

WHO Thematic Paper on Health and Peace



I. Background: Linkages Between Health and Peace

- A. **Armed conflicts and violence have obvious impacts on health.** Conflict cause direct, violent deaths among civilians and combatants alike, and lead to physical and mental disabilities. Conflicts disrupt health systems, disrupt/interfere with medical supply chains, break social systems, and cause health care workers to leave and upsurges in both epidemics and starvation. As a result, rates of infant mortality, sexual violence, and mental disorders such as depression, anxiety, and post-traumatic stress disorders increase significantly. Since the Ottawa Charter for Health Promotion (1986), peace is the first cited in a list of fundamental conditions for health.
- B. **The lack of access to healthcare fuels conflicts.** For specific population groups (e.g. ethnic, regional, religious) the lack of access to health leads to feelings of exclusion and sentiments of unfair treatment by the government. It also generates perceptions of unequal treatment vis-à-vis other groups. In many contexts, these inequities (either through discrimination, marginalization, poor governance systems, or lack of government capacity) lead to grievances, which in turn boil over into protests and later violence. Taking it negatively, health is a key driver and a root cause of conflict. But taking it positively, health is also viewed as a superordinate goal for all sides of a conflict. This in practice allows health initiatives to serve as a neutral starting point for bringing together rival parties as they work towards mutually beneficial objectives.
- C. **Shifting operational landscape:** The scale, nature, and complexity of conflicts have changed, with more violent intra-state conflict over the last few decades. 1.8 billion people live in fragile, conflict affected and violent settings (FCV). It is estimated that by 2030, at least half of the world's poor people will live in FCV countries. In these contexts, weak health systems are unable to meet the health needs of populations. Violent conflicts today are also complex and protracted, involving more non-state groups and regional and international actors. This complexity has made such conflicts resistant to political resolution, often further complicated by failing infrastructure, disrupted public services, chronic hardship and poverty. This increased complexity has made conflicts resolution more complicated and led to a call for renewed conflicts prevention.

II. Health and Peace: a global accountability

A. **Accountability for the UN.** UN peacebuilding and health actors are mutually accountable to each other: UN Member States requested this in the resulting outcomes of several key mandates-setting multilateral processes which form the basis for today's humanitarian-development-peacebuilding nexus, as well as the UNSG prevention agenda.

- **Development mandate – interdependence between SDG 16 and SDG 3:** the 2030 Agenda for Sustainable Development is underpinned by the recognition that progress towards all SDGs are interdependent. SDG 16, which sets out to “promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels” is particularly at risk of not being achieved. With regards to public health, this implies that public institutions must be built in an effective and inclusive manner if they are to implement fair health policies and deliver quality healthcare to reach the various health-related targets of SDG 3.
- **Humanitarian mandate – address root causes and vulnerabilities.** In humanitarian action, the Agenda for Humanity endorsed at the 2016 World Humanitarian Summit calls on global leaders and humanitarian actors to act upon five core responsibilities, the first being peace-related. It underlines that alleviating human suffering requires political solutions, unity of purpose and sustained leadership, and investment in peaceful and inclusive societies.
- **Peacebuilding mandate – sustaining peace as cross-UN responsibility.** The landmark 27 April 2016 resolutions by the UN General Assembly and Security Council on the UN peacebuilding architecture review introduced the concept of “sustaining peace”. They place the prevention of violent conflicts and the need to address their root causes and drivers at the core of the efforts of the United Nations. As a shared responsibility, it must be integrated into the work of all UN entities. To achieve this, UN Agencies, Funds and Programmes shall conduct joint analysis to have a shared understanding of conflict drivers, define collective outcomes, and strategically plan together actions that directly aim at or contribute to sustaining peace.

B. **Accountability for WHO:** WHO defined its 13th Global Programme of Work (GPW 13) for 2019-2023 around 3 mutually-interdependent objectives, which offer plenty of opportunities for promoting sustaining peace:

- **1 Billion more people achieving Universal Health Coverage (UHC).** Working towards universal health coverage (UHC) for all, including the poorest and most marginalized, is a major contribution to more inclusive societies and a key factor for sustainable peace.
- **1 Billion more people protected from health emergencies.** When health emergencies occur in fragile and conflict settings, interventions that prevent health systems collapse and that rebuild them have a knock-on effect of preventing the lack of access to health from becoming a driver of grievances and further unrest.

