HEALTH AND HEALING IN TIMES OF VIOLENCE

Restoring broken bodies, minds and relationships

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Restoring broken bodies, minds and relationships
As the 21st century dawns, the map of our world is filled with the burning lights of violent conflicts. The lives of thousands of women, men and children are threatened. Physical, psychological and emotional health is shattered as individuals and communities are deeply traumatized by other peoples’ cruelty.

An outrageous feature of recent conflicts is the systematic violence against civilians. Against all fundamental values, women, children, elderly people are deliberately made victims of cruelty. The objective of armed groups seems to be to humiliate the enemy rather than to “win”. They attempt to eliminate entire communities by ethnic cleansing or genocide.

This issue of Contact presents stories of those who are striving to protect and provide healing in populations affected by conflict. In Sierra Leone, thousands of men and women, young and old, who have been raped, tortured or maimed need urgent medical attention for their bodily wounds. Both the victims and the perpetrators — usually children who abducted by militias and forced to kill, humiliate and destroy their neighbours — need healing of their wounded minds. The social fabric, torn apart by unprecedented waves of violence needs healing to allow a process of reconstruction. Moral references and value systems have been broken. Social healing requires that these individual and collective traumas be addressed with a wholistic approach in a spirit of reconciliation.

“The task is enormous”, says Marion Morgan in the article on Sierra Leone. With enormous courage and commitment, churches and Christian health organizations in Sierra Leone have continued providing health services and working for reconciliation.

The article from Bosnia tells a remarkable story of women overcoming their own trauma to bring comprehensive health care to displaced women in remote places. Women have been the most affected, wounded in their bodies, and very often violently uprooted from their environment. The “Woman to Woman Programme” that empowered women to rebuild their broken communities illustrates the crucial role that women played in healing and reconciliation processes. Too often, women’s unique contribution is overlooked by the authorities in churches, governments or agencies. The article will inspire all who consider women as victims or as “part of the problem”, while women are usually best placed to become the essential “part of the solution”.

The same inspiring “empowerment approach” can be found in the story from Indonesia. Here again, the violence targeted against the civilian population is provoking lasting fears, distress and anxiety. The authors underline the need to move from a short-term “charity-emergency” approach, to examining the multi-faceted and inter-linked effects of violence. As they say, “besides preventing and treating diseases, there is an equally important need for counselling, training in micro-conflict resolution and in advocacy for basic rights and rehabilitation”. Their experience has taught them that a community-based approach is more effective in responding to the health and healing needs of the victims of inter-religious conflicts.

These examples and other stories in many parts of the world help us understand that working for health and healing during or after violent conflict means working to restore broken bodies, broken minds and broken relationships. It means also that the mission of the health workers and their associations must be an integral part of the processes of peace building and reconciliation. "The need for reconciliation is in proportion to the wounds caused by violence. These wounds affect every aspect of life". As among the first who realize the depth of these wounds, health workers are very well placed to become agents of healing and promoters of peace and reconciliation in times of brokenness and violence.

Geneviève Jacques
Director, Cluster on Relations, WCC.

Cover
Two young Sierra Leonean amputees who suffered at the hands of the rebels.
CHASL
INTRODUCTION

The rebel incursion into Sierra Leone in March 1991 marked the beginning of the war. For seven years the war then confined to the southern, eastern and northern parts of the country, forced thousands to flee from their homes into neighbouring countries and to the capital city, Freetown, which was then relatively safe. This safety was not to last for long. In May 1997, the military took over government in a coup d’état, and held on to power until February 1998 when they were forcibly pushed out by the Economic Community Monitoring Group (ECOMOG) forces, the military arm of the Economic Community of West African States (ECOWAS).

The rebels invaded the city of Freetown in January 1999. The rebels, armed to the teeth with sophisticated weapons and small arms, forced their way into the maximum security prisons and released about 4000 prisoners, some of whom were hard core criminals awaiting trial.

The many atrocities committed earlier are nothing in comparison to the atrocities that happened since 1999. Innocent women and children have been the most affected during these years of war. They have come under direct fire, been forced to carry arms, have been tortured, raped and maimed. According to estimates, over 3000 children, many under the age of sixteen, have been abducted by rebels and drugged.

In promoting community-based health care, we must identify and train workers from within the communities.

The Christian Health Association of Sierra Leone (CHASL), which before the war provided nearly 40% of the health care services in the country, has continued to provide health and related services to the poor despite the devastation caused to its members. Marion Morgan, describes CHASL’s response to the crisis in Sierra Leone.
and coerced into joining the fighting forces. The proliferation of light, easy to use weapons such as the AK47 or M-16 has contributed immensely to the increased use of childsoldiers in our wars. The illegal sale of our diamonds has helped to finance the purchase of arms, thus sustaining the war for eight long years.

**Health deteriorates**

The health situation has grossly deteriorated. The current under-5 mortality rate (316/1000) and infant mortality rate (182/1000) are among the highest in the world. Sierra Leone has been rated by the UN as the second worst country for raising children, and the least developed country in the world! Thirty per cent of the under-fives are malnourished. And this figure is rising.

