lack of socio-economic support. Here, an integrated approach to mental health views the original socio-economic causes of political violence and armed conflict as directly related to mental health issues.

Significantly, the U.N. Secretary General in the 2004 report mentioned above also recognized the imperative of a participant-centered focus in national recovery processes. Successful and sustainable reform requires solidarity with and support of "domestic reform constituencies" and is based on meaningful public participation. The report includes women, minorities, affected groups and the vulnerable among those who should be included in this process. It adds: "Most importantly, our programmes must identify, support and empower domestic reform constituencies." This participant focused model reinforces the idea that mental health recovery occurs inside a movement of human rights and democratic transition. All of this implicates changing the role of therapists and doctors to be equals in the process of healing but also recognizes the interdisciplinary nature of this health recovery process.

6. Looking Back and Looking Forward: Suggestions for the future

Despite the international debate revolving around appropriate and acceptable approaches to mental health for survivors of war, there is weak policy articulation on how to approach mental health in non-emergency, post-conflict settings. While there is a slow movement

away from traditional medicalized ideas of mental health, more focus needs to be directed towards alternative models of communitarian health within a human rights framework that views care recipients as empowered citizens.

Historically, the definition of mental health has centered around mental illness and disabilities, as seen in the World Health Organization (WHO) 2001 Annual Report dedicated to the theme of Mental Health. When discussing post-conflict settings, the WHO often focused on refugees and displaced populations while overlooking the unique mental health needs of survivors still living in their communities of origin where much of the violence took place. At the same time, the definition often overlooked the phenomena of political violence in which a state inflicts the harm, as seen in the WHO's 2002 "World Report on Violence and Health" which did include collective violence such as internal armed conflict in their definition of violence, but focuses primarily on interpersonal violence in its follow-up work (such as policy manuals).

Significantly, the WHO has begun to integrate a psychosocial focus into their guidelines as reflected in the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergencies (2007) to enable humanitarian actors to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psychosocial well-being in the midst of an emergency. Yet, the focus remains on emergencies and humanitarian assistance.

One of the primary consequences of the lack of focus at the international level is that there is less sustainable and long term technical and economic support, especially for survivors still living their communities of origin as well as less international pressure on governments of post-conflict countries to prioritize this issue. Moreover, the topic of health in the area of transitional justice is also often overlooked. While my own observations showed that truth commissions have an undeniable impact on advancing the issue of mental health in post-conflict settings, there is still much work needed in prioritizing this issue to ensure that the right to reparation in mental health and the right to mental health itself is fulfilled.

Moving forward, there needs to be further study of obstacles to exercising right to mental health, more resources for building skills in rights advocacy, more resources towards appropriate approaches to attending psychosocial consequences of political violence and more clarity in national and international policy on the definition of mental health for populations affected by internal armed conflict. Moreover, there needs to be more resources dedicated to the study and evaluation of successful alternative approaches to mental health recovery to support policymakers wishing to set new standards in the field.