- **1 Billion more people with improved health and well-being.** Healthier populations can participate more actively in their community and society and be more constructively involved in post-conflict reconciliation processes.

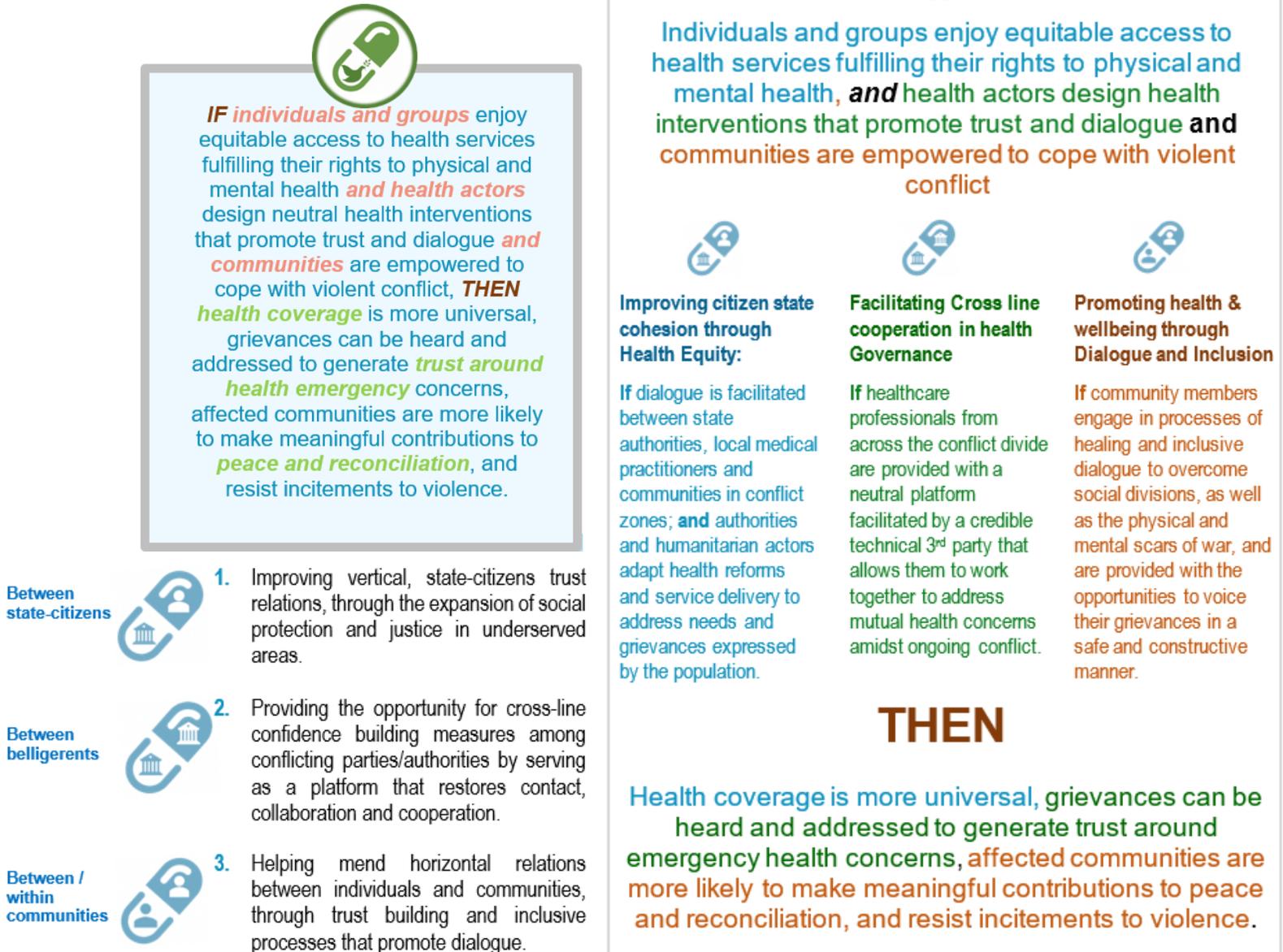
The following section further elaborates on the relationship between health and peace, and how health and peace programming can be tied to specific WHO GPW 13 outputs (see Programmatic overview graph in annex / picture 4).