**HIV/AIDS** is on the increase while several outbreaks of *cholera* and *measles* have been reported during the post war era. Thousands of children and heads of families have had limbs amputated. Almost the entire population of over 4.5 million, has been left traumatized.
Infrastructure and personnel

Yet, a large number of hospitals and clinics, including all the church-related hospitals, have been destroyed or vandalized, causing their closure. The number of health personnel has grossly diminished. Missionaries have left, while many local staff are refugees in other countries or are internally displaced. In terms of professionals, there is approximately one doctor per 20,000 patients, and less than twenty qualified pharmacists in the entire country.

The task of Sierra Leoneans rebuilding their shattered lives is enormous. Ironically the only mental hospital in the whole country was partly burnt and Sierra Leone can boast of only one qualified psychiatrist.

People are asking, “Can any good come out of Sierra Leone?” Some of us wonder how long we have to suffer. Like the people of Judah, “we grow weak carrying burdens; there’s so much rubble to take away, how can we build the wall today?” (Nehemiah 4:10).

Can we ever rebuild our country? As Christians we believe that by God’s help we shall. The first signs have emerged. Due to the significant political pressure a peace agreement between the government and the rebels was signed on 7 July 1999. This has given some semblance of hope to the nation and people are gradually beginning to build their lives again, but the progress is very slow.

Poverty has increased. Many are unemployed. There is considerable hesitation as people still await disarmament and

Peace Campaign

The road to nation building is long. CHASL holds workshops on trauma healing and peace building for internally displaced persons (IDPs) residing at various camps. Through skits and other methods, the workshops address issues such as conflict analysis, stress and trauma, basic helping skills, peace and reconciliation, counselling and disarmament.

Such sessions generate lively and meaningful discussions as well as sharing life experiences. CHASL reminds participants about the need to take prompt and appropriate action in dealing with persons in difficult circumstances in order to avoid serious complications. At the end of the training, participants draw up action plans to benefit the others living in the camp.

A recent action plan following a trauma healing and peace building workshop included community theatre activities as part of a peace campaign at Grafton Displaced Camp. The trauma helpers held banners and read out peace slogans. Their singing and dancing attracted a large number of camp inmates. Many were amazed at the talents of those, some of whom were ex-combatants, who took part in the programme. The group continued their performance in the various sections of the Grafton camp to ensure greater impact.

*Nancy Massaquoi, CHASL*
INTRODUCTION

demobilization of ex-combatants. We hope that in time the dust will begin to settle.

Churches, making peace

What has been the role of the churches in this war-ravaged country, where the people are dejected in spirit and tortured in body?

The Council of Churches in Sierra Leone has been an active participant in negotiations leading up to the signing of the peace accord. The Council has been engaged in relief assistance and through its advocacy desk has conducted a series of experience-sharing meetings for the general public. The Evangelical Fellowship of Sierra Leone has also been active in providing relief assistance and is managing one of the many displaced camps in the western area.

And healing

The Christian Health Association of Sierra Leone (CHASL), which before the war provided nearly 40% of the health care services in the country, has continued to provide health and related services to the poor despite the devastation caused to its members. The first hospital to close down in the early days of the war was a Catholic member hospital where two missionaries were killed. A few years later, as a result of rebel attacks, another Catholic hospital was shut. A third United Brethren in Christ (UBC) hospital closed down also as a result of rebel attacks. With the closure of these three hospitals before the May 1997 coup d’état only four church owned hospitals remained in operation.

Following the events of 1997, the remaining hospitals were forced to close down when rebels in the eastern and northern regions of the country similarly attacked them. In 1998 the last of the hospitals with the only non-government nurses training programme was attacked twice, causing the student nurses to flee and disrupting their training programme.

None of the seven mission hospitals, the many clinics and health projects are now functioning. Most of the structures have been destroyed or vandalized. This has created a heavy dependence on NGOs for basic health as well as other social services, a situation that poses a great challenge for CHASL member institutions.

From a membership of 47 institutions before the war, CHASL’s membership has reduced to about twenty. Most of these institutions have been displaced and are functioning out of their normal areas of operation. Some health centres and hospitals which before the war

A group of Internally displaced Sierra Leoneans at a trauma healing and reconciliation workshop.
were located outside of the city are now operating mini-health centres or clinics inside the city, far away from where they used to work. Though displaced they continue to serve the area and the community in which they find themselves.

**Community health workers work against odds**

Community health workers, particularly those who belonged to the communities where they worked, continued their work as far as it was safe. This is why in promoting community-based health care we must identify and train workers from within the communities.

**Trauma healing and reconciliation**

The task of reconciliation, rehabilitation and reconstruction is enormous. CHASL nurses has embarked on an expanded programme of community-based trauma healing and reconciliation training in various parts of the country.

Participants have included among others, displaced nurses from the CHASL nurses’ training programme, other NGOs and inmates of camps for displaced people. We have conducted training in the western area as well as in the eastern area where it is relatively secure.

**Curriculum**

The curriculum for trauma healing workshops includes topics such as identifying and managing the effects of stress and trauma; response to traumatized children and loss and grief. It also includes helping skills such as effective communication, counselling, traditional ways of helping and teamwork. It analyzes the root causes and dynamics of conflict; transformation and resolution of conflict and reconciliation. Participants learn to plan interventions, to profile communities, assist the government in providing health services, raising community awareness, designing, facilitating and evaluating training programmes.

Although many national NGOs are assisting the government to provide health services, these programmes need to be sustainable. The church needs to reclaim its position as the best provider of health care services to the poor. Overseas partners must not become weary of helping. As Apostle Paul warned the people of Galatia, “Let us not become tired of doing good…So then as often as we have the chance, we should do good to everyone, and especially to those who belong to our family in the faith.”

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A group of displaced people sing a peace song, Grafton Displaced Camp, Sierra Leone.
WOMAN TO WOMAN PROGRAMME

Carolyn Boyd, Field Consultant of the Ecumenical Women’s Solidarity Fund, describes how a programme in Bosnia-Herzegovina to assist women survivors of the organized abuse during the war, has become a model for family health care within rural communities.

The Woman to Woman Programme, aims to bring comprehensive health care to rural communities and to employ local and internally displaced professional women in the building of a rural health care system.

After consulting the local women in the region, we have set up a clinic, staffed entirely by women in a predominantly Muslim area. This team of medical staff will also be instrumental in further motivating the women in these communities. In another rural area of central Bosnia, we have launched a mobile medical team, again staffed by women, offering health care to the returning population.

We hope that by establishing basic medical care for rural communities, displaced families will be encouraged to return. At the same time, the new facilities offer employment to highly trained local women who, without this, would have left the region.

Location

The programme is based in the village of Kosova in central Bosnia-Herzegovina and in the nearby villages surrounding Novi Seher (south-west of Kosova). Kosova is a predominantly Muslim village situated on the banks of the River Bosna. Kosova was a village that found itself in a front line position during the war. Though miraculously saved from major destruction, the population suffered psychological damage.

Novi Seher is about 40 minutes’ drive away and is in an area completely devastated by the war. The entire population, which fled the area, is only now resettling it. The US State Department estimates that there are between 3-4 million landmines in Bosnia-Herzegovina. Although this region has been recently cleared of mines, the inhabitants are still cautious. The majority of the population arrives in the morning to work on their houses and at the end of the day, they return to their refugee accommodation. Work is slow but constant. There is now electricity and water, but no gas and no telephone lines.

Unemployment is very high. Before the war most people gravitated to the nearby

Women victims who survived the nightmare felt afraid, confused, isolated and in pain.
city of Doboj for schooling, employment, health care and shopping. Since the area has been ethnically divided, these communities can no longer use the facilities at Doboj.

A healthy start

The average life expectancy in this region is 50 years. The high humidity and damp gives rise to bronchial illnesses. Chronically-ill patients who had no access to health care during the war now have multiple problems and cardiac illness. There is also the problem of long-term exposure to stress. The first activity of the health programme was mass immunization of children who had been neglected during the war.

The idea for the Woman to Woman Programme was generated in 1995. The Programme has since then moved from providing health care to the refugee population from central Bosnia in Zagreb, to following the displaced population back to Bosnia after the signing of the Peace Accords.

Comprehensive primary health care

The Programme has been offering comprehensive primary health care to the local and surrounding population.

Hands of Solidarity

Rape, torture, war, terror, expulsion, humiliation, betrayal, pain and fear are just some words which come to mind when looking back over the last five years in the lives of the women in Croatia and Bosnia-Herzegovina. While Europe celebrated 50 years of peace following the World War II, there was little cause for celebration in Bosnia-Herzegovina.

In the harsh winter of 1992 the World Council of Churches sent an investigative team from the Women's Desk in Geneva to Croatia, Bosnia and Serbia. Their report, The Rape of Women in War examined the organized abuse during the war, which left a horrific and indelible scar on the women of all communities.

Women victims who survived the nightmare felt afraid, confused, isolated and in pain. There had to be a response. There had to be a sign of solidarity to all women survivors. The Ecumenical Women's Solidarity Fund (EWSF), was launched in 1993, in response to the Report’s findings. Individual churches, church councils and donor agencies from Europe and North America supported the fast-acting Fund. The Fund was to be used by women, for women and to assist women who have suffered to return self-esteem, dignity and basic human rights. It was to offer support and solidarity.

In an environment scarred by ethnic division, the Fund continues to support women victims of war and their families regardless of nationality, religious or ethnic background. The Fund has supported over 100 self-help projects in Croatia, Bosnia-Herzegovina, Serbia and Macedonia benefitting over 55,000 people and has succeeded in building up a network founded on trust and mutual respect.