III. Key Concepts and Theory of Change underpinning Health and Peace:

A. Theories of Change

In relation to the global accountability explained in the previous chapter, WHO developed a global Theory of Change (ToC) underpinning how health programming could support the attainment of peace outcomes, as seen in picture 1 below:

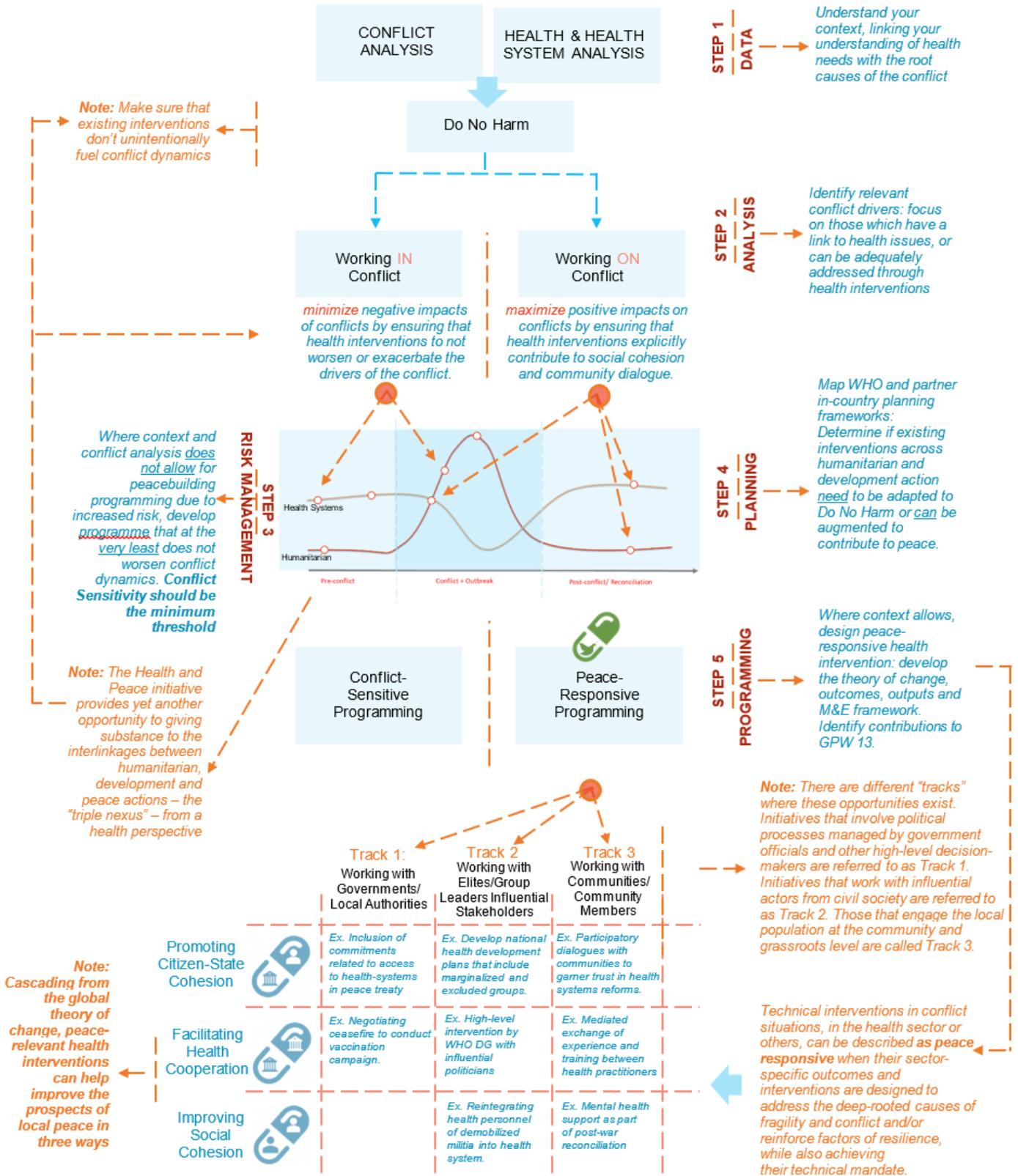
PICTURE 1: Global Theories of change



B. Programmatic approach

Picture 2 below represents a possible practical step-by-step programmatic approach to design health and peace programmes in countries:

PICTURE 2: programmatic approach:



IV. Demonstrating Impact – country examples

These examples do not represent an exhaustive list of country examples where health and peace activities take place but they are indicative of the relevance of health and peace programmes.