As communities return, the Fund goes with them, helping them and showing how a little money can be used in finding creative and far reaching initiatives to solve the many problems they face.

Staff and committee members of Ecumenical Women’s Solidarity Fund in Zagreb during the screening of new projects. April 1998.
The programme also offers specialist examinations with weekly visits from a psychiatrist, gynaecologist, and paediatrician. Each Friday a pharmacist comes to the clinic to dispense medicines. The availability of medical supplies is very limited. The health programme supplies a small fund, which covers payment for x-rays, ECGs, and ultrasound scans — tests that have to be done in the nearby towns. To enable unemployed doctors to practise and receive a small wage, a pool of 24 women doctors, from the surrounding villages — some who are internally displaced and have temporary accommodation in the area — take turns in the clinic. There is a shortage of doctors in Bosnia — most have left the country as refugees and have not returned. The country cannot pay its own doctors so they are desperate to be able to work in their specialist fields and receive some payment.

There are approximately 800,000 internally displaced persons in Bosnia-Herzegovina. They are the forgotten population. For this reason, we actively seek to give them a place in the programme.

### Spreading outwards

The success of the project made us begin an outreach health programme. Two doctors, a nurse and a driver in a four-wheel drive vehicle, visit the villages around Novi Seher twice a week. This area to which approximately 4,000 formerly displaced persons are returning, has no infrastructure, no amenities or social services.

The roads are pitted dirt tracks. Lacking repaired public buildings to use as temporary clinics, the medical team sets up clinics in the shells of houses. The working conditions are extremely bad: no windows, no heating and no running water. The only furniture are a table and two chairs.

Recently a small clinic, attached to a primary school, has been constructed. Displaced families, encouraged by the provision of health care are returning to these villages.

### A committed band

There is carefully chosen small core of dedicated health personnel. Specialized medical staff come once a week. A female doctor, herself displaced within Bosnia-Herzegovina, coordinates the project. The staff, almost all women, comprises nurses, general practitioners (male G P), a secretary, a cleaner, a bookkeeper and a driver. There are two male doctors: the psychiatrist (we could not find a qualified female psychiatrist in the region) and a male GP who is available for patients who are uncomfortable at being examined by a female doctor. The team evaluates, assesses and plans activities at a weekly meeting. The staff work well as...

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**Health Care System in Eastern-Europe**

Before the war 80% of health interventions and all contact with specialists, whether paediatricians or gynaecologists, were restricted to large hospitals. The health system in Bosnia will, in the near future, slowly change from that institution-based, state health care system with a number of specialists, to a privatized, family-medicine oriented health care system with a new system of medical insurance.

Outreach health programmes, general practitioners (GPs) and specialist examinations at the level of a rural clinic that are new to Eastern Europe will be a part of the new health system.
a team, something essential to the success of the project.

Signs of revival

Thanks to the Woman to Woman Programme, the locally trained professional women no longer need to be passive receivers, waiting at home for humanitarian aid and for someone to offer them a better tomorrow. They are taking a strong role in renewing their community. They are empowered and have a sense of ownership. The women of the region are helping to rebuild their community.

Previously remote hilltop villages, which took health workers carrying medicines and medical equipment a whole morning to reach by foot, can now be reached easily through an organized system of rural visits. The vehicle has also been used to take emergency cases to the main hospital in Zenica (45-minutes drive from Kosova).

Legal advice

As a development from the health programme, we have become aware of the greater needs of the community in this post-war and post-communist period. Within Kosova, we have set up activities for children and youth, who as a result of unemployment and general apathy, are increasingly vulnerable. We have also set up a Free Legal Advice Service that works after hours from a room in the clinic.

The Free Legal Advice Service was a new concept for the local population. The aim of this project is to enable the rural population’s access to legal advice and an understanding of their rights in a new post-war democratic society. Though they took time to realize how best it could be used to their advantage, today the office has a queue outside its door. More and more people have become aware of their rights and are receiving invaluable assistance in the legalities of reorganizing their lives.

Unique model

The Woman to Woman Programme is unique within Bosnia-Herzegovina. The Ministry for Health recognizes it as a model for family health care with rural communities and is seen as the future pattern of rural health care. We are improving the quality of health care for the patient by paying attention to the doctor/patient relationship. We try to improve the way medical personnel work and communicate with their patients.

We have the permission and cooperation of the local government and council. We have good relations with the Islamic leaders, who are fully aware that this programme is Christian-supported. We hope it will be a powerful witness that will begin to heal the badly damaged Muslim/Christian relations in the region.

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The Ecumenical Women’s Solidarity Fund is a sign of solidarity by women, to assist women survivors of the organized abuse during the war, to return self-esteem, dignity and basic human rights.
LEARNING FROM THE CRISIS IN AMBON

Sigita Wijayanta and Christina de Vries outline the People-based participatory approach, interfaith cooperation, professional medical teams, and responsive donor partners that were key to CD Bethesda’s innovative relief work in Ambon, Indonesia.