- A. **Ukraine:** WHO works with UN partners at overturning two underlying conflict drivers. On the one hand the lack of practical and tangible trust-building and dialogue-making opportunities: WHO generates opportunities through improved people-to-people connectivity and mediated and direct professional health dialogues and joint achievements. And on the other hand, the strong resentments amongst populations living in the conflict area due to lack of access to healthcare, and amongst the general population of Ukraine regarding a radical but much needed health reform affecting their lives and cultural and social habits. WHO's activities are designed as positive incentives for the larger Ukraine peace process and as prevention requirements to avoid further spread of the conflict.
- B. **Somalia:** WHO, UNICEF, IOM, the Somali National University and the Federal Ministry of Health work together to improve mental health care and psychosocial support (MHPSS) of youth in Somalia. The provision of MHPSS services to targeted youth will lessen the stigma associated with their mental and psychosocial disorders and will reduce their current disenfranchisement and marginalization. The programme aims to enable them to become positive agents of change and social cohesion.
- C. **Sudan:** during the spike in violence early 2019 in Khartoum, WHO targeted violent youth and provided them with opportunities to clean market places from tangible environmental health threats. Similarly, as part of a violence reduction programme in Central Darfur, youth groups at risk of resorting to violence were mobilized by WHO to participate in waste disposal near hospitals. In South and Central Darfur WHO targeted communities antagonistic with each other for decades, and mediated cooperation between them to create local family health units. This activity included the formal signatures of multipartite agreements on land-sharing for establishing these health units.
- D. **Sri Lanka:** As part of the national Peacebuilding Priority Plan, WHO supported the Government in establishing a victim-centred process of accountability, truth-seeking, reparations for past violations with guarantees of nonrecurrence. As part of this plan, WHO provided support to address the psychological impacts of the conflict on women, children and persons with conflict-related disabilities.
- E. **Tunisia:** In post-revolutionary Tunisia, reforms were required in most key public sectors including health. To break with the past denial of citizen participation in public processes, a "Societal Dialogue for Health System Reform" was launched to capture needs, perceptions and ideas of Tunisians for a new health system. The mechanism genuinely involved all segments of society, to address the lack of confidence between institutions and citizens. This societal dialogue was instrumental in generating trust across all segments of society into the health system reforms and to air past grievances. And beyond health, this activity is still seen today by many Tunisians as one of the key factors at play in the immediate follow-up to the revolution which contributed to pacify an explosive society. It allowed very antagonistic social groups, all political rivals and all social classes to engage together into constructive dialogue over a common public good and it generated goodwill to cooperate towards a common future.

V. Progress across the four core areas of Sustaining Peace

- A. Operational and Policy Coherence:** Throughout the year 2019 several global level initiatives by WHO and other health actors have made efforts to strengthen operational and policy coherence in defining how the health sector can contribute to sustaining peace, and vice-versa:
- a. International Disarmament Demobilisation Reintegration Standards (IDDRS):** The new IDDRS describe how soldiers and combatants shall be reintegrated into society. The new standards include new approaches such as reintegration of health personnel in demobilized militias into the health system and addressing the post conflict Mental Health and Psychosocial Support needs of combatants.
 - b. Humanitarian-Development-Peace Nexus Collective Outcomes definition:** WHO, along with UNHCR, co-leads the development of a system-wide guidance on Collective Outcomes for the nexus. It is widely recognized that the current articulations of collective outcomes are not peace-responsive and do not reflect conflict sensitivity well. WHO, in its capacity as co-lead, systematically advocates for integration of Sustaining Peace into Collective Outcomes.
 - c. Technical Meeting on Health and Peace:** In July 2019, WHO organized a two-day technical meeting in Geneva. This brought together technical teams in various health technical areas, health partners such as UNICEF, FAO, MSF, ICRC, MSF, and peacebuilding and mediation actors such as UN DPPA, InterPeace, Geneva Call, the Centre for Humanitarian Dialogue. The technical meeting established a shared understanding on the key principles on how health can contribute to peace and peacebuilding and vice-versa.
 - d. Switzerland/Oman Consultation on Health and Peace:** In November 2019, the Ministers of Health of Switzerland and of the Sultanate of Oman organised a consultation with Member States on health and peace. They also presented a Swiss-Omani statement to promote Health and Peace which welcomes the 2016 resolutions by the UN General Assembly and Security Council on the UN peacebuilding architecture review and recognises the strong linkages between health and peace.
 - e. WHO corporate White Paper:** In December 2019, WHO finalized a corporate white paper on health and peace. This white paper outlines the core elements of peace-responsive health programming, sets-out guiding principles for implementing health interventions in a way that improves social cohesion and the overall prospects of peace. The white paper also promotes integration of sustaining peace into WHO's humanitarian and development interventions.
- B. UN leadership, accountability and capacity:** WHO's global executive management is promoting the concept of sustaining peace and health and peace internally and WHO is also making efforts to promote peace-responsive health programming amongst its regional and country leadership through several accountability and capacity-building efforts:

- a. **WHO's health security council meeting on health and peace:** WHO Director General called on 30 October 2019 a WHO's Health Security Council meeting on health and peace. This internal mechanism gathers WHO headquarters top leadership to review major public health threats or issues. Several action points were decided for follow-up at the highest levels of WHO.
 - b. **WHO Eastern Mediterranean Regional Office (EMRO) health and peace initiative:** WHO EMRO Regional Director officially launched in November 2019 the health and peace regional initiative under his personal patronage and purview, which sets the level of priority for WHO sustaining peace efforts in the region at the highest possible level.
 - c. **Executive Course on Health Diplomacy for Peace Building:** In mid-November 2019, WHO Regional Office for the Eastern Mediterranean developed an executive course for field leaders in Health Diplomacy. The course is a capacity-building initiative for WHO country leaders on conflict analysis, and to enable them to identify programmatic opportunities for peace-dividends in health service delivery.
 - d. **Support to UN Resident Coordinators and their offices:** In some countries WHO Representatives and their teams work with Resident Coordinators and their offices to support their leadership in strengthening the UN sustaining peace positioning and to enable the humanitarian, development, peacebuilding nexus implementation more generally (e.g: Ethiopia, Somalia, Ukraine). However, much efforts are required by the UN system to expand the vision of sustaining peace of UN Resident Coordinators and their offices beyond traditional rule of law and security reforms (cf. recommendations)
- C. **Financing for peacebuilding:** Health and peace interventions are generally very underfunded. The following efforts to address this bottleneck have been done in 2019 or are planned for 2020:
- a. **This thematic paper and the WHO Health and Peace White Paper:** These documents primarily aim at promoting operational and policy coherence by establishing programmatic directions and justification for health and peace programming. However, both documents can be used as sensitization pieces with Donors to establish the role of health in peacebuilding.
 - b. **Internal promotion of participation by WHO country teams into UN peacebuilding programmatic designs:** Internally WHO HQ and WHO ROs have encouraged WHO country teams to participate and be propositional in UNCTs to development health and peace programmes under UN umbrella in countries. The results are still limited but some success is to be noted (e.g: Somalia with the first WHO-led PBF programme accepted). More will be done in 2020 but motivation from WHO country teams to engage will also depend on UNRCs and RCOs' support (cf recommendations).
 - c. **Global, regional and country-specific briefings to Donors planned for 2020**

- D. Partnerships:** Multilateralism and partnerships are at the core of the sustaining peace agenda and by extension of the health and peace agenda. The following progress in partnerships-building and partnerships reinforcing can be reported.
- a. Full alignment with the UN system positions and strategies:** In all countries where health and peace programmes are taking place they are conceptualized and implemented in full alignment with the UN system strategies and in close consultations with RCOs and PDAs.
 - b. Humanitarian-Development-Peacebuilding nexus:** Health actors have a role to play to promote system-wide coherence, and Health and Peace programmes provide an opportunity to give substance to the so-called “triple nexus”, as many health actors naturally work across all three dimensions. WHO believes in such coherence and volunteered with UNHCR to co-lead the development of a light guidance on collective outcomes, on behalf of the UN Joint Steering Committee and the IASC Results Group on the nexus.
 - c. Operational partnerships:** Partnerships and cooperation at global and country levels are being established between UN Agencies (e.g: DPPA at global policy level, UNICEF in South Sudan, OHCHR and UNHCR in Ukraine, UNICEF and IOM in Somalia, etc) as well as with specialized peacebuilding actors (eg: Conflict Analysts Network, Interpeace, International Peace Institute, HD Centre at global level; Interpeace, International Alert, Institute for Peace and Common Ground in Ukraine), and with research institutions (eg: Institut de Recherche et de Développement, Manchester University). WHO and health actors require specialized peacebuilding, mediation, and conflict analysis expertise to develop good health and peace programmes. And vice-versa, peacebuilding partners will benefit from the scientific rigour of public health research and assessment methodologies to improve peacebuilding programmes which are currently assessed as weak in establishing actual attribution.