Conflict of course, was always there. Indonesia, a country consisting of 17,000 islands and many ethnic minority groups, languages, religions, cultures and traditions — recently experienced such widespread and large-scale aggression against the civilian population, systematically targeting women, children, students, religious leaders, the elderly and the weak.

Although the quest for independence of East-Timor has caught the attention of the international media, serious violence also occurred in areas like Atjeh and Ambon.

Ambon island, in Malaku province, consisting of three districts, is multi-ethnic and multi-religious. It is home to over 210,000 people, mainly Christians (50%), Muslims (40%), Hindus and people, who practise traditional religions.

As a result of first clash between Muslims and Christians in Ambon, 12,239 people (2,408 families) were displaced. They were concentrated in 37 temporary camps. The crowding, humidity, insufficient and bad quality of water, insanitary toilets and poor drainage in the camps perhaps caused the marked increase of diseases such as malaria, respiratory tract infections and diarrhoea. Already many individuals’ coping skills were worn down due to the unrest and violence.

The medical facilities such as government health centres, the Red Cross office and the military health teams oriented to a health-clinic approach had little sense of emergency. The referral system for injured victims did not work because of security reasons. Centralized bureaucracy complicated access to medical supplies, while communication and transport in the field were complicated.

Following a needs’ assessment, a local health team with two nurses from the Community Development Unit of Bethesda Hospital (CD Bethesda) organized a workshop attended by all the volunteers in the camps — internally displaced people themselves. The internally displaced people at camp-level agreed on a strategy.
A Strategy

- **Response**: A charity emergency response changed into a shelter-based community organizing, empowerment response.

  The problems of displacement were not just the physical needs, but the distress caused by fear and uncertainty about safety, traumata and the future.

- **Recognition**: Counselling, training at the grassroot level in micro-conflict resolution, problem solving skills, advocacy for basic rights and rehabilitation were recognized as important as food, disease prevention and treatment.

- **Approach**: The approach became community-based / camp-based. At weekly planning meetings the internally displaced people set their own priorities and decided whom to work with.

- **Emphasis**: Without neglecting the material needs required by the internally displaced people, the package of interventions shifted to support for human development. This had implications for budget, logistics and staff.

- **Flexibility**: CD Bethesda as a relief organization needed flexibility in management. Good communication and clearly defined responsibilities between local staff and the staff at headquarters were important tools.

**Results**

Planning by internally displaced people ensured more coordinated and effective volunteer activity in the camps. Teams of volunteers set up:

- drains for better drainage
- rosters for cleaning the latrines
- clean water supply, kitchen facilities
- health education
- racks for drying clothes (clothes were being dried on the grass, a cause for itchy skin conditions)

**Situation worsens**

Just when the relief work was being organized, the fighting, clashes and riots continued. Relief goods could not be distributed inland. Logistic supplies were stopped due to the warehouse of the distributor being burnt, and the airport being closed. Goods were sold at very high prices, much above the purchasing powers of the people in the camps.

The second wave in the conflict became more brutal. Women, children and humanitarian personnel received no protection. Unpredictable issues complicated the relief effort. Rumours of every kind sparked off new aggression. Radicals on both sides accused the members of the interfaith volunteer teams working in the camps of betrayal. Members of volunteer-teams abused their position to help certain groups better than others.

**Response**

CD Bethesda responded to the worsening situation by reorganizing their staff and camp volunteers in three teams: a mobile

The participatory “shelter-based, community-organizing, empowerment approach” by internally displaced people ensured effectiveness.

Poverty and unjust social structures often cause illnesses in communities. Solutions to problems of illness, poverty and injustice need a wholistic approach. The Community Development Unit of Bethesda Hospital was established in 1974, under the Yogyakarta branch of the Christian Foundation for Public Health (YAKKUM) to assist poor patients whose problems could not be solved by the hospital alone. CD Bethesda tries to help communities to solve their own problems.

Currently CD Bethesda serves 165 villages mostly in the eastern part of Indonesia extending from Central and East Java to Flores, Sumba, Alor, Irian Jaya and East Timor.
Medical team, logistic team and a team for camp-based, peace and non-violence campaign.

Medical mobile team It was decided that a volunteer living in the camp would run the health post. Training and supervision was organized on a weekly basis at health posts in each camp.

Logistic team This team was responsible to ensure that all supplies were distributed punctually and that they would reach real beneficiaries — the elderly, women, children and those who were sick.

Peace and non-violence campaign The peace and non-violence campaign used radio, leaflets and posters, and by published a newsletter Seed Of Peace. The team liaised with opinion-makers and developed a campaign to control rumours.

Campaigns take effect

These changes made in a very short time span proved effective. Such response to the new problems was possible due to several reasons:

- the participatory “shelter-based, community-organizing, empowerment approach” helped the displaced people to make their own decisions. Thus they were quickly motivated, informed and educated.

- the flexibility of the CD Bethesda staff combined with the well-organized back up from the head office in Yogyakarta proved effective. The head office coordinated logistic supplies, fundraising, reporting to donors, advocacy and coordination with other relief organizations such as the INSIST Emergency Team.

- INSIST, in turn, built national and international solidarity networks and developed peace-building campaigns. And in the second phase of the conflict, they also sent materials to the camps at short notice.

Building Peace

Ensuring continuing community action was dependent on building peace between the people in the camps. Peace was an essential condition for volunteers to promote health and to treat ailments. For the individuals, the community activities as well as the results of the activities began a process of healing.

Health intervention has proven to be very effective as the entry point to promote peace.

The community activities begin a process of healing.

It cannot be repeated often enough: peace is the most significant intervention one can make in this world for all to reach a state of health.

May peace be with you.
**ROLE OF THE HEALTH WORKERS IN TIMES OF POLITICAL VIOLENCE**

*Draw attention to the ill effects of violence and repression — the poor health, disruption of health services and the destruction of health-promoting infrastructure, says Laifungbam Debabrata Roy as she outlines some principles for working with communities in conflict zones.*

1. Oppose repression, militarism and inequalities in society.
2. Be aware and adhere to the basic premises of the Hippocratic Oath, the Declaration of Tokyo and other codes.
3. Resist becoming drawn into violent situations over which they have no control.
4. Respond ethically. Refuse to participate in a web of silence and a closed system of detention, torture and limited medical care for political enemies — both of the state as well as of opposing groups.
5. Help set up local bodies to publicize and monitor violations of medical ethics and human rights by physicians. Support those who are threatened for their human rights activities.
6. Advocate to national and regional medical/health associations a clear policy based on a universal code of medical ethics that refers to violations of human rights.
7. Document and analyze the ill effects of violence and repression. Draw attention to the poor health, disruption of health services and the destruction of health-promoting infrastructure.
8. Educate health workers about the ill effects of political violence on health, particularly psychosocial health. Empower health workers with communication skills, psychosocial assessment procedures, and appropriate sectoral and cross-sectoral referral.
9. Collaborate with non-medical groups to educate the community, raise awareness and encourage governments and the media to focus attention of political violence and its ill effects.
10. Traditional and indigenous knowledge systems and practices can be beneficial to community psychosocial wellbeing. Where formal sector health workers can do little directly, complement and strengthen such indigenous interventions.

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Adapted from [Towards Psychosocial Care and Support for Communities in Conflict-related Stress: Need for long term perspectives in Manipur, North East Region of India by Laifungbam Debabrata Roy, Royal Tropical Institute, Amsterdam, 1997](#)
ACT (Action by Churches Together), is a world-wide network of churches and related agencies meeting human need through co-ordinated emergency response. WCC’s emergency response office. Physicists for Human Rights, does monitoring, advocacy and documentation of human rights abuses particularly in situations of war and conflict. 

Overcoming violence, ECHOES(13/1998), reported creative models to build bridges between communities in conflict from Kingston, Jamaica; Boston, USA; Colombo, Sri Lanka; Durban, South Africa; Rio de Janeiro, Brazil; and Suva, Fiji.


The landmines campaign still needs the churches! A publication with text by Mariette Grange and Rebecca Larson. 1998. Available in English, French, German and Spanish


Health in emergencies is the quarterly newsletter of WHO’s Division of Emergency and Humanitarian Action. It includes news, current projects, announcements of publications and training programmes.

The SPHERE handbook is a path breaking book that sets out a Humanitarian Charter and minimum standards that people affected by disasters have a right to expect. The minimum standards include standards of water supply and sanitation, nutrition, food aid, shelter and site planning, and health services. Published by The Sphere Project and distributed by Oxfam Great Britain. 330 pages. English. ISBN 0 85598 445 7. The French, Spanish and Russian versions will be available in May 2000. Price $17.

War and public health is a handbook for those working in emergency and disaster situations. It covers topics such as planning, food and nutrition, water supply, medical and surgical care, disasters and medical development and humanitarian ethics. (ed.) Pierre Perrin, 1996. 446 pp. International Committee of the Red Cross, Geneva

Tuberculosis control in refugee situations: an inter agency field manual: Available in English and French, Global Tuberculosis Programme, 20 Avenue Appia, 1211 Geneva 27, Switzerland. E-mail: deslobainsm@who.ch

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Traumatic stress: the effects of overwhelming experience on mind, body, and society An essential book that raises intellectual, ethical and political questions. Edited by Bessel A. van der Kolk, Alexander C. McFarlane and Lars Weisath, 1996. Price US$ 56.95, £40. Hard Cover. 596 pp. Guilford Press, 72 Spring Street, New York, NY 10012. Tel: 800-365-7006, 212-431-9800 Fax: (212) 966-6708 E-mail: info@guilford.com

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OTHER PUBLICATIONS

contact n°167- October-December 1999
PEACE, FORGIVENESS OR BOTH?

MATTHEW 18: 21-35

The following reflection has been prepared by Paul Kortenhoven, a missionary involved in development and relief who has lived in Sierra Leone since 1980. Paul Kortenhoven is the country representative for Christian Extension Services (CES), of the Christian Reformed Church in North America.