VI. Challenges and Recommendations:

A. Challenges

- a. **Centrality of social services is not well reflected in Sustaining Peace policy, programming and financial tracking systems:** Most conflict contexts are borne out of long standing grievances due to social injustices, marginalization, and targeted and/or historical discrimination. Some root and proximate causes of these conflicts are based on inequities/grievances about basic services, including health. However, peacebuilding policy and programming keep on focusing on areas such as security sector reforms, demobilization of soldiers, demining, and rule of law. It is imperative that space is afforded for contributions by social sectors to peacebuilding. In addition, the tracking of peacebuilding funding by OECD Donors (cf OECD DAC State of Fragility 2018) also reflects this reality: peacebuilding budget codes don't make any space for social sectors. Even budget code 15220 (civilian peacebuilding) when looking at the subcategories identified by the Institute for Economics and Peace are all focused on rule of law promotion and don't make any space for health and peace activities. This creates disincentives to peacebuilding donors to invest (cf picture 3).

Picture 3:

	DOMAIN	NUMBER	CATEGORY DESCRIPTION	CRS CODE
CORE PEACE-BUILDING	1. Basic safety and security	1.1	Security system management and reform	15210
		1.2	Reintegration and SALW control	15240
		1.3	Removal of land mines and explosive remnants of war	15250
		1.4	Child soldiers (prevention and demobilization)	15261
		1.5	Participation in international peacekeeping operations	15230
	Other		Other specific peace-related expenses	
		2.8	Civilian peacebuilding, conflict prevention and resolution	15220
SECONDARY PEACE-BUILDING	2. Inclusive political processes	2.1	Legal and judicial development	15130
		2.2	Legislatures and political parties	15152
		2.3	Anti-corruption organisations and institutions	15113
		2.4	Democratic participation and civil society	15113
		2.5	Media and free flow of information	15153
		2.6	Human rights	15160
		2.7	Women's equality organisations and institutions	15170
	3. Core government functions	3.1	Public sector policy and administrative management	15110
		3.2	Public finance management	15111
		3.3	Decentralisation and support to subnational government	15112

- b. **Insufficient incentive structures and process-flow for UN Peacebuilding Fund (PBF) proposals:** the PBF has grown in stature and importance, cementing itself as a critical catalyst for developing innovative multi-sectoral peacebuilding programming. However, the PBF incentivizes competition amongst UNCT Members with limited envelope to be shared amongst a maximum of 3 to 4 Agencies, irrespective of the peacebuilding objectives to be met, and with no clear characterisation of comparative advantages. In addition, RC/HCs most often rigidly prioritise "historical" implementers of PBF programmes (UNDP and one or two other UN partners in most contexts) and these actors in turn are reluctant to give away financial space. These issues create brick-walls challenging the access to PBF programming and funding for technical Agencies such as WHO. In practice, this means that technical health agencies are disincentivized to engage in time-consuming PBF programmes which often result in refusals or even non-consideration from the get-go.

- c. **Lack of “bilingual” staff in health and peacebuilding in international organisations and donors portfolio managers:** The peacebuilding and the health communities are most largely disconnected and unaware of the potential for peacebuilding of the health sector as the former is overly focused on rule of law and governance, and the latter often doesn’t consider the bigger picture beyond clinical and public health outputs.