There is so much written about peacemaking, forgiveness and reconciliation that I thought it worthwhile to go back to our Lord’s advice on the subject. Jesus had quite a bit to say about this. The classic passage is taken from the Gospel of Matthew 18:21: “How many times shall I forgive my brother (or sister) when he (or she) sins against me?”

Read Matthew 18: 21-35

The parable of the unmerciful servant depicts the best and the worst in all of us. A man hopelessly in debt obtains mercy. We are really happy for him but before we can blink our eyes this suddenly debt-free man grabs his colleague and has him thrown in a debtor’s prison for a much smaller amount.

We are appalled and want to enter the story on the side of the right. Almost as an extension of our own wishes, the king in the story steps in and does intervene giving the unmerciful servant exactly what he deserves. Great story with a proper ending, right? But is that all Jesus wanted to teach? I have lived through a terrible civil war in Sierra Leone. Perhaps you have heard about or seen on your TV news programmes, the terrible human rights violations suffered by civilians during this conflict. Child-soldiers who were caught up in violence they did not understand committed many of these atrocities.

What is the place of mercy and forgiveness for a captured 12 year-old rebel who murdered your entire family? Or for another who put the torch to your village, farm and food supply? Or for the commanding officer who sent him to destroy? It is a good prayer, and valid, to acknowledge our feelings of helplessness and to put those questions to the Lord, just as Peter did, with all the feelings that go with them. How many times must we forgive? Jesus made it quite clear that we should forgive as many times as it takes to bring peace and reconciliation to the wounded parties.

That is a very tall order! This is hard for me to accept and certainly harder for those who have lost children and limbs and everything they owned to a drug-crazed child soldier. Actually, I wish Jesus had not told this story, but he did!

Read Matthew 5: 9, 6:14-15 and Luke 17: 4

Forgiveness is foundational to reconciliation and therefore to peace at all levels. Isn’t this what Jesus taught his disciples and to you and me?

Let me tell you one short story that illustrates real forgiveness. I have a wonderful Ugandan friend who experienced incredible tragedy in her life during the terrible 1980s. A political enemy killed her husband and her father and her sisters were shot to death. Her mother died of shock when she heard of their deaths.

As I listened to her, my heart broke and anger welled up inside of me. But then looking at me she said, “Paul, I want you to know that I have forgiven this man for all these terrible things. It took a long time, but I no longer have anger or vengeance in my soul. You have to convince Sierra Leoneans who suffered that the only way to a lasting peace is also to forgive.. no matter how hard it is and no matter how long it takes.”

She knows the real meaning of Jesus’ answer, “I tell you, not seven times, but seventy times seven”.

Question for discussion

1. After reading the Bible passage and this reflection, ask yourself, “How can I be a forgiving peacemaker in my life situation?”
The World Council of Churches (WCC) has highlighted the serious consequences of the Trade Related Intellectual Property Rights (TRIPS) on the majority of the world’s population. Several WCC publications focused on the advent of global capitalism, and the trade related agenda at the centre of the World Trade Organization (WTO).

The WCC was not alone in calling for a new look at WTO and TRIPS. Three organizations, Health Action International (HAI), of which the Pharmaceutical Programme of the WCC is a member), Médecins sans Frontières (MSF) and Consumer Project on Technology (CPT) took the lead in the campaign to increase access to essential drugs.

**Why campaign to increase access to essential drugs?**

Right from the beginning, experts had predicted negative consequences of TRIPS. Protecting drug patents does not promote investment in pharmaceuticals.

The gravest concern was on access to drugs. Even without TRIPS, about 50% of the planet’s population lacked access to essential drugs (ED). The TRIPS agreement requires all WTO members, even poor countries, to have 20-year patents on new pharmaceutical inventions, up from a maximum of 10-15 years earlier.

**Medicines: beyond reach**

For 20 years the pharmaceutical company launching a new product can monopolize the market. As there is no competition, monopolies can seek high prices. And the high prices will prevent essential drugs from reaching those who need them.

Some essential drugs of critical importance to poor patients in developing countries will be in short supply and be very expensive. For example, in these countries, infectious diseases are main killers. The mainstream treatment is antimicrobial agents. Yet resistance to almost all currently available and accessible antibiotics has been reported throughout the world. In some cases as much as 97% of the samples tested for sensitivity have shown resistance.

New antibiotics will be needed. Access to these essential drugs will be affected.

Even today’s available treatments and research innovations are beyond reach for poor people. A year’s supply of medicines for AIDS costs about US$ 15,000 per year! Exorbitant in the North, unattainable in developing world!

In some cases, older medications thought to be unnecessary in the First World and commercially unviable in the Third World, have been withdrawn from the market, e. g. drugs for tuberculosis. In Russia, medicines to treat drug-resistant TB cost about US$ 6,000. The drugs would be almost 10 times cheaper if generic versions of the drugs were made available.

**The campaign so far**

The campaign has provided a forum to exchange of information and experiences. The first conference held in Geneva in March 1999 raised awareness on the possibilities open to developing countries in implementing TRIPS.
Several conference participants returned to their own countries and demanded the use of legal means to increase supply of affordable essential drugs. There was also a call for the WHO to take the lead in assisting countries in analyzing the implications of the World Trade Organization (WTO) on the public health. These discussions may have contributed to the unanimous passage by the World Health Assembly of a resolution (WHA 52.19) that gave WHO a mandate to monitor the health implications of trade agreements and to provide assistance to countries in implementing trade regulation while protecting public health.

The second meeting held in November 1999 in Amsterdam, organized by HAI/MSF/CPT in the week before the WTO ministerial assembly in Seattle brought together about 300 health advocates and public health professionals from NGOs, international organizations, WHO, governments, academicians and the pharmaceutical industry. The focus was on increasing access to essential drugs in a globalized economy. The participants called for public interest rather than commercial concern to be the key motive in international trade.

In an open letter to WTO member countries, participants outlined several possible actions and strategies to redress the negative effects of the agreement. A delegation representing the three organizers and their coalition partners followed up these proposals in Seattle.

The coalition welcomed President Clinton’s speech raising health as a critical issue on the WTO agenda and also the change in US trade policy, to support greater access to lifesaving medicines.

Which way forward?

The US policy change is an important first step, but much more needs to be done. Action must follow words and health concerns must be integrated into the WTO rules. The HAI/MSF/CPT coalition has sought the creation of a WTO Standing Working Group on Access to Drugs to review intellectual property rules related to access to drugs. The working group would also help developing countries use the existing provisions within TRIPS to protect health.

The failure of the WTO Seattle gives developing countries more opportunity to make sure their interests are considered. Much will depend on the next five years. Developing countries, if required, must change their domestic laws, to provide for compulsory licensing and parallel imports and make effective international alliances.

**Access to Drugs**

The working group would also help developing countries use the existing provisions within TRIPS to protect health.

**Practical action areas**

Each individual can defend everyone’s right to enjoy good health, including access to drugs. We can:

- take an informed stand.
- understand the issues, inform others and garner support.
- participate in both local and international meetings. Meetings provide information, they enable opinion sharing and adds a voice.
- research to provide evidence of the effects of the globalization. This can range from recording changes in drug prices to comparing the pricing of different supplies and manufacturers.
- intensively raise awareness on consumer rights and mobilize consumers to demand equity, and to protect local traditional and herbal medicines. Communities are strong latent powers that have yet to be mobilized in this issue. Drugs save lives; we must not allow them to be treated merely as products of commerce.
LETTERS

Chewing stick and AIDS

Is the chewing stick widely used in Africa, safe? If a person with AIDS contaminates the stick could not another user of the same stick get infected through his or her injured gums? Is it not possible that the mosquito or bed bug can spread AIDS? I would be happy to have any relevant material concerning AIDS.

I would also be grateful if you could help me procure a hospital laboratory microscope.

Sule Mohammad
Kadara Clinic, P.O. Box 137, Bawku, U.E.R., Ghana, West Africa

Manoj Kurian responds:
Thank you for your questions about aspects of transmission of HIV/AIDS in the communities. If a chewing stick is shared and if the person who used it first is infected with HIV and has bleeding gums, there is a possibility of transmission of the disease (however remote) to the next user. Usually where each person keeps his or her chewing stick separately there is no danger of transmitting various oral infections.

Mosquito bite does not spread HIV/AIDS.

We have sent some copies of HIV/AIDS education material for you and for you to share in the community.

ANNOUNCEMENTS

The Fifth Global Conference on Health Promotion

The Conference to be held at Mexico City, 5-9 June, 2000 is structured around successful and effective case studies, which highlight how health promotion strategies add to the effectiveness of health and development policies, programmes and projects.

WHO is looking for case studies to showcase at the Conference which demonstrate how health promotion projects have improved health and wellbeing, particularly among vulnerable groups of people. At the Fourth Conference held in Jakarta in 1997 in Jakarta, domestic and civil violence was shown to be one of the most crucial determinants of health.

NGOs are particularly encouraged to participate in the conference organized by the Mexican Government, World Health Organization and the Pan-American Health Organization (PAHO).

Contact: Joanna Koch, Fax 41-1-715413, E-mail: joannakoch@gmx.net

Consultation on health, faith and healing

Healing experiences and the role of faith have acquired growing importance. Based on the long tradition of WCC’s former Christian Medical Commission work with questions of health, religion and healing, about thirty theologians, health professionals and others involved in health care activities will share individual and community experiences of healing at an international consultation at Hamburg, Germany from June 5-9, 2000.

The consultation, organized by the Mission and Evangelism Team of the WCC and the Academy of Mission at the University of Hamburg, will deal with issues such as: healing in mission, in charismatic churches and movements and in indigenous cultures; interdisciplinary dialogue on faith and healing, and local congregations as healing communities.