B. Recommendations

a. To UN DPPA:

- i. **Continue to support global policy development and programmatic operational framing** for health and peace
- ii. **Facilitate initial PBF engagement by technical health Agencies** but also more largely of social sectors into PBF programmes. The New York PBF team could work with WHO and selected RCs to initiate special projects in countries with high potential, and/or could send a global advisory to all UNRCs sensitizing them to the high potential of health for sustaining peace and encouraging them to propose project proposals in this area.
- iii. **Identify best practices in countries and document them**, in partnership with WHO and other technical health Agencies.
- iv. **Improve peacebuilding monitoring and evaluation systems by using public health methodologies** Eg: epidemiology applied to conflict analysis (epidemiology of hate), randomized controlled trials to demonstrate peacebuilding results and prove attribution.

b. To UNDCO:

- i. **Promote the triple nexus in countries**, with special attention to sustaining peace, to go beyond the current neglect for the peace dimension in nexus efforts by UNCTs.
- ii. **Promote the use by UNCTs of the forthcoming UN/IASC guidance on collective outcomes** for developing CCA/UNSDCF.
- iii. **Share with UNRCs, RCOs, PDAs this thematic paper and/or the WHO white paper** to sensitize them to the potential of health and peace programmes for sustaining peace.

c. To UNRCs, RCOs, Peace and Development Advisors:

- i. **Encourage WHO teams to develop health and peace programmes**, and more generally train/sensitize health actors in country into peacebuilding programmes

d. To the OECD DAC:

- i. **Review the coding of peacebuilding expenditures** to allow explicitly health and peace programming to be coded as peacebuilding investments

e. To the UN Peacebuilding Commission:

- i. **Organise thematic meetings on health and peace** to review progress made by Members States and by UN Organizations, with tracking systems for progress.

- f. **To International Donors:**
 - i. **Support financially** global, regional, and/or country health and peace programmes development
- g. **To International Financial Institutions:**
 - i. **Soften the conditioning of loans for macro-economic stabilization by introducing conditions of equitable access to essential services** such as health, if necessary with third party monitoring of success with organizations such as WHO.

- h. **To research institutions (Interpeace, IEP, IPI, IRD, SIPRI, others):**
 - i. **Undertake quantitative and qualitative research** on peace dividends of health programmes, health dividends of peacebuilding programmes, and interlinkages between health and conflict more generally.

Annex: (Picture 4): Indicative menu of possible health and peace interventions

Legend:

 WHO GPW13 output reference

2nd Level Theories of Change and Associated Programmatic Entry points



IMPROVING CITIZEN-STATE COHESION THROUGH HEALTH:

Conflict Factors/
Dynamics

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

Theory of Change

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

Policy dialogue and recommendations by WHO to MoH to address requirements of most dissatisfied populations, and support to implement recommendations.

1.1.3

Healthcare delivery by Government, WHO and humanitarian partners to affected communities, based on participatory needs assessment and essential health package of services.

1.1.1

2.3.3

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

1.5.5

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

1.1.4



FACILITATING CROSS-LINE COLLABORATION IN HEALTH

Conflict Factors/
Dynamics

Mistrust between conflict parties stemming from issues related to religion, ethnicity, and/or other differences are politicized; disputes over limited resources;

Theory of Change

If healthcare professionals from across the conflict divide are provided with a neutral platform facilitated by a credible technical 3rd party that allows them to work together to address mutual health concerns amidst ongoing conflict, **then** mutual understanding and cooperation can be fostered to prepare and respond to health emergencies, and cooperation/dialogue on broader health system and more sensitive, political issues can be encouraged.

2.1.2

WHO-facilitated dialogues bringing together health professionals belonging to all conflict parties on communicable diseases and IHR.

2.2.2

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

2.1.2

Health Mediation: participatory peacebuilding approaches to improve trust in communities and negotiate access to hard to reach areas.

2.2.2

Cross-lines health service delivery facilitated by WHO (e.g. patient referrals, delivery of medication), benefitting the local communities affected by the conflict and/or stopping transmission of diseases.

2.3.2

2.3.3

2.2.4



PROMOTING HEALTH & WELLBEING THROUGH DIALOGUE & INCLUSION

Conflict Factors/
Dynamics

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

Theory of Change

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

3.1.1

Expansion of coverage of MHPSS services through MHGap promotion and capacity-building of national mental health networks

1.1.2

Improve access to rehabilitation services. Including for conflict victims

4.2.6

Meet the needs of persons with disability through access promotion

1.5.5

Reintegrate health personnel from demobilized militias back into the health system by supporting governments and civil society in post conflict settings

3.2.2

Group-focused mental health interventions, such as interpersonal group therapy, or community healing dialogues to promote community dialogue

3.1.1